DAVID Y. IGE
GOVERNOR

SHAN S. TSUTSUI
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. Box 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
www.hawaii.gov/dcca

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON HEALTH

TWENTY-EIGHTH LEGISLATURE
Regular Session of 2016

Monday, February 8, 2016
1:45 p.m.

TESTIMONY ON HOUSE BILL NO. 1952 – RELATING TO INSURANCE.

TO THE HONORABLE DELLA AU BELATTI, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department").

The Department supports the intent of this bill and submits the following comments.

Consumers should not be receiving unexpected follow-up provider billings when it is their belief and understanding that those services are covered by their health insurance. Insurer notification and education of policies' benefits to consumers will help address some of the problems but there will be inevitable billing disputes between providers and insurers with consumers being caught in the middle.

We understand the structure this bill establishes is to take effect on July 1, 2016, through a process established by the Commissioner and with the adoption of rules. Currently, because of numerous rulemaking steps which must be adhered to, the rulemaking and adoption process takes anywhere from 12 – 18 months depending on the complexity of the rules and public input. It is unlikely that the process contemplated by this bill will be in place on July 1, 2016.

We thank the Committee for the opportunity to present testimony on this matter.

February 8, 2016 at 1:45 PM
Room 329

House Committee on Health

To: Chair Della Au Belatti
Vice Chair Richard P. Creagan

From: George Greene
President and CEO
Healthcare Association of Hawaii

Re: Submitting comments
HB 1952, Relating to Insurance

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 180 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

We would like to thank Chair Belatti, Vice Chair Creagan and members of the House Committee on Health for the opportunity to **submit comments** on HB 1952. The issue of balance billing has gained national attention as states consider initiatives to mitigate or ban the practice. We appreciate the intent of this legislation to address balance billing in Hawaii but would respectfully request that your committee create a task force to discuss and better understand the issue of balance or surprise billing in Hawaii to ensure that any solution addresses the distinct problems that consumers in this state may be experiencing.

It would be particularly helpful to discuss the extent of this problem and determine the prevalence and particularities of balance billing in Hawaii. The task force would also be able to discuss different policies related to balance billing and could provide recommendations best suited to the needs of consumers. For example, the National Association of Insurance Commissioners provides model language on this issue that could be tailored to the needs of both patients and providers in this state.

Working on producing a policy on this issue that is attuned to the distinct needs of patients in Hawaii would be consistent with how balance billing is addressed across the country. Every

state has varying policies on balance billing, including disclosure requirements, mediation or arbitration requirements, and if the policies apply to individuals in emergency situations.

The variation is necessary considering how different each state's health care market is. New York, for example, is much larger in population size, has many times the hospital providers and has a less concentrated insurance market than smaller states like New Mexico or Hawaii. Other states that have grappled with this issue, such as Texas and Pennsylvania, have engaged all stakeholders in a deliberative process to ensure that the concerns of consumers, providers and state agencies are fully addressed.

The task force could also address some of the concerns we have regarding disclosure requirements in the bill. First, the bill would require all hospitals to disclose their charges. This information is generally considered proprietary and is used in private negotiations between hospitals and insurers. Another requirement in the bill would require facilities to track and update the carriers that all physicians contract with, which would impose a considerable time burden. Lastly, there are concerns about how this would affect contracted physicians, who are often on-call specialists needed in particularly difficult or acute cases. Our members worry that the legislation as written could limit the availability of these specialists by making it less attractive to practice in the state.

Therefore, we would respectfully request that your committee defer this measure in favor of establishing a task force to ensure that we fully understand this issue, hear from all viewpoints and ensure that unnecessary requirements for physicians, providers and insurers are not levied. Thank you for your time and consideration of this matter.

Monday February 8, 2016
1:45 PM.
Capitol Rm. 329

To: HOUSE COMMITTEE ON HEALTH
Rep. Della Au Belatti, Chair
Rep. Richard Creagan, Vice Chair

From: Hawaii Medical Association
Dr. Scott McCaffrey, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Ronald Keinitz, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: HB 1952 – RELATING TO INSURANCE

IN OPPOSITION

Chair, Vice Chair, and Committee Members:

The Hawaii Medical Association opposes HB1952. This bill serves to price fix medical services, without input from stakeholders or the legislature.

Hawaii is a unique state in the health care market. Hawaii is second in the nation with respect to the least amount of competition among health insurers. The dominant insurer controls 90+% of the PPO market and 70+% of the overall market. Non-participation by patient care providers is not realistic in a market this restricted. When approached about payment issues, whether monetary or not, this insurer has repeatedly told the HMA, "we do not negotiate." Provider contracts are offered on a "take it or leave it' basis.

