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 Consumer Protection and Commerce
Thursday, February 13, 2020
2:00 p.m.
State Capitol, Conference Room 329

On the following measure:
H.B. 2504, H.D. 1, RELATING TO HEALTH INSURANCE

Chair Takumi 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 offers comments on this bill.

The purposes of this bill are to: (1) establish disclosure and consent requirements for nonparticipating health care providers; (2) prohibit nonparticipating health care providers from balance billing patients in specific circumstances; and (3) require the use of dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider.

The Department appreciates the intent of relieving consumers of the impacts of unexpected balance bills. However, the Department has the following concerns with H.D. 1:

- H.D. 1 places the provisions regulating health care provider conduct in Hawaii Revised Statutes (HRS) chapter 431, article 10A (Accident and Health or

Sickness Insurance Contracts); chapter 431, article 14G (Health Insurance Rate Regulation); chapter 432, article 1 (Mutual Benefit Societies); and chapter 432D (Health Maintenance Organization Act). For example, section 3 of the bill on page 10, lines 19 to 21 amends HRS chapter 431, article 10A with language that includes "[n]o nonparticipating health care provider . . . may maintain any ***action at law***" (emphasis added).

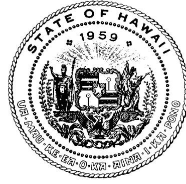
- H.D. 1 amends section 2 by placing on the health plan requirements that the original version of the bill had imposed on providers. For example, page 5, lines 14 to 19 requires a health plan "twenty-four hours prior to the provision of non-emergency services, disclose to the patient . . . the amount or estimated amount that the health care provider, health care facility, or hospital will bill the patient[.]" A health plan may not be necessarily aware of services its enrollees are pursuing from out-of-network providers. This amendment places the disclosure burden on the health plan rather than on the provider. As the issue of balance billing includes balance bills that are issued by providers, the Department respectfully suggests that the Committee restore the obligations on providers that were in the bill as introduced.
- Section 2 of this bill on page 6, line 20 to page 7, line 1 provides, "A health care plan that fails to comply with this section shall not bill or collect any amount from the insured in excess of the in-network cost-sharing owed by the insured[.]" Preventing a health plan from balance billing does not address balance billing by providers.
- While the "hold harmless" provisions of this bill prohibit providers from "maintain[ing] any ***action at law*** against [a consumer] to collect sums in excess of the amount owed by [the consumer] as a copayment, coinsurance, or deductible[,]" see e.g. page 10, line 19 to page 11, line 2, this does not appear to cover other attempts to collect in general (emphasis added). The Department offers that the "hold harmless" provisions would be more comprehensive if they were amended to protect consumers from attempts to collect in general, rather than only from attempts to collect by maintaining an "action at law."

- The "hold harmless" provisions for emergency services include a subsection that is vague as to against whom it may be enforced. Page 9, lines 3 to 8 provides, "When an insured receives emergency services from a provider who is not a participating provider . . . the insured shall not incur greater out-of-pocket costs for emergency services than the insured would have incurred with a participating provider of health care services." It is unclear whom will ensure that a consumer does not "incur greater out-of-pocket costs."
- The definition for "emergency services" on page 18, lines 11 to 19 is inconsistent with the definition in HRS chapter 432E. Accordingly, the Department suggests amending the definition of "emergency services" to be consistent with HRS chapter 432E.
- The dispute resolution provisions in H.D. 1 provide that health plans and nonparticipating providers "shall come to an agreement through an independent dispute resolution process, as established by the commissioner." See e.g. page 11, lines 19 to 21. While the Department does not oppose subjecting disputes between health plans and providers to alternative dispute resolution, the Insurance Commissioner should not preside over those proceedings, as the Insurance Commissioner does not adjudicate conflicts between private parties and lacks staffs to administer these duties. In addition, a resolution rendered in a process established by the Insurance Commissioner could be subject to appeal under HRS chapter 91. Appellate proceedings would significantly extend the time to reach a resolution and potentially disadvantage smaller providers with fewer resources to conduct appellate proceedings. Therefore, the Department suggests that dispute resolution may be more efficient and meaningful if it were not established by the Insurance Commissioner.
- The dispute resolution provisions of H.D. 1 provide that if there is no resolution, health plans "shall pay the nonparticipating provider the amount billed by the nonparticipating provider." See e.g. page 12, lines 1 to 2. This may incentivize nonparticipating providers to avoid reaching a resolution and may encourage bad faith participation in resolution efforts. The Department notes that some

other benchmark, which would incentivize good faith participation in dispute resolution, may be more appropriate.

