# ACT 178

S.B. NO. 2297

A Bill for an Act Relating to Health.

*Be It Enacted by the Legislature of the State of Hawaii:*

SECTION 1. Health care is an evolving industry. New technologies, procedures, and pharmaceuticals have contributed to better health care for the consumer. However, new advances in medicine are not cheap. One problem with health care has been rising costs. One way health plans attempt to deal with rising costs of medicine is through managed care. Major features of a managed care system are prevention, use of ''gatekeepers'', and capitation.

Managed care has evolved, and Hawaii has been fortunate not to experience the questionable practices of certain entities engaging in managed care. Nevertheless, legitimate concerns provide the legislature with sufficient reason to protect the citizens of this State from certain practices of managed care.

The purpose of this Act is to create a new chapter to afford patients of managed care systems certain rights and protections.

SECTION 2. Title 24, Hawaii Revised Statutes, is amended by adding a new chapter to be appropriately designated and to read as follows:

## ''CHAPTER
## HAWAII PATIENT BILL OF RIGHTS AND RESPONSIBILITIES ACT

§ **-1 Definitions.** As used in this chapter, unless the context otherwise requires:

''Appeal'' means a request from an enrollee to change a previous decision made by the managed care plan.

''Commissioner'' means the insurance commissioner.

''Complaint'' means an expression of dissatisfaction, either oral or written.

''Emergency services'' means services provided to an enrollee when the enrollee has symptoms of sufficient severity that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the enrollee's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death.

''Enrollee'' means a person who enters into a contractual relationship or who is provided with health care services or benefits through a managed care plan.

''Health maintenance organization'' means a health maintenance organization as defined in section 432D-1.

''Managed care plan'' means any plan, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary,

a payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:

(1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and

(2) Financial incentives for enrollees to use participating providers and procedures provided by a plan;

provided, that for the purposes of this chapter, an employee benefit plan shall not be deemed a managed care plan with respect to any provision of this chapter or to any requirement or rule imposed or permitted by this chapter which is superseded or preempted by federal law.

"Participating provider" means a licensed or certified provider of health care services or benefits, including mental health services and health care supplies, that has entered into an agreement with a managed care plan to provide those services or supplies to enrollees.

§ **-2 Conflict with other laws.** If there is a conflict with any other law, this chapter shall prevail to the extent that this chapter offers greater protection or rights to the enrollee.

§ **-3 Access to services.** A managed care plan shall demonstrate to the commissioner upon request that its plan:

(1) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner which promotes continuity in the provision of health care services;

(2) Provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay;

(3) When medically necessary, provides health care services twenty-four hours a day, seven days a week;

(4) Provides a reasonable choice of qualified providers of women's health services such as gynecologists, obstetricians, certified nurse-midwives, and advanced practice nurses to provide preventive and routine women's health care services; and

(5) Provides payment or reimbursement for emergency services.

§ **-4 Enrollee participation in treatment decisions.** (a) An enrollee shall have the right to be informed fully prior to making any decision about any treatment, benefit, or nontreatment.

(b) In order to inform enrollees fully, the provider shall:

(1) Discuss all treatment options with an enrollee and include the option of no treatment at all;

(2) Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan; and

(3) Discuss all risks, benefits, and consequences to treatment and nontreatment.

(c) The provider shall discuss with the enrollee and the enrollee's immediate family both living wills and durable powers of attorney in relation to medical treatment, as provided for in chapter 327D and section 551D-2.5.

(d) A managed care plan shall be prohibited from imposing any type of prohibition, disincentive, penalty, or other negative treatment upon a provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by the managed care plan.

§ **-5 Complaints and appeals procedure for enrollees.** (a) A managed care plan with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and appeals.

(b) The managed care plan at all times shall make available its complaints and appeals procedures. The complaints and appeals procedures shall be reasonably understandable to the average layperson and shall be provided in languages other than English upon request.

§ **-6 Appeals to the commissioner.** (a) After exhausting all internal complaint and appeal procedures available, an enrollee may appeal an adverse decision of a managed care plan to a three member review panel appointed by the commissioner composed of a representative from a health plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for review to the commissioner within thirty days from the date of the final determination by the managed care plan.
(2) Upon receipt of the request and upon a showing of good cause, the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91.
(3) After considering the enrollee's complaint, the plan's response, and any affidavits filed by the parties, the commissioner may dismiss the appeal if it is determined that the appeal is frivolous or without merit.

