THE SENATE
TWENTY-NINTH LEGISLATURE, 2017
STATE OF HAWAII

S.B. NO. 387 S.D. 1 H.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

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

"ARTICLE

HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY

§431: -A Definitions. As used in this article:

"Active course of treatment" means:

(1) An ongoing course of treatment for a life-threatening condition;

(2) An ongoing course of treatment for a serious acute condition;

(3) The second or third trimester of pregnancy; or

(4) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

The term "active course of treatment" includes treatment of a covered person on a regular basis by a provider being removed from or leaving the network.

"Affordable Care Act" refers to the Patient Protection and Affordable Care Act (42 U.S.C. 18001, et seq.), as amended, and its related regulations.

"Authorized representative" means:

(1) A person to whom a covered person has given express written consent to represent the covered person;

(2) A person authorized by law to provide substituted consent for a covered person; or

(3) The covered person's treating health care professional only when the covered person or persons authorized pursuant to paragraphs (1) and (2) of this definition are unable to provide consent.

"Commissioner" means the insurance commissioner of the State.

"Covered benefit" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan, offered or administered by a person or entity, including but not limited to an insurer governed by this chapter, a mutual benefit society governed by article 1 of chapter 432, and as a health maintenance organization governed by chapter 432D.

"Essential community provider" means a provider that:

(1) Serves predominantly low-income, medically underserved individuals, including a health care provider that is a covered entity as defined in section 340B(a)(4) of the Public Health Service Act; or

(2) Is described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by section 221 of Public Law 111-8.

"Facility" means an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, urgent care centers, diagnostic facilities, laboratories, and imaging centers, and rehabilitation and other therapeutic health

settings licensed or certified by the department of health under chapter 321.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered by, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services pursuant to chapter 87A, 431, 432, or 432D.

"Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with the practitioner's scope of practice under state law.

"Health care provider" or "provider" means a health care professional, pharmacy, or facility.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance use disorders.

"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver,

arrange for, pay for, or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Health carrier" or "carrier" includes an accident and health or sickness insurer that issues health benefit plans under part I of article 10A of this chapter, a mutual benefit society under article 1 of chapter 432, and a health maintenance organization under chapter 432D.

"Integrated delivery system" means a health carrier that provides a majority of its members' covered health care services through physicians and non-physician practitioners employed by the health carrier or through a single contracted medical group.

"Intermediary" means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network, if applicable.

"Limited scope dental plan" means a plan that provides coverage primarily for treatment of the mouth, including any organ or structure within the mouth, under a separate policy,

certificate, or contract of insurance or is otherwise not an integral part of a health benefit plan.

"Limited scope vision plan" means a plan that provides coverage primarily for treatment of the eye through a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a health benefit plan.

"Network" means the group or groups of participating providers providing services under a network plan.

"Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with, or employed by the health carrier.

"Participating provider" means a provider who, under a contract with the health carrier or with the health carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

"Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust,

an unincorporated organization, any similar entity, or any combination of the foregoing.

"Primary care" means health care services for a range of common conditions provided by a physician or non-physician primary care professional.

"Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

"Serious acute condition" means a disease or condition for which the covered person is currently requiring complex ongoing care, such as chemotherapy, post-operative visits, or radiation therapy.

"Specialist" means a physician or non-physician health care professional who focuses on a specific area of health care services or on a group of patients and who has successfully completed required training and is recognized by the state in which the physician or non-physician health care professional practices to provide specialty care.

"Specialist" includes a subspecialist who has additional training and recognition above and beyond the subspecialist's specialty training.

"Specialty care" means advanced medically necessary care and treatment of specific health conditions or health conditions that may manifest themselves in particular ages or subpopulations that are provided by a specialist, preferably in coordination with a primary care professional or other health care professional.

"Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located.

"Tier" means specific groups of providers and facilities identified by a network and to which different provider reimbursement, covered person cost-sharing, provider access requirements, or any combination thereof, apply for the same services.

§431: -B Applicability and scope. (a) Except as otherwise provided in this section, this article applies to all health carriers that offer fully insured network plans.

(b) The following shall not apply to health carriers that offer network plans that consist solely of limited scope dental plans or limited scope vision plans:

(1) Section 431: -C(a)(2);

(2) Section 431: -C(f)(7)(E) and (f)(8)(B);

(3) Paragraphs (1) and (3) of the definition of "active course of treatment" under section 431: -A;

(4) Section 431: -D(l)(6)(C);

(5) Section 431: -E(a)(3)(B) and (C); and

(6) Section 431: -E(a)(4)(A)(i) and (ii) and (a)(4)(B).

