DAVID Y. IGE
GOVERNOR

JOSH GREEN
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
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CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

Testimony of the Department of Commerce and Consumer Affairs

Before the
House Committee on Health
Tuesday, February 4, 2020
8:30 a.m.
State Capitol, Conference Room 329

On the following measure:
H.B. 1881, RELATING TO MEDICAL SERVICE BILLING

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 this bill.

The purposes of this bill are to: (1) establish billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers; and (2) specify the circumstances in which health care providers and facilities can bill health carriers and enrollees for health intervention services that are medical necessities.

The Department appreciates efforts to relieve consumers of the burdens of surprise balance billing and understands that various stakeholders are working together to resolve this issue. The Department is available to work with these stakeholders to find a resolution.

The Department notes, however, that implementation and enforcement of the provider provisions in this bill (see, for example, page 2, lines 12 to 16) may be challenging, as the Insurance Division does not currently exercise jurisdiction over providers.

Thank you for the opportunity to testify on this bill.

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376
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HOUSE COMMITTEE ON HEALTH
Rep. John Mizuno, Chair
Rep. Bertrand Kobayashi, Vice Chair

Date: February 4, 2020
Time: 8:30 a.m.
Place: Conference Room 329
From: Hawaii Medical Association
Michael Champion, MD, President
Christopher Flanders, DO, Executive Director

Re: HB 1881 Relating to Health Insurance
Position: OPPOSE

The Hawaii Medical Association feels strongly that patients should not be caught up in what, in many cases, should be contractual arrangements between parties. While this is not the larger issue it is on the mainland, Hawaii does experience rare payment disagreements between health systems, health systems and providers, and insurers and health systems or providers.

The position of the Hawaii Medical Association is that statutory setting of payment rates is an unsatisfactory method of resolving disputes. The linking of statutory rates to Medicare or "usual and customary" rates is problematic in that Medicare rates are not designed to be a benchmark for rates over large geographic areas, nor are they designed for regional insurers to tie their rates. Rather, the use of available all payor claims databases, such as Fair Health, should be used to establish existing community standards.

The Hawaii Medical Association supports the establishment a fair arbitration system in which to mediate disputes, such as the arbitration system enacted by New York, whereby each side presents their settlement figure and a decision is made between submitted figures by the Insurance Commissioner.

Thank you for allowing the Hawaii Medical Association to testify on this issue.

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

Tuesday, February 4, 2020 at 8:30 am
Conference Room 329

<u>House Committee on Health</u>

To: Chair John M. Mizuno
Vice Chair Bertrand Kobayashi

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

Re: Submitting Comments
HB 1881, Relating to Medical Service Billing

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** on this measure. Our members have not reached a consensus agreement on a position on this legislation. However, there is an important position that all members can agree on—that patients should be protected from gaps in coverage that result in surprise bills and that any policy solution should remove patients from payment negotiations between insurers and providers. With that as a guiding principle, the task before providers, insurers, and policy makers is how to best reach an agreement on payment for services provided out-of-network.

This legislation, like HB 2504, puts the burden of resolving balance billing issues on providers, and sets rates at Medicare—this is problematic because the rates that Medicare pays generally cover only 80% of costs. 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. We would appreciate a discussion about the appropriate benchmark rate and the potential for adding a mediation process.

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 continue our discussions as an organization on the major provisions and provide support, education, and research as necessary. Thank you for your consideration of our comments.

KAISER PERMANENTE® Government Relations

Testimony of
Frank Richardson
Vice President & Regional Counsel

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

February 4, 2020
8:30 a.m.
Conference Room 329

Re: HB1881, Relating to Medical Service Billing.

Chair Mizuno, Vice-Chair Kobayashi, and committee members, thank you for this opportunity to provide testimony on HB1881, which establishes billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers.

> **Kaiser Permanente Hawai'i supports the intent of HB1881 and offers the following COMMENTS.**

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.

HB1881 seeks to provide a solution to address certain billing practices that can have an immensely negative financial impact on consumers when they are at their most vulnerable -- when they are receiving emergency care from a non-participating (sometimes called an out of network) provider. In Hawaii, there is **no limit to what these out-of-network providers or facilities can charge for emergency services**. As a result, the patient may be billed for the remaining charges after their insurer pays. These "balance bill" 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. HB1881 aims to **protect consumers and remove them from the middle of billing disputes** between providers and insurance companies.

Kaiser Permanente Hawai‘i supports removing patients from the middle of balance and surprise billing disputes between plans and providers and ensuring providers get paid a fair and reasonable market-based rate.

HB1881 establishes a benchmark rate that a non-participating provider of emergency services may bill a patient not to exceed the Medicare rate. We suspect that providers and hospitals will object to this rate as being too low to cover their costs. **As such, we prefer legislation that allows for providers to get paid a market-based rate. We also support protecting patients in surprise billing situations where consumers unknowingly receive care from an out of network provider in an in-network facility. We request the committee consider HB2504, which protects consumers from balance and surprise bills, and provides a reasonable market-based rate for payment for out of network providers.**

The payment benchmark in HB2504, in contrast to HB1881, ensures that the costs of the services are covered, without driving up costs to the healthcare system and to health insurance premiums. Additionally, we believe any payment solution must not be based on charges that are billed by the provider (“billed charges”) or any database that uses “billed charges,” because there is no limit to what a facility or provider may bill. Instead, by basing the benchmark on average in-network rates paid by carriers to contracted in-network providers or an equivalent percentage of the Medicare reimbursement rate, we ensure a fair and reasonable reimbursement rate for patients, providers, health plans and the healthcare system as a whole.

