DAVID Y. IGE
GOVERNOR OF HAWAII

BRUCE S. ANDERSON, PHD
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony COMMENTING on HB2504
RELATING TO HEALTH INSURANCE.

REP. JOHN M. MIZUNO, CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date: February 4, 2020 Room Number: 329

Fiscal Implications: 1.0 FTE and $100,000 general fund appropriation for salary and operating expenses if enforcement authority is granted.

Department Testimony: The Department of Health (DOH) provides comments only regarding SECTION 2 of HB2504, and defers to the Department of Commerce and Consumer Affairs for amendments to chapters 431 and 432, Hawaii Revised Statutes.

HB2504 amends chapter 321 to compel health care providers, health care facilities, or hospitals to disclose in writing estimates of the cost of care that are not authorized by a patient's health plan, and which subsequently become the financial liability of the patient.

The lack of investigative and enforcement authority, including penalties, for DOH may negatively impact compliance with this statute. If health care providers, health care facilities, or hospitals do not fulfill the obligations of this Act, the patient does not appear to have recourse, at least through the Department of Health. If the Legislature authorizes regulatory and enforcement provisions for the department, at least 1.0 FTE is requested to manage this new responsibility. Future expansion is likely given the volume of health care service transaction per year.

The department respectfully recommends repealing SECTION 2 in its entirety and deleting all references to DOH unless appropriate regulatory powers are authorized.

Thank you for the opportunity to testify.

DAVID Y. IGE
GOVERNOR

JOSH GREEN
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
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CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

Testimony of the Department of Commerce and Consumer Affairs

Before the
House Committee on Health
Tuesday, February 4, 2020
8:30 a.m.
State Capitol, Conference Room 329

On the following measure:
H.B. 2504, RELATING TO HEALTH INSURANCE

Chair Mizuno and Members of the Committee:

My name is Colin Hayashida, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purposes of this bill are to: (1) establish disclosure and consent requirements for nonparticipating health care providers; (2) prohibit nonparticipating health care providers from balance billing patients in specific circumstances; and (3) establish rate calculation requirements for reimbursement of nonparticipating providers.

The Department appreciates the intent of relieving consumers of the impacts of unexpected balance bills. However, the Department has concerns that the provisions regulating health care provider conduct are being improperly placed in Hawaii Revised Statutes (HRS) chapter 431, article 10A (Accident and Health or Sickness Insurance Contracts); chapter 431, article 14G (Health Insurance Rate Regulation); chapter 432, article 1 (Mutual Benefit Societies); and chapter 432D (Health Maintenance

Organization Act). For example, section 3 of the bill at page 9, lines 8 to 10 amends HRS chapter 431, article 10A with language that includes "the participating ***provider*** shall not collect or attempt to collect from the insured sums owed by the insurer" (emphasis added).

Additionally, the bill references "usual and customary rate" on page 12, lines 4 and 19 to 20; page 16, line 9; page 17, lines 3 to 4; page 20, line 18; and page 21, lines 14 to 15. The bill defines "usual and customary rate" as the insurance provider's "average contracted rate." See, e.g., page 12, lines 20 to 21. The Insurance Division does not maintain information on contract rates that would allow it to readily verify the average contracted rate.

Thank you for the opportunity to testify on this bill.

HAWAII MEDICAL ASSOCIATION
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Phone (808) 536-7702 Fax (808) 528-2376
www.hawaiimedicalassociation.org

HOUSE COMMITTEE ON HEALTH
Rep. John Mizuno, Chair
Rep. Bertrand Kobayashi, Vice Chair

Date: February 4, 2020
Time: 8:30 a.m.
Place: Conference Room 329
From: Hawaii Medical Association
Michael Champion, MD, President
Christopher Flanders, DO, Executive Director

Re: HB 2504 Relating to Health Insurance
Position: CONCERNS WITH COMMENTS

The Hawaii Medical Association feels strongly that patients should not be caught up in what, in many cases, should be contractual arrangements between parties. While this is not the larger issue it is on the mainland, Hawaii does experience rare payment disagreements between health systems, health systems and providers, and insurers and health systems or providers.

The position of the Hawaii Medical Association is that statutory setting of payment rates is an unsatisfactory method of resolving disputes. The linking of statutory rates to Medicare or "usual and customary" rates is problematic in that Medicare rates are not designed to be a benchmark for rates over large geographic areas, nor are they designed for regional insurers to tie their rates. Rather, the use of available all payor claims databases, such as Fair Health, should be used to establish existing community standards.

The Hawaii Medical Association supports the establishment a fair arbitration system in which to mediate disputes, such as the arbitration system enacted by New York, whereby each side presents their settlement figure and a decision is made between submitted figures by the Insurance Commissioner.

Thank you for allowing the Hawaii Medical Association to testify on this issue.

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the House Committee on Health
Tuesday, February 4, 2020; 8:30 a.m.
State Capitol, Conference Room 329

RE: HOUSE BILL NO.2504, RELATING TO HEALTH INSURANCE.

Chair Mizuno, Chair Kobayashi, and Members of the Joint Committee:

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS** House Bill No. 2504, RELATING TO HEALTH INSURANCE.

The bill, as received by your Committee, would:

(1) Establish disclosure and consent requirements for health care providers, health care facilities, and hospitals that are nonparticipating providers in a patient's health care plan;

(2) Clarify the circumstances in which a patient not be liable to a health care provider for any sums owed by an insurer, mutual benefit society, or health maintenance organization; and

(3) Establish the rate at which a health insurance plan reimburses a nonparticipating provider who provides health care to a patient, unless otherwise agreed to by the nonparticipating provider and the health insurance plan.

By way of background, the HPCA represents Hawaii Federally-Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

The HPCA agrees with the findings asserted in SECTION 1 of the bill -- that "balance billing" or "surprise billing" creates significant financial hardships for patients who inadvertently receive medical services from out-of-network providers (as has been the case in emergency situations). The unwelcomed shock of unexpected medical bills to patients who had unknowingly received out-of-network services has become a growing problem for the consuming public. As this bill promotes greater transparency and protections to patients, the HPCA fully supports these efforts.

This bill places greater responsibility on the part of the provider to inform the patient on the extent and cost of the health care services being provided to the patient. The HPCA believes this is sound public policy.

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

It should be noted that FQHCs must provide services to all patients, regardless of their ability to pay, and that we are required to work with the patient when Medicaid or insurance reimbursement do not cover the entire costs of services provided. By law, FQHCs must let patients pay on a sliding scale based on their ability to pay. Losses are ultimately subsidized through government assistance in reimbursement. While no system is perfect, this approach is just one more model that can used by lawmakers to gain a better understanding of how to pay for health care in the private market.

Lastly, we note that while the proposed amendments in this bill would apply primarily to the private market, because Medicaid is governed through a partnership between the federal and State government rather than solely through state statute, we would recommend that the Hawaii State Department of Human Services be notified of this bill to ensure that there be seamless application of this public policy for both Medicaid recipients and private insureds throughout our State.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

AARP Real Possibilities in Hawaii

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HOUSE OF REPRESENTATIVES
Committee on Health
Tuesday, February 4, 2020
8:30 a.m.
Conference Room 329

To: Representative John Mizuno, Chair
Re: HB 2504 Relating to Health Insurance

Dear Chair Mizuno, Vice-Chair Kobayashi, and Members of the Committee,

My name is Keali'i Lopez, and I am the State Director for AARP Hawai'i. AARP is a membership organization of people age fifty and over, with nearly 145,000 members in Hawai'i. AARP advocates for issues that matter to Hawai'i families, including the high cost of long-term care; access to affordable, quality health care for all generations; and serving as a reliable information source on issues critical to people over the age of fifty.

AARP Hawai'i **supports HB 2504 with comments**. This bill establishes disclosure and consent requirements for nonparticipating health providers; prohibits nonparticipating health care providers from balance billing patients in specific circumstances.

AARP supports efforts to protect consumers against surprise bills from nonparticipating providers who provide services without the consumer's knowledge or consent in an otherwise in-networking setting. We particularly support provisions that prevent these unexpected bills when a person needs to use emergency services, and requiring insurers to notify enrollees by mail and websites of their rights and potential costs for out-of-network procedures.

To clarify and further strengthen this bill, the Committee may want to address a few additional issues:

- Provisions for enforcement
- Consumer reimbursement if a consumer pays a bill they weren't supposed to pay
- Use of out-of-network provider by the in-network facility without the knowledge or choice of the patient
- Extending the 24 hour timeframe to disclose the requirements of a nonparticipating provider in advance. (e.g. People may have taken time off from work, or traveled from neighbor islands and cannot easily change their decision if a disclosure is given only 24 hours in advance)

Thank you very much for the opportunity to support HB 2504, and to provide comments.

KAISER PERMANENTE®

Government Relations

Testimony of
Frank Richardson
Vice President & Regional Counsel

Before:
House Committee on Health
The Honorable John H. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair

February 4, 2020
8:30 a.m.
Conference Room 329

Re: HB2504, RELATING TO HEALTH INSURANCE.

Chair Mizuno, Vice-Chair Kobayashi, and committee members, thank you for this opportunity to provide testimony on HB2504 which seeks to protect Hawai'i consumers from egregious and unexpected out-of-network bills from facilities and providers.

Kaiser Permanente Hawai'i SUPPORTS HB2504

Kaiser Permanente Hawai'i is Hawai'i's largest integrated health system that provides care and coverage for approximately 259,000 members. Each day, more than 4,500 dedicated employees and more than 600 Hawai'i Permanente Medical Group physicians and providers come to work at Kaiser Permanente Hawai'i to care for our members at our 21 medical facilities, including Moanalua Medical Center, providing high-quality care for our members and delivering on our commitment to improve the health of the 1.4 million people living in the communities we serve.

As a not-for-profit health plan, Kaiser Permanente does not answer to shareholders. Our duty is to our members — firefighters, police officers, teachers, bus drivers, shipyard workers, and all the hard-working people of Hawai'i — who depend on us for affordable, high-quality care.

