



DAVID Y. IGE
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**STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS**

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Testimony of the Department of Commerce and Consumer Affairs

**Before the
House Committee on Health
Thursday, March 12, 2020
9:00 a.m.
State Capitol, Capitol Auditorium**

**On the following measure:
S.B. 2278, S.D. 2, 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 supports the intent of and offers comments on this bill.

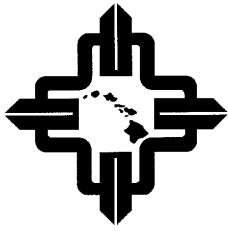
The purposes of this bill are to: (1) prohibit nonparticipating health care providers from balance billing patients in specific circumstances; and (2) establish rate calculation requirements for reimbursement of nonparticipating providers.

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

- S.D. 2 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. 2 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. 2 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 instead be reported to the Insurance Division.
- S.D. 2 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.



HAWAII HEALTH SYSTEMS

C O R P O R A T I O N

Quality Healthcare For All

COMMITTEE ON HEALTH
Representative John M. Mizuno, Chair
Representative Bertrand Kobayashi, Vice Chair

March 12, 2020
Capitol Auditorium
9:00 a.m.
Hawaii State Capitol

Comments

Senate Bill 2278, S.D. 2

RELATING TO HEALTH INSURANCE

Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers. Repeals January 2, 2025. Effective 1/2/2050

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

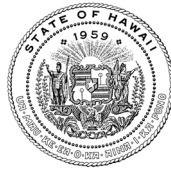
The Hawaii Health Systems Corporation (HHSC) provides **comments** on SB 2278, SD2.

HHSC is deeply concerned about the effect of unanticipated medical bills on Hawaii's patients for care they thought was covered by their health plan which could impact their out-of-pocket costs and undermine their trust and confidence in their caregivers and Hawaii's hospitals. Consumers are best served when both plans and providers are incentivized so there are not any nonparticipating providers. Providers deserve to receive a fair payment for the medical services rendered to patients. Passing statutory protections in state law to address this issue is challenging, yet is worthy of our collective efforts to address. As such, HHSC joins in partnership with HAH and most of the other of Hawaii's major healthcare systems to propose substantive amendments to clarify and recognize the duty and obligation of healthplans to resolve claims with out-of-network providers.

Thank you for the opportunity to testify on this measure.

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DAVID Y. IGE
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ASSISTANT ADMINISTRATOR
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TESTIMONY BY DEREK MIZUNO
ADMINISTRATOR, HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE HOUSE COMMITTEE ON HEALTH
ON SENATE BILL NO. 2278 S.D. 2

March 12, 2020
9:00 a.m.
Capitol Auditorium

RELATING TO HEALTH INSURANCE

Chair Mizuno, Vice Chair Kobayashi, 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, if necessary. 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.

EUTF's Mission: We care for the health and well being of our beneficiaries by striving to provide quality benefit plans that are affordable, reliable, and meet their changing needs. We provide informed service that is excellent, courteous, and compassionate.



**Testimony to the House Committee on Health
Tuesday, March 12, 2020; 9:00 a.m.
State Capitol, Auditorium**

RE: SENATE BILL NO.2278, SENATE DRAFT 2, RELATING TO HEALTH INSURANCE.

Chair Mizuno Vice 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** Senate Bill No. 2278, Senate Draft 2, 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.

Testimony on Senate Bill No. 2278, Senate Draft 2
Tuesday, March 12, 2020; 9:00 a.m.
Page 2

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 be 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@hawaiiipca.net.



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HOUSE OF REPRESENTATIVES
Committee on Health
Thursday, March 12, 2020
9:00 a.m.
Conference Room- Capitol Auditorium

To: Representative John Mizuno, Chair
Re: SB 2278 SD2 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 SB 2278 SD2**. 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 SD2.





March 12, 2020 at 9:00 am
Capitol Auditorium

To: Chair John M. Mizuno
Vice Chair Bertrand Kobayashi

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

Re: **Submitting Comments**
SB 2278 SD 2, 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 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 using a benchmark of Medicare or UCR 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.

To resolve payment disputes, we would suggest creating 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 would suggest eliminating Sections 3, 4, 5, and 6. Removing those sections is important to removing problematic rate-setting provisions using Medicare or a non-transparent payment based on usual and customary rates. It is also important to remove those sections since some of them are placed into HRS §431, which applies to all lines of insurance, not just health insurance. We would also suggest that the dispute resolution language in SB 2423 SD 1 be considered as an addition to this bill, which would establish an independent process to allow for providers and plans to resolve payment disagreements without putting the patient in the middle.

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 commit to continuing discussions on this issue and working with stakeholders on finding a solution. Thank you for your consideration of our comments and amendments.