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

January 31, 2020

Representative John Mizuno
Chair, House Committee on Health

Representative Bertrand Kobayashi
Vice Chair, House Committee on Health

HB1881: Relating to Medical Services Billing

Testimony in **OPPOSITION**

Hawaii ACEP represents 152 emergency physicians in Hawaii. I am writing on their behalf in opposition of HB1881. While we agree that legislation is needed to resolve the surprise billing issue, HB1881 would be devastating to emergency providers in the state and negatively impact access to quality emergency services, especially on the neighbor islands and at our critical access hospitals. We are proposing solutions to end surprise billing that would be fair to providers and create more transparency in health care.

HB1881 would limit reimbursement for emergency care by non-participating providers to Medicare rates. The immediate impact would be a sudden and significant loss of income for all providers of emergency care in Hawaii. Long term, the legislation would effectively cap reimbursement for emergency care in the Hawaii to Medicare rates. Reimbursement rates for emergency physicians in Hawaii already ranks among the bottom five states in the country and all of our emergency physician groups in the state struggle to recruit high quality emergency physicians, especially to the neighbor islands and rural areas of Oahu.

We ask that you consider the implications of capping emergency services by non-participating providers to Medicare rates. In effect, you would be setting an extremely low rate of reimbursement for all emergency providers. As a managed care plan, why would you negotiate a higher rate with any provider if you know you will only have to pay Medicare rates if they are non-participating? As emergency physicians, we are bound by EMTALA to see any patient who comes to our emergency department without regard to their ability to pay. We have no leverage in that negotiation once balance billing has been taken out of the equation, and we would in effect be forced to accept the rate that non-participating providers are allowed. Across the country where similar laws have passed, we are seeing

managed care plans cancelling contracts in order to take advantage of these new non-participating rates.

We want to be part of the solution and we have suggested a plan based on successful laws in other states, such as New York, that would keep patients out of the middle of billing disputes and create a fair environment for physicians to negotiate rates with insurers. HB1881 would drive emergency providers from our state and leave the people of Hawaii vulnerable when they need our help the most.

Sincerely,

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

February 2, 2020

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

Re: HB 1881 – Relating to Medical Service Billing

Dear Chair Mizuno, Vice Chair Kobayashi, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 1881, which establishes billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers. Additionally, this measure specifies the circumstances in which health care providers and facilities can bill health carriers and enrollees for health intervention services that are medical necessities.

HMSA supports this measure and the protections that it extends to patients when they unknowingly receive services from a provider outside of their network. 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 provide testimony on this measure. Your consideration of our comments is appreciated.

Sincerely,

Pono Chong
Vice President, Government Relations

HB-1881
Submitted on: 2/3/2020 2:50:03 AM
Testimony for HLT on 2/4/2020 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Jennifer Azuma Chrupalyk	Individual	Support	No

Comments:

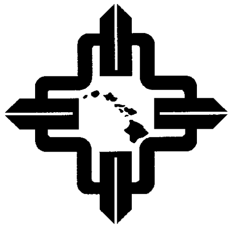
HB-1881
Submitted on: 2/3/2020 1:18:04 PM
Testimony for HLT on 2/4/2020 8:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Craig Thomas	Hawaii Emergency Physicians Associated	Oppose	No

Comments:

I believe out of network billing is a serious issue that needs resolution on a national level, this will likely benefit both patients and providers in Hawaii.

However, in absence of a national solution, local restrictions will impair our ability to compete against mainland groups to attract and retaing excellent physicians, particularly at rural sites.



HAWAII HEALTH SYSTEMS
C O R P O R A T I O N
Quality Healthcare For All

LATE

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

February 4, 2019
Conference Room 329
8:30 a.m.
Hawaii State Capitol

Testimony Supporting Intent with Request for Amendments
House Bill 1881
Establishes billing requirements for unanticipated medical billing and unanticipated coverage gaps for patients for out of network emergency services received from non-participating providers. Specifies the circumstances in which health care providers and facilities can bill health carriers and enrollees for health intervention services that are medical necessities.

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

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporate Board of Directors, thank you for the opportunity to present testimony **supporting the intent with a request for amendments to H.B. 1881** that establishes billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers, while specifying the circumstances in which health care providers and facilities can bill health carriers and enrollees for health intervention services that are medical necessities.

While HHSC understands the impact that unanticipated medical billing, or surprise medical billing can have to patients, this bill does not provide the correct remedy regarding provider reimbursement. As written, the measure removes incentives to arrive at fair contracts with providers. Therefore, HHSC joins in partnership with most the other of Hawaii's major healthcare systems to propose amendments that require the insurer to negotiate with the out-of-network provider to resolve payment.

Thank you for the opportunity to testify before this committee. We appreciate the Committee's continued focus on improving healthcare for our island communities.

THE QUEEN'S HEALTH SYSTEMS

LATE

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: February 3, 2020
Hrg: House Committee on Health Hearing; Tuesday, February 4, 2020 at 8:30 AM in Room 329

Re: **Comments HB 2504, Relating to Health Insurance**

The Queen's Health Systems (Queen's) is a not-for-profit corporation that provides expanded health care capabilities to the people of 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, 66 health care centers and labs, and more than 1,600 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 HB 2504, which establishes disclosure and consent requirements for nonparticipating health care providers; 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.

The bill ties provider reimbursement to 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 incentive to provide an adequate network for their insured and ultimately limits access to care.

Additionally, when a patient receives a bill from an out-of-network provider it is because the insurance company refuses to pay the claim. Insurers have a duty and obligation to their insured to satisfy and resolve claims with out-of-network providers.