This bill would provide this dominant insurer the ability to extend this same oppressive leverage to providers who choose not to participate in the insurers network. Antitrust issues aside, this serves to discourage physicians from considering a career in Hawaii, accelerating the severe shortage and lack of patient access to physician services in the state.

Passage of this bill is supportive of maintaining this dysfunctional relationship.

Thank you for the opportunity to provide this testimony.

Testimony in Support of HB1952, With Amendments
To Rep. Della Au Belatti, Chair, Rep. Richard Creagan, V. Chair, and
Members of the House Committee on Health
February 7, 2016

Honorable Chair Belatti, Vice Chair Creagan, and Members of HI House Health Committee:

I am writing on behalf of Hawaii Society of Naturopathic Physicians (HSNP) in support of HB1952, with amendments that further address the issue of network adequacy. As written, this bill does not ensure network adequacy to specific provider TYPES, which is of concern to Naturopathic Doctors (NDs) who continue to struggle to gain access as providers within most Hawaii health insurance networks. This discrimination represents the ongoing noncompliance of Federal law by these health insurance companies.

HMSA (Hawaii's largest health insurer) is currently working closely with HSNP to credential NDs in Hawaii as Primary Care Physicians, so they are leading the industry in compliance efforts in this State. Similar efforts are underway with the office of Medicaid, but companies like UHA and Kaiser Permanente have shown no signs of complying. We are hoping that our efforts with HMSA will begin a trend, with the other insurance groups in Hawaii following their lead, but we respectfully request the additional push from the Legislature with amendments to this bill to assist in creating the necessary pressure on the insurance companies to fully comply with Federal law.

Copied below is the excerpt from the May 26, 2015 FAQ issued by HHS, DOL and Treasury on Section 2706 of the Affordable Care Act. It follows a couple other questions [Q1, 2 and 3] on out of pocket costs limitations that are not relevant to 2706, and also attached below is the entire FAQ itself:

PHS Act section 2706(a), as added by the Affordable Care Act, states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law." PHS Act section 2706(a) "shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer," and nothing in PHS Act section 2706(a) prevents "a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures." ***Similar language is included in section 1852(b)(2) of the Social Security Act[4] and HHS implementing regulations.[5]***

[4] ***Section 1852(b)(2) of the Social Security Act provides that "A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on***

the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan."

[5]***42 CFR 422.205 provides, in part, that a "[Medicare Advantage (MA)] organization may select the practitioners that participate in its plan provider networks. In selecting these practitioners, an MA organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If an MA organization declines to include a given provider or group of providers in its network, it must furnish written notice to the effected [sic] provider(s) of the reason for the decision." Section 422.205 further provides that it "does not preclude any of the following [actions] by the MA organization:*** (1) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for MA private-fee-for-service plans, which may not refuse to contract on this basis); ***(2) Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty;*** [and] (3) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities."

[6] See FAQs about Affordable Care Act Implementation Part XV, available at http://www.dol.gov/ebsa/faqs/faq-aca15.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.

[7] S. Rep. No. 113-71, at 126 (2013). Additionally, in Title I of the report, regarding the Department of Labor Employee Benefits Security Administration, the Committee "directs the Department to work with HHS and the Department of the Treasury to revise their joint FAQ regarding section 2706 of the ACA, as explained in the HHS title of this report." Id. At 27.

On April 29, 2013, the Departments issued FAQs,[6] which addressed, among other issues, provider nondiscrimination requirements under PHS Act section 2706(a). Subsequently, the Senate Committee on Appropriations issued a report dated July 11, 2013 (to accompany S. 1284) raising questions about the Departments' FAQs addressing provider nondiscrimination.[7] The Departments published a request for information (RFI) on March 12, 2014, seeking comment on all aspects of interpretation of PHS Act section 2706(a).[8]

The RFI specifically solicited comments on access, costs, other federal and state laws, and feasibility. The Departments received over 1,500 comments in response to the RFI. The House Committee on Appropriations subsequently issued an explanatory statement dated December 11, 2014 (to accompany 113 H.R. 83), directing the Centers for Medicare & Medicaid Services to provide a corrected FAQ or provide an explanation.

[8] 79 FR 14051 (March 12, 2014).

[9] 160 Cong. Rec. H9837(daily ed. Dec. 11, 2014).

The Departments are issuing the following FAQs in response to the December 11, 2014 explanatory statement.

