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
Phone Number: 586-2850
Fax Number: 586-2856
cca.hawaii.gov

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

Testimony of the Department of Commerce and Consumer Affairs

Before the
Senate Committee on Judiciary
Tuesday, February 25, 2020
12:30 p.m.
State Capitol, Conference Room 016

On the following measure:
S.B. 2278, S.D. 1, RELATING TO HEALTH INSURANCE

WRITTEN TESTIMONY ONLY

Chair Rhoads 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 supports the intent of and offers comments on this bill.

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

The Department appreciates the intent of relieving consumers of the impacts of unexpected balance bills and offers the following comments:

- S.D. 1 deletes proposed HRS chapter 321 provisions from the original S.B. 2278 that placed various obligations on providers. As balance billing includes balance bills that are issued by providers, the Department believes this bill would be more comprehensive if it retains those obligations on providers.

- While the “hold harmless” provisions of S.D. 1 prohibit providers from “maintain[ing] any action at law against [a consumer] to collect sums” owed (see, e.g., page 4, lines 17 to 19), this does not appear to cover other attempts to collect in general. The “hold harmless” provisions would be more comprehensive if they were amended to protect consumers from attempts to collect in general, rather than only from attempts to collect by maintaining an “action at law.”
- S.D. 1 provides that disputes between health plans and providers “shall be submitted to mandatory mediation to be overseen by the insurance division.” See, e.g., page 6, lines 1 to 3. The Insurance Division lacks the expertise and staff that would be required to perform this duty. Instead, the Department suggests that the Insurance Division have oversight over mediations, rather than provide a mediation forum, and that settlements could instead be reported to the Insurance Division.
- S.D. 1 references “usual and customary rate” on page 8, lines 1 and 11 to 12; page 12, line 10; page 13, lines 1 to 2; page 17, line 6; and page 17, lines 18 to 19. The bill defines “usual and customary rate” as the insurance provider’s “average contracted rate.” See, page 17, lines 18 to 20. The Insurance Division does not maintain information on contract rates that would allow it to readily verify the average contracted rate.
- The definition of “emergency services” (see, e.g., page 6, line 17 to page 7, line 4) is inconsistent with the definition in HRS chapter 432E. Accordingly, the Department suggests amending the definition of “emergency services” to be consistent with HRS chapter 432E.

Thank you for the opportunity to testify on this bill.

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Karl Rhoads, Chair
The Honorable Jarrett Keohokalole, Vice Chair
Members, Committee on Judiciary

From: Mich Riccioni, Executive Vice President and Chief Financial Officer, The Queen's Health Systems
Colette Masunaga, Manager, Government Relations & External Affairs, The Queen's Health Systems

Date: February 22, 2020

Hrg: Senate Committee on Judiciary Decision Making; Tuesday, February 25, 2020 at 12:30 p.m. in Room 016

Re: **Comments SB 2278 SD1, 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 Hawaiʻi 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 Hawaiʻi. 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 Hawaiʻi, 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 S.B. 2278 SD1, which 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. While we support the intent of the bill, as written, we do not believe the measure improves upon the current system. The bill ties provider reimbursement to either the arbitrary rate set by the plan or some percent of 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. Providers deserve to receive fair payment for the medical services they provides to patients. Any attempts to benchmark payment to arbitrary plan rates or Medicare rates would jeopardize patient access to hospital care, especially for those in rural communities.

Reimbursement for non-contracted health plans should be set at a higher rate than those who are contracted, otherwise contracted health plans 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.

To best serve the interests of our patients, Queen's concurs with the amendments offered by the Healthcare Association of Hawaii (HAH), which removes reference to harmful rate setting language and takes patients out of the middle between provider and health plan disputes by establishing an independent dispute resolution process. The proposed amendments also recognize the duty and obligation a health plan has to their insured to satisfy and resolve claims with out-of-network providers.

Thank you for the opportunity to testify on this measure and your consideration of the amendments.

Testimony to the Senate Committee on Judiciary
Tuesday, February 25, 2020; 12:30 p.m.
State Capitol, Conference Room 016

RE: SENATE BILL NO.2278, SENATE DRAFT 1, RELATING TO HEALTH INSURANCE.