To best serve the interests of our patients, Queen's, Hawaii Pacific Health, Adventist Health Castle, and Hawaii Health Systems Corporation are proposing amended language that:

- Clarifies that the health care plan is responsible for the disclosure and consent requirements since they would most appropriately know which providers are participating or not in their network.
- Takes the patient out of the middle by requiring the insurer to negotiate with the out-of-network provider to resolve payment and removes references that tie provider reimbursement to Medicare.
- Directs the Insurance Commissioner to establish a dispute resolution process for non-emergent services.
- Maintains an insurers' responsibility to their insured.

We would also note that the Congress is currently considering measures to address out-of-network billing and is expected to address this issue by the end of May, so the bill may not be necessary. Thank you for the opportunity to testify on this measure and your consideration of the amendments.

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

H.B. NO. 2504

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

1 SECTION 1. The legislature finds that the patients with
2 health insurance who receive treatment from an out-of-
3 network provider may be subject to the practice known as
4 "balance billing" or "surprise billing", where the
5 provider bills the patient for the difference between
6 what the patient's health insurance chooses to reimburse
7 and what the provider chooses to charge. These bills
8 occur most often when patients inadvertently receive
9 medical services from out-of-network providers, such as
10 when a patient is undergoing surgery and is not informed
11 that a member of the medical team is not a participating
12 provider in the patient's health insurance's provider
13 network, or when a patient is in need of emergency
14 services and is taken to the nearest medical facility,
15 regardless of the facility's or its providers' network
16 status. Out-of-network providers may not have a
17 contracted rate with a health insurer for services;
18 therefore, the prices these providers may charge may be
19 much greater than the price charged by in-network
20 providers for similar services.
21
22 The legislature further finds that balance bills or
23 surprise bills can be an unwelcome shock to patients who
24 may have unknowingly received health care services
25 outside of their provider network. These unexpected
26 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 specify:

(1) 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) 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; and

(3) 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.

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

(1) At least twenty-four hours prior to the provision of non-emergency services, disclose to the patient or prospective patient in writing and in compliance with subsection (c), the amount or estimated amount that the health care provider, health care facility, or hospital will bill the patient or prospective patient for non-emergency health care services provided or anticipated to be provided to the patient or prospective patient, not including unforeseen medical circumstances that may arise when the health care services are provided; and

(2) At least twenty-four hours 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) Any communication from the ~~nonparticipating health care provider, health care facility, or hospital~~health care plan to the ~~patient or prospective patient~~insured shall include notice in a twelve-point bold type stating that the communication is not a bill and informing the ~~patient or prospective patient~~insured that the insured ~~patient or prospective patient~~ shall not pay any amount or estimated amount until the insured ~~patient's or prospective patient~~'s health care plan informs the insured ~~patient or prospective patient~~ of any applicable cost-sharing.

(d) A ~~nonparticipating health care provider, health care facility, or hospital~~health care plan that fails to comply with this section shall not bill or collect any amount from the insured ~~patient or prospective patient~~ in excess of the in-network cost-sharing owed by the insured~~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:

1 "Health care facility" means any institution, place,
2 building, or agency, or portion thereof, licensed or
3 otherwise authorized by the State, whether organized for
4 profit or not, used, operated, or designed to provide
5 medical diagnosis, treatment, or rehabilitative or
6 preventive care to any person or persons.
7 "Health care plan" means a policy, contract, plan,
8 or agreement delivered or issued for delivery by a health
9 insurance company, mutual benefit society governed by
10 article 1 of chapter 432, health maintenance organization
11 governed by chapter 432D, or any other entity delivering
12 or issuing for delivery in the State accident and health
13 or sickness insurance as defined in section 431:1-205,
14 other than disability insurance that replaces lost
15 income.
16 "Health care provider" means an individual who is
17 licensed or otherwise authorized by the State to provide
18 health care services.
19 "Hospital" means:
20 (1) An institution with an organized medical staff, regulated under section 321-
21 11(10), that admits patients for inpatient care, diagnosis, observation, and treatment;
22 and
23 (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.** (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 too:~~

~~(1) eCollect sums owed by the insurer.; or~~

1 (2) Collect sums in excess of the amount owed by the insured as a copayment,
2 coinsurance, or deductible under the insured's policy of accident and health or
3 sickness insurance.
4 (be) When an insured receives emergency services
5 from a provider who is not a participating provider in
6 the provider network of the insured, the insured shall
7 not incur greater out-of-pocket costs for emergency
8 services than the insured would have incurred with a
9 participating provider of health care services. No
10 nonparticipating provider, or agent, trustee, or assignee
11 thereof, may maintain any action at law against an
12 insured to collect sums in excess of the amount owed by
13 the insured as a copayment, coinsurance, or deductible
14 under the insured's policy of accident and health or
15 sickness insurance.
16 (d) When the insured receives emergency services from
17 a provider who is not a participating provider in the
18 provider network of the insured, an insurer shall be
19 responsible to fulfill their obligation to the insured
20 and shall enter into negotiation with the provider who is
21 not a participating provider in the provider network of
22 the insured to resolve any sums owed by the insurer.
23 (ed) For purposes of this section:

1 "Emergency condition" means a medical or behavioral
2 condition that manifests itself by acute symptoms of
3 sufficient severity, including severe pain, such that a
4 prudent layperson, possessing an average knowledge of
5 medicine and health, could reasonably expect the absence
6 of immediate medical attention to result in:

7 (1) Placing the health of the person afflicted with the condition in serious
8 jeopardy;

9 (2) Serious impairment to the person's bodily functions;

10 (3) Serious dysfunction of any bodily organ or part of the person; or

11 (4) Serious disfigurement of the person.