Thank you for the opportunity to testify on this bill.

DAVID Y. IGE
GOVERNOR OF HAWAII



BRUCE S. ANDERSON, PHD
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony in OPPOSITION to HB2504 HD1
RELATING TO HEALTH INSURANCE.

REP. JOHN M. MIZUNO, CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date: February 4, 2020 Room Number: 329

1 **Fiscal Implications:** N/A.

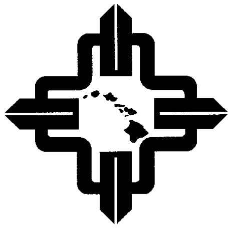
2 **Department Testimony:** The Department of Health (DOH) respectfully opposes Bill Section 2
3 and recommends repealing all amendments to chapter 321 proposed by HB2504 HD1, as well as
4 deleting all references to DOH. The department takes no position on the other sections of this
5 bill.

6 Bill Section 2 amends chapter 321 to require disclosure and consent for health care providers,
7 health care facilities, and hospitals that are nonparticipating providers in a patient's health care
8 plan, and restricts health care plan billing and collections from the patient for non-compliance.

9 While the experience of a "surprise billing" is negative for a patient, involving the Department of
10 Health as part of a framework for protection from surprise bills or balance bills does not add
11 value. DOH lacks the authority and experience to regulate the business practices of health care
12 plans and health care providers, and it is inappropriate for the DOH to impose restrictions on
13 health care plan operations and private commercial health care transactions because there is no
14 threat to public health.

15 Furthermore, HB2504 HD1 does not provide DOH with investigative or enforcement authority,
16 which will dilute compliance to patient protections sought by this measure.

17 Thank you for the opportunity to testify.



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

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Roy M. Takumi, Chair
Rep. Linda Ichiyama, Vice Chair

February 13, 2020
Conference Room 329
2:00 p.m.
Hawaii State Capitol

Support
House Bill 2504, HD1
RELATING TO HEALTH INSURANCE
Establishes disclosure and consent requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Requires the use of dispute solution when a dispute exists as to the reimbursement of a nonparticipating provider.

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

The Hawaii Health Systems Corporation (HHSC) **supports** HB 2504, HD1 which establishes disclosure and consent requirements for nonparticipating health care providers. Further, it prohibits nonparticipating health care providers from balance billing patients in specific circumstances and requires the use of dispute solution when a dispute exists as to the reimbursement of a nonparticipating provider.

HHSC is deeply concerned about the effect of unanticipated medical bills on Hawaii's patients for care they thought was covered by their health plan which could impact their out-of-pocket costs and undermine their trust and confidence in their caregivers and Hawaii's hospitals. Consumers are best served when both plans and providers are incentivized so there are not any nonparticipating providers. Passing statutory protections in state law to address this issue is challenging, but is worthy of our collective efforts to address.

Thank you for the opportunity to testify on this measure.

3675 KILAUEA AVENUE • HONOLULU, HAWAII 96816 • PHONE: (808) 733-4020 • FAX: (808) 733-4028

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www.hhsc.org

Testimony to the House Committee on Consumer Protection and Commerce
Thursday, February 13, 2020; 2:00 p.m.
State Capitol, Conference Room 329

RE: HOUSE BILL NO.2504, HOUSE DRAFT 1, RELATING TO HEALTH INSURANCE.

Chair Takumi, Vice Chair Ichiyama, and Members of the Joint Committee:

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS** House Bill No. 2504, House Draft 1, RELATING TO HEALTH INSURANCE.