(c) This article shall not apply to limited benefit health insurance, as provided in section 431:10A-102.5, except as to limited scope dental plans or limited scope vision plans as specified in subsection (b).

(d) Notwithstanding any other provision in this article to the contrary, health benefit plans contracted with the department of human services med-QUEST division to provide services for medicaid beneficiaries shall continue to be subject to the network provider adequacy standards and oversight of the federal medicaid program; provided that the department of human services and the commissioner may collaborate to align such

standards wherever possible. Nothing in this article is intended to change, delegate, or diminish the sole responsibility to monitor and regulate the medicaid managed care plans from the single state medicaid agency.

§431: -C Network adequacy. (a) Network adequacy requirements shall be as follows:

(1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered benefits will be accessible without unreasonable travel or delay; and

(2) Covered persons shall have access to emergency services twenty-four hours per day, seven days per week.

(b) The commissioner shall determine sufficiency in accordance with the requirements of this section by considering any reasonable criteria, which may include but shall not be limited to:

(1) Provider-to-covered person ratios by specialty;

(2) Primary care professional-to-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic, or complex health conditions or physical or mental disabilities, or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telehealth, mobile clinics, centers of excellence, integrated delivery systems, and other ways of delivering care; and

(9) The volume of technologically advanced and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

(c) A health carrier shall have the following process requirements:

(1) A health carrier shall have a process to ensure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(A) The health carrier has a sufficient network but does not have a type of participating provider available to provide the covered benefit to the covered person or does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(B) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay;

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-

participating provider as provided in paragraph (1) when:

(A) The covered person is diagnosed with a condition or disease that requires specialty care; and

(B) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty and who possesses the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay;

(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to paragraph (2) as if the services were provided by a participating

provider, including counting the covered person's cost-sharing for those services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan;

(4) The process described in paragraphs (1) and (2) shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition;

(5) The health carrier shall establish and maintain a system that documents all requests to obtain a covered benefit from a non-participating provider pursuant to this subsection and shall provide this information to the commissioner upon request;

(6) The process established pursuant to this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with this article nor is it intended to be used by covered persons to circumvent the use of covered benefits

available through a health carrier's network delivery system options; and

(7) This section does not prevent a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

(d) The health carrier shall be subject to the following adequate arrangement requirements:

(1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this paragraph, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration; and

(2) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

(e) A health carrier shall meet the following access plan requirements:

(1) Beginning on the effective date of this Act, a health carrier shall file with the commissioner for approval, prior to or at the time it files a newly offered network plan, in a manner and form defined by rule of the commissioner, an access plan that meets the requirements of this article;

(2) The health carrier may request the commissioner to deem sections of the access plan as proprietary, competitive, or trade secret information that shall not be made public. Information is proprietary, competitive, or a trade secret if disclosure of the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary, competitive, or trade secret information, available online, at the health carrier's business premises, and to any person upon request; and

(3) The health carrier shall prepare an access plan prior to offering a new network plan and shall notify the

commissioner of any material change to any existing network plan within fifteen business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which the carrier will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

(f) In addition to the requirements of subsection (e), the access plan shall describe or contain at least the following:

(1) The health carrier's network, including how telehealth or other technology may be used to meet network access standards, if applicable;

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(4) The factors the health carrier uses to build its provider network, including a description of the network and the criteria used to select providers;

(5) The health carrier's efforts to address the needs of covered persons, including children and adults, those with limited English proficiency, illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. Information required under this paragraph shall include the carrier's efforts, when appropriate, to include various types of essential community providers in the carrier's network. A health carrier that is subject to the Affordable Care Act alternative standard shall demonstrate to the commissioner that the health carrier meets that standard;

(6) The health carrier's methods for assessing the health care needs of covered persons and the covered persons' satisfaction with services;

(7) The health carrier's method of informing covered persons of the plan's covered services and features, including:

(A) The plan's grievance and appeals procedures;

(B) The plan's process for choosing and changing providers;

(C) The plan's process for updating its provider directories for each of its network plans;

(D) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

(E) The plan's procedures for covering and approving emergency, urgent, and specialty care, if applicable;

(8) The health carrier's system for ensuring the coordination and continuity of care:

(A) For covered persons referred to specialists; and

(B) For covered persons using ancillary services, including social services and other community resources, if applicable;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier's proposed plan for providing continuity of care if a contract termination occurs between the health carrier and any of its participating providers or in the event of the health carrier's insolvency or other inability to continue operations. The proposed plan for providing continuity of care shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations and transitioned to other providers in a timely manner; and

(11) Any other information required by the commissioner to determine compliance with this article.