Chair Rhoads, Vice Chair Keohokalole, 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** Senate Bill No. 2278, Senate Draft 1, RELATING TO HEALTH INSURANCE.

The bill, as received by your Committee, would:

(1) Specify 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;

(2) Specify 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;

(3) Require health insurance payors to use a transparent third-party database on which to calculate out-of-network provider reimbursements for emergency services; and

(4) Require mandatory mediation to resolve disputes between insurers and providers to be overseen by the Insurance Division of the Department of Commerce and Consumer Affairs.

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.

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.

1132 Bishop Street, #1920 | Honolulu, HI 96813
1-866-295-7282 | Fax: 808-537-2288 | TTY: 1-877-434-7598
aarp.org/hi | hiaarp@aarp.org | twitter: @AARPHawaii
facebook.com/AARPHawaii

LATE

THE SENATE
Committee on Judiciary
Tuesday, February 25, 2020
12:30 p.m.
Conference Room 016

To: Senator Karl Rhoads, Chair
Re: SB 2278 SD 1 Relating to Health Insurance

Dear Chair Rhoads, Vice-Chair Keohokalole, 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 SB 2278 SD1**. 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.

Thank you very much for the opportunity to support SB 2278 SD1.

February 25, 2020 at 12:30 pm
Conference Room 016

<u>Senate Committee on Judiciary</u>

To: Chair Karl Rhoads
Vice Chair Jarrett Keohokalole

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

Re: Submitting Comments
SB 2278 SD 1, 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**. We support the intent of this measure. From the hospital perspective, we strongly agree that patients should be protected from gaps in coverage that result in surprise bills that arise when a patient receives unanticipated out-of-network care from a nonparticipating provider for emergency or other medical services. We also agree that any policy solution should remove patients from payment negotiations between managed care plans and providers. With that as a guiding principle, the task before providers, managed care plans, and policy makers in how to best reach an agreement on payment for services provided out-of-network.

As drafted, this measure could be disadvantageous to providers in maintaining appropriate leverage in contract negotiations because it sets rates at either some percentage of Medicare or a "usual and customary rate" (or "UCR") that the insurance company provides. This is problematic because the rates that Medicare pays generally cover only 80-90% of costs, and UCR is not a well-defined or transparent rate for providers. Insufficient payment for services is a factor some providers have noted as reasons it is difficult to practice in Hawaii and, as we consider other measures to address our physician shortage, we believe that any rate-setting could make the issue worse. Further, there are some service lines (e.g., pediatrics and certain women's services) that Medicare does not pay for, which would create issues for determining payments.

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

To resolve payment disputes, we would suggest taking out any problematic rate-setting provisions and instead create an independent dispute resolution process similar to what many states have in place. This process should only be used if the plan and the provider are unable to come to an agreement through a normal negotiation, and will provide an independent, fair process by which providers and plans can resolve their disputes. We would prefer this over the mandatory mediation process required under this current bill because it would encourage plans and providers to settle this matter before engaging in a formal, binding arbitration process.

To achieve these goals, we have provided amendments to take out rate-setting provisions and create an independent dispute resolution process. **These amendments should be substantially similar, if not identical to, those adopted in SB 2423 SD 1, which also seeks a solution to the balance billing issue.**

The proposed new Section 2 holds patients harmless in a balance billing situation in emergency services, and the proposed new Section 3 sets up an independent dispute resolution process. Those amendments would also clarify that these provisions should be housed under HRS §432E, which regulates health insurance plans, rather than in §431, which regulates all types of insurance. The proposed new Section 4 clarifies that the Insurance Commissioner has purview over non-participating providers in balance billing situations, which was also an amendment that was raised in discussion SB 2423.

Other amendments would clean up the language to make it more simple, which is why the existing Sections 3, 4, 5, and 6 would be struck.

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. Thank you for your consideration of our comments and amendments.

Proposed HAH Amendments for SB 2278 SD 1

SECTION 2. Chapter 432E [~~1~~], Hawaii Revised Statutes, is amended by adding [~~two~~] a new section[~~s to article 10A~~] to be appropriately designated and to read as follows:

§432E[~~1:10A-A Balance billing; hold harmless; emergency services; mandatory mediation~~] Emergency services; billing.