The bill, as received by your Committee, would:

(1) Establish 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) Clarify the circumstances in which a patient not be liable to a health care provider for sums owed by an insurer, mutual benefit society, or health maintenance organization; and

(3) Require insurers, mutual benefit societies, and health maintenance organizations to enter into independent dispute resolutions with nonparticipating providers to resolve outstanding obligations.

This bill would also take effect on July 1, 2050.

By way of background, the HPCA represents Hawaii Federally-Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

The HPCA agrees with the findings asserted in SECTION 1 of the bill -- that "balance billing" or "surprise billing" creates significant financial hardships for patients who inadvertently receive medical services from out-of-network providers (as has been the case in emergency situations). The unwelcomed shock of unexpected medical bills to patients who had unknowingly received out-of-network services has become a growing problem for the consuming public. As this bill promotes greater transparency and protections to patients, the HPCA fully supports these efforts.

This bill places greater responsibility on the part of the provider to inform the patient on the extent and cost of the health care services being provided to the patient. The HPCA believes this is sound public policy.

It should be noted that FQHCs must provide services to all patients, regardless of their ability to pay, and that we are required to work with the patient when Medicaid or insurance reimbursement do not cover the entire costs of services provided. By law, FQHCs must establish a sliding fee scale based on a patient's income level and family size where only a nominal fee can be charged for those at or below 100% of the federal poverty level. While no system is perfect, this approach is just one more model that can used by lawmakers to gain a better understanding of how to pay for health care in the private market.

Lastly, we note that while the proposed amendments in this bill would apply primarily to the private market, because Medicaid is governed through a partnership between the federal and State government rather than solely through state statute, we would recommend that the Hawaii State Department of Human Services be notified of this bill to ensure that there be seamless application of this public policy for both Medicaid recipients and private insureds throughout our State.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

February 13, 2020 at 2:00 pm
Conference Room 329

<u>House Committee on Consumer Protection and Commerce</u>

To: Chair Roy M. Takumi
Vice Chair Linda Ichiyama

From: Hilton Raethel
President and CEO
Healthcare Association of Hawaii

Re: Testimony in Support
HB 2504 HD 1, Relating to Health Insurance

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

Thank you for the opportunity to provide **support** for this measure. From the hospital perspective, we strongly agree that patients should be protected from gaps in coverage that result in surprise bills that arises when a patient receives unanticipated out-of-network care from a nonparticipating provider for emergency or other medical services. We also agree that any policy solution should remove patients from payment negotiations between insurers and providers. With that as a guiding principle, the task before providers, insurers, and policy makers in how to best reach an agreement on payment for services provided out-of-network.

There is support from the hospitals on this version of the bill, which took out problematic rate-setting provisions. Providers and hospitals strongly support an alternative dispute resolution (ADR) mediation or arbitration process which allows both parties to come together and negotiate the payment amount for services provided in an unanticipated out-of-network situation. We would suggest that the mediation or arbitration process (or some part of the process) be independent but housed under the Insurance Commissioner's office. We would also suggest appropriate timelines for both the initiation of ADR in the event the parties cannot reach agreement, and for resolution of the ADR process.

The notification and disclosure section may also not be necessary. If balance billing is prohibited under Hawaii state law, then providing notice and disclosure as outlined in this bill may cause unnecessary anxiety for patients. We would suggest that the sections on notice and disclosure be struck.

Hospitals and affiliated providers 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 through no fault of their own. However, any proposal must protect the balance in negotiations, and both providers and plans must bear responsibility for a resolution. Thank you for your consideration of our comments.

HB-2504-HD-1
Submitted on: 2/12/2020 8:40:49 AM
Testimony for CPC on 2/13/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Mark Baker	Hawaii Chapter American College Emergency Physicia	Comments	No

Comments:

Thank you for the opportunity to submit testimony on HB2504 HD1. I am the current president of the Hawaii Chapter of the American College of Emergency Physicians. We are in support of HB2504 with some further modifications as submitted by our political liason, Dr. Will Scruggs. He is submitting detail. We agree that patients should not be 'held hostage' by out of network bills and in the same way clinicians should be allowed a fair decision making process when there is a dispute.