§431: -D Requirements for health carriers and participating providers. (a) A health carrier shall establish a mechanism by which participating providers shall be notified on an ongoing basis of the specific covered health care services for which the providers will be responsible, including any limitations or conditions on services.

(b) Every contract between a health carrier and a participating provider shall contain the following hold harmless

statement, specifying protection for covered persons, or a substantially similar statement:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or a person other than the health carrier or intermediary, as applicable, acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons; provided that a provider shall not bill or collect from a covered person or a person acting on behalf of a covered person any charges for non-covered services or services that do not meet the criteria in section 432E-1.4, Hawaii Revised Statutes, unless an agreement of financial

responsibility specific to the service is signed by the covered person or a person acting on behalf of the covered person and is obtained prior to the time services are rendered. This agreement does not prohibit a provider, except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person; provided that the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

(c) Every contract between a health carrier and a participating provider shall provide that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing shall continue until the earlier of:

(1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or

(2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

(d) Contract provisions required by subsections (b) and (c) shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation-of-covered services requirements under subsections (b) and (c).

(e) In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

(f) Selection standards shall be developed pursuant to the following:

(1) Health carrier selection standards for selecting and tiering, as applicable, participating providers shall be developed for providers and each health care professional specialty;

(2) The standards shall be used in determining the selection of participating providers by the health carrier and the intermediaries with which the health carrier contracts. The standards shall meet requirements relating to health care professional credentialing verification developed by the commissioner through rules adopted pursuant to chapter 91;

(3) Selection criteria shall not be established in a manner:

(A) That would allow a health carrier to discriminate against high risk populations by excluding

providers because the providers are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health care services utilization;

(B) That would exclude providers because the providers treat or specialize in treating populations presenting a risk of higher than average claims, losses, or health care services utilization; or

(C) That would discriminate with respect to participation under the health benefit plan against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations; provided that this subparagraph shall not be construed to require a health carrier to contract with any provider who is willing to abide by the terms and conditions for participation established by the carrier;

(4) Notwithstanding paragraph (3), a carrier shall not be prohibited from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this article; and

(5) This article does not require a health carrier, its intermediaries, or the provider networks with which the carrier and its intermediaries contract, to employ specific providers acting within the scope of the providers' license or certification under applicable state law that may meet the selection criteria of the carrier, or to contract with or retain more providers acting within the scope of the providers' license or certification under applicable state law than are necessary to maintain a sufficient provider network.

(g) A health carrier shall make its standards for selecting participating providers available for review and approval by the commissioner. A description in plain language of the selection standards of the health carrier shall be made available to the public.

(h) A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to:

(1) Payment terms;

(2) Utilization review;

(3) Quality assessment and improvement programs;

(4) Credentialing procedures;

(5) Grievance and appeals procedures;

(6) Data reporting requirements including requirements for timely notice of changes in practice, such as discontinuance of accepting new patients;

(7) Confidentiality requirements; and

(8) Any applicable federal or state programs.

(i) A health carrier shall not offer an inducement to a provider that would encourage or otherwise motivate the provider not to provide medically necessary services to a covered person.

(j) A health carrier shall not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf

of covered persons within the utilization review or grievance or appeals processes established by the carrier or a person contracting with the carrier or in accordance with any rights or remedies available under applicable state or federal law.

(k) Every contract between a health carrier and a participating provider shall require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of, or amend the person's medical and health records.