HB 2504 is a fair and reasonable market-based solution to addresses certain billing practices that can have an immensely negative financial impact on consumers when they are at their most vulnerable – including when they are receiving emergency care at out-of-network facilities and from out-of-network providers at in-network locations. Sometimes, consumers unknowingly receive care from a provider who is not in their health insurance network. In Hawaii, there is **no limit to what these out-of-network providers or facilities can charge**. As a result, the patient may be billed for the remaining charges after their insurer pays. These "surprise bills" put consumers at significant financial risk of medical debt from bills they should not owe. This burden can prolong patient suffering long after their health has been restored. HB 2504 is a common-sense way to **protect consumers and remove them from the middle of billing disputes** between providers and insurance companies while ensuring out-of-network providers receive a market-based rate that covers theirs costs. We believe HB 2504 will protect patients and is the best way to **address these soaring health care costs through a market-based approach.**

For too long, we've operated under a system that allows out-of-network facilities and providers to directly bill patients for remaining billed charges with virtually no restrictions. The burden of this market failure falls on the hardworking men and women of Hawai‘i – not just those who are balance-billed directly – but the entire community that bears these costs systemwide.

HB2504 ensures that for emergency situations and for situations where consumers go to an in-network hospital but see an out-of-network doctor, the payment to the out-of-network doctor or hospital reasonably covers their costs without incentivizing other providers to stay out-of-network or driving up costs to the system, including healthcare premiums. As a fully integrated system, which includes over 600 Hawai‘i Permanente Medical Group physicians and providers, Kaiser Permanente understands that any benchmark rate in HB2504 needs to cover the cost of services provided.

Kaiser Permanente Hawai‘i notes that the payment benchmark will only be applied to out-of-network providers operating at in-network facilities and to out-of-network facilities. It does not affect providers and hospitals that are in-network, which is the norm.

The payment benchmark ensures that the costs of the services are covered, without driving up costs to the system and to health insurance premiums. We believe payments should not be based on charges that are billed by the provider ("billed charges") or any database that uses "billed charges," because there is no limit to what a facility or provider may bill. Instead, by basing the benchmark on average in-network rates paid by carriers to contracted in-network providers or an equivalent percentage of the Medicare reimbursement rate, we ensure a fair and reasonable reimbursement rate for patients, providers, health plans and the healthcare system as a whole.

Thank you for the opportunity to provide testimony on this important measure.

Tuesday, February 4, 2020 at 8:30 am
Conference Room 329

House Committee on Health

To: Chair John M. Mizuno
Vice Chair Bertrand Kobayashi

From: Paige Heckathorn Choy
Director of Government Affairs
Healthcare Association of Hawaii

Re: Submitting Comments
HB 2504, Relating to Health Insurance

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 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.

Thank you for the opportunity to provide **comments** on this measure. Our members have not reached a consensus agreement on a position on this legislation. However, there is an important position that all members can agree on—that patients should be protected from gaps in coverage that result in surprise bills and that any policy solution should remove patients from payment negotiations between insurers and providers. With that as a guiding principle, the task before providers, insurers, and policy makers is how to best reach an agreement on payment for services provided out-of-network.

However, there is a responsibility on both providers and insurers to resolve this problem. Current discussions among members are focused on the benchmark rates used to pay providers, what types of appeals and mediation practices could be used in any dispute between a plan and a provider, where the responsibility of notification and disclosure should fall, and network adequacy. There is concern among providers that, as written, the burden of providing pertinent information to patients would likely fall predominantly on the hospital, facility, or individual practitioner who may not have access to the information required in this bill in a timely manner. Providers would also be interested in discussing the benchmark rates used and the potential of a mediation process.

Ultimately, HAH and its members do not want patients to bear the burden of being an intermediary between plans and providers and be caused undue stress over a surprise bill. We will continue our discussions as an organization on the major provisions and provide support, education, and research as necessary. Thank you for your consideration of our comments.

Phone: (808) 521-8961 | Fax: (808) 599-2879 | HAH.org | 707 Richards Street, PH2 - Honolulu, HI 96813

HAWAII / ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

January 31, 2020

Representative John Mizuno
Chair, House Committee on Health

Representative Bertrand Kobayashi
Vice Chair, House Committee on Health

HB2504: Relating to Health Insurance

Testimony in **OPPOSITION**

On behalf of our 152 emergency physician members, I am writing in opposition to SB2278. The legislation, as currently proposed, would have immediate and lasting effects on Hawaii's ability to provide quality care to those who are most vulnerable in our state.

We agree that a legislative solution to the surprise billing issue is necessary. Our proposal is based on very effective laws already in place in Connecticut and New York that ban balance billing while creating a fair and transparent system for determining out of network reimbursement for emergency care.

Here are the necessary components:

1. Remove patients from billing disputes by banning balance billing.

2. Use of a transparent, third-party database (not run by insurance companies) on which to base out of network reimbursement for emergency care. The FAIR Health Database is one such option.

3. Creation of a baseball-style arbitration system to resolve disputes between providers and insurers

The proposed use of the median in-network rate as determined by insurers in unacceptable. Insurers refuse to share information about their rates with providers or the public. **Four out of five 'Big Insurers' in the U.S. have been sued for illegally manipulating their 'usual, customary, and reasonable' (UCR) rates.** One such case (Ingenix, subsidiary of UnitedHealth Group), resulted in at least two multimillion-dollar settlements for fraudulently manipulating provider reimbursement. We suggest a transparent, third party database such as FAIR Health, that would inform the public and all health care stakeholders about charges from providers and reimbursement from insurers, and provide fair data on which

non-participating providers would be reimbursed. The FAIR Health Database in already in place and providing information across the country.

A cap on out on network charges based on Medicare rates would also harm providers and reduce access to care. Consider the negative impact on provider negotiation if out of network charges were limited to a given percentage of Medicare. Why would any insurer negotiate a rate of reimbursement greater than that cap if the out of network rate is already set? Government would effectively set the maximum rate of reimbursement for emergency providers without regard to market conditions.

Emergency physicians, on average, provide $138,000 in uncompensated care each year; far more than any other specialty. We treat any patient who comes to the emergency department asking for help regardless of their ability to pay. Hawaii's board-certified emergency physicians are as well trained as any in the world. They can work anywhere, and Hawaii faces stiff competition for their services from 49 states and the entire Pacific Rim. Reimbursement for emergency physicians in Hawaii already ranks in the bottom five states in the country. Our emergency physician groups routinely lose potential hires to other places solely because of compensation, and our neighbor islands and critical access hospitals are most at risk.

We ask for your help in creating a fair solution to surprise billing that will improve transparency in the health care system, protect patients, and maintain our ability to recruit and retain excellent emergency physicians to care for all of Hawaii.

Aloha

William Scruggs, MD
President-Elect, Hawaii College of Emergency Physicians
Chief of Staff, Adventist Health Castle

An Independent Licensee of the Blue Cross and Blue Shield Association

February 2, 2020

The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
House Committee on Health

Re: HB 2504 – Relating to Health Insurance

Dear Chair Mizuno, Vice Chair Kobayashi, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 2504, which establishes disclosure and consent requirements for nonparticipating health care providers. This measure also prohibits nonparticipating health care providers from balance billing patients in specific circumstances and establishes rate calculation requirements for reimbursement.

HMSA supports this measure and the protections that it extends to patients when they unknowingly receive services from a provider outside of their network. Nationally this issue is being discussed as an important consumer protection issue. We understand the issues that this measure tries to address are complicated, and therefore we remain open to more discussions and working with all stakeholders.

Thank you for the opportunity to provide testimony on this measure. Your consideration of our comments is appreciated.

Sincerely,

Pono Chong
Vice President, Government Relations

HB-2504
Submitted on: 2/3/2020 2:49:29 AM
Testimony for HLT on 2/4/2020 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Jennifer Azuma Chrupalyk	Individual	Support	No

Comments:

HB-2504
Submitted on: 2/3/2020 1:20:30 PM
Testimony for HLT on 2/4/2020 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Craig Thomas	Hawaii Emergency Physicians Associated	Oppose	No

Comments:

I believe this issue should be addressed nationally. Applying local control will disadvantage us in our competition with mainland groups to obtain excellent ED physicians at our rural sites.

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
Quality Healthcare For All

LATE

House Committee on Health
Representative John M. Mizuno, Chair
Representative Bertrand Kobayashi, Vice Chair

February 4, 2019
Conference Room 329
8:30 a.m.
Hawaii State Capitol

Testimony Supporting Intent with Request for Amendments
House Bill 2504
Establishes disclosure and consent requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers.

Linda Rosen, M.D., M.P.H.
Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporate Board of Directors, thank you for the opportunity to present testimony **supporting the intent with a request for amendments to H.B. 2504** that establishes disclosure and consent requirements for nonparticipating health care providers, prohibits nonparticipating health care providers from balance billing patients in specific circumstances, and establishes rate calculation requirements for reimbursement of nonparticipating providers.

While HHSC understands the impact that unanticipated medical billing, or surprise medical billing can have to patients, as written, this measure removes incentives to arrive at fair contracts with providers. Therefore, HHSC joins in partnership with most the other of Hawaii's major healthcare systems to propose amendments that clarify that the responsibility for disclosure and consent requirements should be with the member's health care plan, since they would most appropriately know which providers are participating or not. An amendment towards the removal of reference to rate setting and replacing it with a requirement that the insurer negotiate with the out-of-network provider to resolve payments and directing the Insurance commissioner to establish a dispute resolution process is also requested.

Thank you for the opportunity to testify before this committee. We appreciate the Committee's continued focus on improving healthcare for our island communities.