Thank you,

Mark Baker MD, FACEP, FAMIA

President, Hawaii Chapter of the American College of Emergency Physicians

BEFORE THE

HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE

Representative Roy M. Takumi, Chair
Representative Linda Ichiyama, Vice Chair

HB2504 HD1 RELATING TO INSURANCE

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

February 13, 2020, 2:00 p.m.
State Capitol Conference Room 329

Chair Takumi, Vice Chair Ichiyama, and Committee Members:

My name is William C. McCorriston, President and Chief Executive Officer of Hawaii Medical Assurance Association (HMAA). HMAA provides comments with respect to HB2504 HD1. While HMAA strongly supports the intent of HB2504, it opposes the language proposed in Sections 2 and 4 of HB2504 HD1.

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

The intent behind HB2504 is to provide strong protections to Hawaii's consumers against "surprise billing" and removing these consumers from the middle of billing disputes. An independent dispute resolution process established by and facilitated by the Insurance Commissioner, however, would be detrimental to consumers.

In a recent September 26, 2019 article by Forbes entitled *How Arbitration for Surprise Medical Bills Leads to Runaway Costs & Higher Premiums*, Forbes noted that arbitration provisions included in other "surprise billing" legislation has led to higher overall medical costs for consumers. As the article noted:

> [Arbitration] leads to higher prices. In New York, the largest state where arbitration is used for surprise bills, arbitrators are instructed to use the 80th percentile of hospital list prices

> as the benchmark for their decision. These hospital list prices are a lot like paying full fare for an airline ticket; they often come out to *10 or 20 times* what Medicare pays emergency rooms for the same services. By benchmarking out-of-network prices at such a high rate, the New York law incentivizes ER doctors to raise their prices even higher, knowing that by doing so, the benchmark for arbitration will also go up.[1]

Unlike the New York law, California's "surprise billing" law does not include an arbitration provision. The Forbes article notes, "a study of 23 million claims by the USC-Brookings Schaeffer Initiative for Health Policy found that the California law reduced the share of out-of-network billing in affected specialties by 17 percent, on average. Surprise bills in the ER dropped by 5 percent."[2] Utilization of a standard benchmark, such as Medicare which is based upon cost reports provided to the Centers for Medicare & Medicaid Services by medical providers themselves, provides a much more logical approach to resolving reimbursement disputes. Even a benchmark with a margin, for example 110% of Medicare for arbitrating disputes, would avoid the problems being experienced in New York and avoid unnecessary cost hikes that would then be reflected in higher premium rates.

Moreover, Section 2 of HD1 proposes disclosure and notification provisions required by health care plans to insureds prior to the provision of non-emergency services that are not authorized by the health care plan. A health care plan would not know when an insured is seeking non-emergency health care services, so Section 2 of HD1 imposes requirements that are onerous and impractical.

Considering the foregoing, HMAA supports the proposed HB2504 HD1 **without** the revised disclosure, notification, and consent provisions set forth in Section 2 of HD1 and the mandatory independent dispute resolution process set forth in Section 4 of HD1. Thank you for the opportunity to submit written testimony on this matter of critical importance.

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[1] Avik Roy, *How Arbitration for Surprise Medical Bills Leads to Runaway Costs & Higher Premiums* (Sep. 26, 2019), available at https://www.forbes.com/sites/theapothecary/2019/09/26/how-arbitration-for-surprise-medical-bills-leads-to-runaway-costs-higher-premiums/#54cdc0df4442 (emphasis in original).

[2] *Id.*

February 12, 2020

Representative Roy Takumi
Chair, House Committee on Consumer Protection & Commerce

Representative Linda Ichiyama
Vice Chair, House Committee on Consumer Protection & Commerce

HB2504 HD1: Relating to Health Insurance

Testimony in **SUPPORT with Amendments**

Dear Representative Takumi and Committee Members,

I am writing on behalf of the Hawaii College of Emergency Physicians and our 152 emergency physician members. We support the intent of this bill and we agree that patients should be removed from billing disputes between health care plans and providers. It is important to note that surprise billing legislation uniquely affects emergency physicians and our ability to recruit and retain quality emergency physicians to serve our communities, particularly our neighbor islands and critical access facilities. We believe that with an appropriate dispute resolution process, this legislation can be a solution for Hawaii.

