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.

LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
LT. GOVERNOR

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TO THE SENATE COMMITTEE ON
COMMERCE AND CONSUMER PROTECTION

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Monday, March 2, 2009
10:00 a.m.

TESTIMONY ON SENATE BILL NO. 891 – RELATING TO INSURANCE.

TO THE HONORABLE ROSALYN H. BAKER, 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 defining prohibited practices for health insurers. We believe that these practices are unfair and that if we sought enforcement in the courts, we would obtain favorable court rulings. However, obviously, it is preferable that the Legislature set public policy and it is preferable for insurers to be put on notice as to the practices deemed unfair ahead of time by legislative enactment rather than have to await administrative and court rulings. We view the provisions in this bill protective of consumers' rights, but also the kinds of things that a health plan should not have undue objection to because they are unfair practices that no health plan should be engaged in.

This bill is based partly on the California Knox-Keene Act regulating managed care plans and federal law.

Specifically, this bill:

- Prohibits disenrollment because of medical condition similar to §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 similar to §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 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 as prohibited by §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 $54. 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 practice 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 non-participating provider eligible charges.

Last year, the Department introduced a similar bill which passed both chambers with no opposition and, indeed, with HMSA supporting the measure. However, the Senate and House versions had slightly different wording and the bill died in conference committee when questions were raised as to possible preemption by the federal Employee Retirement Income Security Act of 1974 ("ERISA"). We did not view ERISA preemption as a problem because the Patient's Bill of Rights and Responsibilities by its own terms does not apply to plans that are preempted by federal law. That should be true of this bill also.

Nevertheless, this year, in order to entirely avoid ERISA issues we reintroduced the measure as Senate Bill 891 proposing to amend the Unfair and Deceptive Insurance Practices Statute (HRS Article 431:13) instead of the Patients' Bill of Rights statute (HRS Chapter 432E). This was done because the Unfair and Deceptive Insurance Practices statute is clearly a regulation of insurance that can only be enforced by the Commissioner. Because private individuals may not use this statute to obtain remedies not provided by ERISA, there can be no ERISA preemption. Even so, in an abundance of caution, the Attorney General's Office recommended that we add a clause to S. B. 891 specifying that "This section shall be applicable to every health care insurer except to the extent preempted by federal law." Of course, that would be true whether or not the statute so states, but it makes it crystal clear for anyone who wishes to raise issues.

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

March 2, 2009

The Honorable Rosalyn Baker, Chair
The Honorable David Ige, Vice Chair

Senate Committee on Commerce and Consumer Protection

Re: SB 891 – Relating to Insurance

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 891.

This bill 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 has been providing quality health care to Hawaii's community since 1938 and does not engage in any of the practices listed in SB 891.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Assistant Vice President
Government Relations

March 2, 2009 @ 10:00 a.m. Room 229

To: Senate Committee on Commerce & Consumer Protection
Senator Rosalyn H. Baker, chair
Senator David Y. Ige, Vice Chair

By: Hawaii Medical Association
Gary A. Okamoto, MD, President
Philip Hellreich, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Richard C. Botti, Government Affairs
Lauren Zirbel, Government Affairs

Re: SB 891 RELATING TO INSURANCE

In Support

Chairs & Committee Members:

We feel this measure is an important piece of the puzzle to increasing access to medical care in Hawaii during our current crisis. We ask that the following language be included in subparagraph (b)(5) on page 3 of the bill:

, and refusing to make payment directly to the non participating health care provider for services enumerated in the health plan/ subscriber contract.

This would assure that any nonparticipating health care provider services would be sent directly to the provider with the patient's prior approval, completing the circle. The issue is that many patients during hard financial times would receive payment from the carrier and cash the check, thus avoiding paying the health care provider. Paragraph (5) would read:

(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, and refusing to make payment directly to the non participating health care provider for services enumerated in the health plan/ subscriber contract. 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

Thank you for the opportunity to provide this testimony.

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