HOUSE OF REPRESENTATIVES
TWENTY-FIFTH LEGISLATURE, 2010
STATE OF HAWAII

H.B. NO. 2335

A BILL FOR AN ACT

RELATING TO THE FAIR ACCESS TO MEDICAL CARE ACT.

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

SECTION 1. The purpose of this Act is to ensure that health insurance rates adequately reflect the need to provide an effective treatment of an illness or injury that is administered in accordance with a reasonable standard of care and generally accepted medical practices and to prevent the manipulation of treatment and care standards in a manner that would maximize an insurer's rate of return while diminishing an insured's access to care.

This Act shall be known and may be cited as the Fair Access to Medical Care Act.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 14G to be appropriately designated and to read as follows:

"**§431:14G- Health care treatment advisory panel.** (a) There is established the health care treatment advisory panel. For administrative purposes only, the panel shall be assigned to the department of commerce and consumer affairs. The panel

shall review all rate filings for accident and health or sickness insurance to ensure that the filing provides for adequate treatment to ensure that consumers receive appropriate levels of treatment that are in accord with a reasonable standard of care and generally accepted medical practices to effectively recover from an injury or illness.

(b) The panel shall consist of fifteen members to be appointed without regard to section 26-34 as follows:

(1) One person licensed by the Hawaii medical board who practices medicine in the area of general medicine or adult internal medicine and is appointed by the president of the senate;

(2) One person licensed by the Hawaii medical board who practices medicine in the area of obstetrics and gynecology and is appointed by the speaker of the house of representatives;

(3) One person licensed by the Hawaii medical board who practices medicine in the area of pediatric medicine and is appointed by the president of the senate;

(4) One person licensed by the Hawaii medical board who practices medicine in the area of geriatric medicine

and is appointed by the speaker of the house of representatives;

(5) One person licensed by the Hawaii medical board who practices medicine in the area of operative surgery and is appointed by the president of the senate;

(6) One person who is licensed as a registered nurse or is granted recognition as an advanced practice registered nurse and is appointed by the speaker of the house of representatives;

(7) One person who is licensed as a physical therapist by the board of physical therapy and is appointed by the president of the senate;

(8) One person who is registered as an occupational therapist by the department of commerce and consumer affairs and is appointed by the speaker of the house of representatives;

(9) One person who is licensed as a mental health counselor by the department of commerce and consumer affairs and is appointed by the president of the senate;

(10) One person who is licensed as a naturopathic physician by the board of naturopathic medicine and is appointed by the speaker of the house of representatives;

(11) One person who is licensed to practice chiropractic by the board of chiropractic examiners and is appointed by the president of the senate;

(12) One person who represents the public health nursing services program and is appointed by the speaker of the house of representatives;

(13) One person who represents essential community providers as defined in section 321-1.6 and is appointed by the president of the senate;

(14) One person who is a member of the corporation board of the Hawaii health systems corporation and is appointed by the speaker of the house of representatives; and

(15) One person who is a member of the public at large and is appointed by the director of commerce and consumer affairs; provided that the public member shall not be an officer or employee of the State or its political subdivisions.

The members of the health care treatment advisory panel shall serve without compensation, but shall be reimbursed for

necessary expenses incurred in the performance of their duties, including travel expenses. The chairperson of the panel shall be elected by the members from among their membership. A majority of the members of the panel shall constitute a quorum for the conduct of business of the panel. A majority vote of the members present at a meeting at which a quorum is established shall be necessary to validate any action of the panel.

(c) The panel shall convene within thirty days of notification of a new rate filing by the commissioner, as provided in section 431:14G-105(c), and shall review each filing and issue findings to the commissioner; provided that if more than one rate filing is submitted to the commissioner in a thirty-day period, the panel may review and issue findings regarding multiple filings at a single meeting. In reviewing rate filings, the panel shall determine whether a rate adequately provides for the effective treatment of an injury or illness according to a reasonable standard of care and generally accepted medical practices and shall issue a finding as to whether the proposed rate adequately provides for such care. If the panel finds that a rate filing is inadequate, the commissioner shall disapprove the rate filing as provided in

section 431:14G-105(j). If the panel does not have sufficient information to issue a finding of adequacy of a rate, the commissioner may require that the managed care plan furnish additional information pursuant to section 431:14G-105(e).