We appreciate the changes that were made to the initial legislation removing the benchmarking to median in network rates and Medicare and the inclusion of a dispute resolution process. Those components would have given significant leverage to insurers and would harm the ability of emergency physicians to negotiate fair market rates. A fair dispute resolution process is the key component to removing patients from the middle of billing disputes while maintaining access to care. We suggest the following language to create a fair process:

432:1- Out-of-network or nonparticipating provider reimbursement; dispute resolution.

(a) A health care plan shall be responsible to fulfill their obligation to the subscriber or member and enter into negotiation with the nonparticipating provider. If no resolution is met within 30 days, the managed care plan shall pay the nonparticipating provider the amount billed by the nonparticipating provider.

(b) If there are disputes regarding the out of network charges or reimbursement for emergency services, either the health care plan or the nonparticipating provider may institute mediation pursuant to the dispute resolution process.

432E- Dispute Resolution

(a) When the nonparticipating provider and health care plan are unable to reach an agreement as to the amount to be paid for the services provided by the nonparticipating provider of emergency services, the matter may be submitted to the commissioner for binding arbitration or mediation.

(b) The commissioner shall establish a dispute resolution process by which a dispute for a bill for emergency services by a nonparticipating provider may be resolved. The commissioner shall adopt standards pursuant to chapter 91 to establish an independent dispute resolution process.

(c) In determining the appropriate amount to pay a nonparticipating provider for an emergency health care service, a mediator shall consider all relevant factors, including:

> (1) whether there is a gross disparity between the fee charged by the physician or hospital for services rendered as compared to:
>
> > (i) the fees paid to the involved physician or hospital for the same services rendered by the physician or hospital to other patients in health care plans in which the physician or hospital is not participating, and
> >
> > (ii) in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified physicians or hospitals for the same services in the same region who are not participating with the health care plan;
>
> (2) the level of training, education and experience of the provider, and in the case of a hospital, the teaching staff, scope of services, and case mix;
>
> (3) the provider's usual billed charge for comparable services with regard to patients in health care plans in which the physician or hospital is not participating;
>
> (4) the circumstances and complexity of the particular case, including time and place of service;
>
> (5) individual patient characteristics;
>
> (6) the 80th percentile of billed charges for similar services in the same geozip area determined by an independent, third party benchmarking database (e.g. FAIR Health).
>
> (7) the 50th percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area by an independent, third party benchmarking database (e.g. FAIR Health).

(d) A provider may bundle multiple claims in a single mediation if the disputed charges

(1) involve the identical health care plan or issuer and provider;

(2) involve claims with the same or related current procedural codes (CPT); and

(3) involve claims that occur within 180 days of each other.

(e) A patient that is not insured or the patient's provider may submit a dispute regarding a fee for emergency services for binding arbitration or mediation upon approval of the commissioner.

(f) For disputes involving an insured, when the dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the non-participating provider. When the dispute resolution entity determines the non-participating provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan. When a good faith negotiation directed by the dispute resolution entity results in a settlement between the health care plan and non-participating provider, the health care plan and the non-participating provider shall evenly divide and share the prorated cost for dispute resolution.

(g) For disputes involving a patient that is not an insured, when the dispute resolution entity determines the provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient. The commissioner shall promulgate a regulation to determine payment for the dispute resolution process in cases of hardship. When the dispute resolution entity determines the physician's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the provider.

(h) The mediator shall issue a decision on a submitted case within 30 days of the commencement of binding arbitration or mediation process.

Sincerely,

William Scruggs, MD
Emergency Physician
President-Elect, Hawaii College of Emergency Physicians

February 11, 2020

The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair
House Committee on Consumer Protection & Commerce

Re: HB 2504, HD1 – Relating to Health Insurance

Dear Chair Takumi, Vice Chair Ichiyama, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 2504, HD1, which establishes disclosure and consent requirements for nonparticipating health care providers. This measure also prohibits nonparticipating health care providers from balance billing patients in specific circumstances and requires the use of dispute solution when a dispute exists as to the reimbursement of a nonparticipating provider.

