S.B. NO. 891

JAN 26 2009

A BILL FOR AN ACT

RELATING TO INSURANCE.

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

SECTION 1. Chapter 431, Hawaii Revised Statutes, is amended by adding to part I of article 13 a new section to be appropriately designated and to read as follows:

"**§431:13- Unfair or deceptive acts or practices in the accident and health or sickness insurance business.** (a) This section applies to health care insurers under 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) In addition to acts, methods, and practices generally prohibited by this article, the following are defined as unfair or deceptive acts or practices in the health care insurance business and shall also be prohibited:

(1) Canceling or nonrenewing an enrollment or subscription in a health care plan because of the enrollee's or subscriber's health status or requirements for health care services;

(2) Rescinding or modifying an authorization for a specific type of treatment by a health care provider after the provider renders the health care service pursuant to the authorization;

(3) Changing the premium rates, copayments, coinsurances, or deductibles of a contract after receipt of payment by the health care insurer of the premium for the first month of coverage in accordance with the contract effective date; provided that changes will be allowed if authorized or required in the group contract, or if the contract was agreed to under a preliminary agreement that states that it is subject to the execution of a definitive agreement, or if the health care insurer and the contract-holder mutually agree in writing;

(4) Engaging in post-claims underwriting. As used herein, "post-claims underwriting" means the rescinding, canceling, or limiting of a health care plan contract due to the health care insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the health

care plan contract. This section shall not limit a health care insurer's remedies upon a showing of fraud or wilful misrepresentation; and

(5) Establishing an eligible charge for a nonparticipating health care provider service that is different from the eligible charge paid for the same service rendered by a participating provider. As used herein, "eligible charge" means the amount that is payable by the health care insurer for a treatment, service, or supply prior to making a deduction for cost-sharing.

(c) The commissioner shall notify the health care insurer by certified mail of each consumer or health care provider complaint filed with the commissioner under this section.

(d) A health care insurer shall issue a written response with reasonable promptness, in no case more than fifteen working days, to any notification regarding a consumer or provider complaint or any written inquiry made by the commissioner concerning the health care insurer's business practices pursuant to this section. The response shall be more than an acknowledgment that the commissioner's communication has been received, and shall adequately address the complaint or concerns stated in the communication.

(e) If it is found by the commissioner, after notice and an opportunity to be heard, that a health care insurer has violated this section, each instance of noncompliance may be treated as a separate violation of this section.

(f) Evidence as to numbers and types of complaints to the commissioner against a health care insurer, and the commissioner's complaint experience with other health care insurers, shall be admissible in an administrative or judicial proceeding brought under this section.

(g) This section shall be applicable to every health care insurer except to the extent preempted by federal law."

SECTION 2. New statutory material is underscored.

SECTION 3. This Act shall take effect on July 1, 2009.

INTRODUCED BY: _____

BY REQUEST

S.B. NO. 891

Report Title:
Insurance; Health Insurers

Description:
Amends the unfair or deceptive insurance practices statutes by prohibiting certain unfair or deceptive practices by health insurers.

SB 891

JUSTIFICATION SHEET

DEPARTMENT: Commerce and Consumer Affairs

TITLE: A BILL FOR AN ACT RELATING TO INSURANCE.

PURPOSE: Amends article 13 of the Insurance Code by prohibiting certain unfair or deceptive business practices by health plans.

MEANS: Adds a new section to part I of article 13 of chapter 431, Hawaii Revised Statutes.

JUSTIFICATION: Protects consumers by establishing prohibited practices for health care plans. This bill is based partly on the California managed care plan statutes and accomplishes the following:

- Prohibits disenrollment because of medical condition;
- Prohibits withdrawal of authorization for a procedure by the health plan after the provider has taken action;
- Prohibits contract modifications during the term of the contract, unless such modifications are agreed to in the contract;
- Prohibits post claims underwriting, i.e., ousting an individual from a health plan because the plan discovers a medical condition that they did not know about at the time of underwriting. Health care insurer's remedies for fraud or willful misrepresentation are unaffected;
- Provides that eligible charges for nonparticipating providers should be the same as for participating providers. This will give insureds some protection against the insurer setting unreasonably low and arbitrary eligible charges for nonparticipating providers.

Impact on the public: Adds protection for consumers by allowing action against

insurers by way of complaint or investigation rather than having external review as the only mechanism for redress. Often consumers cannot obtain legal representation for external review appeals.

Impact on the department and other agencies: Gives the Commissioner greater flexibility in addressing consumer grievances. Allows resolution by administrative action without obtaining participation by a physician and an insurance company representative for a three-member external review panel. No impact on other agencies.

GENERAL FUND:	None.
OTHER FUNDS:	None.
PPBS PROGRAM DESIGNATION:	CCA-106
OTHER AFFECTED AGENCIES:	None.
EFFECTIVE DATE:	July 1, 2009.