12 "Emergency services" means, with respect to an
13 emergency condition:

14 (1) A medical screening examination as required under section 1867 of the Social
15 Security Act, title 42 United States Code section 1395dd; and

16 (2) Any further medical examination and treatment, as required under section
17 1867 of the Social Security Act, title 42 United States Code section 1395dd, to
18 stabilize the patient.

19 **§431:10A-B Balance billing; hold harmless; non-**
20 **emergency services.** (a) ~~Absent a signed consent form as~~
21 ~~required under section 321- ,~~ no nonparticipating
22 health care provider, health care facility, or hospital,
23 or agent, trustee, or assignee thereof, may maintain any

1 action at law against an insured to collect sums in
2 excess of the amount owed by the insured as a copayment,
3 coinsurance, or deductible for similar services provided
4 by a participating provider under the insured's policy of
5 accident and health or sickness insurance.
6 (b) When the insured receives emergency services from a
7 provider who is not a participating provider in the
8 provider network of the insured, an insurer shall be
9 responsible to fulfill their obligation to the insured
10 and shall enter into negotiation with the provider who is
11 not a participating provider in the provider network of
12 the insured to resolve any sums owed by the insurer."
13 SECTION 4. Chapter 431, Hawaii Revised Statutes, is
14 amended by adding a new section to article 14G to be
15 appropriately designated and to read as follows:
16 "§431:14G- **Out-of-network or nonparticipating**
17 **provider reimbursement; rate calculation.** (a) ~~Absent a~~
18 ~~signed consent form as required under section 321- or~~
19 ~~any contract to the contrary, Aa~~ managed care plan shall
20 be responsible to fulfill their obligation to the insured
21 and enter into negotiation with the non-participating
22 provider. The managed care plan and non-participating
23 provider shall come to an agreement through an
24 independent dispute resolution process, as established by

the insurance commissioner. If not resolution is met, the managed care plan shall pay the non-participating provider shall pay the non-participating provider the amount billed by the non-participating provider. The insurance commissioner shall adopt rules pursuant to chapter 91 to establish an independent dispute resolution process. ~~be responsible to fulfill their obligation to the enrollee and enter into negotiation with the non-participating provider. The managed care plan and non-participating provider shall come to an agreement within thirty days of issuance of an invoice for the emergency services provided as to the amount the non-participating provider shall be compensated. If no agreement is reached within thirty days, the manage care plan shall pay the non-participating provider the amount billed by the non-participating provider.~~ ~~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. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from enrollees who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321-   .

~~(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-   Balance billing; hold harmless; emergency services.** (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~~

1 ~~prohibition, the participating provider shall not collect~~
2 ~~or attempt to collect from the subscriber or member sums~~
3 ~~owed by the mutual benefit society. No participating~~
4 ~~provider, or agent, trustee, or assignee thereof, may~~
5 ~~maintain any action at law against a subscriber or member~~
6 ~~to:~~
7 ~~(1) cCollect sums owed by the mutual benefit society; or.~~
8 ~~(2) Collect sums in excess of the amount owed by the subscriber or member as a copayment,~~
9 ~~coinsurance, or deductible under the subscriber's or member's plan contract.~~
10 (c) When a subscriber or member receives emergency
11 services from a provider who is not a participating
12 provider in the provider network of the subscriber or
13 member, the subscriber or member shall not incur greater
14 out-of-pocket costs for emergency services than the
15 subscriber or member would have incurred with a
16 participating provider of health care services. ~~No~~
17 ~~nonparticipating provider, or agent, trustee, or assignee~~
18 ~~thereof, may maintain any action at law against a~~
19 ~~subscriber or member to collect sums in excess of the~~
20 ~~amount owed by the subscriber or member as a copayment,~~
21 ~~coinsurance, or deductible under the subscriber's or~~
22 ~~member's plan contract.~~
23 (d) When a subscriber or member receives emergency
24 services from a provider who is not a participating

1 provider in the provider network of the subscriber or
2 member, the mutual benefit society shall be responsible
3 to fulfill their obligation to the subscriber or member
4 and shall enter into negotiation with the provider who is
5 not a participating provider in the provider network of
6 the subscriber or member, to resolve any sums owed by the
7 mutual benefit society.

8 (e~~d~~) For purposes of this section:

9 "Emergency condition" means a medical or behavioral
10 condition that manifests itself by acute symptoms of
11 sufficient severity, including severe pain, such that a
12 prudent layperson, possessing an average knowledge of
13 medicine and health, could reasonably expect the absence
14 of immediate medical attention to result in:

15 (1) Placing the health of the person afflicted with the condition in serious
16 jeopardy;

17 (2) Serious impairment to the person's bodily functions;

18 (3) Serious dysfunction of any bodily organ or part of the person; or

19 (4) Serious disfigurement of the person.

20 "Emergency services" means, with respect to an
21 emergency condition:

22 (1) A medical screening examination as required under section 1867 of the Social
23 Security Act, title 42 United States Code section 1395dd; and

1 (2) Any further medical examination and treatment, as required under section
2 1867 of the Social Security Act, title 42 United States Code section 1395dd, to
3 stabilize the patient.