(a) When an enrollee in a managed care plan receives emergency services from a non-participating provider, the non-participating provider shall not be entitled to bill the enrollee any amount in excess of any applicable charges the enrollee would be responsible for if they had received the services from a participating provider. This includes, but is not limited to, any copayment, coinsurance, or deductible amount.

(b) When an enrollee receives emergency services from a non-participating provider, a managed care plan shall be responsible to fulfill its obligation to the enrollee and shall enter into negotiation with the non-participating provider to resolve any sums owed by the managed care plan. If the managed care plan and the non-participating provider cannot come to an agreement on a payment amount within 45 days of a non-participating provider notifying an managed care plan that they disagree with the payment amount, either party may elect to enter into an independent dispute resolution process, as established in §432E-   .

(c) 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 non-participating 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.

(d) For the purposes of this section, "non-participating provider" means a facility, health care provider, or health care professional that is not subject to a written agreement with the enrollee's health carrier governing the provision of 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 to:~~

~~(1) Collect 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.

(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 an insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, the insurer shall use data from a transparent, third-party database upon which to calculate out-of-network reimbursements for emergency services.

(e) Any dispute between an insurer and provider that arises pursuant to this section shall be submitted to mandatory mediation to be overseen by the insurance division.

(f) 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. 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."]

[SECTION 3. 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) Notwithstanding section 431:10A-A or any contract to the contrary, a managed care plan shall 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.

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

SECTION 4. 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-A Balance billing; hold harmless; emergency services; mandatory mediation.** (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) Collect 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 use data from a transparent, third-party database upon which to calculate out-of-network reimbursements for emergency services.~~

~~(e) Any dispute between a mutual benefit society and provider that arises pursuant to this section shall be submitted to mandatory mediation to be overseen by the insurance division.~~

~~(f) 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-B Balance billing; hold harmless; non-emergency services.** 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.~~

~~**§432:1-C Out-of-network or nonparticipating provider reimbursement; rate calculation.** (a) Notwithstanding section 432:1-A, and absent any contract to the contrary, a mutual benefit society shall 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 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.~~

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

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

"**§432D-A Balance billing; hold harmless; emergency services; mandatory mediation.** (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 health maintenance organization shall use data from a transparent, third-party database upon which to calculate out-of-network reimbursements for emergency services.~~

~~(e) Any dispute between a health maintenance organization and provider that arises pursuant to this section shall be submitted to mandatory mediation to be overseen by the insurance division.~~

~~(f) 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-B Balance billing; hold harmless; non-emergency services. 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-C Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) Notwithstanding section 432D-A or any contract to the contrary, a health maintenance organization shall 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.

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

[Section 6. 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, 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 3. Chapter 432E, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§432E- Dispute resolution. (a) If an insurer and a non-participating provider are unable to reach an agreement as to the amount to be billed for emergency services provided by a non-

participating provider within 45 days of a non-participating provider notifying an insurer that they disagree with the payment amount, the matter may be submitted to the commissioner, who will refer the matter to an independent dispute resolution entity for binding arbitration.

(b) In determining the appropriate amount to pay a nonparticipating provider for an emergency service, an arbitrator shall consider all relevant factors, including:

(1) Whether there is a gross disparity between the fee charged by the health care provider or hospital for services rendered as compared to:

(A) The fees paid to the involved health care provider or hospital for the same services rendered by the health care provider or hospital to other patients in plans in which the health care provider or hospital is not participating; and

(B) In the case of a dispute involving a managed care plan, fees paid by the managed care plan to reimburse similarly qualified health care providers or hospitals for the same services in the same region who are not participating with the managed care plan;

(2) The level of training, education, and experience of the provider, and in the case of a hospital, the teaching staff, scope of services, and case mix;

(3) The provider's usual billed charge for comparable services with regard to patients in plans in which the health care provider or hospital is not participating;

(4) The circumstances and complexity of the particular case, including time and place service; and

(5) Individual patient characteristics.

(c) A provider may bundle multiple claims in a single mediation if the disputed charges involve:

(1) The identical plan or issuer and provider;

(2) Claims with the same or related current procedural codes; and

(3) Claims that occur within one hundred eighty days of each other.