THE QUEEN'S HEALTH SYSTEMS

LATE

To: The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
Members, Committee on Health

From: Mich Riccioni, Executive Vice President and Chief Financial Officer, The Queen's Health Systems
Lehua Pate, Director, Corporate Revenue Cycle, The Queen's Health Systems
Date: February 3, 2020
Hrg: House Committee on Health Hearing; Tuesday, February 4, 2020 at 8:30 AM in Room 329

Re: **Comments HB 2504, Relating to Health Insurance**

The Queen's Health Systems (Queen's) is a not-for-profit corporation that provides expanded health care capabilities to the people of Hawai'i and the Pacific Basin. Since the founding of the first Queen's hospital in 1859 by Queen Emma and King Kamehameha IV, it has been our mission to provide quality health care services in perpetuity for Native Hawaiians and all of the people of Hawai'i. Over the years, the organization has grown to four hospitals, 66 health care centers and labs, and more than 1,600 physicians statewide. As the preeminent health care system in Hawai'i, Queen's strives to provide superior patient care that is constantly advancing through education and research.

Queen's appreciates the opportunity to offer comments with serious concerns for HB 2504, which establishes disclosure and consent requirements for nonparticipating health care providers; prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and establishes rate calculation requirements for reimbursement of nonparticipating providers.'

Queen's is committed to protecting patients from balance bills that result from unexpected gaps in insurance coverages, inadequate networks, and medical emergencies. Unfortunately, the proposed bill does not improve upon the current system, harms providers' ability to deliver quality care, and potentially limits access by creating a disincentive for insurers to contract with out-of-network providers.

The bill ties provider reimbursement to Medicare, which does not cover the cost of care. In FY2019, Queen's absorbed over $35.7 million in health care costs when Medicare reimbursement did not fully cover the cost of care. In total that year, Queen's absorbed over $82.8 million in reimbursement shortfall from both Medicaid and Medicare. By benchmarking payment to Medicare, the bill jeopardizes patient access to hospital care, especially for those in rural communities. Reimbursement for non-contracted insurers should be set at a higher rate than those who are contracted, otherwise contracted insurers will have no incentive to contract or

renew contracts on services. Thus, no incentive to provide an adequate network for their insured and ultimately limits access to care.

Additionally, when a patient receives a bill from an out-of-network provider it is because the insurance company refuses to pay the claim. Insurers have a duty and obligation to their insured to satisfy and resolve claims with out-of-network providers.

To best serve the interests of our patients, Queen's, Hawaii Pacific Health, Adventist Health Castle, and Hawaii Health Systems Corporation are proposing amended language that:

- Clarifies that the health care plan is responsible for the disclosure and consent requirements since they would most appropriately know which providers are participating or not in their network.
- Takes the patient out of the middle by requiring the insurer to negotiate with the out-of-network provider to resolve payment and removes references that tie provider reimbursement to Medicare.
- Directs the Insurance Commissioner to establish a dispute resolution process for non-emergent services.
- Maintains an insurers' responsibility to their insured.

We would also note that the Congress is currently considering measures to address out-of-network billing and is expected to address this issue by the end of May, so the bill may not be necessary. Thank you for the opportunity to testify on this measure and your consideration of the amendments.

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

H.B. NO. 2504

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that the patients with health insurance who receive treatment from an out-of-network provider may be subject to the practice known as "balance billing" or "surprise billing", where the provider bills the patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge. These bills occur most often when patients inadvertently receive medical services from out-of-network providers, such as when a patient is undergoing surgery and is not informed that a member of the medical team is not a participating provider in the patient's health insurance's provider network, or when a patient is in need of emergency services and is taken to the nearest medical facility, regardless of the facility's or its providers' network status. Out-of-network providers may not have a contracted rate with a health insurer for services; therefore, the prices these providers may charge may be much greater than the price charged by in-network providers for similar services.

The legislature further finds that balance bills or surprise bills can be an unwelcome shock to patients who may have unknowingly received health care services outside of their provider network. These unexpected medical bills are a major concern for Americans.

According to a September 2018 Kaiser Family Foundation poll, two-thirds of respondents said they were "very worried" or "somewhat worried" that they or a family member would receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses. Furthermore, out-of-network bills sent to health insurers or carriers from physicians can be more than thirty times the average in-network rate for those same services.

Currently, there is no comprehensive protection from surprise bills or balance bills at the federal level and, while there is a growing trend toward state action to protect patients from surprise bills or balance bills, most state laws do not provide comprehensive protections. However, the trend is changing. At least nine states including California, Oregon, Maryland, Connecticut, Illinois, New York, New Hampshire, New Jersey, and Florida have enacted comprehensive approaches to end balance billing and surprise bills. Similarly, New Mexico, Texas, Washington, and Colorado passed new comprehensive laws in 2019. Hawaii patients continue to be at risk of being caught in the middle of balance billing disputes between health insurers and providers or being hit with significant surprise bills.

The purpose of this Act is to specify:

(1) Disclosure and consent requirements for health care providers, health care facilities, and hospitals that are nonparticipating providers in a patient's health care plan;

(2) The circumstances in which a patient shall not be liable to a health care provider for any sums owed by an insurer, mutual benefit society, or health maintenance organization; and

(3) The rate at which a health insurance plan must reimburse a nonparticipating provider who provides health care to a patient, unless otherwise agreed to by the nonparticipating provider and the health insurance plan.

SECTION 2. Chapter 321, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§321-___ Disclosure and consent required.** (a) A health care plan~~health care provider, health care facility, or hospital~~ shall disclose the following information in writing to their insured ~~patients or prospective patients~~ prior to the provision of non-emergency services that are not authorized by the patients' health care plan:

(1) That certain health care facility-based health care providers may be called upon to render care to a covered person during the course of treatment;

(2) That those health care facility-based health care providers may not have contracts with the covered person's health care plan and are therefore considered to be out-of-network providers;

(3) That the services provided will be on an out-of-network basis and the cost may be substantially higher than if the services were provided in-network;

(4) A notification that the covered person may either agree to accept and pay the charges for the out-of-network services or rely on any other rights and remedies that may be available under state or federal law; and

(5) A statement indicating that the covered person may obtain from the covered person's health care plan a list of health care facility-based health care providers who are participating providers and the covered person may request those participating facility-based health care providers.

(b) If a health care provider, health care facility, or hospital is not a participating provider in a patient's or prospective patient's health care plan network, and the patient is receiving non-emergency health care services, the health care ~~provider, health care facility, or hospital~~plan shall:

(1) At least twenty-four hours prior to the provision of non-emergency services, disclose to the patient or prospective patient in writing and in compliance with subsection (c), the amount or estimated amount that the health care provider, health care facility, or hospital will bill the patient or prospective patient for non-emergency health care services provided or anticipated to be provided to the patient or prospective patient, not including unforeseen medical circumstances that may arise when the health care services are provided; and

(2) At least twenty-four hours prior to the provision of non-emergency services, obtain the written consent of the patient or prospective patient for provision of services by the nonparticipating health care provider, health care facility, or hospital in writing separate from the document used to obtain the consent for any other part of the care or procedure; provided that the consent shall not be obtained at the time of

admission or at any time when the patient or prospective patient is being prepared for surgery or any other procedure.

(c) Any communication from the ~~nonparticipating health care provider, health care facility, or hospital~~health care plan to the ~~patient or prospective patient~~insured shall include notice in a twelve-point bold type stating that the communication is not a bill and informing the ~~patient or prospective patient~~insured that the insured ~~patient or prospective patient~~ shall not pay any amount or estimated amount until the insured ~~patient's or prospective patient~~'s health care plan informs the insured ~~patient or prospective patient~~ of any applicable cost-sharing.

(d) A ~~nonparticipating health care provider, health care facility, or hospital~~health care plan that fails to comply with this section shall not bill or collect any amount from the insured ~~patient or prospective patient~~ in excess of the in-network cost-sharing owed by the insured~~patient or prospective patient~~ that would be billed or collected for the same services rendered by a participating health care provider, health care facility, or hospital.

(e) For purposes of this section:

"Health care facility" means any institution, place, building, or agency, or portion thereof, licensed or otherwise authorized by the State, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, or rehabilitative or preventive care to any person or persons.

"Health care plan" means a policy, contract, plan, or agreement delivered or issued for delivery by a health insurance company, mutual benefit society governed by article 1 of chapter 432, health maintenance organization governed by chapter 432D, or any other entity delivering or issuing for delivery in the State accident and health or sickness insurance as defined in section 431:1-205, other than disability insurance that replaces lost income.

"Health care provider" means an individual who is licensed or otherwise authorized by the State to provide health care services.

"Hospital" means:

(1) An institution with an organized medical staff, regulated under section 321-11(10), that admits patients for inpatient care, diagnosis, observation, and treatment; and

(2) A health facility under chapter 323F.

"In-network cost-sharing" means the amount owed by a covered person to a health care provider, health care facility, or hospital that is a participating member of the covered person's health care plan's network."

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

"**§431:10A-A Balance billing; hold harmless; emergency services.** (a) Every contract between an insurer and a participating provider of health care services shall be in writing and shall set forth that in the event the insurer fails to pay for health care services as set forth in the contract, the insured shall not be liable to the provider for any sums owed by the insurer.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the insured sums owed by the insurer. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against an insured too:~~

~~(1) cCollect sums owed by the insurer.; or~~

~~(2) Collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible under the insured's policy of accident and health or sickness insurance.~~

(b~~c~~) When an insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, the insured shall not incur greater out-of-pocket costs for emergency services than the insured would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against an insured to collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible under the insured's policy of accident and health or sickness insurance.~~

(d) When the insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, an insurer shall be responsible to fulfill their obligation to the insured and shall enter into negotiation with the provider who is not a participating provider in the provider network of the insured to resolve any sums owed by the insurer.

(e~~d~~) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§431:10A-B Balance billing; hold harmless; non-emergency services. (a) ~~Absent a signed consent form as required under section 321- , ~~ no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any

action at law against an insured to collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the insured's policy of accident and health or sickness insurance.