4 **§432:1- Balance billing; hold harmless; non-**
5 **emergency services.** (a) ~~Absent a signed consent form as~~
6 ~~required under section 321- ,~~ N~~n~~o nonparticipating
7 health care provider, health care facility, or hospital,
8 or agent, trustee, or assignee thereof, may maintain any
9 action at law against a subscriber or member to collect
10 sums in excess of the amount owed by the subscriber or
11 member as a copayment, coinsurance, or deductible for
12 similar services provided by a participating provider
13 under the subscriber's or member's plan contract.
14 (b) When a subscriber or member receives non-emergency
15 services from a provider who is not a participating
16 provider in the provider network of the subscriber or
17 member, the mutual benefit society shall be responsible
18 to fulfill their obligation to the subscriber or member
19 and shall enter into negotiation with the provider who is
20 not a participating provider in the provider network of
21 the subscriber or member, to resolve any sums owed by the
22 mutual benefit society.
23

1 **§432:1-   Out-of-network or nonparticipating**
2 **provider reimbursement; rate calculation.** (a) A~~Absent a~~
3 ~~signed consent form as required under section 321-   or~~
4 ~~any contract to the contrary, a~~ mutual benefit society
5 shall be responsible to fulfill their obligation to the
6 subscriber or member and enter into negotiation with the
7 non-participating provider. The mutual benefit society
8 and non-participating provider shall come to an agreement
9 through an independent dispute resolution process, as
10 established by the insurance commissioner. If not
11 resolution is met, the mutual benefit society shall pay
12 the non-participating provider shall pay the non-
13 participating provider the amount billed by the non-
14 participating provider. The insurance commissioner shall
15 adopt rules pursuant to chapter 91 to establish an
16 independent dispute resolution process. ~~be responsible to~~
17 ~~fulfill their obligation to the subscriber or member and~~
18 ~~enter into negotiation with the non-participating~~
19 ~~provider. The mutual benefit society and non-~~
20 ~~participating provider shall come to an agreement within~~
21 ~~thirty days of issuance of an invoice for the non-~~
22 ~~emergency services provided as to the amount the non-~~
23 ~~participating provider shall be compensated. If no~~
24 ~~agreement is reached within thirty days, the mutual~~

~~benefit society shall pay the non-participating provider the amount billed by the non-participating provider.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. Nothing in this section shall be construed to prohibit nonparticipating providers from seeking the uncovered cost of services rendered from subscribers or members who have consented to receive the health care services provided by the nonparticipating provider in accordance with section 321-   .

~~(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-   Balance billing; hold harmless; emergency services.** (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:~~

~~c(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

1 not incur greater out-of-pocket costs for emergency
2 services than the subscriber or enrollee would have
3 incurred with a participating provider of health care
4 services. ~~No nonparticipating provider, or agent,~~
5 ~~trustee, or assignee thereof, may maintain any action at~~
6 ~~law against a subscriber or enrollee to collect sums in~~
7 ~~excess of the amount owed by the subscriber or enrollee~~
8 ~~as a copayment, coinsurance, or deductible under the~~
9 ~~subscriber's or enrollee's policy, contract, plan, or~~
10 ~~agreement.~~
11 (d) When a subscriber or enrollee receives emergency
12 services from a provider who is not a participating
13 provider in the provider network of the subscriber or
14 enrollee, the carrier or health maintenance organization
15 shall be responsible to fulfill their obligation to the
16 subscriber or enrollee and shall enter into negotiation
17 with the provider who is not a participating provider in
18 the provider network of the subscriber or enrollee, to
19 resolve any sums owed by the carrier or health
20 maintenance organization.
21 (e~~d~~) For purposes of this section:
22 "Emergency condition" means a medical or behavioral
23 condition that manifests itself by acute symptoms of
24 sufficient severity, including severe pain, such that a

1 prudent layperson, possessing an average knowledge of
2 medicine and health, could reasonably expect the absence
3 of immediate medical attention to result in:

4 (1) Placing the health of the person afflicted with the condition in serious
5 jeopardy;

6 (2) Serious impairment to the person's bodily functions;

7 (3) Serious dysfunction of any bodily organ or part of the person; or

8 (4) Serious disfigurement of the person.

9 "Emergency services" means, with respect to an
10 emergency condition:

11 (1) A medical screening examination as required under section 1867 of the Social
12 Security Act, title 42 United States Code section 1395dd; and

13 (2) Any further medical examination and treatment, as required under section
14 1867 of the Social Security Act, title 42 United States Code section 1395dd, to
15 stabilize the patient.

16 **§432D- Balance billing; hold harmless; non-**
17 **emergency services.** ~~Absent a signed consent form as~~
18 ~~required under section 321- ,~~ N~~n~~o nonparticipating
19 health care provider, health care facility, or hospital,
20 or agent, trustee, or assignee thereof, may maintain any
21 action at law against a subscriber or enrollee to collect
22 sums in excess of the amount owed by the subscriber or
23 enrollee as a copayment, coinsurance, or deductible for

1 similar services provided by a participating provider
2 under the subscriber's or enrollee's policy, contract,
3 plan, or agreement.