(l) The departure of a provider from a network shall be subject to the following requirements:

(1) A health carrier and participating provider shall provide at least sixty days' written notice to each other before the provider is removed or leaves the network without cause;

(2) The health carrier shall make a good faith effort to provide written notice of a provider's removal or

leaving the network within thirty days of receipt or issuance of a notice provided in accordance with paragraph (1) to all covered persons who are patients seen on a regular basis by the provider who is being removed or leaving the network, irrespective of whether the removal or leaving the network is for cause or without cause;

(3) When the provider being removed or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. When the provider either gives or receives the notice in accordance with paragraph (1), the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier;

(4) When a provider leaves or is removed from the network, a health carrier shall establish reasonable procedures to transition all covered persons who are in an active course of treatment to a participating provider in a manner that provides for continuity of care;

(5) The health carrier shall provide the notice required under paragraph (1) and shall make available to all covered persons a list of available participating providers in the same geographic area who are of the same provider type and information about how the covered persons may request continuity of care as provided under paragraph (6);

(6) The continuity of care procedures shall provide that:

(A) Any request for continuity of care shall be made to the health carrier by the covered person or the covered person's authorized representative;

(B) Requests for continuity of care shall be reviewed by the health carrier's medical director after consultation with the treating provider for patients who are under the care of a provider who has not been removed or left the network for cause and who meet the criteria specified under the definition of:

(i) Active course of treatment;

(ii) Life-threatening health condition; or

(iii) Serious acute condition;

(C) Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;

(D) The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and

(E) The continuity of care period for covered persons who are undergoing an active course of treatment shall extend through the earliest of:

(i) The termination of the course of treatment by the covered person or the treating provider;

(ii) Ninety days, unless the medical director determines that a longer period is necessary;

(iii) The date that care is successfully transitioned to a participating provider;

(iv) The date that benefit limitations under the plan are met or exceeded; or

(v) The date that care is not medically necessary; and

(7) A continuity of care request shall only be granted when:

(A) The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and

(B) The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

(m) The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by either party without the prior written consent of the other party.

(n) A health carrier shall be responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This subsection shall not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(o) A health carrier shall notify participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

(p) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

(q) A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the health carrier.

(r) A contract between a health carrier and a provider shall not contain provisions that conflict with the network plan or this article.

(s) A contract between a health carrier and a provider shall be subject to the following requirements:

(1) At the time the contract is signed, the health carrier and, if appropriate, the intermediary shall timely notify the participating provider of all provisions and other documents incorporated by reference in the contract;

(2) While the contract is in force, the carrier shall timely notify the participating provider of any changes to those provisions or documents that would result in material changes in the contract;

(3) The health carrier shall timely inform the provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider; and

(4) For purposes of this subsection, the contract shall define what is considered timely notice and what is considered a material change.

§431: -E Provider directories. (a) A health carrier shall post electronically a current and accurate provider directory for each of the carrier's network plans with the information and search functions described in paragraphs (3) and (4) and:

(1) The health carrier shall ensure that the general public is able to view all current providers for a plan through an identifiable link or tab and without creating or accessing an account or entering a policy or contract number;

(2) The health carrier shall update each network plan provider directory at least monthly and shall periodically audit a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request;

(3) For each network plan, the health carrier shall make available the following information in a searchable format:

(A) For health care professionals:

(i) Name;

(ii) Gender;

(iii) Participating office locations;

(iv) Specialty, if applicable;

(v) Medical group affiliations, if applicable;

(vi) Facility affiliations, if applicable;

(vii) Participating facility affiliations, if applicable;

(viii) Languages spoken other than English, if applicable; and

(ix) Whether accepting new patients;

(B) For hospitals:

(i) Hospital name;

(ii) Hospital type, such as acute, rehabilitation, children's, or cancer;

(iii) Participating hospital location; and

(iv) Hospital accreditation status; and

(C) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Type of services performed; and

(iv) Participating facility locations; and

(4) In addition to the information in paragraph (3), a health carrier shall make available the following information for each network plan:

(A) For health care professionals:

(i) Contact information;

(ii) Board certifications; and

(iii) Languages spoken other than English by clinical staff, if applicable; and

(B) For hospitals and facilities other than hospitals: telephone number.

(b) Upon the request of a covered person or prospective covered person, a health carrier shall provide a print copy of a current provider directory or of the requested directory information as follows:

(1) The following provider directory information for the applicable network plan shall be included:

(A) For health care professionals:

(i) Contact information;

(ii) Participating office locations;

(iii) Specialty, if applicable;

(iv) Languages spoken other than English, if applicable; and

(v) Whether accepting new patients;

(B) For hospitals:

(i) Hospital name;

(ii) Hospital type, such as acute, rehabilitation, children's, or cancer; and

(iii) Participating hospital location and telephone number;

(C) For facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility locations and telephone number; and

(2) The health carrier shall include a disclosure in the provider directory that the information in paragraph

(1) included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website or call customer service to obtain current directory information.