(b) When the insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, an insurer shall be responsible to fulfill their obligation to the insured and shall enter into negotiation with the provider who is not a participating provider in the provider network of the insured to resolve any sums owed by the insurer."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 14G to be appropriately designated and to read as follows:

"§431:14G- **Out-of-network or nonparticipating provider reimbursement; rate calculation.** (a) ~~Absent a signed consent form as required under section 321- or any contract to the contrary,~~ Aa managed care plan shall be responsible to fulfill their obligation to the insured and enter into negotiation with the non-participating provider. The managed care plan and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by

the insurance commissioner. If not resolution is met, the managed care plan shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~be responsible to fulfill their obligation to the enrollee and enter into negotiation with the non-participating provider. The managed care plan and non-participating provider shall come to an agreement within thirty days of issuance of an invoice for the emergency services provided as to the amount the non-participating provider shall be compensated. If no agreement is reached within thirty days, the manage care plan shall pay the non-participating provider the amount billed by the non-participating provider. reimburse a nonparticipating provider the greater of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the insured's managed care plan; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a managed care plan to cover services not

required by law or by the terms and conditions of the managed care plan. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from enrollees who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section "usual and customary rate" shall mean the managed care plan's average contracted rate."~~

SECTION 5. Chapter 432, Hawaii Revised Statutes, is amended by adding three new sections to article 1 to be appropriately designated and to read as follows:

"§432:1- **Balance billing; hold harmless; emergency services.** (a) Every contract between a mutual benefit society and a participating provider of health care services shall be in writing and shall set forth that in the event the mutual benefit society fails to pay for health care services as set forth in the contract, the subscriber or member shall not be liable to the provider for any sums owed by the mutual benefit society.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required~~

~~prohibition, the participating provider shall not collect or attempt to collect from the subscriber or member sums owed by the mutual benefit society. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to:~~

~~(1) cCollect sums owed by the mutual benefit society; or.~~

~~(2) Collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible under the subscriber's or member's plan contract.~~

(c) When a subscriber or member receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or member, the subscriber or member shall not incur greater out-of-pocket costs for emergency services than the subscriber or member would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible under the subscriber's or member's plan contract.~~

(d) When a subscriber or member receives emergency services from a provider who is not a participating

provider in the provider network of the subscriber or member, the mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or member, to resolve any sums owed by the mutual benefit society.

(e~~d~~) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§432:1- Balance billing; hold harmless; non-emergency services. (a) ~~Absent a signed consent form as required under section 321- , N~~no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the subscriber's or member's plan contract.

(b) When a subscriber or member receives non-emergency services from a provider who is not a participating provider in the provider network of the subscriber or member, the mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or member, to resolve any sums owed by the mutual benefit society.

§432:1- Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) ~~AAbsent a signed consent form as required under section 321- or any contract to the contrary, a~~ mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and enter into negotiation with the non-participating provider. The mutual benefit society and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by the insurance commissioner. If not resolution is met, the mutual benefit society shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~be responsible to fulfill their obligation to the subscriber or member and enter into negotiation with the non-participating provider. The mutual benefit society and non-participating provider shall come to an agreement within thirty days of issuance of an invoice for the non-emergency services provided as to the amount the non-participating provider shall be compensated. If no agreement is reached within thirty days, the mutual~~

~~benefit society shall pay the non-participating provider the amount billed by the non-participating provider.of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the subscriber's or member's plan contract; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a mutual benefit society to cover services not required by law or by the terms and conditions of the plan contract. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from subscribers or members who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section "usual and customary rate" shall mean the mutual benefit society's average contracted rate."~~

SECTION 6. Chapter 432D, Hawaii Revised Statutes, is amended by adding three new sections to be appropriately designated and to read as follows:

"**§432D- Balance billing; hold harmless; emergency services.** (a) Every contract between a health

maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the carrier or health maintenance organization.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to:~~

~~(1) Collect sums owed by the health maintenance organization; or~~

~~(2) Collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible under the subscriber's or enrollee's policy, contract, plan, or agreement.~~

(c) When a subscriber or enrollee receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or enrollee, the subscriber or enrollee shall

not incur greater out-of-pocket costs for emergency services than the subscriber or enrollee would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible under the subscriber's or enrollee's policy, contract, plan, or agreement.~~

(d) When a subscriber or enrollee receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or enrollee, the carrier or health maintenance organization shall be responsible to fulfill their obligation to the subscriber or enrollee and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or enrollee, to resolve any sums owed by the carrier or health maintenance organization.

(e~~d~~) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a

prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§432D- Balance billing; hold harmless; non-emergency services. ~~Absent a signed consent form as required under section 321- ,~~ No nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible for

similar services provided by a participating provider under the subscriber's or enrollee's policy, contract, plan, or agreement.

§432D- Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) ~~AAbsent a signed consent form as required under section 321- or any contract to the contrary, a~~ health maintenance organization shall be responsible to fulfill their obligation to the subscriber or enrollee and enter into negotiation with the non-participating provider. The health maintenance organization and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by the insurance commissioner. If not resolution is met, the health maintenance organization shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~reimburse a nonparticipating provider the greater of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the subscriber's or enrollee's policy, contract, plan, or agreement; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a health maintenance organization to cover services not required by law or by the terms and conditions of the policy, contract, plan, or agreement. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from subscribers or enrollees who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section "usual and customary rate" shall mean the carrier or health maintenance organization's average contracted rate."~~

SECTION 7. Section 431:10-109, Hawaii Revised Statutes, is amended to read as follows:

"[~~§~~]§431:10-109[~~:~~] **Disclosure of [~~health care coverage and benefits.~~] information.** (a) In order to ensure that all individuals understand their health care options and are able to make informed decisions, all insurers shall provide current and prospective insureds with written disclosure of [~~coverages and benefits,~~

~~including information on coverage principles and any exclusions or restrictions on coverage.~~] the following information:

(1) Coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage;

(2) With regard to out-of-network coverage:

(A) For non-emergency services where the insured has consented to services provided by an out-of-network provider in accordance with section 321- , the amount that the insurer will reimburse under the rate calculation for out-of-network health care specified in section 431:14G- ; and

(B) Examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and

(3) Information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area based upon the difference between what the insurer will reimburse for out-of-network health care services and the rate calculation specified in section 431:14G- for out-of-network health care services.

(b) The information provided shall be current, understandable, and available prior to the issuance of a

policy, and upon request after the policy has been issued[.]; provided that nothing in this section shall prevent an insurer from changing or updating the materials that are made available to insureds.

(c) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient."

SECTION 8. In codifying the new sections added by section 3 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 9. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 10. This Act shall take effect upon its approval.

INTRODUCED BY: _____

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S.B. NO. 2278

Report Title:
Balance Billing; Surprise Billing; Prohibitions; Health Insurance; Nonparticipating Providers

Description:
Establishes disclosure and consent requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers.

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

Adventist Health Castle

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Tel (808) 263-5500
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February 3, 2020

LATE

To: The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
Members, Committee on Health

From: Kathy Raethel, President, Adventist Health Castle

Date: February 3, 2020
Hrg: House Committee on Health Hearing (Room 329)
Hearing Date/Time: Wednesday, February 4, 2020, 8:30 a.m.

RE: **Comments H.B. 2504, Relating to Health Insurance**

Dear Chair Mizuno and Members of the Committee:

Adventist Health Castle appreciates the opportunity to offer comments to H.B. 2504, which seeks to establish disclosure and consent requirements for providers regarding plan information; prohibits nonparticipating health care providers from balance billing patients in certain circumstances; and seeks to institute rate calculation requirements for reimbursement for non-participating providers.

AH Castle is fully supports the intent of the bill, which is to protect patients from any gaps in payor networks and insulate them from billing disputes between a payor and provider. AH Castle strongly believes, however, that the substance of the bill fails to meet its intent.

The notice and requirement portion of the bill places the onus on providers to communicate to patients the details of their insurance plan prior to commencing non-emergent treatment, something that as providers, we are not easily as privy to as the payors themselves. This notice includes not just informing the patient whether a provider (or multiple providers as the case may be) is in-network, but arguably includes informing the patient whether the service provided is in their plan. Such information is most accurately conveyed by the payor who set up the network and designed the plan, not by the provider, and is more appropriately the responsibility of the payor with whom the patient contracted with.

The bill also seeks to establish baseline payment amounts for out-of-network providers, setting the rate at either the "usual and customary" plan rate or at Medicare rates. This leaves numerous swaths of the population vulnerable, as Medicare does not cover certain services (i.e. women and children) and some plans fail to provide coverage for particular services, leaving the bench mark of "usual and customary" obsolete. A rate baseline that is to be determined solely by the health plan, and/or a rate baseline that is set below cost, disincentivizes health plans to negotiate in good faith with providers, and patients are left paying for a network that shrinks with every contract renewal.

In an effort to meet the needs of our patients and further the intent of the bill, AH Castle, Queens Health Systems, Hawaii Pacific Health and Hawaii Health Systems Corporation, support the attached amendments that include language that:

- Clarifies that the health care plan is responsible to inform the insured the details of their plans and networks;
- Requires that the health care plan and the provider seek a resolution to any billing dispute without including the patient;

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- Removes the disincentive for health care plans to negotiate in good faith with providers by removing references to Medicare rates or “usual and customary” rates;
- Directs the Insurance Commissioner to establish a dispute resolution proccess for non-emergent procedures;

Sincerely,

DocuSigned by:
Kathy Raethel
0C1EC2CCABA9454...

Kathy Raethel
President
Adventist Health Castle

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

H.B. NO. 2504

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that the patients with health insurance who receive treatment from an out-of-network provider may be subject to the practice known as "balance billing" or "surprise billing", where the provider bills the patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge. These bills occur most often when patients inadvertently receive medical services from out-of-network providers, such as when a patient is undergoing surgery and is not informed that a member of the medical team is not a participating provider in the patient's health insurance's provider network, or when a patient is in need of emergency services and is taken to the nearest medical facility, regardless of the facility's or its providers' network status. Out-of-network providers may not have a contracted rate with a health insurer for services; therefore, the prices these providers may charge may be much greater than the price charged by in-network providers for similar services.

The legislature further finds that balance bills or surprise bills can be an unwelcome shock to patients who may have unknowingly received health care services outside of their provider network. These unexpected medical bills are a major concern for Americans.

According to a September 2018 Kaiser Family Foundation poll, two-thirds of respondents said they were "very worried" or "somewhat worried" that they or a family member would receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses. Furthermore, out-of-network bills sent to health insurers or carriers from physicians can be more than thirty times the average in-network rate for those same services.