BEFORE THE

HOUSE COMMITTEE ON HEALTH

Representative John M. Mizuno, Chair
Representative Bertrand Kobayashi, Vice Chair

SB 2278, SD 2 RELATING TO HEALTH INSURANCE

**TESTIMONY OF
WILLIAM C. McCORRISTON
President and Chief Executive Officer,
Hawaii Medical Assurance Association**

March 12, 2020, 9:00 a.m.
Capitol Auditorium

Chair Mizuno, Vice Chair Kobayashi, and Committee Members:

My name is William C. McCorrison, President and Chief Executive Officer of Hawaii Medical Assurance Association (HMAA). HMAA supports the intent of SB 2278 SD 2 but offers comments.

By way of background, HMAA is a non-profit mutual benefit society that provides health insurance to over 30,000 Hawai'i residents. HMAA occupies about three percent of Hawaii's health insurance market. As a small kama'aina insurer, HMAA takes special pride in providing health insurance to sole-proprietors and small businesses, a segment of Hawaii's market that often has a difficult time obtaining affordable health-related insurance.

The intent behind SB 2278 SD 2 is to protect patients who unknowingly receive emergency care services from a non-participating provider. Hawai'i does not currently impose any limitations on the charges that non-participating emergency care services providers can assess on patients, resulting in patients being billed for any remaining charges after charges paid by his or her insurer. Patients are thereafter balance billed for the remaining charges, which can put these patients through significant financial hardship. SB 2278 SD 2 provides these patients with important protections that eliminates these potential financial burdens.

Yet, issues remain with respect to SB 2278 SD 2's requirement that health plans "use data from a transparent, third-party database upon which to calculate out-of-network reimbursements for *emergency services*." This third-party data is based on full charge rates and not average contracted rates, and payments for emergency services should not be based on charges that are billed by the provider or any database that

uses “billed charges,” because there is no limit to what a facility or provider may bill. To ensure fair reimbursement while preventing further escalation of healthcare costs and premiums, HMAA believes that the proper benchmark is average in-network rates paid by carriers to contracted in-network providers or an equivalent percentage of the Medicare reimbursement rate.

Thank you for the opportunity to submit written testimony on this matter of critical importance.



Community hospitals affiliated with KAISER PERMANENTE.

Chair John Mizuno
Vice Chair Bertrand Kobayashi
Members of the House Committee on Health

RE: Testimony of Michael Rembis, CEO
March 12, 2020

Aloha Chair Mizuno, Vice Chair Kobayashi and members of the committee,

My name is Michael Rembis, and I am the Chief Executive Officer of Maui Health Systems (“MHS”). Thank you for the opportunity to provide comments on **S.B. 2278, SD 2** relating to health insurance. MHS supports the intent of this measure.

MHS agrees that patients should be protected from gaps in coverage that result 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.

We do, however, have concerns with this measure as drafted.

First, we believe that providers will be adversely impacted in the contract negotiation process should the state require that rates be set at some percentage of Medicare or a “usual and customary rate” (or “UCR) that the insurance company provides. This is disadvantageous to providers since Medicare payments typically cover only 80-90% costs. Moreover, the UCR is not a well-defined rate for providers, and therefore is not at all transparent. Both of these rate setting mechanisms will likely discourage physicians from practicing in Hawaii, a state that is already suffering from an acute physician shortage. Further, there are service lines (e.g., pediatrics and certain women’s services) that Medicare does not pay for, which would create additional issues in determining payments.

MHS instead encourages the legislature to create an independent dispute resolution process to resolve payment disputes, similar to processes adopted and utilized in many other states. This process would allow a provider and plan who are unable to come to agreement in their negotiations to work within an independent, fair and neutral process to resolve disputes without having to engage in a full and formal, binding arbitration process.

For these reasons, we fully support and encourage this committee to adopt the amendments offered in the testimony submitted by the Healthcare Association of Hawaii (“HAH”). MHS will continue to work with HAH, its other members, and other stakeholders on this issue. Thank you for your consideration of our comments.

Mahalo for your consideration,

Michael Rembis, FACHE
Chief Executive Officer

Thursday, March 12, 2020 at 9:00 AM
Capital Auditorium

House Committee on Health

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

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

Re: **Comments on SB 2278, SD2
Relating to Health Insurance**

My name is Michael Robinson, Vice President, Government Relations & Community Affairs at Hawai'i Pacific Health. 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.

I write to provide comments on SB 2278, SD2 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.

Hawai'i 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 shared 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.

HPH will continue its dialogue with other stakeholders in order to craft a solution to this issue which is reasonable and fair.

Thank you for the opportunity to testify.

