HOUSE OF REPRESENTATIVES
TWENTY-SIXTH LEGISLATURE, 2011
STATE OF HAWAII

H.B. NO. 405

A BILL FOR AN ACT

RELATING TO HEALTH CARE PAYMENTS.

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

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

The purpose of this Act is to further the public's interest in maintaining a financially sound health care system by requiring 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. This Act also ensures that nonparticipating

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

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

"§431:10A- **Direct payment for health care services.** (a) An insurer shall make payment directly to the health care provider that provided the services, regardless of the health care provider's participatory status with the insurer's plan; provided that this subsection shall not require payment for services that are not covered under the plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Emergency services" means:

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

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

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

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

"**§432:1- Direct payment for health care services.** (a) A mutual benefit society shall make payment directly to the health care provider that provided the services, regardless of the health care provider's participatory status with the society's health care plan; provided that this subsection shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) "Emergency services" means:

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

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

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

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

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

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

organization from recovering any amount mistakenly paid to the enrollee.

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

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

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

§432D- **Emergency services by nonparticipating providers.** (a) Each policy, contract, plan, or agreement issued in the State by a health maintenance organization pursuant to this

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

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

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

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

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

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

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

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

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

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

(2) "Emergency services" means:

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

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

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

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

SECTION 5. New statutory material is underscored.

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

INTRODUCED BY: Calvin K. Say

BY REQUEST

JAN 21 2011

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.