Currently, there is no comprehensive protection from surprise bills or balance bills at the federal level and, while there is a growing trend toward state action to protect patients from surprise bills or balance bills, most state laws do not provide comprehensive protections. However, the trend is changing. At least nine states including California, Oregon, Maryland, Connecticut, Illinois, New York, New Hampshire, New Jersey, and Florida have enacted comprehensive approaches to end balance billing and surprise bills. Similarly, New Mexico, Texas, Washington, and Colorado passed new comprehensive laws in 2019. Hawaii patients continue to be at risk of being caught in the middle of balance billing disputes between health insurers and providers or being hit with significant surprise bills.

The purpose of this Act is to specify:

(1) Disclosure and consent requirements for health care providers, health care facilities, and hospitals that are nonparticipating providers in a patient's health care plan;

(2) The circumstances in which a patient shall not be liable to a health care provider for any sums owed by an insurer, mutual benefit society, or health maintenance organization; and

(3) The rate at which a health insurance plan must reimburse a nonparticipating provider who provides health care to a patient, unless otherwise agreed to by the nonparticipating provider and the health insurance plan.

SECTION 2. Chapter 321, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§321- Disclosure and consent required.** (a) A health care plan~~health care provider, health care facility, or hospital~~ shall disclose the following information in writing to their insured ~~patients or prospective patients~~ prior to the provision of non-emergency services that are not authorized by the patients' health care plan:

(1) That certain health care facility-based health care providers may be called upon to render care to a covered person during the course of treatment;

(2) That those health care facility-based health care providers may not have contracts with the covered person's health care plan and are therefore considered to be out-of-network providers;

(3) That the services provided will be on an out-of-network basis and the cost may be substantially higher than if the services were provided in-network;

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(4) A notification that the covered person may either agree to accept and pay the charges for the out-of-network services or rely on any other rights and remedies that may be available under state or federal law; and

(5) A statement indicating that the covered person may obtain from the covered person's health care plan a list of health care facility-based health care providers who are participating providers and the covered person may request those participating facility-based health care providers.

(b) If a health care provider, health care facility, or hospital is not a participating provider in a patient's or prospective patient's health care plan network, and the patient is receiving non-emergency health care services, the health care ~~provider, health care facility, or hospital~~plan shall:

(1) At least twenty-four hours prior to the provision of non-emergency services, disclose to the patient or prospective patient in writing and in compliance with subsection (c), the amount or estimated amount that the health care provider, health care facility, or hospital will bill the patient or prospective patient for non-emergency health care services provided or anticipated to be provided to the patient or prospective patient, not including unforeseen medical circumstances that may arise when the health care services are provided; and

(2) At least twenty-four hours prior to the provision of non-emergency services, obtain the written consent of the patient or prospective patient for provision of services by the nonparticipating health care provider, health care facility, or hospital in writing separate from the document used to obtain the consent for any other part of the care or procedure; provided that the consent shall not be obtained at the time of

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admission or at any time when the patient or prospective patient is being prepared for surgery or any other procedure.

(c) Any communication from the ~~nonparticipating health care provider, health care facility, or hospital~~health care plan to the ~~patient or prospective patient~~insured shall include notice in a twelve-point bold type stating that the communication is not a bill and informing the ~~patient or prospective patient~~insured that the insured ~~patient or prospective patient~~ shall not pay any amount or estimated amount until the insured ~~patient's or prospective patient~~'s health care plan informs the insured ~~patient or prospective patient~~ of any applicable cost-sharing.

(d) A ~~nonparticipating health care provider, health care facility, or hospital~~health care plan that fails to comply with this section shall not bill or collect any amount from the insured ~~patient or prospective patient~~ in excess of the in-network cost-sharing owed by the insured~~patient or prospective patient~~ that would be billed or collected for the same services rendered by a participating health care provider, health care facility, or hospital.

(e) For purposes of this section:

"Health care facility" means any institution, place, building, or agency, or portion thereof, licensed or otherwise authorized by the State, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, or rehabilitative or preventive care to any person or persons.

"Health care plan" means a policy, contract, plan, or agreement delivered or issued for delivery by a health insurance company, mutual benefit society governed by article 1 of chapter 432, health maintenance organization governed by chapter 432D, or any other entity delivering or issuing for delivery in the State accident and health or sickness insurance as defined in section 431:1-205, other than disability insurance that replaces lost income.

"Health care provider" means an individual who is licensed or otherwise authorized by the State to provide health care services.

"Hospital" means:

(1) An institution with an organized medical staff, regulated under section 321-11(10), that admits patients for inpatient care, diagnosis, observation, and treatment; and

(2) A health facility under chapter 323F.

"In-network cost-sharing" means the amount owed by a covered person to a health care provider, health care facility, or hospital that is a participating member of the covered person's health care plan's network."

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

"**§431:10A-A Balance billing; hold harmless; emergency services.** (a) Every contract between an insurer and a participating provider of health care services shall be in writing and shall set forth that in the event the insurer fails to pay for health care services as set forth in the contract, the insured shall not be liable to the provider for any sums owed by the insurer.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the insured sums owed by the insurer. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against an insured too:~~

~~(1) cCollect sums owed by the insurer.; or~~

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~~(2) Collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible under the insured's policy of accident and health or sickness insurance.~~

(b~~c~~) When an insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, the insured shall not incur greater out-of-pocket costs for emergency services than the insured would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against an insured to collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible under the insured's policy of accident and health or sickness insurance.~~

(d) When the insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, an insurer shall be responsible to fulfill their obligation to the insured and shall enter into negotiation with the provider who is not a participating provider in the provider network of the insured to resolve any sums owed by the insurer.

(e~~d~~) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§431:10A-B Balance billing; hold harmless; non-emergency services. (a) ~~Absent a signed consent form as required under section 321- , ~~no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any

action at law against an insured to collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the insured's policy of accident and health or sickness insurance.

(b) When the insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, an insurer shall be responsible to fulfill their obligation to the insured and shall enter into negotiation with the provider who is not a participating provider in the provider network of the insured to resolve any sums owed by the insurer."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 14G to be appropriately designated and to read as follows:

"**§431:14G- Out-of-network or nonparticipating provider reimbursement; rate calculation.** (a) ~~Absent a signed consent form as required under section 321- or any contract to the contrary,~~ ~~A~~a managed care plan shall be responsible to fulfill their obligation to the insured and enter into negotiation with the non-participating provider. The managed care plan and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by

the insurance commissioner. If not resolution is met, the managed care plan shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~be responsible to fulfill their obligation to the enrollee and enter into negotiation with the non-participating provider. The managed care plan and non-participating provider shall come to an agreement within thirty days of issuance of an invoice for the emergency services provided as to the amount the non-participating provider shall be compensated. If no agreement is reached within thirty days, the manage care plan shall pay the non-participating provider the amount billed by the non-participating provider. reimburse a nonparticipating provider the greater of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the insured's managed care plan; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a managed care plan to cover services not

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required by law or by the terms and conditions of the managed care plan. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from enrollees who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section "usual and customary rate" shall mean the managed care plan's average contracted rate."~~

SECTION 5. Chapter 432, Hawaii Revised Statutes, is amended by adding three new sections to article 1 to be appropriately designated and to read as follows:

"**§432:1- Balance billing; hold harmless; emergency services.** (a) Every contract between a mutual benefit society and a participating provider of health care services shall be in writing and shall set forth that in the event the mutual benefit society fails to pay for health care services as set forth in the contract, the subscriber or member shall not be liable to the provider for any sums owed by the mutual benefit society.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required~~

~~prohibition, the participating provider shall not collect or attempt to collect from the subscriber or member sums owed by the mutual benefit society. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to:~~

~~(1) cCollect sums owed by the mutual benefit society; or.~~

~~(2) Collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible under the subscriber's or member's plan contract.~~

(c) When a subscriber or member receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or member, the subscriber or member shall not incur greater out-of-pocket costs for emergency services than the subscriber or member would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible under the subscriber's or member's plan contract.~~

(d) When a subscriber or member receives emergency services from a provider who is not a participating

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provider in the provider network of the subscriber or member, the mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or member, to resolve any sums owed by the mutual benefit society.

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(ed) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§432:1- Balance billing; hold harmless; non-emergency services. (a) ~~Absent a signed consent form as required under section 321- , N~~no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the subscriber's or member's plan contract.

(b) When a subscriber or member receives non-emergency services from a provider who is not a participating provider in the provider network of the subscriber or member, the mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or member, to resolve any sums owed by the mutual benefit society.

§432:1- Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) AAbsent a signed consent form as required under section 321- or any contract to the contrary, a mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and enter into negotiation with the non-participating provider. The mutual benefit society and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by the insurance commissioner. If not resolution is met, the mutual benefit society shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. be responsible to fulfill their obligation to the subscriber or member and enter into negotiation with the non-participating provider. The mutual benefit society and non-participating provider shall come to an agreement within thirty days of issuance of an invoice for the non-emergency services provided as to the amount the non-participating provider shall be compensated. If no agreement is reached within thirty days, the mutual

~~benefit society shall pay the non-participating provider the amount billed by the non-participating provider.of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the subscriber's or member's plan contract; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a mutual benefit society to cover services not required by law or by the terms and conditions of the plan contract. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from subscribers or members who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section "usual and customary rate" shall mean the mutual benefit society's average contracted rate."~~

SECTION 6. Chapter 432D, Hawaii Revised Statutes, is amended by adding three new sections to be appropriately designated and to read as follows:

"§**432D- Balance billing; hold harmless; emergency services.** (a) Every contract between a health

maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the carrier or health maintenance organization.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to:~~

~~(1) Collect sums owed by the health maintenance organization; or~~

~~(2) Collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible under the subscriber's or enrollee's policy, contract, plan, or agreement.~~

(c) When a subscriber or enrollee receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or enrollee, the subscriber or enrollee shall

not incur greater out-of-pocket costs for emergency services than the subscriber or enrollee would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible under the subscriber's or enrollee's policy, contract, plan, or agreement.~~

(d) When a subscriber or enrollee receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or enrollee, the carrier or health maintenance organization shall be responsible to fulfill their obligation to the subscriber or enrollee and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or enrollee, to resolve any sums owed by the carrier or health maintenance organization.