(c) For electronic and print provider directories, a health carrier shall indicate the following information:

(1) For each network plan:

(A) A description of the criteria the carrier has used to build the carrier's provider network;

(B) If applicable, a description of the criteria the carrier has used to tier providers;

(C) If applicable, the method by which the carrier designates the different provider tiers or levels in the network and identifies, for each specific provider, hospital, or other type of facility in the network, the tier in which each is placed, such as by name, symbols, or grouping, so that a covered person or prospective covered person may identify the provider tier; and

(D) If applicable, that authorization or referral may be required to access some providers;

(2) The provider directory applicable to a network plan, such as inclusion of the specific name of the network plan as marketed and issued in this State; and

(3) A customer service electronic mail address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(d) For the information required by subsections (a)(3), (a)(4), and (b)(1) in a provider directory pertaining to a health care professional, hospital, or facility other than a hospital, the health carrier shall make available through electronic and print provider directories the source of the information and any limitations, if applicable.

(e) The electronic and print provider directories shall accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency.

§431: -F Intermediaries. (a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of section 431: -D.

(b) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

(c) A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in the carrier's own network or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

(d) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the State or ensure that the carrier has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty days' prior written notice from the health carrier.

(e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and

appropriateness of payments made to providers and health care services received by covered persons.

(f) If applicable, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the State and preserve them for the time period required by law in a manner that facilitates regulatory review.

(g) An intermediary shall allow the commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons, as necessary to determine compliance with this article.

(h) If an intermediary is insolvent, a health carrier may require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services. If a health carrier requires assignment, the health carrier shall remain obligated to pay the provider for furnishing covered services under the same terms and conditions as the intermediary prior to the insolvency.

(i) Notwithstanding any other provision of this section to the contrary, to the extent the health carrier delegates its responsibilities to the intermediary, the carrier shall retain

full responsibility for the intermediary's compliance with this article.

§431: -G Enforcement. (a) If the commissioner determines that:

(1) A health carrier has not contracted with a sufficient number of participating providers to ensure that covered persons have accessible health care services in a geographic area;

(2) A health carrier's network access plan does not ensure reasonable access to covered benefits;

(3) A health carrier has entered into a contract that does not comply with this article; or

(4) A health carrier has not complied with this article,

the commissioner shall require a modification to the access plan, institute a corrective action plan that shall be followed by the health carrier, or use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this article.

(b) The commissioner shall not arbitrate, mediate, or settle disputes regarding a decision not to include a provider in a network plan or provider network or regarding any other

dispute between a health carrier, its intermediaries, or one or more providers arising under a provider contract or its termination.

§431: -H Regulations. The commissioner may adopt rules pursuant to chapter 91 to carry out this article.

§431: -I Penalties. A violation of this article shall result in penalties as provided in this chapter.

§431: -J Severability. If any provision of this article or the application of any provision to a person or circumstance shall be held invalid, the remainder of this article and the application of the provision to a person or circumstance, other than those to which it is held invalid, shall not be affected."

SECTION 2. Chapter 432F, Hawaii Revised Statutes, is repealed.

SECTION 3. In codifying the new sections added by section 1 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

SECTION 4. This Act shall take effect on July 1, 2070, and shall apply to plan filings made in 2018 for health benefit

plans with a plan year that commences on or after January 1, 2019; provided that:

(1) Section 2 shall take effect on January 1, 2019;

(2) All provider and intermediary contracts in effect on the effective date of this Act shall comply with this Act no later than eighteen months after the effective date of this Act; provided that the insurance commissioner may extend the period of compliance for an additional period not to exceed six months if the health carrier demonstrates good cause for an extension;

(3) A new provider or intermediary contract that is issued or put in force on or after the effective date of this Act shall comply with this Act upon its effective date; and

(4) A provider contract or intermediary contract that is not described in paragraph (2) or (3) shall comply with this Act no later than eighteen months after the effective date of this Act.

S.B. NO. 387 S.D. 1 H.D. 1

Report Title:
Health Insurance; Network Access and Adequacy

Description:
Requires a health carrier with a network plan to maintain a network that includes sufficient numbers of appropriate types of providers to ensure that covered persons have access to covered services. Specifies contract, disclosure, continuity of care, and directory publication requirements. (SB387 HD1)

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