ACT 137 S.B. NO. 1452

A Bill for an Act Relating to Health.

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

SECTION 1. Act 178, Session Laws of Hawaii 1998, enacted the Hawaii Patient Bill of Rights and Responsibilities Act to regulate managed care. Act 178 also required the insurance commissioner to convene a task force to review various laws providing protection of patient rights and responsibilities with regard to health care, especially managed care. This Act contains the statutory revisions recommended by the task force to ensure the protection of consumer rights.

The purpose of this Act is to strengthen the protection of the consumer rights of patients receiving health care under managed care plans and from health maintenance organizations.

SECTION 2. Chapter 432E, Hawaii Revised Statutes, is amended by adding three new sections to be appropriately designated and to read as follows:

"**§432E-A Annual report.** The commissioner shall submit annually to the legislature a report that shall contain the number of external review hearing cases reviewed, the type of cases reviewed, a summary of the nature of the cases reviewed, and the disposition of the cases reviewed. The identities of the plan and the enrollee shall be protected from disclosure in the report.

§432E-B Accreditation of managed care plans. (a) Beginning January 1, 1999, the commissioner shall contract with one or more certified vendors of the consumer assessment health plan survey to conduct a survey of all managed care plans actively offering managed care plans in this State to provide managed care plans an opportunity to learn whether any deficiencies exist or any improvements are required; provided that the information collected shall be kept confidential in the first year, and thereafter shall be available to the public.

(b) The commissioner shall conduct a program that promotes public awareness and education about managed care plans so that consumers may make better or more informed choices when selecting a managed care plan.

(c) Beginning January 1, 2000, unaccredited plans shall submit a plan to the commissioner to achieve national accreditation status within five years. After the first year of the five-year plan, each unaccredited plan shall also submit an annual progress report to the commissioner on the status of gaining national accreditation. The commissioner shall determine which national accreditation organization is appropriate for each type of plan.

(d) Every mutual benefit society, every health maintenance organization, and every other entity offering or providing health benefits or services under the regulation of the commissioner, except an insurer licensed to offer health insurance under article 10A of chapter 431, shall deposit with the commissioner a fee to provide for the actual costs of the survey and educational program to be determined by the commissioner on July 1 of each year, to be credited to the insurance regulation fund. In addition, every mutual benefit society, every health maintenance organization, and every other entity offering or providing health benefits or services under the regulation of the commissioner, except an insurer licensed to offer health insurance under article 10A of chapter 431, shall pay to the commissioner at a time to be determined by the commissioner, a one-time assessment in an amount to be determined by the commissioner, to be credited to the insurance regulation fund.

§432E-C Rules. The commissioner shall adopt rules pursuant to chapter 91 necessary for the purposes of this chapter."

SECTION 3. Section 431:10C-103, Hawaii Revised Statutes, is amended by adding three new definitions to be appropriately inserted and to read as follows:

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

(1) Placing the health of the individual, including the health of a pregnant woman or her unborn child, in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

"Emergency services" means:

(1) A medical screening examination, if required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition; or
(2) Further medical examination and treatment, if required by federal law, that is within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital to stabilize an emergency medical condition.

"Stabilize" means the provision of medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer to another facility, if the medical condition could result in placing the health of the individual or the health of a pregnant woman or her unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."

SECTION 4. Section 432E-3, Hawaii Revised Statutes, is amended to read as follows:

"**[[]§432E-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 adequately documented emergency services[.] as provided in this chapter; and
(6) Allows standing referrals to specialists capable of providing and coordinating primary and specialty care for an enrollee's life-threatening, chronic, degenerative, or disabling disease or condition."

SECTION 5.[1] Section 432E-5, Hawaii Revised Statutes, is amended to read as follows:

"**[[]§432E-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.

(c) A managed care plan shall send notice of its final internal determination to the enrollee, the enrollee's appointed representative, if applicable, and the commissioner. The notice shall include information regarding the enrollee's rights and procedures under section 432E-6."

SECTION 6.[1] Section 432E-6, Hawaii Revised Statutes, is amended to read as follows:

"**[[]§432E-6[]] Appeals to the commissioner.** (a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may appeal an adverse decision of a managed care plan to a [three member] 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. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel;

(3) The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the case; provided that the hearing shall be held no later than sixty days from the date of the request for the hearing;

(4) The commissioner may retain, without regard to chapters 76 and 77, an independent medical expert trained in the field of medicine most appropriately related to the matter under review. Presentation of evidence for this purpose shall be exempt from section 91-9(g);

[(3)] (5) 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[.]; and

(6) The review panel shall review every adverse determination to determine whether or not the plan involved acted reasonably and with sound medical judgment. The review panel shall consider the clinical standards of the plan, the information provided, the attending physician's recommendations, and generally accepted practice guidelines.