We support the intent of this measure, to extend protections to patients that unknowingly receive services from a provider outside of their network, but we have serious concerns regarding how this measure currently reads.

Section 2 places the burden of notifying potential patients, within twenty-four hours of receiving services from an out-of-network provider, of an estimate amount that the out-of-network provider may bill the patient, on a health care plan. The health care plan is also required to obtain a written consent from the patient for these out-of-network services. This type of disclosure and consent would be impossible for a health care plan to perform. First, the health care plan would not have any idea what codes the out-of-network provider would be using to bill the patient for services. Secondly, the health care plan would not have access to the charges that the out-of-network provider could potentially assess for those billed services. Lastly, a health care plan is usually the last to be notified that a member has seen an out-of-network provider. The provider is the first and primary point of contact with the patient, not the health plan. We ask that the bill revert to the original draft and that Section 7 of the prior draft (Disclosure of information) be changed to require the out-of-network provider or health care facility (not the health plan), provide the disclosure.

Finally, this measure requires that a health care plan and an out-of-network provider settle any reimbursement issues through an independent dispute resolution (IDR) process. If no resolution is met through the IDR, the health care plan is required to pay the nonparticipating provider the amount billed by the nonparticipating provider. Networks are established to provide access, quality and predictable costs to our members. IDR could create an incentive for providers to not be part of a health plans network. As we have seen in other states that have implemented an independent resolution process, this type of resolution has added costs to the entire health care system.

Thank you for the opportunity to provide testimony on this measure. Your consideration of our comments is appreciated.

Sincerely,

Jennifer Diesman
Senior Vice-President-Government Relations

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

February 12, 2020

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

From: Kathy Raethel, President, Adventist Health Castle

Hrg: House Committee on Health Hearing (Room 329)
Thursday, February 13, 2020, 2:00 p.m.

RE: **Testimony in Support <u>H.B. 2504 H.D.1, Relating to Health Insurance</u>**

Dear Chair Mizuno and Members of the Committee:

Adventist Health Castle appreciates the opportunity to provide testimony in **SUPPORT** of H.B. 2504, H.D.1 which requires payors to negotiate with nonparticipating providers for sums owed by payors; specifies obligations of payors to the insureds to resolve outstanding sums owed by these entities; removes the requirement that rates are paid at the usual and customary rate or in relation to Medicare reimbursements when there is a failure to come to an agreement; and outlines the procedures for dispute resolution between payors and nonparticipating providers.

AH Castle truly believes that patients should be insulated from any gaps in payor networks and any resulting billing disputes between a payor and provider.

The amendments that were made greatly improve the original bill. We appreciate the appropriate placement of the notice responsibility with the entity that has the readily available information: the payor. In addition, we support the removal of the rate-setting provisions and feel that, as written now, both parties have an incentive to negotiate in good faith and strive to reach the end result of maintaining quality care for patients. We also believe that the establishment of an independent dispute resolution process, housed under the Insurance Commissioner's office, would provide an efficient and clear path forward when dealing with any disputes and would serve as an incentive to reach a settlement in a timely manner.

Thank you for your consideration of this matter.

Sincerely,

Kathy Raethel
President
Adventist Health Castle

To: The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair
Members, Committee on Consumer Protection & Commerce

From: Mich Riccioni, Executive Vice President and Chief Financial Officer, The Queen's Health Systems
Colette Masunaga, Manager, Government Relations and External Affairs, The Queen's Health Systems
Date: February 11, 2020
Hrg: House Committee on Consumer Protection & Commerce Hearing; Thursday, February 13, 2020 at 2:00 pm in Room 329

Re: **Support for HB 2504 HD1, 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 testimony in support for HB 2504 HD1, which establishes disclosure and consent requirements for nonparticipating health care providers; prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and requires the use of dispute solution when a dispute exists as to the reimbursement of a nonparticipating provider.

Queen's is committed to protecting patients from balance bills that result from unexpected gaps in insurance coverages, inadequate networks, and medical emergencies. The HD1 version of the bill not only protects patients from being stuck in the middle between health plans and providers, it also recognizes that health care plans have a responsibility to work with providers directly for resolution of claims.