Q4. What is the Departments' approach to PHS Act section 2706(a)?

In light of the breadth of issues identified in the comments to the RFI, the Departments are re-stating their current enforcement approach to PHS Act section 2706(a). Until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision, which states:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

Q5. Does Q2 in FAQs about Affordable Care Act Implementation Part XV continue to apply?

No. Q2 in FAQs about Affordable Care Act Implementation Part XV, which previously provided guidance from the Departments on PHS Act section 2706(a), is superseded by this FAQ and notation will be made on the Departments' websites to reflect this modification.

The Departments will continue to work together with employers, plans, issuers, states, providers, and other stakeholders to help them comply with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended.

We at HSNP are pleased to see that existing language does appear in this statute (HB1952) providing grounds to submit complaints to the Insurance Commissioner for the lack of adequate networks of Naturopathic Physicians at UHA and Kaiser:

"A provider network shall be considered adequate if it provides access to sufficient numbers and types of providers to ensure
that all covered services will be accessible without unreasonable

delay, after taking into consideration geography. The commissioner
shall also consider any applicable federal standards on network
adequacy. A certification from a national accreditation organization
shall create a rebuttable presumption that the network of a managed
care plan is adequate. This presumption may be rebutted by evidence
submitted to, or collected by, the commissioner."

Thank you for the opportunity to testify,

Dr. Karen Frangos
President and Legislative Committee Chair,
Hawaii Society of Naturopathic Physicians
P.O. Box 941
Kihei, HI 96753
p: 808-891-1111
f: 808-442-9938
e: hawaiind@gmail.com
www.hawaiind.org

UHA HEALTH INSURANCE

February 8, 2016

Representative Della Au Belatti, Chair
Representative Richard P. Creagan, Vice Chair
Committee on Health
Conference Room 329

RE: HB1952 Relating to Insurance

Dear Chair Belatti, Vice Chair Creagan and Members of the Committee:

We respectfully oppose HB1952 Relating to Insurance because it would eliminate incentives for participating providers and would create a cumbersome fee dispute resolution process for the nonparticipating providers to challenge any lower fees.

Many of our customers understand and value participating providers because it helps to maintain the current fees and keep the costs of health care reasonable. Our members are already notified that if they see a non-participating provider, they will be responsible for the out-of-pocket costs associated with the service by that non-participating provider. For emergency services, we have a process where members can appeal their use of a non-participating emergency room services, which we understand is often necessary when members are traveling.

This bill dramatically changes the relationship between the insurer and the provider by removing this mechanism. Our concern is that many physicians and providers will choose to become a nonparticipating provider because they can then charge a higher fee. That higher fee, for any charges over the reimbursement rate by the insurer, will have to be borne by the member. Members will have to pay these fees as upfront costs to the nonparticipating providers. The overall net outcome of this approach will result in driving up the costs for everyone, including those who are not be able to afford it, and especially those who are using the benefits prudently.

We urge you to oppose this bill. Thank you for the opportunity to submit written comments.

Respectfully submitted,

Howard Lee
President, CEO

HAWAII / ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

February 6, 2016

Representative Della Au Belatti
Chair
House Committee on Health

HB 1952: Relating to Insurance

Letter in OPPOSITION

Dear Representative Belatti and Committee Members:

Thank you for the opportunity to comment on HB 1952. On behalf of our 150 emergency physician members providing care in Hawaii, I am writing in opposition to the bill.

The Emergency Medical Treatment and Labor Act (EMTALA) requires that all patients presenting to an emergency department be medically stabilized without regard to their ability to pay for services. We whole-heartedly agree with the premise of EMTALA; that all people deserve emergency medical care regardless of their ability to pay. However, we ask that the committee consider how balance billing prohibitions uniquely harm physicians providing emergency care, including emergency physicians and specialists providing call coverage for our emergency departments.

When negotiating with managed care organizations, the ONLY leverage emergency providers have is the threat of balance billing patients for charges not covered by insurers. Physicians not bound by EMTALA simply walk away from unacceptable contracts. Those of us providing emergency care are legally required to continue to see the patients covered by such contracts. We recognize that the practice of balance billing may surprise patients and is not ideal for any party, but it is a necessary evil when managed care organizations reimburse below the cost of providing care. Removing balance billing essentially allows managed care organizations to set market rates for emergency care and strips the rights of emergency providers to independently set fees for their services.