4 **§432D- Out-of-network or nonparticipating**
5 **provider reimbursement; rate calculation.** (a) AAbsent a
6 signed consent form as required under section 321- or
7 any contract to the contrary, a health maintenance
8 organization shall be responsible to fulfill their
9 obligation to the subscriber or enrollee and enter into
10 negotiation with the non-participating provider. The
11 health maintenance organization and non-participating
12 provider shall come to an agreement through an
13 independent dispute resolution process, as established by
14 the insurance commissioner. If not resolution is met, the
15 health maintenance organization shall pay the non-
16 participating provider shall pay the non-participating
17 provider the amount billed by the non-participating
18 provider. The insurance commissioner shall adopt rules
19 pursuant to chapter 91 to establish an independent
20 dispute resolution process. reimburse a nonparticipating
21 provider the greater of:
22 (1) The usual and customary rate for similar services provided by a participating
23 provider under the subscriber's or enrollee's policy, contract, plan, or agreement; or

1 ~~(2) per cent of the amount medicare reimburses on a fee-for-service basis for~~
2 ~~the same or similar services in the general geographic region in which the services~~
3 ~~were rendered.~~
4 (b) Nothing in this section shall be construed to
5 require a health maintenance organization to cover
6 services not required by law or by the terms and
7 conditions of the policy, contract, plan, or
8 agreement. Nothing in this section shall be construed to
9 prohibit nonparticipating providers from seeking the
10 uncovered cost of services rendered from subscribers or
11 enrollees who have consented to receive the health care
12 services provided by the nonparticipating provider in
13 accordance with section 321- .
14 ~~(c) For purposes of this section "usual and~~
15 ~~customary rate" shall mean the carrier or health~~
16 ~~maintenance organization's average contracted rate."~~
17 SECTION 7. Section 431:10-109, Hawaii Revised
18 Statutes, is amended to read as follows:
19 "[~~[~~]§431:10-109[~~]~~] **Disclosure of** [~~**health care**~~
20 ~~**coverage and benefits.**~~] **information.** (a) In order to
21 ensure that all individuals understand their health care
22 options and are able to make informed decisions, all
23 insurers shall provide current and prospective insureds
24 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 where the insured has consented to services provided by an out-of-network provider in accordance with section 321-   , the amount that the insurer will reimburse under the rate calculation for out-of-network health care specified in section 431:14G-   ; and

(B) Examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and

(3) Information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area based upon the difference between what the insurer will reimburse for out-of-network health care services and the rate calculation specified in section 431:14G-   for out-of-network health care services.

(b) The information provided shall be current, understandable, and available prior to the issuance of a

policy, and upon request after the policy has been issued[,]; provided that nothing in this section shall prevent an insurer from changing or updating the materials that are made available to insureds.

(c) For purposes of this section:

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

(1) Placing the health of the person afflicted with the condition in serious jeopardy;

(2) Serious impairment to the person's bodily functions;

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of the person.

"Emergency services" means, with respect to an emergency condition:

(1) A medical screening examination as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd; and

(2) Any further medical examination and treatment, as required under section 1867 of the Social Security Act, title 42 United States Code section 1395dd, to stabilize the patient."

__.B. NO.______

1 SECTION 8. In codifying the new sections added by
2 section 3 of this Act, the revisor of statutes shall
3 substitute appropriate section numbers for the letters
4 used in designating the new sections in this Act.
5 SECTION 9. Statutory material to be repealed is
6 bracketed and stricken. New statutory material is
7 underscored.
8 SECTION 10. This Act shall take effect upon its
9 approval.
10
11
12
13
14 INTRODUCED BY: ______________________________

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S.B. NO. 2278

Report Title:
Balance Billing; Surprise Billing; Prohibitions; Health Insurance; Nonparticipating Providers

Description:
Establishes disclosure and consent requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers.

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

Adventist Health
Castle

640 'Ulukahiki Street
Kailua, Hawai'i 96734-4498
Tel (808) 263-5500
AdventistHealthCastle.org

February 3, 2020

LATE

To: The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
Members, Committee on Health

From: Kathy Raethel, President, Adventist Health Castle

Date: February 3, 2020
Hrg: House Committee on Health Hearing (Room 329)
Hearing Date/Time: Wednesday, February 4, 2020, 8:30 a.m.

RE: **Comments H.B. 1881, Relating to Medical Service Billing**

Dear Chair Mizuno and Members of the Committee:

Adventist Health Castle appreciates the opportunity to offer comments to H.B. 1881, which seeks to establish billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers.

AH Castle is fully supports the intent of the bill, which is to protect patients from any gaps in payor networks and insulate them from billing disputes between a payor and provider. AH Castle strongly believes, however, that the substance of the bill fails to meet its intent.

The bill seeks to establish baseline payment amounts for out-of-network providers, setting the rate at Medicare rates. This leaves numerous swaths of the population vulnerable, as Medicare does not cover certain services (i.e. women and children). Having a rate baseline that is set below cost will disincentivize health care plans to negotiate in good faith with providers, and leave patients paying for a network that shrinks with every contract renewal.

In an effort to meet the needs of our patients and further the intent of the bill, AH Castle, Queens Health Systems, Hawaii Pacific Health and Hawaii Health Systems Corporation, support the attached amendments that include language that:

- Requires that the health care plan and the provider seek a resolution to any billing dispute without including the patient;
- Removes the disincentive for health care plans to negotiate in good faith with providers by removing references to Medicare rates;
- Directs the Insurance Commissioner to establish a dispute resolution proccess for non-emergent procedures;

Sincerely,

Kathy Raethel
President, Adventist Health Castle

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

H.B. NO. 1881

A BILL FOR AN ACT

RELATING TO MEDICAL SERVICE BILLING.