(d) In reviewing rate filings, the panel may consider any outside information that the panel finds to be appropriate, including but not limited to professional or academic publications, expert opinions or testimony, recommended standards of care published by professional organizations, industry best practices, and the policies of other jurisdictions.

(e) The panel shall adopt rules in accordance with chapter 91 for its governance.

(f) The department of commerce and consumer affairs shall provide staff and other support required by the panel for the performance of its duties."

SECTION 3. Section 431:13-108, Hawaii Revised Statutes, is amended to read as follows:

"**§431:13-108 Reimbursement for accident and health or sickness insurance benefits.** (a) This section applies to accident and health or sickness insurance providers under part I of article 10A of chapter 431, mutual benefit societies under

article 1 of chapter 432, dental service corporations under chapter 423, and health maintenance organizations under chapter 432D.

(b) Unless shorter payment timeframes are otherwise specified in a contract, an entity shall reimburse a claim that is not contested or denied not more than thirty calendar days after receiving the claim filed in writing, or fifteen calendar days after receiving the claim filed electronically, as appropriate.

(c) If a claim is contested or denied or requires more time for review by an entity, the entity shall notify the health care provider in writing or electronically not more than fifteen calendar days after receiving a claim filed in writing, or not more than seven calendar days after receiving a claim filed electronically, as appropriate. The notice shall identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may request additional information; provided that a notice shall not be required if the entity provides a reimbursement report containing the information, at least monthly, to the provider.

(d) Every entity shall implement and make accessible to providers a system that provides verification of enrollee eligibility under plans offered by the entity.

(e) If information received pursuant to a request for additional information is satisfactory to warrant paying the claim, the claim shall be paid not more than thirty calendar days after receiving the additional information in writing, or not more than fifteen calendar days after receiving the additional information filed electronically, as appropriate.

(f) Payment of a claim under this section shall be effective upon the date of the postmark of the mailing of the payment, or the date of the electronic transfer of the payment, as applicable.

(g) Notwithstanding section 478-2 to the contrary, interest shall be allowed at a rate of fifteen per cent a year for money owed by an entity on payment of a claim exceeding the applicable time limitations under this section, as follows:

(1) For an uncontested claim:

(A) Filed in writing, interest from the first calendar day after the thirty-day period in subsection (b); or

(B) Filed electronically, interest from the first calendar day after the fifteen-day period in subsection (b);

(2) For a contested claim filed in writing:

(A) For which notice was provided under subsection (c), interest from the first calendar day thirty days after the date the additional information is received; or

(B) For which notice was not provided within the time specified under subsection (c), interest from the first calendar day after the claim is received; or

(3) For a contested claim filed electronically:

(A) For which notice was provided under subsection (c), interest from the first calendar day fifteen days after the additional information is received; or

(B) For which notice was not provided within the time specified under subsection (c), interest from the first calendar day after the claim is received.

The commissioner may suspend the accrual of interest if the commissioner determines that the entity's failure to pay a claim

within the applicable time limitations was the result of a major disaster or of an unanticipated major computer system failure.

(h) Any interest that accrues in a sum of at least $2 on a delayed clean claim in this section shall be automatically added by the entity to the amount of the unpaid claim due the provider.

(i) No entity shall reduce the rate of reimbursement to a provider purely for the purpose of realizing a higher rate of return to the entity.

[~~(i)~~] (j) In determining the penalties under section 431:13-201 for a violation of this section, the commissioner shall consider:

(1) The appropriateness of the penalty in relation to the financial resources and good faith of the entity;

(2) The gravity of the violation;

(3) The history of the entity for previous similar violations;

(4) The economic benefit to be derived by the entity and the economic impact upon the health care facility or health care provider resulting from the violation; and

(5) Any other relevant factors bearing upon the violation.

[~~(j)~~] (k) As used in this section:

"Claim" means any claim, bill, or request for payment for all or any portion of health care services provided by a health care provider of services submitted by an individual or pursuant to a contract or agreement with an entity, using the entity's standard claim form with all required fields completed with correct and complete information.

"Clean claim" [~~means~~]:

(1) Means a claim in which the information in the possession of an entity adequately indicates that:

[~~(1)~~] (A) The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract;

[~~(2)~~] (B) The claim has no material defect or impropriety;

[~~(3)~~] (C) There is no dispute regarding the amount claimed; and

[~~(4)~~] (D) The payer has no reason to believe that the claim was submitted fraudulently.