We do not have data related to balance billing complaints in Hawaii, and we would welcome a review of that data. The vast majority of emergency care in Hawaii is provided by participating providers, and those patients do not routinely receive balance bills by virtue of provider contracts in Hawaii. Almost all balance bills sent by

OFFICE

3215-A Pawale Place
Honolulu, HI 96822-1152
hi.chapter@acep.org

emergency physicians from Hawaii involve non-residents of Hawaii and out of state insurance coverage. Even when emergency providers send a balance bill, it is generally for relatively small amounts. An analysis by Thomas Reuters for the California HealthCare Foundation in 2006 found that the average potential balance bill for an emergency physician was $27[1].

We ask that the committee also consider that many bills that surprise patients are actually related to the structure of their health care coverage. High deductible plans are now commonplace, and patients may not understand the scope of their cost sharing. Such 'surprise' bills related to copays and deductibles are inarguably appropriate and are specifically allowed in HB 1952.

The proposed independent dispute resolution process also threatens to negatively impact emergency providers. The definition of 'usual and customary' cost does not identify the benchmark from which the 80th percentile would be derived. In explaining the dispute resolution process, the bill allows the health care plan to pay "an amount that the health care plan determines is reasonable." What is reasonable is determined solely by the health care plan without transparency and without regard to provider charges. Further, dispute resolution programs in California and Florida are little used, generally favor the managed care organizations, and are considered overly burdensome for providers. Experts suggest policymakers limit their expectations of their usefulness[1,2].

We would welcome efforts to improve the transparency in the process by which health care plans set rates, which would lead to reduced need for balance billing and dispute resolution. The lack of transparency by health care plans has long been a problem and has recently been the source of settled litigation brought by providers in New York. The American College of Emergency Physicians advocates for fair pay practices determining 'usual, customary, and reasonable' by way of an independent charge database. We feel such a practice, if established appropriately, would lead to a more stable emergency care environment for both patients and providers.

We sympathize with the concerns of our patients, but we should be clear about who balance billing prohibitions really benefit. *Banning balance billing is not a patient protection initiative; it is a profit protection initiative for health care plans*. Without balance billing, negotiating power will be stripped from physicians providing emergency care in Hawaii. Efforts to limit reimbursement to emergency physicians and specialist physicians providing emergency care threaten to further limit access to emergency health care in Hawaii.

Sincerely,

William Scruggs, MD, RDMS, FACEP
President, Hawaii College of Emergency Physicians

1. Hoadley J, Lucia K, Schwart S. Unexpected Charges: What States Are Doing About Balance Billing. California Health Care Foundation.[Accessed June 30, 2013].

2. Florida Agency for Health Care Administration. Statewide Provider and Health Plan Claim Dispute Resolution Program [Internet]. 2015 [cited 2016 Feb 6];:1–4. Available from: http://ahca.myflorida.com/mchq/Health_Facility_Regulation/Commercial_Managed_Care/docs/SPHPClaimDRP/AnnualReportFeb-2015.pdf

An Independent Licensee of the Blue Cross and Blue Shield Association

February 8, 2016

The Honorable Della Au Belatti, Chair
The Honorable Richard P. Creagan, Vice Chair
House Committee on Health

Re: HB 1952 – Relating to Insurance

Dear Chair Au Belatti, Vice Chair Creagan, and Members of the Committees:

The Hawaii Medical Association (HMSA) appreciates the opportunity to testify on HB 1952, which establishes a dispute resolution process for a "surprise bill" to be resolved. It additionally specifies provisions related to the relationship between a health plan and an out of network provider. With all due respect HMSA opposes this Bill as drafted.

We understand that HB 1952 attempts to incorporate into statue provisions of the NAIC Health Benefit Plan Network Access and Adequacy Model Act (Model Act). However, there are considerable differences between the Model Act and this Bill. For example, the Model Act provides that payment to a nonparticipating provider rendering services at a participating facility is presumed reasonable if it is the higher of the health plan's payment to participating providers or [XX] percent of Medicare for the same or similar service ("benchmark payment"). HB 1952 requires an "independent dispute resolution entity" to determine a reasonable amount based on numerous, but vague criteria. In addition, the Model Act has a minimum dollar threshold to invoke mediation in certain instances; HB 1952 does not include a minimum threshold.

The provisions of this Bill are duplicative of the Affordable Care Act (ACA) which already prohibits greater out of pocket costs for emergency services received from a nonparticipating provider. The ACA does not prevent balance billing, but it requires plans to reimburse a "reasonable" amount for emergency services rendered by nonparticipating providers and includes a formula for calculating the amount.