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

1 SECTION 1. The legislature finds that unanticipated
2 medical billing can cause significant financial hardship
3 to patients. Unanticipated medical billing, also known
4 as surprise medical billing, arises when a patient
5 receives unanticipated out-of-network care from a non-
6 participating provider for emergency or other medical
7 services. The medical services may be from a health care
8 provider or a health care facility that is outside of the
9 patient's insurer's network and, as such, the patient's
10 health care plan ends up paying less than the patient
11 expected for the medical services received.
12 The legislature also finds that in the case of
13 surprise medical billing for emergency services, patients
14 often do not have the ability to select the emergency
15 room, treating physician and other medical specialists,
16 or ambulance provider. Furthermore, when physician
17 groups and insurers are unable to resolve reimbursement
18 disputes, patients are saddled with high medical bills,
19 sometimes resulting in significant financial hardship

1 from the higher out-of-network charges and medical
2 reimbursements.
3 The purpose of this Act is to protect patient access
4 to health care by addressing unanticipated medical
5 coverage gaps for patients who receive emergency services
6 from non-participating providers.
7 SECTION 2. Chapter 432E, Hawaii Revised Statutes, is
8 amended by adding a new section to be appropriately
9 designated and to read as follows:
10 "**§432E- Emergency services; billing.** (a) When
11 an enrollee in a managed care plan receives emergency
12 services from a non-participating provider, the non-
13 participating provider shall not be entitled to bill the
14 enrollee. The manage care plan shall be responsible to
15 fulfill their obligation to the enrollee and enter into
16 negotiation with the non-participating provider. The
17 managed care plan and non-participating provider shall
18 come to an agreement within thirty days of issuance of an
19 invoice for the emergency services provided as to the
20 amount the non-participating provider shall be
21 compensated. If no agreement is reached within thirty
22 days, the manage care plan shall pay the non-
23 participating provider the amount billed by the non-
24 participating provider~~, managed care plan, or any other~~

1 ~~entity any amount in excess of any applicable charges the~~
2 ~~provider would be entitled to charge a medicare enrollee~~
3 ~~who receives such services, including, without~~
4 ~~limitation, any copayment, coinsurance, or deductible~~
5 ~~that would be owed by a medicare enrollee to the non-~~
6 ~~participating provider for the services.~~
7 (b) The non-participating provider shall accept
8 payment of the amounts under subsection (a) as payment in
9 full for the emergency services rendered.
10 ~~(c) To the extent that the emergency services are~~
11 ~~covered under the enrollee's managed care plan, any~~
12 ~~liability the managed care plan may have for the services~~
13 ~~shall not exceed the amount the non-participating~~
14 ~~provider is entitled to bill under this section.~~
15 (c~~d~~) A health care provider or facility shall bill a
16 health carrier only for a health intervention service
17 that is a medical necessity. The health care provider or
18 facility shall not bill or otherwise attempt to collect
19 from an enrollee any amount not paid by a health carrier
20 for a health intervention service that is a medical
21 necessity, other than an applicable copayment,
22 coinsurance, or deductible.
23 (d~~e~~) For the purposes of this section, "non-
24 participating provider" means a licensed or certified

__.B. NO.______

1 provider of health care services or benefits, including
2 mental health services and health care supplies, who has
3 not entered into an agreement with a health carrier to
4 provide those services or supplies to enrollees." ~~means a~~
5 ~~facility, health care provider, or health care~~
6 ~~professional that is not subject to a written agreement~~
7 ~~with the enrollee's health carrier governing the~~
8 ~~provision of emergency services.~~"
9 SECTION 3. New statutory material is underscored.
10 SECTION 4. This Act shall take effect on January 1,
11 2021.
12
13
14
15 INTRODUCED BY: _____________________________

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S.B. NO. 2423

Report Title:
Emergency Services; Medical Necessity; Billing; Non-Participating Providers; Managed Care Plans

Description:
Establishes billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers. Specifies the circumstances in which health care providers and facilities can bill health carriers and enrollees for health intervention services that are medical necessities. Effective 1/1/2021.

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

LATE

LATE

Date: February 4, 2020
Time: 8:30 am
Room: Conference Room 329

House Committee on Health

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

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

Re: HB 1881 – Relating To Medical Service Billing
SUPPORT INTENT PROVIDING PROPOSED LANGUAGE

My name is Michael Robinson, Vice President, Government Relations and Community Affairs at Hawai'i Pacific Health (HPH). 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.

We support the intent and offer suggested amendments to HB 1881 which establishes billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers. Specifies the circumstances in which health care providers and facilities can bill health carriers and enrollees for health intervention services that are medical necessities.

Hawai'i Pacific Health has experience working with a variety of insurers and providers and believes 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/insured. As a provider organization, we also assume that both healthcare insurers and healthcare providers have a *shared* responsibility to protect patients from financial burdens to ensure access to medically necessary care.

Hawai'i Pacific Health believes that for emergency services, where medical necessity eliminates the opportunity for a patient to make a choice based on a provider's network status with a health plan, the patient should not be responsible for charges where patient choice is not possible. While we share the stated intent of this bill, we have the following concerns of the current bill as drafted:

- **Section 2**: We agree that an when an enrollee in a managed care plan receives emergency services from a non-participating provider, the non-particapting provider shall not be entiled to bill the enrollee. However we also believe that the insurer should be required to fulfill their obligation to their member and be required to work with the health care provider to negotiate a settlement to resolve any sums owed on behalf of their insured.

Additonally, we note that the specification of reimbursement to be paid based on a statutory defined reimbursement rate of Medicare for non-participating providers will not adequately cover the entire range of medical services for billing that a patient may encounter.

For example:

(1) 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 services delivered for these populations could potentially be incalculable with the bill as written.

To address these concerns, Hawai'i Pacific Health is currently working with HAH members Queens Health System, Castle Medical Center, Hawai'i Health System Corporation on language that would achieve the following goals (see attached Proposed Amendments);

- Remove disincentives for a plan and provider to come to the table to negotiate contract terms for payment for medical services provided to a plan member;
- Incentivize health plans to make reasonable efforts to invest in developing an adequate network for its members by retaining incentives for insurers to contract for services with providers.