Testimony of
Jonathan Ching
Government Relations Manager

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

March 12, 2020
9:00 a.m.
Capitol Auditorium

Re: SB2278 SD2, RELATING TO HEALTH INSURANCE.

Chair Mizuno, Vice Chair Kobayashi, and committee members, thank you for this opportunity to provide testimony on SB2278 SD2, which seeks to protect Hawai‘i consumers from egregious and unexpected out-of-network bills from facilities and providers.

Kaiser Permanente Hawai‘i SUPPORTS SB2278 SD2 with AMENDMENTS.

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.

SB2278 SD2 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 SD2’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 SD2 would provide a comprehensive and common-sense solution to simultaneously bring down significant health care

costs, **protect consumers and remove them from the middle of billing disputes** between providers and insurance companies, while ensuring out-of-network providers receive a fair market-based rate for their services. We believe SB2278 SD2 will best protect patients through a consistent market-based approach to **address these soaring health care costs for balance and surprise billing situations.**

SB2278 SD2 proposes that health plans use a “transparent, third-party database” to calculate reimbursement amounts for out-of-network emergency situations and would require mandatory mediation 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 SD2 proposes for surprising billing situations) will lead to higher costs in the state. For example, a binding “baseball style” arbitration model implemented in New York state in 2015 without a benchmark rate and reliant on billed charges has led to significantly higher costs in the state, according to a recent financial analysis by New York’s Department of Financial Services.¹

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.

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 also 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. We support upholding negotiated contracted rates between carriers and providers and protecting plan provider networks.

As such, we would recommend the committee consider the following amendments (attached).

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

¹ <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/>

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S . B . NO . 2278
S . D . 2

PROPOSED
H . D . 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that 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:

(1) Specify 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) Specify 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;

(3) 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;

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

(5) 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.

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 provider, health care facility, or hospital shall disclose the following information in writing to 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 shall:

(1) At least a reasonable period 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) A nonparticipating health care provider, health care facility, or hospital that fails to comply with this section shall not bill or collect any amount from the patient or prospective patient in excess of the in-network cost-sharing owed by the 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; mandatory mediation. (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. 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) The average of paid claims data from a transparent,
third-party database that has sufficient information based on
allowed amounts paid upon which to calculate out-of-network
reimbursements for emergency services on a fee-for-service basis
for the same or similar services in the general geographic
region in which the services were rendered.

(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 to determine
whether there is a gross disparity between the fee charged by
the health care provider or hospital for services rendered as
compared to:-

(1)

(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;

(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.

(g) Nothing in this section shall be construed to require an insurer to cover services not required by law or by the terms and conditions of the insured's policy of accident and health or sickness insurance.

(h) For purposes of this section "usual and customary rate" shall mean the policy or plan's average contracted rate."

§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 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) Notwithstanding section 431:10A-A ~~or any contract to the contrary,~~ and absent a signed consent form in "§321- , 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 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-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.~~ 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) The average of paid claims data from a transparent third-party database that has sufficient information based on allowed amounts paid upon which to calculate out-of-network reimbursements for emergency services on a fee-for-service-basis for the same or similar services in the general geographic region in which the services were rendered.

(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 to determine whether there is a gross disparity between the fee charged by the health care provided or hospital for services rendered compared to:-

- (1) (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; or
(B) In the case of a dispute involving a mutual benefit society fees paid by the mutual benefit society to reimburse similarly qualified health care providers or hospitals for the same services in the

same region who are not participating with the mutual benefit society;

(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.

(g) 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 subscriber or member's plan contract.

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

§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 a ~~signed consent form in "§321- ,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 6. 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.~~ 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) The average of paid claims data from a transparent, third-party database that has sufficient information based on

allowed amounts paid upon which to calculate out-of-network reimbursements for emergency services on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.

(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 to determine whether there is a gross disparity between the fee charged by the health care provider or hospital for services rendered as compared to:-

(1)

(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 health maintenance organization, fees paid by the health maintenance organization to reimburse similarly qualified health care providers or hospitals for the same services in the same region who are not participating with the health maintenance organization;

(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
- (3) 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.

(g) 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 subscriber's or enrollee's policy, contract, plan, or agreement.

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

§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,~~ and absent a signed consent form in "§321- , 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 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, the amount that the insurer will reimburse under the rate calculation for out-of-network health care specified in section 431:14C; 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 431:14C 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 7. In codifying the new sections added by sections 2, 4, and 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 8. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 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.