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.]

(c) Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section.

(d) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs of suit in an action brought against the managed care plan."

SECTION 7.[1] Section 432E-7, Hawaii Revised Statutes, is amended to read as follows:

"**[[]§432E-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;] be updated on a regular basis indicating, at a minimum, their specialty and whether the provider is accepting new patients;
(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)] (6) Information on complaints and appeals procedures; and
[(8)] (7) 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 the commissioner and 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.] participating provider agreements, services, or benefits, if the change affects the organization or operation of the managed care plan and the enrollee's services or benefits. The managed care plan shall provide notice to enrollees not more than sixty days after the change in a format that makes the notice clear and conspicuous so that it is readily noticeable by the enrollee.

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

(c) A managed care plan shall provide generic participating provider contracts to enrollees, upon request."

SECTION 8.[1] Section 432E-10, Hawaii Revised Statutes, is amended to read as follows:

"**[[]§432E-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] for example, 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] one thousand 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] one thousand enrollees and the number of primary care physicians per [1,000] one thousand enrollees; the number of participating hospitals per [10,000] ten thousand 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 9.[1] Section 1 of Act 246, Session Laws of Hawaii 1998, is amended by amending subsection (f) of the new section added to article 10A of chapter 431, Hawaii Revised Statutes, to read as follows:

"(f) A health plan shall reimburse an emergency provider and an emergency department for any items or services not necessary to stabilize the patient [but that] under at least one of the following:

(1) The items or services are determined to be medically necessary to treat the illness that [lead] led the patient to believe that [he or she] the patient had an emergency medical condition, and that a reasonable patient would expect to receive such items or services from a physician at the time of presentation[.]; or

(2) The items or services are determined to be medically necessary by the emergency provider, if the emergency department:

(A) After a documented good faith effort, is unable to reach the enrollee's health plan:

(i) Within thirty minutes from the initial examination of the enrollee; or

(ii) If the enrollee needs to be stabilized, within thirty minutes of stabilization;

(B) Has successfully contacted the plan as required in subparagraph (A), and has not received a denial from the plan within thirty minutes of the initial contact, unless the plan is able to document that it has made an unsuccessful good faith effort to reach the emergency department within thirty minutes after receiving the request for authorization; or

(C) Has successfully contacted the plan and has received a denial from a person other than a participating physician and:

(i) A participating physician authorized by the plan to review denials reverses the denial; or

(ii) A participating physician authorized by the plan to review denials fails to communicate a determination affirming the denial (unless the treating physician waives the requirement for such determination), within thirty minutes after the initial denial is communicated by the plan.

A health plan shall immediately arrange for an alternate plan of treatment for the member if a non-participating emergency provider and the plan are unable to reach agreement on services necessary beyond those immediately needed to stabilize the member, under which:

(A) A participating physician with privileges at the hospital arrives at the emergency department of the hospital promptly and assumes responsibility for the treatment of the member; or

(B) With the agreement of the treating physician or another health professional in the emergency department:

(i) Arrangement is made for transfer of the member to another facility using medical resources consistent with the condition of the enrollee;

(ii) An appointment is made with a participating physician or provider for treatment needed by the enrollee; or

(iii) Another arrangement is made for treatment of the enrollee.''

SECTION 10.[1] Section 2 of Act 246, Session Laws of Hawaii 1998, is amended by amending subsection (f) of the new section added to article 1 of chapter 432, Hawaii Revised Statutes, to read as follows:

''(f) A health plan shall reimburse an emergency provider and an emergency department for any items or services not necessary to stabilize the patient [but that] under at least one of the following:

(1) The items or services are determined to be medically necessary to treat the illness that [lead] led the patient to believe that [he or she] the patient had an emergency medical condition, and that a reasonable patient would expect to receive such items or services from a physician at the time of presentation[.]; or

(2) The items or services are determined to be medically necessary by the emergency provider, if the emergency department:

(A) After a documented good faith effort, is unable to reach the enrollee's health plan:

(i) Within thirty minutes from the initial examination of the enrollee; or

(ii) If the enrollee needs to be stabilized, within thirty minutes of stabilization;