[~~The term does~~]

(2) Does not include:

[~~(1)~~] (A) Claims for payment of expenses incurred during a period of time when premiums were delinquent;

[~~(2)~~] (B) Claims that are submitted fraudulently or that are based upon material misrepresentations;

[~~(3)~~] (C) Medicaid or Medigap claims; and

[~~(4)~~] (D) Claims that require a coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability.

"Contest", "contesting", or "contested" means the circumstances under which an entity was not provided with, or did not have reasonable access to, sufficient information needed to determine payment liability or basis for payment of the claim.

"Deny", "denying", or "denied" means the assertion by an entity that it has no liability to pay a claim based upon eligibility of the patient, coverage of a service, medical necessity of a service, liability of another payer, or other grounds.

"Entity" means accident and health or sickness insurance providers under part I of article 10A of chapter 431, mutual benefit societies under article 1 of chapter 432, dental service corporations under chapter 423, and health maintenance organizations under chapter 432D.

"Health care facility" shall have the same meaning as in section 327D-2.

"Health care provider" means a Hawaii health care facility, physician, nurse, or any other provider of health care services covered by an entity."

SECTION 4. Section 431:14G-102, Hawaii Revised Statutes, is amended by adding a new definition to be appropriately inserted and to read as follows:

""Panel" means the health care treatment advisory panel established pursuant to section 431:14G- ."

SECTION 5. Section 431:14G-105, Hawaii Revised Statutes, is amended to read as follows:

"[~~§~~]**§431:14G-105**[~~]~~] **Rate filings.** (a) Every managed care plan shall file in triplicate with the commissioner, every rate, charge, classification, schedule, practice, or rule and every modification of any of the foregoing that it proposes to use. Every filing shall state its proposed effective date and shall indicate the character and extent of the coverage contemplated. The filing also shall include a report on investment income.

(b) Each filing shall be accompanied by a $50 fee payable to the commissioner and shall be deposited in the commissioner's education and training fund.

(c) The commissioner shall notify the panel of each filing submitted pursuant to this section within five working days of the filing.

[~~(c)~~] (d) At the same time as the filing of the rate, every managed care plan shall file all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The managed care plan may satisfy its obligation to file supplementary rating and supporting information by reference to material that has been approved by the commissioner. The information furnished in support of a filing may include or consist of a reference to:

(1) Its interpretation of any statistical data upon which it relies;

(2) The experience of other managed care plans; or

(3) Any other relevant factors.

[~~(d)~~] (e) When a filing is not accompanied by supporting information or if the commissioner or the panel does not have sufficient information to determine whether the filing meets the requirements of this article, the commissioner shall require the managed care plan to furnish additional information and, in that event, the waiting period shall commence as of the date the information is furnished. Until the requested information is

provided, the filing shall not be deemed complete or filed and the filing shall not be used by the managed care plan. If the requested information is not provided within a reasonable time period, the filing may be returned to the managed care plan as not filed and not available for use. Rates shall be open to public inspection upon filing with the commissioner; provided that the commissioner establishes rules to ensure that confidential and proprietary information is protected and shall not be subject to public inspection.

[~~(e)~~] (f) Rates shall be established in accordance with actuarial principles, based on reasonable assumptions and reasonable standards of care and generally accepted medical practices, and supported by adequate supporting and supplementary rating information. After reviewing a managed care plan's filing, the commissioner may require that the managed care plan's rates be based upon the managed care plan's own loss and expense information.

(g) The commissioner shall review any rate filing that includes a reduction in the rate of reimbursement to ensure that any reduction is based on good cause. For the purposes of this subsection, good cause shall mean a demonstrable decrease in the

cost of providing a service or the correction of historical overpayment for a service.

[~~(f)~~] (h) The commissioner shall review filings promptly after the filings have been made to determine whether the filings meet the requirements of this article.

[~~(g)~~] (i) Except as provided herein, each filing shall be on file for a waiting period of sixty days before the filing becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the managed care plan that made the filing, that the commissioner or the panel needs the additional time for the consideration of the filing. Upon written application by the managed care plan, the commissioner may authorize a filing that the commissioner has reviewed, to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner, as provided in section 431:14G-107, within the waiting period or any extension thereof. The rates shall be deemed to meet the requirements of this article until the time the commissioner reviews the filing and so long as the filing remains in effect.

