

JAN 21 2011

S.B. NO. 792

A BILL FOR AN ACT

RELATING TO HEALTH CARE PAYMENTS.

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

1 SECTION 1. The legislature finds that the State's health
2 care system is in financial crisis due to low reimbursements and
3 increasing costs. The low reimbursement rates have forced
4 hospitals and other providers to institute cost-cutting measures
5 that may not be in the best interest of consumers. The delay
6 and refusal to make payment directly to nonparticipating
7 providers, particularly for high cost emergency services where
8 providers are required by federal law to administer emergency
9 treatment, may have a significant impact on cash flow for the
10 provider.

11 The purpose of this Act is to further the public's interest
12 in maintaining a financially sound health care system by
13 requiring insurers, mutual benefit societies, and health
14 maintenance organizations to pay health care providers directly
15 regardless of the health care provider's participatory status
16 with the insurer, mutual benefit society, or health maintenance
17 organization. This Act also ensures that nonparticipating



1 providers who provide emergency services are paid promptly and
2 directly for the treatment rendered.

3 SECTION 2. Chapter 431, Hawaii Revised Statutes, is
4 amended by adding two new sections to article 10A to be
5 appropriately designated and to read as follows:

6 "§431:10A- Direct payment for health care services. (a)

7 An insurer shall make payment directly to the health care
8 provider that provided the services, regardless of the health
9 care provider's participatory status with the insurer's plan;
10 provided that this subsection shall not require payment for
11 services that are not covered under the plan.

12 (b) If the insurer makes payment to the insured, the
13 insurer shall remain liable for payment to the health care
14 provider. This subsection shall not prohibit the insurer from
15 recovering any amount mistakenly paid to the insured.

16 (c) "Health care provider" as used in this section means a
17 "provider of services", as defined in Title 42 United States
18 Code Section 1395x(u), a provider of "medical and other health
19 services", as defined in Title 42 United States Code Section
20 1395x(s), and any other person or organization who furnishes,
21 bills, or is paid for health care in the normal course of
22 business.

1 (d) The provisions of this section shall not apply to any
2 entity or situation when their application to the entity or
3 situation would be preempted under the Employee Retirement
4 Income Security Act of 1974, Title 29 United States Code
5 Sections 1001, et seq.

6 (e) An insurer providing a policy, contract, plan, or
7 agreement pursuant to this chapter shall make available its
8 policies on nonparticipating providers to any health care
9 provider upon request.

10 §431:10A- Emergency services by nonparticipating
11 providers. (a) Each policy, contract, plan, or agreement
12 issued in the State by an insurer pursuant to this chapter shall
13 cover and forward reimbursement to the provider of emergency
14 services in the following manner:

15 (1) Without the need for any prior authorization
16 determination, even if the emergency services are
17 provided by an out-of-network provider;

18 (2) Without regard to whether the provider furnishing the
19 emergency services is a participating network provider
20 with respect to the services;

21 (3) If the emergency services are provided out of network,
22 without imposing any administrative requirement or

1 limitation on coverage that is more restrictive than
2 the requirements or limitations that apply to
3 emergency services received from in-network providers;

4 and

5 (4) Any other provisions required by state or federal law.

6 (b) For contracted providers without a written contract
7 and for non-contracted providers, each policy, contract, plan,
8 or agreement issued in the State by an insurer pursuant to this
9 chapter shall require the insurer to reimburse a provider for
10 the provider's provision of emergency services in an amount
11 equal to the usual and customary value.

12 (c) After a provider submits a claim for reimbursement for
13 emergency services to an insurer, the insurer shall promptly
14 adjudicate the claim and forward the reimbursement required by
15 this section directly to the provider regardless of whether the
16 provider is out-of-network. The insurer shall be financially
17 responsible to pay an amount equal to the usual and customary
18 value to providers for services furnished by providers if the
19 patient is admitted as an inpatient to an out-of-network
20 hospital related to an emergency medical condition, and may not
21 preclude the patient's use of an out-of-network provider with
22 respect to the emergency medical condition if the use is deemed

1 by a licensed physician to be in the best interests of the
2 patient. The provider is not prohibited from collecting usual
3 and customary co-payments and deductibles from the patient.

4 (d) For purposes of this section, the following
5 definitions shall have the following meaning:

6 (1) "Emergency medical condition" means a medical
7 condition manifesting itself by acute symptoms of
8 sufficient severity (including severe pain) so that a
9 prudent layperson who possesses an average knowledge
10 of health and medicine could reasonably expect the
11 absence of immediate medical attention to result in a
12 condition described in clause (i), (ii), or (iii) of
13 Section 1867(e)(1)(A) of the Social Security Act (42
14 U.S.C. 1395dd(e)(1)(A)); and

15 (2) "Emergency services" means:

16 (A) Any medical screening examination or other
17 evaluation which is either deemed necessary by a
18 licensed physician or required by state or
19 federal law to be provided in the emergency
20 facility of a hospital to determine whether a
21 medical emergency condition exists;

1 (B) Services provided in an emergency facility or
2 hospital that are deemed necessary by a licensed
3 physician to address an emergency medical
4 condition, including the treatment and
5 stabilization of an emergency medical condition
6 as required by state or federal law; or

7 (C) Medical or hospital services that follow the
8 treatment or stabilization of an emergency
9 medical condition and are deemed necessary by a
10 licensed physician to provide proper care to the
11 patient, including the admission of a patient to
12 an inpatient hospital service for continued care
13 arising from the emergency medical condition."