Report Title:

Balance Billing; Surprise Billing; Prohibitions; Health Insurance; Nonparticipating Providers

Description:

Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers. Repeals January 2, 2025. Effective 1/2/2050. (SD2)

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

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: March 11, 2020

Hrg: Hosue Committee on Health Hearing; Thursday, March 12, 2020 at 9:00 a.m. in the Capitol Auditorium

Re: **Comments S.B. 2278 SD2, Relating to Health Insurance**

The Queen's Health Systems (Queen's) is a nonprofit 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 and more than 1,500 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 S.B. 2278 SD2, 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. 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. We concur with the testimony offered by the Healthcare Association of Hawaii, which provides for a fair process for both providers and plans, while leaving the patient out of the middle.

The bill ties provider reimbursement to the arbitrary usual and customary rate set by the plan and 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. 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

The mission of The Queen's Health Systems is to fulfill the intent of Queen Emma and King Kamehameha IV to provide in perpetuity quality health care services to improve the well-being of Native Hawaiians and all of the people of Hawai'i.

incentive to provide an adequate network for their insured and ultimately limits access to care. As HAH mentions in their testimony, the removal of Sections 3, 4, 5, and 6 would resolve the problematic rate-setting provisions.

Additionally, when a patient receives a bill from an out-of-network provider it is because the health care insurance company refuses to pay the claim. Plans have a duty and obligation to their insured to satisfy and resolve claims with out-of-network providers. An independent dispute resolution process should be established to ensure that when providers and plans cannot come to an agreement, a fair process to resolve disputes is available. We agree with HAH and other hospitals that the dispute resolution language in SB 2423 SD 1 be considered as an addition to this bill.

Thank you for the opportunity to testify on this measure.



LATE

March 11, 2020

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

Re: SB 2278, SD2 – 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 SB 2278, SD2, 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

LATE

SB-2278-SD-2

Submitted on: 3/11/2020 6:08:44 PM
Testimony for HLT on 3/12/2020 9:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Terri O'Connell	UHA Health Insurance	Support	No

Comments:

Chair Mizuno, Vice Chair Kobayashi, and Members of the Committee on Health:

UHA Health Insurance (“UHA”) supports the intent of SB2278 SD2 to protect Hawaii patients from “balance billing” or “surprise billing” by out-of-network health care providers.

However, UHA has several requests. If a transparent third-party database is to be used to calculate reimbursements for out-of-network emergency services, then the database should be based on Hawaii’s eligible charges. UHA would prefer that the same methods be used to pay for emergency and non-emergency services provided by out-of-network providers. Finally, UHA would prefer the establishment of payment benchmarks rather than using mediation to resolve payment disputes. UHA’s preferences are based on the belief that surprise bills are important to resolve but the resolutions must be done without driving up health insurance premiums for Hawaii’s employers and employees.

UHA Health Insurance appreciates the opportunity to submit this testimony.

Terri O'Connell, VP, UHA Health Insurance



March 11, 2020

Representative John Mizuno
Chair, House Committee on Health

Representative Bertrand Kobayashi
Vice Chair, House Committee on Health

SB2278 SD2: Relating to Health Insurance

Testimony in **OPPOSITION**

Thank you for the opportunity to submit testimony on SB2278. The Hawaii College of Emergency Physicians represents 152 practicing emergency physicians in Hawaii. We agree that patients should be left out of billing disputes between providers and insurers, and we are committed to helping Hawaii find a comprehensive solution to the out of network billing issue. While we oppose SB2278, we believe there is a potential solution in SB2423.

Out of network billing uniquely affects emergency physicians because we are mandated to care for patients by federal statute without regard for their ability to pay. We agree that all patients should be cared for in our emergency departments and are proud of our position as the safety net of the health care system. However, because we do not refuse care to anyone, we have no leverage in negotiation with insurance providers for fair rates of reimbursement.

Legislation stopping the practice of banning billing must be comprehensive and provide a means for providers to negotiate fair market rates. This truly is an access to care issue. Reimbursement rates for emergency physicians in Hawaii already rank among the bottom five states in the country. Emergency groups in the state already have a difficult time recruiting physicians, especially to our neighbor islands and critical access hospitals. Further limiting reimbursement rates will make it increasingly difficult to recruit and retain high quality physicians where they are needed most.

Several states have successfully and fairly addressed this issue. We have worked closely with the HAH in suggesting amendments to proposed legislation. Here are the necessary components:

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

2. Avoiding a benchmark rates based on Medicare or insurance usual and customary rates. If benchmarking is necessary, independent, third party databases are available (i.e. FAIR Health) to provide guidance that we would support.

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 is already in place and providing information across the country.

A cap on out of 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 are committed to helping Hawaii find a fair solution to out of network 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.

Sincerely,

A handwritten signature in blue ink, appearing to read 'W. Scruggs', with a large, stylized initial 'W' and a long, sweeping tail.

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