(d) For disputes involving an enrollee, when the dispute resolution entity determines the plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating provider. When the dispute resolution entity determines the non-participating provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the plan. When a good faith negotiation directed by the dispute resolution entity results in a settlement between the plan and non-participating provider, the plan and the non-participating provider shall evenly divide and share the prorated cost for dispute resolution.

(e) The arbitrator shall issue a decision on a submitted case no later than 45 days from the commencement of binding arbitration.

(f) The commissioner may adopt rules pursuant to chapter 91 on this part.

Section 4. Chapter 432E-8, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

Enforcement. All remedies, penalties, and proceedings in articles 2 and 13 of chapter 431 made applicable hereby to managed care plans and non-participating providers under §432E-_____ shall be invoked and enforced solely and exclusively by the commissioner.

SECTION 5 [7]. In codifying the new sections added by sections 2, 3 [4], and 4 [5] 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 6 [8]. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 7 [9]. This Act shall take effect on January 2, 2050, and shall be repealed on January 2, 2025; provided that section 431:10-109 shall be reenacted in the form in which it read on the day before this effective date of this Act.

DAVID Y. IGE
GOVERNOR

BOARD OF TRUSTEES
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HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
201 MERCHANT STREET, SUITE 1700
HONOLULU, HAWAII 96813
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

TESTIMONY BY DEREK MIZUNO
ADMINISTRATOR, HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE SENATE COMMITTEE ON JUDICIARY
ON SENATE BILL NO. 2278 S.D. 1

February 25, 2020
12:30 p.m.
Room 016

RELATING TO HEALTH INSURANCE

Chair Rhoads, Vice Chair Keohokalole, and Members of the Committee:

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) Board of Trustees supports the financial protection of the individual from balance billing and the intent to develop a reasonable basis for determining reimbursement of nonparticipating providers by insurers (health plans) contained in this bill.

§431:14G, §432:1-C and §432D-C of the bill provides a reasonable benchmark for non-emergency services to determine nonparticipating provider reimbursement of the greater of 1) usual and customary rates for similar services provided by participating providers and 2) an unspecified percentage of Medicare reimbursement rates. We recommend use of the same benchmark in §431:10A-A, §432:1-A and §432D-A for emergency services. The EUTF is concerned about the possible impact on EUTF plan medical costs if a reasonable benchmark for nonparticipating provider reimbursements is not agreed upon.

Thank you for the opportunity to testify.

February 23, 2020

The Honorable Karl Rhoads, Chair
The Honorable Jarrett Keohokalole, Vice Chair
Senate Committee on Judiciary

Re: SB 2278, SD1 – Relating to Health Insurance

Dear Chair Rhoads, Vice Chair Keohokalole, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2278, SD1, which prohibits nonparticipating health care providers from balance billing patients in specific circumstances. This measure also establishes rate calculation requirements for reimbursement of nonparticipating providers.

HMSA supports the intent of this measure and the protections that it extends to patients when they unknowingly receive services from a provider outside of their network. However, we have serious concerns with the requirement placed in this measure that states health plans must use a third-party data base to calculate the reimbursements for out-of-network emergency services. Networks have been established to provide access, quality and predictable costs to our members. It is our understanding that the third party data that this bill suggests using is based on full charge rates and not average contracted rates. Using the data of a third-party to calculate out-of-network reimbursements jeopardizes a health plan's network, by potentially creating an incentive for providers to no longer be a part of a health plan's network. Additionally, this measure establishes mandatory mediation as the dispute resolution process. However, as we have seen in other states that have implemented a similar resolution process, this type of resolution has added costs to the entire health care system.

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 respectfully provide testimony in opposition to this measure. Your consideration of our comments is appreciated.

Sincerely,

Pono Chong
Vice President, Government Relations

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Tuesday, February 25, 2020 at 12:30 PM
Conference Room 016

<u>Senate Committee on Judiciary</u>

To: Senator Karl Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair

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

Re: Comments on SB 2278, SD1
Relating to Health Insurance

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

I write to provide comments on SB 2278, SD1 which prohibits nonparticipating health care providers from balance billing patients for reimbursement in specific circumstances. The measure also requires an insurer, mutual benefit society, and health maintenance organization to use data from a transparent, third-party database upon which to calculate out-of-network reimbursements for emergency services, and requires any dispute between an insurer, mutual benefit society, or health maintenance organization and a provider that arises pursuant to this measure to be submitted to mandatory mediation to be overseen by the Insurance Division of the Department of Commerce and Consumer Affairs.