(~~ed~~) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a

prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§432D- Balance billing; hold harmless; non-emergency services. ~~Absent a signed consent form as required under section 321- ,~~ ~~N~~no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible for

similar services provided by a participating provider under the subscriber's or enrollee's policy, contract, plan, or agreement.

§432D- Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) ~~AAbsent a signed consent form as required under section 321- or any contract to the contrary, a~~ health maintenance organization shall be responsible to fulfill their obligation to the subscriber or enrollee and enter into negotiation with the non-participating provider. The health maintenance organization and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by the insurance commissioner. If not resolution is met, the health maintenance organization shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~reimburse a nonparticipating provider the greater of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the subscriber's or enrollee's policy, contract, plan, or agreement; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a health maintenance organization to cover services not required by law or by the terms and conditions of the policy, contract, plan, or agreement. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from subscribers or enrollees who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section "usual and customary rate" shall mean the carrier or health maintenance organization's average contracted rate."~~

SECTION 7. Section 431:10-109, Hawaii Revised Statutes, is amended to read as follows:

"[~~§~~]**§431:10-109**[~~§~~] **Disclosure of** [~~**health care coverage and benefits.**~~] **information.** (a) In order to ensure that all individuals understand their health care options and are able to make informed decisions, all insurers shall provide current and prospective insureds with written disclosure of [~~coverages and benefits,~~

~~including information on coverage principles and any exclusions or restrictions on coverage.~~] the following information:

(1) Coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage;

(2) With regard to out-of-network coverage:

(A) For non-emergency services where the insured has consented to services provided by an out-of-network provider in accordance with section 321- , the amount that the insurer will reimburse under the rate calculation for out-of-network health care specified in section 431:14G- ; and

(B) Examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and

(3) Information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area based upon the difference between what the insurer will reimburse for out-of-network health care services and the rate calculation specified in section 431:14G- for out-of-network health care services.

(b) The information provided shall be current, understandable, and available prior to the issuance of a

policy, and upon request after the policy has been issued[.]; provided that nothing in this section shall prevent an insurer from changing or updating the materials that are made available to insureds.

(c) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient."

__.B. NO._____

SECTION 8. In codifying the new sections added by section 3 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 9. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 10. This Act shall take effect upon its approval.

INTRODUCED BY: _____

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S.B. NO. 2278

Report Title:
Balance Billing; Surprise Billing; Prohibitions; Health Insurance; Nonparticipating Providers

Description:
Establishes disclosure and consent requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers.

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

LATE

HB-2504
Submitted on: 2/3/2020 7:23:08 PM
Testimony for HLT on 2/4/2020 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Lee R Weiss MD	Maui Emergent Medical Associates	Oppose	No

Comments:

Regarding SB2278/HB2504, SB2423/HB1881

Respectfully we are requesting consideration for the following amendments

1. There needs to be a fair and equitable arbitration process.

New York State has addressed this with legislation https://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills

https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/

https://www.vox.com/health-care/2019/3/19/18233051/surprise-medical-bills-arbitration-new-york

A “baseball” form of arbitration would be fair to both providers and insurers.

1. There needs to be a fair unbiased method to value provider work product, such as www.fairhealth.org

2. Definitions of balanced and surprise billing needs clarity as patients frequently are not aware of their responsibilities according to their own health insurance. Especially in instances of high deductible health insurance claims.
3. We respectively suggest Emergency Physicians and providers deserve special consideration and dispensation for their unique EMTALA burden such as provided by exemption in CA AB 72.
4. Balance billing from Hawaii emergency physicians for those with Hawaii health care plans is very rare. Hawaii's Insurance Division informed us that, after removing 14 complaits related to air transport in 2015, Hawaii has averaged less than 3 balance billing complaints each year since 2009. Balance billing from emergency physicians in Hawaii is limited to patients with mainland coverage, and is only used when the patient's plans do not reimburse appropriately. Often, we have little contact and few patients with those plans and have very little opportunity to contract with the
5. Patients should not be in the middle of disputes between insurers and providers. However, in the absence of the above amendments and an equal playing field between insurers and providers, there will be little to jo incentive for the insurers to negotiate in a good faith manner with providers. Downward pressure on provider reimbursement will place the patient back in the middle now related to declining access to care. A Kaiser Foundation study suggests that 25% of Hawaiian practicing physicians are at a retirement age. HI has a 700+ plus physician shortage becoming more hyper Acute yearly. Access to primary and specialty care is already critically difficult. Prohibiting balance billing would harm patients by limiting access to emergency care.
6. Recruiting high-quality emergency physicians to Hawaii is already challenging, particularly for rural areas and neighbor islands. Emergency physicians provide, on average, $138,000 in uncompensated care each year. Hawaii's emergency physician compensation consistently ranks among the bottom five states in the country, even before considering the high cost of living. The vast majority of Hawaii's emergency physicians are board-certified in emergency medicine. They are true specialists, and as well trained as any emergency phsyicians in the world. They can work anywhere, and Hawaii faces stiff competition from 49 other states and the rest of the pacific rim. Our emergency physician groups routinely lose potential hires to other states solely because of compensation. Continued downward pressure on reimbursement through devices such as SB2668 will make staffing our emergency departments with quality physicians increasingly difficult.

LATE

Comments on SB2278 & HB2504

The last 15 years in health care has led to radical changes in what insurers pay for. There has been the introduction of "high deductible; health plans which in some cases makes the patients responsible for the first $5,000 to $10,000 of annual costs. The co-pays have also risen dramatically, and patients seem shocked when they get bills because they do not understand their co-pays and deductibles. Federal law already protects patients seeking emergency care form being exposed to higher co-pays and deductibles even if they are out of network. So regardless of being a participating provider or out of network in both cases co-pays and deductibles will be the same.

Clarification of what constitute surprise billing and definition of terms

Deductible: the amount that is the patient's responsibility as defined in the insurance that has been given to the patient

Co-pay: for each and every service the amount that is the patient's responsibility

In Network vs Out of Network typically after a negotiation period between a provider and a health plan the provider agrees to provide a discount from their usual fees in return for a volume of referrals and for prompt payment. This is the benefit of the bargain when a provider contracts.

It makes practical sense to contract with dominant health plans on the island or within the state. It is not possible nor practical to contract with health plans in all 50 states as there is no substantial volume of patients coming from out of state plans.

ERISA claims: Certain insurance plans are governed by federal not state laws and these have come to be known as ERISA plans. For these plans the insurance company pays the enrollee and providers then bill the enrollee for the full amount. This is totally permissible.

UC&R Usual, Customary and Reasonable is a term that refers to the providers charges which are based upon their experience, their practice costs and the cost of living in the area they practice in. UCR in Hawaii is substantially more than in Florida or Texas so practice costs must be considered. Charges for a board-certified specialist with more training will be more than a family physician.

Health plans need to clarify clearly on patient benefits and EOB's what is the yearly deductible for their health plan and what their co-pay is as well. There is total confusion on what is a patients legal responsibility and unfortunately this confusion frequently leads to the perception that a patients bill is a surprise bill when in reality it is a legitimate bill which encompasses their deductible and their co-pay or a non-covered benefit.

Health care is analogous to a three-legged stool.

- There are PATIENTS who do not want to be in the middle of payor provider disputes but who also want access to quality care and specialists.
- There are INSURERS who are struggling to control the costs of healthcare and equally have a profit motive that the less they pay the more they make.
- There are the PROVIDERS who took an oath to advocate what is in the best interests of their patients and whom struggle with the high costs of living in the islands and who leave training burdened with massive amounts of student loans often approaching $500,000 at the end of their training

There is a delicate ecosystem that needs to be preserved. There is general consensus that the patients need to be kept out of the middle of billing disputes but at the same time in planning a system that does so we all need to be mindful of preserving QUALITY and ACCESS.

Hawaii is suffering from a lack of physicians which has led to less ACCESS and this shortage jeopardizes QUALITY. The following 2019 article highlights this issue:

https://www.hawaiinewsnow.com/2019/09/10/hawaiis-doctor-shortage-is-taking-troubling-turn-worse/

- in 2019 there was an exodus of physicians
- Estimates indicate we need 700 more physicians in the islands
- Fully 25% of HI physicians are over the age of 60 and with retirement looming this shortage will get worse

With all of this in mind it is critical that a system be carefully designed to keep patients out of the middle but we also need to be mindful that reimbursements need to be enough to keep physicians in the islands and attract new physicians to alleviate our upcoming shortage.

The current proposed legislation needs several modifications to ensure that all goals are met, and that the system be transparent and fair to all.

Other states have already tackled this issue and we can learn by those that have crafted solutions before us:

In CA AB 72 was passed in 2016. This bill recognizes that Emergency physicians bear the burden of caring for the uninsured and provides certain practical exemptions for Emergency providers

In NY the legislature passed in 2015 a bill Insurance Section 3241c that was intended to stop surprise billing

The current proposals shift power significantly from the system as it currently exists to benefit the insurers.

1) It allows insurance companies to pay providers who are not in network to pay the average of their current contracted in network rates. This system is not known to the public nor is it transparent. A proper system would be to use a public database maintained by an independent third party and to set this to the 50=75% of the average of charges submitted within that zip code.

An example of a publicly available database is: FAIRhealth.org

2) New York's bill allows for an independent dispute resolution process. They use independent arbitrators and baseball style arbitration to resolve disputes between the insurance companies and providers.