[~~(h)~~] (j) If the commissioner or the panel finds that a filing does not meet the requirements of this article, the commissioner, as provided in section 431:14G-107, shall send the managed care plan a notice of disapproval within the applicable sixty-day period or fifteen-day extension provided by subsection [~~(g).~~] (i).

[~~(i)~~] (k) The commissioner, by written order, may suspend or modify the requirement of filing as to any class of health insurance, subdivision, or combination thereof, or as to classes of risks, the rates which cannot practicably be filed before they are used. The order shall be made known to the affected managed care plan. The commissioner may make examinations that the commissioner deems advisable to ascertain whether any rates affected by the order meet the standards set forth in section 431:14G-103.

[~~(j)~~] (l) No managed care plan shall make or issue a contract or policy except in accordance with filings that are in effect for the managed care plan as provided in this article.

[~~(k)~~] (m) The commissioner may make the following rate effective when filed: any special filing with respect to any class of health insurance, subdivision, or combination thereof

that is subject to individual risk premium modification and has been agreed to under a formal or informal bid process.

[~~(l)~~] (n) For managed care plans having annual premium revenues of less than $10,000,000, the commissioner may adopt rules and procedures that will provide the commissioner with sufficient facts necessary to determine the reasonableness of the proposed rates without unduly burdening the managed care plan and its enrollees; provided that the rates meet the standards of section 431:14G-103.

[~~(m)~~] (o) Subsections (a) through [~~(l)~~] (n) shall not apply to third party administrator services, prepaid dental insurance offered by managed care plans, prepaid vision insurance offered by managed care plans and disability insurers licensed under chapter 431. For managed care plans with rates based totally or in part on the individual group's claims experience, insurers subject to this subsection shall submit to the commissioner for approval descriptions of the methodology to be used in creating rates and every modification thereof that it proposes to use. The description of methodology shall contain specific information allowing a determination of rates that meet the standards of section 431:14G-103(a) and supporting information and justification. Every filing shall state its

proposed effective date and shall indicate the character and extent of the coverage contemplated. Complete supporting and supplementary rating information for rates shall be maintained and made available to the commissioner upon request."

SECTION 6. Section 431:14G-107, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) If, within the waiting period or any extension of the waiting period as provided in section 431:14G-105, the commissioner or the panel finds that a filing does not meet the requirements of this article, the commissioner shall send to the managed care plan that made the filing, written notice of disapproval of the filing specifying in what respects the filing fails to meet the requirements of this article, specifying the actuarial, statutory, and regulatory basis for the disapproval, including an explanation of the application thereof that resulted in disapproval, and stating that the filing shall not become effective."

SECTION 7. There is appropriated out of the compliance resolution fund established pursuant to section 26-9, Hawaii Revised Statutes, the sum of $ or so much thereof as may be necessary for fiscal year 2010-2011 to carry out the purposes of this Act, including the hiring of necessary staff.

The sum appropriated shall be expended by the department of commerce and consumer affairs.

SECTION 8. The director of commerce and consumer affairs shall report to the legislature no later than sixty days before the commencement of the 2016 regular session on the implementation of this Act. The report shall include information on the rate filings approved and disapproved by the health care treatment advisory panel, the cost of the operations of the health care treatment advisory panel, and recommendations as to whether the health care treatment advisory panel should be made permanent after the expiration of the five-year pilot program authorized by this Act.

SECTION 9. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 10. This Act shall take effect on July 1, 2010; provided that:

(1) On December 31, 2016, sections 1, 2, 4, 5, and 6 of this Act shall be repealed and sections 431:14G-102, 431:14G-105, and 431:14G-107(a), Hawaii Revised Statutes, are reenacted in the form in which they read on the day before the approval of this Act; and

(2) Section 431:14G-105(g), Hawaii Revised Statutes, added by this Act regarding the requirement that the insurance commissioner review rate filings that include a reduction in the rate of reimbursement, shall not be repealed when section 431:14G-105, Hawaii Revised Statutes, is reenacted pursuant to this Act.

INTRODUCED BY: Calvin K.Y. Say

BY REQUEST JAN 21 2010

Report Title:
Rate Filings; Accident and Health or Sickness Insurance; Appropriation

Description:
Establishes health care treatment advisory panel which shall review health insurance rate filings to ensure that rates incorporate appropriate levels of health care treatment. Makes appropriation from compliance resolution fund.

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