HB 1952's dispute resolution process adds an additional layer of bureaucracy that is unnecessary and only adds to the cost of compliance and regulatory enforcement without providing additional benefit. Nonparticipating providers have numerous avenues to resolve disputes with health plans including bringing suit, mediation or settlement.

We also are concerned that the vague and overbroad provisions in the Bill create uncertainty that will result in inconsistent application of the law and will increase costs without adding benefit. : As an example, the vague criteria to be used by the independent dispute resolution entity in determining a reasonable fee will lead to arbitrary and disparate reimbursement for the same services.

The bill requires health plans to accept assignment of benefits. This will impair a health plan's ability to create and maintain networks, which benefit consumers. If health plans are deprived of incentives to attract participating providers, such as direct reimbursement in exchange for

An Independent Licensee of the Blue Cross and Blue Shield Association

delivering insureds, the cost of providing health care to consumers will increase along with premiums for coverage.

We are concerned that State regulation thru HB 1952 is duplicative and inconsistent with existing rights or federal regulation. This measure will create an undue burden on regulators and the regulated entities alike. The provisions of this Bill will increase the cost of health care coverage,

Thank you for allowing us to testify on HB 1952, and your consideration of our concerns is appreciated.

Sincerely,

Jennifer Diesman
Vice President, Government Relations.

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, February 06, 2016 3:34 PM
To: HLTtestimony
Cc: dylanarm@hawaii.edu
Subject: *Submitted testimony for HB1952 on Feb 8, 2016 13:45PM*

HB1952
Submitted on: 2/6/2016
Testimony for HLT on Feb 8, 2016 13:45PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Dylan Armstrong	Individual	Support	Yes

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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February 7, 2016

The Honorable Chair Belatti, Vice Chair Creagan, and Members of the House Committee on Health:

RE: HB1952 – in support with amendments

I am Landon Opunui, ND, a naturopathic physician in private practice in Honolulu for the past 2 years. I am writing in support of HB1952, with amendments that further address the issue of network adequacy. As written, this bill does not ensure network adequacy for specific provider types, which is a concern to the naturopathic medical profession who is not allowed parity within most health insurance networks in Hawaii. This treatment of unfairness and discrimination represents the ongoing noncompliance of Federal law by these health insurance companies pertaining to Section 2706 of the Affordable Care Act.

The language that appears in this bill, as stated below, is important to keep the health insurers that do not have proper network adequacy accountable which is currently not the case.

"A provider network shall be considered adequate if it provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay, after taking into consideration geography. The commissioner shall also consider any applicable federal standards on network adequacy. A certification from a national accreditation organization shall create a rebuttable presumption that the network of a managed care plan is adequate. This presumption may be rebutted by evidence submitted to, or collected by, the commissioner."

For these reasons, I support HB1952 with amendments.

Mahalo,
Landon Opunui, ND

Representative Dell Au Belatti
Chair
House Committee on Health

HB 1952: Relating to Insurance

Letter in OPPOSITION

Dear Representative Belatti and Committee Members:

Thank you for the opportunity to comment on HB 1952. I have been an emergency physician working on the Big Island of Hawaii for the past 2 years. Due to poor legislation such as this, I have chosen to leave my work in Hawaii. If you pass this bill, I am certain that more young, highly trained emergency physicians and specialists will find opportunities in areas other than Hawaii.

I am writing in opposition to the bill.

The proposed legislation, among other things, would prohibit balance billing of patients by emergency physicians and specialist physicians who provide call coverage, and create a dispute resolution process for bills related to emergency care.

Banning balance billing is not a patient protection initiative. It is a profit protection initiative for health care plans. The Emergency Medicine Treatment and Labor Act (EMTALA) requires the emergency providers provide stabilizing medical care without regard to the patient's ability to pay. While EMTALA appropriately protects access to emergency care, it inadvertently negates leverage of emergency providers in negotiating rates for their care. We cannot walk away from unacceptable contracts because we are legally bound to care for any patient who comes to the emergency department. Our only leverage in such negotiations is the threat to bill patients for the uncovered costs of care. Stripping emergency physicians and specialists providing emergency care of the right to set our own rates for our services will further limit access to emergency care in Hawaii.

The proposed dispute resolution process lacks transparency. The criteria for dispute resolution would effectively allow health care plans to set market rates for emergency services, further limiting the ability of emergency and specialist physician to charge rates that would fully cover the cost of care.

Please strike down SB 2668. Rather than protecting patients, it will harm patients by further limiting their access to essential emergency care in Hawaii.

Sincerely,

Suprina Dorai