The addition of items 1&2 above would significantly help establish a fair system between providers and insurers while keeping patients out of the middle of these disputes

HAWAI'I PACIFIC HEALTH | KAPI'OLANI PALI MOMI STRAUB WILCOX

LATE

LATE

Date: February 4, 2020
Time: 8:30 am
Room: Conference Room 329

House Committee on Health

To: Representative John Mizuno, Chair
Representative Bert Kobayashi, Vice Chair

From: Michael Robinson
Vice President – Government Relations & Community Affairs

Re: HB 2504 – Relating To Health Insurance
SUPPORT INTENT PROVIDING PROPOSED LANGUAGE

My name is Michael Robinson, Vice President, Government Relations and Community Affairs at Hawai'i Pacific Health (HPH). Hawai'i Pacific Health is a not-for-profit health care system comprised of its four medical centers – Kapi'olani, Pali Momi, Straub and Wilcox and over 70 locations statewide with a mission of creating a healthier Hawai'i.

We support the intent and offer suggested amendments to HB 2504 which establishes disclosure and consent requirements for nonparticipating health care providers and prohibits nonparticipating health care providers from balance billing patients in specific circumstances. The bill also stablishes rate calculation requirements for reimbursement of nonparticipating providers.

Hawai'i Pacific Health has experience working with a variety of insurers and providers and believes in maintaining the integrity of the contracting process between health providers and health insurers in determining fair and adequate reimbursement methodologies for health care services that have already been delivered to patients/insured. As a provider organization, we also assume that both healthcare insurers and healthcare providers have a *shared* responsibility to protect patients from financial burdens to ensure access to medically necessary care.

Hawai'i Pacific Health believes that for emergency services, where medical necessity eliminates the opportunity for a patient to make a choice based on a provider's network status with a health plan, the patient should not be responsible for charges where patient choice is not possible.

While we share the stated intent of this bill, we have the following concerns of the current bill as drafted:

- **Section 2**: The disclosure and consent requirement as written places the responsibility *solely upon the health-care provider to inform the patient of a provider's network status with an insurer*. Placing this responsibility solely upon the healthcare provider is misplaced and will be inadequate for the patient. It would be more helpful to the patient for the insurer to be responsible to provide this notice to its subscribers as the health plan would have more timely

and helpful information for a subscriber to make a decision on where to access care, than information the health care provider would be able to provide at the point of care.

A health plan would also be able to provide to its subscriber/patient the most important information to a member: (1) whether the particular scheduled service is covered by the insured's plan; (2) how much their out of pocket would be for the service for that particular plan for that particular member. By placing this requirement on the healthcare provider – instead of the insurer – this requirement as written would create unnecessary patient anxiety and potentially appointment cancellations by having the provider bear the responsibility of the disclosure and consent form.

Section 3, Section 5, Section 6: We agree that a patient should not incur greater out-of-pocket costs for emergency services than the insured would have incurred with a participating provider of health care services. However we also believe that the insurer should be required to fulfill their obligation to their member and be required to work with the health care provider to negotiate a settlement to resolve any sums owed on behalf of their insured.

Section 4: The specification of a statutory defined reimbursement rate of the greater of "usual and customary" and *any* percent of Medicare will not adequately cover the entire range of medical services for billing that a patient may encounter. For example:

(1) What would the "usual and customary rate" be for a service that an HMO does not provide either generally or "...in the *general geographic region in which the services were rendered*"? For example Wilcox is the only provider of trauma and neurology services in *the general geographic region of Kaua'i.* What would the "usual and customary rate" of that service be for an HMO that currently does not deliver that service for itself on the island of Kaua'i.

(2) There is no applicable Medicare reimbursement methodology for most pediatric procedures and services for women of child-rearing age who are not disabled. Utilizing Medicare as a basis for reimbursement for services delivered for these populations could potentially be incalculable with the bill as written.

To address these concerns, Hawai'i Pacific Health is currently working with HAH members Queens Health System, Castle Medical Center, Hawai'i Health System Corporation on language that would achieve the following goals (see attached Proposed Amendments);

- For non-emergent services, provide a disclosure and consent requirement process that provides patients with the most accurate, meaningful and timely status of a provider's network status with a plan;

- Remove disincentives for a plan and provider to come to the table to negotiate contract terms for payment for medical services provided to a plan member;

- Incentivize health plans to make reasonable efforts to invest in developing an adequate network for its members by retaining incentives for insurers to contract for services with providers.

Finally, we support the establishment of a dispute resolution process before a disinterested 3rd party. The establishment of such a process would incentivize both plans and providers to reach

a settlement with knowledge of binding arbitration being a possible remedy. The insurance commissioner who has the ability to promulgate administrative rules is ideally situated to assume the role of arbitrator or mediator in resolving issues involving out-of-network charges and medical reimbursements.

Accordingly, we suggest the following amendments.

"<u>432E- Dispute resolution.</u>

(a) When the non-participating health care provider and the managed care plan are unable to reach an agreement as to the amount to be billed for the services provided by the non-participating provider, the matter shall be submitted to the insurance commissioner for binding arbitration or mediation.

(b) The non-participating provider and managed care plan shall agree on whether the matter shall be subject to binding arbitration or mediation within 45 days of notification by the managed care plan to the non-participating provider that the managed care plan disagrees with the amount billed for the services rendered to the enrollee.

(c) The insurance commissioner may adopt rules to enact this section.

(d) This section shall apply to emergency and non-emergency services provided by a non-participating provider.

Thank you for your consideration of this important matter. Proposed bill amendments attached.

THE ~~SENATE~~HOUSE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

H.B. NO. 2504

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that the patients with health insurance who receive treatment from an out-of-network provider may be subject to the practice known as "balance billing" or "surprise billing", where the provider bills the patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge. These bills occur most often when patients inadvertently receive medical services from out-of-network providers, such as when a patient is undergoing surgery and is not informed that a member of the medical team is not a participating provider in the patient's health insurance's provider network, or when a patient is in need of emergency services and is taken to the nearest medical facility, regardless of the facility's or its providers' network status. Out-of-network providers may not have a contracted rate with a health insurer for services; therefore, the prices these providers may charge may be much greater than the price charged by in-network providers for similar services.

The legislature further finds that balance bills or surprise bills can be an unwelcome shock to patients who may have unknowingly received health care services outside of their provider network. These unexpected medical bills are a major concern for Americans.

According to a September 2018 Kaiser Family Foundation poll, two-thirds of respondents said they were "very worried" or "somewhat worried" that they or a family member would receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses. Furthermore, out-of-network bills sent to health insurers or carriers from physicians can be more than thirty times the average in-network rate for those same services.

Currently, there is no comprehensive protection from surprise bills or balance bills at the federal level and, while there is a growing trend toward state action to protect patients from surprise bills or balance bills, most state laws do not provide comprehensive protections. However, the trend is changing. At least nine states including California, Oregon, Maryland, Connecticut, Illinois, New York, New Hampshire, New Jersey, and Florida have enacted comprehensive approaches to end balance billing and surprise bills. Similarly, New Mexico, Texas, Washington, and Colorado passed new comprehensive laws in 2019. Hawaii patients continue to be at risk of being caught in the middle of balance billing disputes between health insurers and providers or being hit with significant surprise bills.

The purpose of this Act is to specify:

(1) Disclosure and consent requirements for health care providers, health care facilities, and hospitals that are nonparticipating providers in a patient's health care plan;

(2) The circumstances in which a patient shall not be liable to a health care provider for any sums owed by an insurer, mutual benefit society, or health maintenance organization; and

(3) The rate at which a health insurance plan must reimburse a nonparticipating provider who provides health care to a patient, unless otherwise agreed to by the nonparticipating provider and the health insurance plan.

SECTION 2. Chapter 321, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§321-___ Disclosure and consent required.** (a) A ~~health care plan, health care provider, health care facility, or dentist~~ shall disclose the following information in writing to their insured ~~patients or prospective patients~~ prior to the provision of non-emergency services that are not authorized by the patients' health care plan:

(1) That certain health care facility-based health care providers may be called upon to render care to a covered person during the course of treatment;

(2) That those health care facility-based health care providers may not have contracts with the covered person's health care plan and are therefore considered to be out-of-network providers;

(3) That the services provided will be on an out-of-network basis and the cost may be substantially higher than if the services were provided in-network;

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(4) A notification that the covered person may either agree to accept and pay the charges for the out-of-network services or rely on any other rights and remedies that may be available under state or federal law; and

(5) A statement indicating that the covered person may obtain from the covered person's health care plan a list of health care facility-based health care providers who are participating providers and the covered person may request those participating facility-based health care providers.

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(b) If a health care provider, health care facility, or hospital is not a participating provider in a patient's or prospective patient's health care plan network, and the patient is receiving non-emergency health care services, the health care provider, health care facility, or hospital shall:

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(1) At least twenty-four hours prior to the provision of non-emergency services, disclose to the patient or prospective patient in writing and in compliance with subsection (c), the amount or estimated amount that the health care provider, health care facility, or hospital will bill the patient or prospective patient for non-emergency health care services provided or anticipated to be provided to the patient or prospective patient, not including unforeseen medical circumstances that may arise when the health care services are provided; and

(2) At least twenty-four hours prior to the provision of non-emergency services, obtain the written consent of the patient or prospective patient for provision of services by the nonparticipating health care provider, health care facility, or hospital in writing separate from the document used to obtain the consent for any other part of the care or procedure; provided that the consent shall not be obtained at the time of

admission or at any time when the patient or prospective patient is being prepared for surgery or any other procedure.

(c) Any communication from the ~~nonparticipating health care provider, health care facility, or hospital~~health care plan to the ~~patient or prospective patient~~insured shall include notice in a twelve-point bold type stating that the communication is not a bill and informing the ~~patient or prospective patient~~insured that the ~~insured patient or prospective patient~~ shall not pay any amount or estimated amount until the ~~insured patient's or prospective patient~~'s health care plan informs the ~~insured patient or prospective patient~~ of any applicable cost-sharing.

(d) A ~~nonparticipating health care provider, health care facility, or hospital~~health care plan that fails to comply with this section shall not bill or collect any amount from the ~~insured patient or prospective patient~~ in excess of the in-network cost-sharing owed by the ~~insured patient or prospective patient~~ that would be billed or collected for the same services rendered by a participating health care provider, health care facility, or hospital.

