THE SENATE
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

S.B. NO. 2287

JAN 22 2016

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 health plan enrollees who are in good standing have a fundamental right to an adequate health plan provider network. The inability of health plan enrollees to access medically-necessary care in a timely manner can result in unnecessary suffering and disability, and this puts strain on families, social service agencies, police and first responders, homeless service providers, and the criminal justice system.

The legislature further finds that there is general agreement health plan provider networks in Hawaii are inadequate and that many plan enrollees face unreasonable delays and hardship due to an insufficient number of participating physicians. This is particularly true in Hawaii, Maui, and Kauai counties and in areas designated as a health professional shortage area and communities identified as a medically underserved area/population by the office of primary care and rural health of the department of health.

The legislature further finds that despite evidence of inadequate health plan provider networks in Hawaii, few health plan enrollees are aware of their right to an adequate health plan network and no meaningful enforcement actions have been taken by responsible state officials.

The purpose of this Act is to improve the adequacy, accessibility, and transparency of health care services offered under managed care plans and to assist enrollees in accessing participating providers by:

(1) Requiring health carriers to maintain accurate and accessible directories of all participating network providers; and

(2) Ensuring that all health plan enrollees are adequately informed of their right to an adequate provider network.

SECTION 2. Section 432E-7, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) The managed care plan shall provide to its enrollees upon enrollment and thereafter upon request the following information:

(1) A [~~list~~] directory of participating providers which shall be updated [~~on a regular basis indicating, at a minimum, their specialty and whether the provider is accepting new patients;~~] at least monthly and audited for accuracy at least every six months, which shall be available to the general public in print and electronically in a searchable format and through a clearly identifiable link or tab without creating or accessing an account or entering a policy or contract number, and which shall include in plain language in the electronic and print directory, the following information:

(A) The specific name of the plan as marketed and issued in the State;

(B) The source of the information and any limitations;

(C) For all participating health care professionals:

(i) Name;

(ii) Gender;

(iii) Participating office location(s);

(iv) Specialty;

(v) Medical group affiliations;

(vi) Facility affiliations;

(vii) Participating facility affiliations;

(viii) Languages spoken other than English;

(ix) Description and date of most recent board certification(s) or recertification(s), including expired certification(s); and

(x) Whether accepting new patients;

(D) For all participating hospitals:

(i) Hospital name;

(ii) Hospital type (i.e., acute, rehabilitation, children's, psychiatric, cancer);

(iii) Hospital location;

(iv) Telephone number;

(v) Website; and

(vi) Hospital accreditation status and the description and date of most recent accreditation;

(E) For all participating facilities, other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed;

(iv) Location;

(v) Telephone number;

(vi) Website; and

(vii) Description and date of most recent accreditation or certification(s);

(F) Note if authorization or referral may be required to access the provider or facility;

(G) A customer service email address and telephone number that enrollees or the general public may use to notify the carrier of inaccurate provider directory information; and

(H) A disclosure that the information included is accurate as of the date of printing and that enrollees or prospective enrollees should consult the carrier's electronic provider directory, website address, and appropriate customer service telephone number to obtain the most current provider directory information.

The provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency;

(2) A complete description of benefits, services, and copayments;

(3) A statement on enrollee's rights, responsibilities, and obligations[~~.~~], including the right to an adequate plan network with access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay, after taking into consideration geography;

(4) An explanation of the referral process, if any;

(5) Where services or benefits may be obtained;

(6) Information on the internal and external complaints and appeals procedures; and

(7) The telephone number and hyperlink to the website of the insurance division[~~.~~] office in charge of health insurance complaints.

This information shall be provided to prospective enrollees upon request."

SECTION 3. Section 432F-2, Hawaii Revised Statutes, is amended to read as follows:

"**[~~[~~]§432F-2[~~]~~] Health care provider network adequacy.** (a) On or before January 1 of each calendar year, each managed care plan shall demonstrate the adequacy of its provider network to the commissioner. A provider network shall be considered adequate if it provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay, after taking into consideration geography. The commissioner shall also consider any applicable federal standards on network adequacy. A certification from a national accreditation organization shall create a rebuttable presumption that the network of a managed care plan is adequate. This presumption may be rebutted by evidence submitted to, or collected by, the commissioner.

(b) A managed care plan that does not have a certification from a national accreditation organization may submit to the commissioner a plan to become accredited by a national accreditation organization within a period of two years if the

managed care plan has provided sufficient evidence that its network is reasonably adequate at the time of submission of the plan. The commissioner shall also consider any applicable federal standards on network adequacy. The commissioner may extend the period of time for accreditation.

(c) The commissioner shall approve or disapprove a managed care plan's annual filing on network adequacy. If the commissioner deems the filing incomplete, additional information and supporting documentation may be requested. A managed care plan shall have sixty days to appeal an adverse decision by the commissioner in an administrative hearing pursuant to chapter 91.

~~[(d) To enable the commissioner to determine the network adequacy for qualified health plans to be listed with the Hawaii health connector under section 435H-11, the commissioner may request that a managed care plan demonstrate the adequacy of its provider network at the time that it files its health plan benefit document with the commissioner.~~

~~(e)~~] (d) This section shall apply to any managed care plan qualified as a prepaid health care plan pursuant to chapter 393."

SECTION 4. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

INTRODUCED BY:

S.B. NO. 2287

Report Title:
Health Insurance; Health Plan Provider Network

Description:
Requires health care plan carriers to maintain directories of all participating network providers to ensure accessibility and transparency to enrollees seeking care. Requires information to be made more accessible to enrollees upon enrollment. Repeals discretion of insurance commissioner to request managed care plans to demonstrate adequacy of its provider network for purposes of listing with the Hawaii health connector.

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