The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing.

(b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers.

(c) The commissioner may adopt rules pursuant to chapter 91 to carry out the purposes of this section.

§ **-7 Information to enrollees.** (a) The managed care plan shall provide to its enrollees upon enrollment and thereafter upon request the following information:

(1) A list of participating providers which shall indicate their specialty and whether board certification has been attained;
(2) A complete description of benefits, services, and copayments;
(3) A statement on enrollee's rights, responsibilities, and obligations;
(4) An explanation of the referral process, if any;
(5) Where services or benefits may be obtained;
(6) A statement regarding informed consent;
(7) Information on complaints and appeals procedures; and
(8) The telephone number of the insurance division and the office of consumer complaints.

This information shall be provided to prospective enrollees upon request.

(b) Every managed care plan shall provide to its enrollees notice of any material change in the operation of the organization initiated by the plan that will affect them directly within thirty days of the material change.

(c) For purposes of this section "material change" means a change in participating provider agreements, services, or benefits.

§ **-8 Enforcement.** All remedies, penalties, and proceedings in articles 2 and 13 of chapter 431 made applicable hereby to managed care plans shall be invoked and enforced solely and exclusively by the commissioner.

§ **-9 Utilization review.** (a) Every managed care plan shall establish procedures for continuous review of quality of care, performance of providers, utilization of health services, facilities, and costs.

(b) Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in quality of care or utilization reviews by peer review committees for any act performed during the reviews if the person acts without malice, makes a reasonable effort to obtain the facts, and believes that the action taken is warranted by the facts.

(c) No peer review committee under this section shall be subject to discovery, and no person in attendance at the reviews shall be required to testify as to what transpired at the reviews. The utilization review requirements and administrative treatment guidelines of the health maintenance organization shall not fall below the appropriate standard of care and shall not impinge upon the independent medical judgment of the treating health care provider.

(d) Nothing in this section shall be construed to prevent a health maintenance organization from conducting a utilization review and quality assurance program.

§ **-10 Managed care plan performance measurement and data reporting standards.** (a) It is the policy of this State that all managed care plans shall adopt and comply with nationally developed and promulgated standards for measuring quality, outcomes, access, satisfaction, and utilization of services. Every contract between a managed care plan and a participating provider of health care services shall require the participating provider to comply with the managed care plan's requests for any information necessary for the managed care plan to comply with the requirements of this chapter. The standard to be applied is the Health Employer Data and Information Set (HEDIS) 3.0 data set, as amended from time to time. The State shall require that:

(1) Consumers, providers, managed care plans, purchasers, and regulators shall be equitably represented in the development of standards; and

(2) Standards shall result in measurement and reporting that is purposeful, valid and scientifically based, applied in a consistent and comparable manner, efficient and cost effective, and designed to minimize redundancy and duplication of effort.

(b) All managed care plans, no less than annually, shall report to the commissioner comparable information on performance, including measures of quality, outcomes, access, satisfaction, and utilization of services; provided that:

(1) Reporting shall be based upon a core data and information set that builds upon nationally recognized performance measurement systems. The core data and information set shall include standardized measures of:

(A) Effectiveness and appropriateness of care (the impact of care delivered to managed care plan enrollees, including results of the plan for childhood immunizations, cholesterol screening, mammography screening, cervical cancer screening, prenatal visits in the first trimester of pregnancy, and diabetic retinal examinations);

(B) Access and availability of care (the extent to which plan enrollees have access to the health care providers they need or desire to see, and receive appropriate services in a timely manner, without inappropriate barriers or inconvenience);

(C) Satisfaction with the experience of care (the results of the most recent enrollee satisfaction survey using standardized survey design and methods);