Finally, we support the establishment of a dispute resolution process before a disinterested 3rd party. The establishment of such a process would incentivize both plans and providers to reach a settlement with knowledge of binding arbitration being a possible remedy. The insurance commissioner who has the ability to promulgate administrative rules is ideally situated to assume the role of arbitrator or mediator in resolving issues involving out-of-network charges and medical reimbursements.

Accordingly, we suggest the following amendments.

"432E- Dispute resolution.

(a) When the non-participating health care provider and the managed care plan are unable to reach an agreement as to the amount to be billed for the services provided by the non-participating provider, the matter shall be submitted to the insurance commissioner for binding arbitration or mediation.

(b) The non-participating provider and managed care plan shall agree on whether the matter shall be subject to binding arbitration or mediation within 45 days of notification by the managed care plan to the non-participating provider that the managed care plan disagrees with the amount billed for the services rendered to the enrollee.

(c) The insurance commissioner may adopt rules to enact this section.

(d) This section shall apply to emergency and non-emergency services provided by a non-participating provider.

Thank you for your consideration of this important matter. Proposed bill amendments attached.

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

H.B. NO. 1881

A BILL FOR AN ACT

RELATING TO MEDICAL SERVICE BILLING.

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

1 SECTION 1. The legislature finds that unanticipated
2 medical billing can cause significant financial hardship
3 to patients. Unanticipated medical billing, also known
4 as surprise medical billing, arises when a patient
5 receives unanticipated out-of-network care from a non-
6 participating provider for emergency or other medical
7 services. The medical services may be from a health care
8 provider or a health care facility that is outside of the
9 patient's insurer's network and, as such, the patient's
10 health care plan ends up paying less than the patient
11 expected for the medical services received.
12 The legislature also finds that in the case of
13 surprise medical billing for emergency services, patients
14 often do not have the ability to select the emergency
15 room, treating physician and other medical specialists,
16 or ambulance provider. Furthermore, when physician
17 groups and insurers are unable to resolve reimbursement
18 disputes, patients are saddled with high medical bills,
19 sometimes resulting in significant financial hardship

1 from the higher out-of-network charges and medical
2 reimbursements.
3 The purpose of this Act is to protect patient access
4 to health care by addressing unanticipated medical
5 coverage gaps for patients who receive emergency services
6 from non-participating providers.
7 SECTION 2. Chapter 432E, Hawaii Revised Statutes, is
8 amended by adding a new section to be appropriately
9 designated and to read as follows:
10 "**§432E-   Emergency services; billing.** (a) When
11 an enrollee in a managed care plan receives emergency
12 services from a non-participating provider, the non-
13 participating provider shall not be entitled to bill the
14 enrollee. The manage care plan shall be responsible to
15 fulfill their obligation to the enrollee and enter into
16 negotiation with the non-participating provider. The
17 managed care plan and non-participating provider shall
18 come to an agreement within thirty days of issuance of an
19 invoice for the emergency services provided as to the
20 amount the non-participating provider shall be
21 compensated. If no agreement is reached within thirty
22 days, the manage care plan shall pay the non-
23 participating provider the amount billed by the non-
24 participating provider~~, managed care plan, or any other~~

1 ~~entity any amount in excess of any applicable charges the~~
2 ~~provider would be entitled to charge a medicare enrollee~~
3 ~~who receives such services, including, without~~
4 ~~limitation, any copayment, coinsurance, or deductible~~
5 ~~that would be owed by a medicare enrollee to the non-~~
6 ~~participating provider for the services.~~
7 (b) The non-participating provider shall accept
8 payment of the amounts under subsection (a) as payment in
9 full for the emergency services rendered.
10 ~~(c) To the extent that the emergency services are~~
11 ~~covered under the enrollee's managed care plan, any~~
12 ~~liability the managed care plan may have for the services~~
13 ~~shall not exceed the amount the non-participating~~
14 ~~provider is entitled to bill under this section.~~
15 (c~~d~~) A health care provider or facility shall bill a
16 health carrier only for a health intervention service
17 that is a medical necessity. The health care provider or
18 facility shall not bill or otherwise attempt to collect
19 from an enrollee any amount not paid by a health carrier
20 for a health intervention service that is a medical
21 necessity, other than an applicable copayment,
22 coinsurance, or deductible.
23 (d~~e~~) For the purposes of this section, "non-
24 participating provider" means a licensed or certified

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1 provider of health care services or benefits, including
2 mental health services and health care supplies, who has
3 not entered into an agreement with a health carrier to
4 provide those services or supplies to enrollees." ~~means a~~
5 ~~facility, health care provider, or health care~~
6 ~~professional that is not subject to a written agreement~~
7 ~~with the enrollee's health carrier governing the~~
8 ~~provision of emergency services.~~"
9 SECTION 3. New statutory material is underscored.
10 SECTION 4. This Act shall take effect on January 1,
11 2021.
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13
14
15 INTRODUCED BY: ______________________________

THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S.B. NO. 2423

Report Title:
Emergency Services; Medical Necessity; Billing; Non-Participating Providers; Managed Care Plans

Description:
Establishes billing requirements for unanticipated medical billing and unanticipated coverage gaps of patients for out-of-network emergency services received from non-participating providers. Specifies the circumstances in which health care providers and facilities can bill health carriers and enrollees for health intervention services that are medical necessities. Effective 1/1/2021.

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