(e) For purposes of this section:

"Health care facility" means any institution, place, building, or agency, or portion thereof, licensed or otherwise authorized by the State, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, or rehabilitative or preventive care to any person or persons.

"Health care plan" means a policy, contract, plan, or agreement delivered or issued for delivery by a health insurance company, mutual benefit society governed by article 1 of chapter 432, health maintenance organization governed by chapter 432D, or any other entity delivering or issuing for delivery in the State accident and health or sickness insurance as defined in section 431:1-205, other than disability insurance that replaces lost income.

"Health care provider" means an individual who is licensed or otherwise authorized by the State to provide health care services.

"Hospital" means:

(1) An institution with an organized medical staff, regulated under section 321-11(10), that admits patients for inpatient care, diagnosis, observation, and treatment; and

(2) A health facility under chapter 323F.

"In-network cost-sharing" means the amount owed by a covered person to a health care provider, health care facility, or hospital that is a participating member of the covered person's health care plan's network."

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

"**§431:10A-A Balance billing; hold harmless; emergency services.** (a) Every contract between an insurer and a participating provider of health care services shall be in writing and shall set forth that in the event the insurer fails to pay for health care services as set forth in the contract, the insured shall not be liable to the provider for any sums owed by the insurer.

~~(b) If a contract with a participating provider has not been required to writing as required by subsection (a), or if a contract fails to contain the required provision, the participating provider shall not collect or attempt to collect from the insured sums owed by the insurer. No participating provider or agent, trustee, or assignee thereof may maintain any action at law against an insured to:~~

~~(1) Collect sums owed by the insurer; or~~

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~~(2) Collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible under the insured's policy of accident and health or sickness insurance.~~

(b) When an insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, the insured shall not incur greater out-of-pocket costs for emergency services than the insured would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against an insured to collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible under the insured's policy of accident and health or sickness insurance.~~

(a) When the insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, an insurer shall be responsible to fulfill their obligation to the insured and shall enter into negotiation with the provider who is not a participating provider in the provider network of the insured to resolve any sums owed by the insurer.

(c) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§431:10A-B Balance billing; hold harmless; non-emergency services. ~~(a) Absent a signed consent form as required under section 32-----,~~ no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any

action at law against an insured to collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the insured's policy of accident and health or sickness insurance.

(c) When the insurer receives emergency services from a provider who is not a participating provider in the provider network of the insured, an insurer shall be responsible to fulfill their obligation to the insured and shall enter into negotiation with the provider who is not a participating provider in the provider network of the insured to resolve any sums owed by the insurer."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 14G to be appropriately designated and to read as follows:

"**§431:14G- Out-of-network or nonparticipating provider reimbursement; rate calculation.** (a) ~~Absent a signed consent form as required under section 431:14G- or any contract to the contrary,~~ An managed care plan shall be responsible to fulfill their obligation to the insured and enter into negotiation with the non-participating provider. The managed care plan and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by

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the insurance commissioner. If not resolution is met, the managed care plan shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 9 to establish an independent dispute resolution process. ~~be responsible to fulfill their obligation to the provider and enter into negotiation with the non-participating provider. The managed care plan and non-participating provider shall come to an agreement within thirty days of issuance of an invoice for the emergency services provided as to the amount the non-participating provider shall be compensated. If no agreement is reached within thirty days, the managed care plan shall pay the non-participating provider the amount billed by the non-participating provider, reimburse a participating provider the greater of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the insured's managed care plan; or~~

~~(2) 75 per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

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(b) Nothing in this section shall be construed to require a managed care plan to cover services not

required by law or by the terms and conditions of the managed care plan. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from enrollees who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this part, "usual and customary rate" shall mean the managed care plan's average contracted rate.~~"

SECTION 5. Chapter 432, Hawaii Revised Statutes, is amended by adding three new sections to article 1 to be appropriately designated and to read as follows:

"**§432:1- Balance billing; hold harmless; emergency services.** (a) Every contract between a mutual benefit society and a participating provider of health care services shall be in writing and shall set forth that in the event the mutual benefit society fails to pay for health care services as set forth in the contract, the subscriber or member shall not be liable to the provider for any sums owed by the mutual benefit society.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required~~

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~~prohibition, the participating provider shall not collect or attempt to collect from the subscriber or member sums owed by the mutual benefit society. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to~~

~~(1) eCollect sums owed by the mutual benefit society; or.~~

~~(2) Collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible under the subscriber's or member's plan contract.~~

(c) When a subscriber or member receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or member, the subscriber or member shall not incur greater out-of-pocket costs for emergency services than the subscriber or member would have incurred with a participating provider of health care services. ~~No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible under the subscriber's or member's plan contract.~~

(d) When a subscriber or member receives emergency services from a provider who is not a participating

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provider in the provider network of the subscriber or member, the mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or member, to resolve any sums owed by the mutual benefit society.

(e) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

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(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§432:1- Balance billing; hold harmless; non-emergency services. (a) ~~Absent a signed consent form as required under section 321-__, No~~ nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums in excess of the amount owed by the subscriber or member as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the subscriber's or member's plan contract.

(b) When a subscriber or member receives non-emergency services from a provider who is not a participating provider in the provider network of the subscriber or member, the mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and shall enter into negotiation with the provider who is not a participating provider in the provider network or the subscriber or member, to resolve any sums owed by the mutual benefit society.

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§432:1- Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) ~~Absent a signed consent form as required under section 32, or~~ any contract ~~to the contrary,~~ mutual benefit society shall be responsible to fulfill their obligation to the subscriber or member and enter into negotiation with the non-participating provider. The mutual benefit society and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by the insurance commissioner. If not resolution is met, the mutual benefit society shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~be responsible to fulfill their obligation to the subscriber or member and enter into negotiation with the non-participating provider. The mutual benefit society and non-participating provider shall come to an agreement within thirty days of issuance of an invoice for the non-emergency services provided as to the amount the non-participating provider shall be compensated. If no agreement is reached within thirty days, the mutual~~

~~permit society shall pay the nonparticipating provider the amount billed by the nonparticipating provider:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the subscriber's or member's plan contract; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a mutual benefit society to cover services not required by law or by the terms and conditions of the plan contract. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from subscribers or members who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section "usual and customary rate" shall mean the mutual benefit society's average contracted rate."~~

SECTION 6. Chapter 432D, Hawaii Revised Statutes, is amended by adding three new sections to be appropriately designated and to read as follows:

"**§432D- Balance billing; hold harmless; emergency services.** (a) Every contract between a health

maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the carrier or health maintenance organization.

~~(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a carrier fails to contain the required provision, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to:~~

~~(1) Collect sums owed by the health maintenance organization; or~~

~~(2) Collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible under the subscriber's or enrollee's policy, contract, plan, or agreement.~~

(c) When a subscriber or enrollee receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or enrollee, the subscriber or enrollee shall

not incur greater out-of-pocket costs for emergency services than the subscriber or enrollee would have incurred with a participating provider of health care services. ~~No nonparticipating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible under the subscriber's or enrollee's policy, contract, plan, or agreement.~~

(b) When a subscriber or enrollee receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or enrollee, the carrier or health maintenance organization shall be responsible to fulfill their obligation to the subscriber or enrollee and shall enter into negotiation with the provider who is not a participating provider in the provider network of the subscriber or enrollee, to resolve any sums owed by the carrier or health maintenance organization.

(c) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a

prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of the person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient.

§432D- Balance billing; hold harmless; non-emergency services. ~~Absent a signed consent form as required under section [illegible],~~ no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible for

similar services provided by a participating provider under the subscriber's or enrollee's policy, contract, plan, or agreement.

§432D-___ Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) ~~Absent a signed agreement to the contrary, a~~ health maintenance organization shall be responsible to fulfill their obligation to the subscriber or enrollee and enter into negotiation with the non-participating provider. The health maintenance organization and non-participating provider shall come to an agreement through an independent dispute resolution process, as established by the insurance commissioner. If not resolution is met, the health maintenance organization shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~reimburse a nonparticipating provider the greater of:~~

~~(1) The usual and customary rate for similar services provided by a participating provider under the subscriber's or enrollee's policy, contract, plan, or agreement; or~~

~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.~~

(b) Nothing in this section shall be construed to require a health maintenance organization to cover services not required by law or by the terms and conditions of the policy, contract, plan, or agreement. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from subscribers or enrollees who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321- .

~~(c) For purposes of this section, "usual and customary rate" shall mean the carrier or health maintenance organization's average contracted rate.~~"

SECTION 7. Section 431:10-109, Hawaii Revised Statutes, is amended to read as follows:

"[~~1~~]**§431:10-109**[~~1~~] **Disclosure of** [~~**health care coverage and benefits.**~~] **information.** (a) In order to ensure that all individuals understand their health care options and are able to make informed decisions, all insurers shall provide current and prospective insureds with written disclosure of [~~coverages and benefits,~~

~~including information on coverage principles and any exclusions or restrictions on coverage.~~] the following information:

(1) Coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage;

(2) With regard to out-of-network coverage:

(A) For non-emergency services where the insured has consented to services provided by an out-of-network provider in accordance with section 321- , the amount that the insurer will reimburse under the rate calculation for out-of-network health care specified in section 431:14G- ; and

(B) Examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and

(3) Information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area based upon the difference between what the insurer will reimburse for out-of-network health care services and the rate calculation specified in section 431:14G- for out-of-network health care services.

(b) The information provided shall be current, understandable, and available prior to the issuance of a

policy, and upon request after the policy has been issued[~~.~~]; provided that nothing in this section shall prevent an insurer from changing or updating the materials that are made available to insureds.

(c) For purposes of this section:

"Emergency condition" means a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient."

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SECTION 8. In codifying the new sections added by section 3 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 9. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 10. This Act shall take effect upon its approval.

INTRODUCED BY: _____

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S.B. NO. 2278

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Report Title:
Balance Billing; Surprise Billing; Prohibitions; Health Insurance; Nonparticipating Providers

Description:
Establishes standards and consumer requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients for emergency services. Establishes requirements for reimbursement of nonparticipating providers.

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