14 SECTION 3. Chapter 432, Hawaii Revised Statutes, is
15 amended by adding two new sections to article 1 to be
16 appropriately designated and to read as follows:

17 "§432:1- Direct payment for health care services. (a)

18 A mutual benefit society shall make payment directly to the
19 health care provider that provided the services, regardless of
20 the health care provider's participatory status with the
21 society's health care plan; provided that this subsection shall

1 not require payment for services that are not covered under the
2 plan.

3 (b) If the mutual benefit society makes payment to the
4 member, the mutual benefit society shall remain liable for
5 payment to the health care provider. This subsection shall not
6 prohibit the mutual benefit society from recovering any amount
7 mistakenly paid to the member.

8 (c) The term "health care provider" as used in this
9 section means a provider of services, as defined in Title 42
10 United States Code Section 1395x(u), a provider of "medical and
11 other health services", as defined in Title 42 United States
12 Code Section 1395x(s), and any other person or organization who
13 furnishes, bills, or is paid for health care in the normal
14 course of business.

15 (d) The provisions of this section shall not apply to any
16 entity or situation when their application to the entity or
17 situation would be preempted under the Employee Retirement
18 Income Security Act of 1974, Title 29 United States Code
19 Sections 1001, et seq.

20 (e) A mutual benefit society providing a policy, contract,
21 plan, or agreement pursuant to this chapter shall make its

1 policies on nonparticipating providers available to any health
2 care provider upon request.

3 §432:1- Emergency services by nonparticipating
4 providers. (a) Each policy, contract, plan, or agreement
5 issued in the State by a mutual benefit society pursuant to this
6 chapter shall cover and forward reimbursement to the provider of
7 emergency services in the following manner:

8 (1) Without the need for any prior authorization
9 determination, even if the emergency services are
10 provided by an out-of-network provider;

11 (2) Without regard to whether the provider furnishing the
12 emergency services is a participating network provider
13 with respect to the services;

14 (3) If the emergency services are provided out of network,
15 without imposing any administrative requirement or
16 limitation on coverage that is more restrictive than
17 the requirements or limitations that apply to
18 emergency services received from in-network providers;
19 and

20 (4) Any other provisions required by state or federal law.

21 (b) For contracted providers without a written contract
22 and for non-contracted providers, each policy, contract, plan,

1 or agreement issued in the State by a mutual benefit society
2 pursuant to this chapter shall require the mutual benefit
3 society to reimburse a provider for the provider's provision of
4 emergency services in an amount equal to the usual and customary
5 value.

6 (c) After a provider submits a claim for reimbursement for
7 emergency services to a mutual benefit society, the mutual
8 benefit society shall promptly adjudicate the claim and forward
9 the reimbursement required by this section directly to the
10 provider regardless of whether the provider is out-of-network.
11 The mutual benefit society shall be financially responsible to
12 pay an amount equal to the usual and customary value to
13 providers for services furnished by providers if the patient is
14 admitted as an inpatient to an out-of-network hospital related
15 to an emergency medical condition, and may not preclude the
16 patient's use of an out-of-network provider with respect to the
17 emergency medical condition if the use is deemed by a licensed
18 physician to be in the best interests of the patient. The
19 provider is not prohibited from collecting usual and customary
20 co-payments and deductibles from the patient.

21 (d) For purposes of this section, the following
22 definitions shall have the following meaning:

1 (1) "Emergency medical condition" means a medical
2 condition manifesting itself by acute symptoms of
3 sufficient severity (including severe pain) so that a
4 prudent layperson who possesses an average knowledge
5 of health and medicine could reasonably expect the
6 absence of immediate medical attention to result in a
7 condition described in clause (i), (ii), or (iii) of
8 Section 1867(e) (1) (A) of the Social Security Act (42
9 U.S.C. 1395dd(e) (1) (A)); and

10 (2) "Emergency services" means:

11 (A) Any medical screening examination or other
12 evaluation which is either deemed necessary by a
13 licensed physician or required by state or
14 federal law to be provided in the emergency
15 facility of a hospital to determine whether a
16 medical emergency condition exists;

17 (B) Services provided in an emergency facility or
18 hospital that are deemed necessary by a licensed
19 physician to address an emergency medical
20 condition, including the treatment and
21 stabilization of an emergency medical condition
22 as required by state or federal law; or

1 (C) Medical or hospital services that follow the
2 treatment or stabilization of an emergency
3 medical condition and are deemed necessary by a
4 licensed physician to provide proper care to the
5 patient, including the admission of a patient to
6 an inpatient hospital service for continued care
7 arising from the emergency medical condition."