(B) Has successfully contacted the plan as required in subparagraph (A), and has not received a denial from the plan within thirty minutes of the initial contact, unless the plan is able to document that it has made an unsuccessful good faith effort to reach the emergency department within thirty minutes after receiving the request for authorization; or

(C) Has successfully contacted the plan and has received a denial from a person other than a participating physician and:

(i) A participating physician authorized by the plan to review denials reverses the denial; or

(ii) A participating physician authorized by the plan to review denials fails to communicate a determination affirming the denial (unless the treating physician waives the requirement for such determination), within thirty minutes after the initial denial is communicated by the plan.

A health plan shall immediately arrange for an alternate plan of treatment for the member if a non-participating emergency provider and the plan are unable to reach agreement on services necessary beyond those immediately needed to stabilize the member, under which:

(A) A participating physician with privileges at the hospital arrives at the emergency department of the hospital promptly and assumes responsibility for the treatment of the member; or

(B) With the agreement of the treating physician or another health professional in the emergency department:

(i) Arrangement is made for transfer of the member to another facility using medical resources consistent with the condition of the enrollee;

(ii) An appointment is made with a participating physician or provider for treatment needed by the enrollee; or

(iii) Another arrangement is made for treatment of the enrollee.''

SECTION 11.[1] Section 3 of Act 246, Session Laws of Hawaii 1998, is amended by amending subsection (f) of the new section added to chapter 432D, Hawaii Revised Statutes, to read as follows:

"(f) A health plan shall reimburse an emergency provider and an emergency department for any items or services not necessary to stabilize the patient [but that] under at least one of the following:

(1) The items or services are determined to be medically necessary to treat the illness that [lead] led the patient to believe that [he or she] the patient had an emergency medical condition, and that a reasonable patient would expect to receive such items or services from a physician at the time of presentation[.]; or

(2) The items or services are determined to be medically necessary by the emergency provider, if the emergency department:

(A) After a documented good faith effort, is unable to reach the enrollee's health plan:

(i) Within thirty minutes from the initial examination of the enrollee; or

(ii) If the enrollee needs to be stabilized, within thirty minutes of stabilization;

(B) Has successfully contacted the plan as required in subparagraph (A), and has not received a denial from the plan within thirty minutes of the initial contact, unless the plan is able to document that it has made an unsuccessful good faith effort to reach the emergency department within thirty minutes after receiving the request for authorization; or

(C) Has successfully contacted the plan and has received a denial from a person other than a participating physician and:

(i) A participating physician authorized by the plan to review denials reverses the denial; or

(ii) A participating physician authorized by the plan to review denials fails to communicate a determination affirming the denial (unless the treating physician waives the requirement for such determination), within thirty minutes after the initial denial is communicated by the plan.

A health plan shall immediately arrange for an alternate plan of treatment for the member if a non-participating emergency provider and the plan are unable to reach agreement on services necessary beyond those immediately needed to stabilize the member, under which:

(A) A participating physician with privileges at the hospital arrives at the emergency department of the hospital promptly and assumes responsibility for the treatment of the member; or

(B) With the agreement of the treating physician or another health professional in the emergency department:

(i) Arrangement is made for transfer of the member to another facility using medical resources consistent with the condition of the enrollee;

(ii) An appointment is made with a participating physician or provider for treatment needed by the enrollee; or

(iii) Another arrangement is made for treatment of the enrollee."

SECTION 12.[1] The patient rights and responsibilities task force shall develop proposed legislation addressing issues within the scope of the task force's responsibilities under Act 178, Session Laws of Hawaii 1998, left unresolved by this

Act. The proposed legislation shall be submitted to the legislature no later than twenty days before the convening of the regular session of 2000.

SECTION 13.[1] In codifying new sections added by this Act, the revisor shall substitute the appropriate section numbers for the letters used in designating the new sections of this Act.

SECTION 14.[1] Statutory material to be repealed is bracketed. New statutory material is underscored.[2]

SECTION 15.[1] This Act shall take effect upon its approval; provided that sections 3, 9,[1] 10,[1] and 11[1] of this Act shall be repealed on July 1, 2003, and section 431:10C-103, Hawaii Revised Statutes, is reenacted in the form in which it read on the day before the approval of this Act.

(Approved June 25, 1999.)

Notes

1. Section number redesignated.
2. Edited pursuant to HRS §23G-16.5.