Hawaiʻi Pacific Health (HPH) has experience working with a variety of insurers and providers. We believe 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/insureds. As a provider organization, we also assume that both health care insurers and health care providers have a *<u>shared</u>* responsibility to protect patients from financial burdens to ensure access to medically necessary care.

We note that the measure sets an out-of-network rate calculation of the greater of a percentage of Medicare or the usual and customary rate of payment. Setting reimbursement on a percentage of Medicare rates for non-participating providers will not adequately cover the entire range of medical services for billing that a patient may

encounter. For example, 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 these populations could potentially be incalculable.

Thank you for the opportunity to testify.

KAISER PERMANENTE® Government Relations

Testimony of
Jonathan Ching
Government Relations Manager

Before:
Senate Committee on Judiciary
The Honorable Karl Rhoads, Chair
The Honorable Jarrett Keohokalole, Vice Chair

February 25, 2020
12:30 p.m.
Conference Room 016

Re: SB2278 SD1, RELATING TO HEALTH INSURANCE.

Chair Rhoads, Vice Chair Keohokalole, and committee members, thank you for this opportunity to provide testimony on SB2278 SD1 which seeks to protect Hawaiʻi consumers from egregious and unexpected out-of-network bills from facilities and providers.

Kaiser Permanente Hawaiʻi SUPPORTS SB2278 SD1

Kaiser Permanente Hawaiʻi is Hawaiʻi'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 Hawaiʻi Permanente Medical Group physicians and providers come to work at Kaiser Permanente Hawaiʻi 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 Hawaiʻi — who depend on us for affordable, high-quality care.

SB2278 SD1 features several fair and reasonable market-based solutions to addresses certain billing practices that can have an immensely negative financial impact on consumers when they are at their most vulnerable. In particular, we support SB2278 SD1's inclusion of a market-based benchmark rate framework for surprise bills 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.

We urge the committee to follow this same framework for out-of-network balance billing situations for emergency services. With such an amendment, SB 2278 SD 1 would provide a comprehensive and 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 SB2278 SD1 will best protect patients through a consistent market-based approach to **address these soaring health care costs for balance and surprise billing situations.**

SB2278 SD1 proposes that health plans use a "transparent, third-party database" to calculate reimbursement amounts for out-of-network emergency situations and would require mandatory binding arbitration for any reimbursement disputes. As a fully integrated system, which includes over 600 Hawai'i Permanente Medical Group physicians and providers, Kaiser Permanente understands that any balance and surprise billing solution needs to cover the cost of services provided. However, not setting a reliable, and consistent reimbursement rate for balance billing situations for emergency services (the same as SB2278 SD1 proposes for surprising billing situations) could lead to higher costs. Most recently, a binding arbitration model without a benchmark rate has led to higher costs in New York state.

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.

Kaiser Permanente Hawai'i notes that we support a payment benchmark that will only be applied to out-of-network providers operating at in-network facilities and to out-of-network facilities for emergency services. A properly designed benchmark rate 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.

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376
www.hawaiimedicalassociation.org

SENATE COMMITTEE ON THE JUDICIARY
Sen. Karl Rhodes, Chair
Sen. Jerrett Keohokalole , Vice Chair

Date: February 25, 2020
Time: 12:30 p.m.
Place: Conference Room 016
From: Hawaii Medical Association
Elizabeth A Ignacio, MD, Chair, HMA Legislative Committee
Christopher Flanders, DO, Executive Director

Re: SB 2278 SD1 - Relating to Health Insurance
Position: OPPOSE

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. Typically, Medicare rates for services are below costs to a provider. Establishing rates based on Medicare discourages insurers in a non-competitive market, such as Hawaii, from paying above that rate hurting health care system vitality and sustainability. 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.

HMA OFFICERS
President – Michael Champion, MD President-Elect – Angela Pratt, MD Secretary – Thomas Kosasa, MD
Immediate Past President – Jerry Van Meter, MD Treasurer – Elizabeth A. Ignacio, MD
Executive Director – Christopher Flanders, DO