(D) Managed care plan stability (attributes of a managed care plan which affect its ability to deliver high-quality care and service on a sustained basis);
(E) Use of services (rates of service use per 1,000 enrollees as well as percentages of enrollees who receive specified services);
(F) Cost of care (expenditures per enrollee per month, premium rates for selected membership categories, and rates of increases); and
(G) Managed care plan descriptive information (the plan name, location of headquarters, and number of years the plan has been in business; the model type of the plan; the counties in which the plan operates; the total number of participating physicians per 1,000 enrollees and the number of primary care physicians per 1,000 enrollees; the number of participating hospitals per 10,000 enrollees; the percentage of participating physicians who are board certified; and a list of wellness and health care education programs offered by the plan);

(2) Information shall be uniformly reported by managed care plans in a standardized format, as determined by rule;
(3) Information supplied by managed care plans shall be subject to independent audit by the appropriate regulatory agency or its designee to verify accuracy and protect against misrepresentation;
(4) Information reported by managed care plans shall be adjusted, based on standardized methods, to control for the effects of differences in health risk, severity of illness, or mix of services;
(5) A managed care plan shall ensure confidentiality of records and shall not disclose individually identifiable data or information pertaining to the diagnosis, treatment, or health of any enrollee, except as provided under law; and
(6) A managed care plan shall disclose to its enrollees the quality and satisfaction assessments used, including the current results of the assessments."

SECTION 3. Section 432:1-102, Hawaii Revised Statutes, is amended to read as follows:

"**§432:1-102 Applicability of other laws [to nonprofit medical indemnity or hospital service associations: health care coverage for senior citizens].** (a) Part III of article 10A of [the insurance code] chapter 431 shall apply to nonprofit medical indemnity or hospital service associations. Such associations shall be exempt from the provisions of part I of article 10A; provided that such exemption is in compliance with applicable federal statute[1] and regulations.

(b) Article 2 and article 13 of chapter 431, and the powers there granted to the commissioner, shall apply to managed care plans, health maintenance organizations, or medical indemnity or hospital service associations, which are owned or controlled by mutual benefit societies, so long as such application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations."

SECTION 4. Section 432D-19, Hawaii Revised Statutes, is amended to read as follows:

"**[[]§432D-19[]] Statutory construction and relationship to other laws.** (a) Except as provided in subsection (d) and otherwise provided in this chapter, the insurance laws and hospital or medical service corporation laws shall not apply to

the activities authorized and regulated under this chapter of any any health maintenance organization granted a certificate of authority under this chapter. This chapter shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization granted a certificate of authority under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter 453 relating to the practice of medicine or chapter 460 relating to the practice of osteopathic medicine.

(d) Article 2 and article 13 of chapter 431, and the power there granted to the commissioner, shall apply to health maintenance organizations, so long as such application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations."

SECTION 5. (a) The insurance commissioner shall convene a task force comprised of various members from the public and private sector to review various laws which provide protection of patient rights and responsibilities in regards to health care, especially managed care.

(b) The task force shall review this Act and determine whether consumer rights are fully protected under this Act and whether any further action is needed to ensure such protection.

(c) The task force shall be comprised of interested parties with the total membership of the task[2] between twelve and twenty members. The insurance commissioner or the commissioner's designated representative, shall be a member and serve as the chair of the task force and appoint it[2] remaining members. At least one representative from each of the following shall be appointed as a member; members of other groups may also be appointed:

(1) The department of health;
(2) The department of labor and industrial relations, disability compensation division;
(3) A health insurance company that provides accident and sickness policies under chapter 431, article 10A, Hawaii Revised Statutes;
(4) A mutual benefit society that provides health insurance under chapter 432, Hawaii Revised Statutes;
(5) A health maintenance organization that holds a certificate of authority under chapter 432D, Hawaii Revised Statutes;
(6) The American Association of Retired Persons;
(7) The Hawaii Coalition for Health;
(8) The Hawai'i Business Health Coalition;
(9) The Legal Aid Society of Hawaii;
(10) The Hawaii Medical Association;
(11) An organization that represents nurses; and
(12) A hospital or an organization that represents hospitals.

(d) The task force shall submit its preliminary findings and recommendations to the legislature not later than twenty days prior to the convening of the 1999 regular session.

(e) The task force shall continue until terminated by the insurance commissioner.

SECTION 6. If any provision of this Act, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 7. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 8. This Act shall take effect upon its approval.

(Approved July 15, 1998.)

**Notes**

1. Prior to amendment ''statutes'' appeared here.
2. So in original.