8 SECTION 4. Chapter 432D, Hawaii Revised Statutes, is
9 amended by adding two new sections to be appropriately
10 designated and to read as follows:

11 "§432D- Direct payment for health care services. (a) A
12 health maintenance organization shall make payment directly to
13 the health care provider that provided the services, regardless
14 of the health care provider's participatory status with the
15 health maintenance organization health care plan; provided that
16 this subsection shall not require payment for services that are
17 not covered under the plan.

18 (b) If the health maintenance organization makes payment
19 to the enrollee, the health maintenance organization shall
20 remain liable for payment to the health care provider. This
21 subsection shall not prohibit the health maintenance

1 organization from recovering any amount mistakenly paid to the
2 enrollee.

3 (c) The term "health care provider" as used in this
4 section means a provider of services, as defined in Title 42
5 United States Code Section 1395x(u), a provider of "medical and
6 other health services", as defined in Title 42 United States
7 Code Section 1395x(s), and any other person or organization who
8 furnishes, bills, or is paid for health care in the normal
9 course of business.

10 (d) The provisions of this section shall not apply to any
11 entity or situation when their application to the entity or
12 situation would be preempted under the Employee Retirement
13 Income Security Act of 1974, Title 29 United States Code
14 Sections 1001, et seq.

15 (e) A health maintenance organization providing a policy,
16 contract, plan, or agreement pursuant to this chapter shall make
17 its policies on nonparticipating providers available to any
18 health care provider upon request.

19 §432D- Emergency services by nonparticipating providers.

20 (a) Each policy, contract, plan, or agreement issued in the
21 State by a health maintenance organization pursuant to this

1 chapter shall cover and forward reimbursement to the provider of
2 emergency services in the following manner:

3 (1) Without the need for any prior authorization
4 determination, even if the emergency services are
5 provided by an out-of-network provider;

6 (2) Without regard to whether the provider furnishing the
7 emergency services is a participating network provider
8 with respect to the services;

9 (3) If the emergency services are provided out of network,
10 without imposing any administrative requirement or
11 limitation on coverage that is more restrictive than
12 the requirements or limitations that apply to
13 emergency services received from in-network providers;
14 and

15 (4) Any other provisions required by state or federal law.

16 (b) For contracted providers without a written contract
17 and for non-contracted providers, each policy, contract, plan,
18 or agreement issued in the State by a health maintenance
19 organization pursuant to this chapter shall require the health
20 maintenance organization to reimburse a provider for the
21 provider's provision of emergency services in an amount equal to
22 the usual and customary value.

1 (c) After a provider submits a claim for reimbursement for
2 emergency services to a health maintenance organization, the
3 health maintenance organization shall promptly adjudicate the
4 claim and forward the reimbursement required by this section
5 directly to the provider regardless of whether the provider is
6 out-of-network. The health maintenance organization shall be
7 financially responsible to pay an amount equal to the usual and
8 customary value to providers for services furnished by providers
9 if the patient is admitted as an inpatient to an out-of-network
10 hospital related to an emergency medical condition, and may not
11 preclude the patient's use of an out-of-network provider with
12 respect to the emergency medical condition if the use is deemed
13 by a licensed physician to be in the best interests of the
14 patient. The provider is not prohibited from collecting usual
15 and customary co-payments and deductibles from the patient.

16 (d) For purposes of this section, the following
17 definitions shall have the following meaning:

18 (1) "Emergency medical condition" means a medical
19 condition manifesting itself by acute symptoms of
20 sufficient severity (including severe pain) so that a
21 prudent layperson who possesses an average knowledge
22 of health and medicine could reasonably expect the

1 absence of immediate medical attention to result in a
2 condition described in clause (i), (ii), or (iii) of
3 Section 1867(e) (1) (A) of the Social Security Act (42
4 U.S.C. 1395dd(e) (1) (A)); and

5 (2) "Emergency services" means:

6 (A) Any medical screening examination or other
7 evaluation which is either deemed necessary by a
8 licensed physician or required by state or
9 federal law to be provided in the emergency
10 facility of a hospital to determine whether a
11 medical emergency condition exists;

12 (B) Services provided in an emergency facility or
13 hospital that are deemed necessary by a licensed
14 physician to address an emergency medical
15 condition, including the treatment and
16 stabilization of an emergency medical condition
17 as required by state or federal law; and

18 (C) Medical or hospital services that follow the
19 treatment or stabilization of an emergency
20 medical condition and are deemed necessary by a
21 licensed physician to provide proper care to the
22 patient, including the admission of a patient to

1 an inpatient hospital service for continued care
2 arising from the emergency medical condition."

3 SECTION 5. New statutory material is underscored.

4 SECTION 6. This Act shall take effect upon its approval.

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INTRODUCED BY: David Y. Ige

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Report Title:

Health Care; Direct Payment; Nonparticipating Providers

Description:

Requires insurers, mutual benefit societies, and health maintenance organizations to pay health care providers directly regardless of the health care provider's participatory status with the insurer, mutual benefit society, or health maintenance organization. Also requires nonparticipating providers who provide emergency services to be paid promptly and directly for the treatment rendered.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.