We support the HD1 because it excludes previous rate setting language that would have eroded the role of private negotiation and tied provider reimbursement to a health plan's arbitrary rates and a percent of Medicare. Neither of these previous rate setting options would be sufficient in covering the total 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. Providers deserve to receive fair payment for the medical services they provides to patients. Any attempts to

benchmarking payment to Medicare or a health plans arbitrary rates would jeopardizes patient access to hospital care, especially for those in rural communities.

When a patient receives a bill from an out-of-network provider it is because the health plan refuses to pay the claim. Health plans have a duty and obligation to their insured to satisfy and resolve claims with out-of-network providers. HD1 provides the mechanism necessary for health plans to negotiate with a non-participating provider and creates the necessary incentives for health plans to maintain adequate network for their insured.

Queen's supports the HD1's dispute resolution process because it allows the parties to present case-specific information, including clinical factors, network adequacy issues, and provider expertise. Having a dispute resolution process also creates incentives for the parties to reach a voluntary agreement. We would also be open to a binding arbitration process, similar to those in other states like New York, which protects consumers while also facilitating a process for resolution between both parties.

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. Thank you for the opportunity to testify on this measure.

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376
www.hawaiimedicalassociation.org

HOUSE COMMITTEE ON CONSUMER PROTECTION
Rep. Roy Takumi, Chair
Rep. Linda Ishiyama, Vice Chair

Date: February 13, 2020
Time: 2:00 p.m.
Place: Conference Room 325
From: Hawaii Medical Association
Elizabeth A. Ignacio, MD, Chair, HMA Legislative Committee
Christopher Flanders, DO, Executive Director

Re: HB 2504 HD1 - Relating to Health Insurance
Position: CONCERNS WITH COMMENTS

The Hawaii Medical Association feels strongly that patients should not be caught up in what, in many cases, should be settled as contractual arrangements between parties. A workgroup convened by the Insurance Commissioner in 2016 found that out-of-network care was not a major issue in the state, with only a handful of complaints registered with the Office of the Insurance Commissioner, the majority of which did not fall under state jurisdiction. Going forward, we must be mindful as to the true urgency of this action, and to unintended consequences to the unique Hawaii health care system.

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

KAISER PERMANENTE® Government Relations

Testimony of
Jonathan Ching
Government Relations Manager

Before:
House Committee on Consumer Protection & Commerce
The Honorable Roy M. Takumi, Chair
The Honorable Linda Ichiyama, Vice Chair

February 13, 2020
2:00 p.m.
Conference Room 329

Re: HB2504 HD1, RELATING TO HEALTH INSURANCE.

Chair Takumi, Vice Chair Ichiyama, and committee members, thank you for this opportunity to provide testimony on HB2504 HD1, which seeks to protect Hawai‘i consumers from egregious and unexpected out-of-network bills from hospitals, facilities, and providers.

Kaiser Permanente Hawai‘i submits the following COMMENTS ON HB2504 HD1.

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.

As originally introduced, HB2504 provided a fair and reasonable market-based solution to address certain billing practices that can have an immensely negative financial impact on consumers when they are at their most vulnerable – including when they are receiving emergency care at out-of-network facilities and from out-of-network providers at in-network locations. Sometimes, consumers unknowingly receive care from a provider who is not in their health insurance network. In Hawai‘i , there is **no limit to what these out-of-network providers or facilities can charge**. As a result, the patient may be billed for the remaining charges after their insurer pays. These "surprise bills" put consumers at significant financial risk of medical debt from bills they should not owe. This burden can prolong patient suffering long after their health has been restored. We support removing the patient from the middle of disputes between providers and insurers. **Furthermore, we continue to believe the best way to address these soaring health care costs is through a fair and balanced market-based benchmark approach.**

Kaiser Permanente Hawaiʻi has serious concerns with many of the provisions in HB2504 HD1 and does not believe it is reflective of ongoing discussions between stakeholders. We have concerns on the following sections:

1. **Section 2:**

   a. **<u>§321-   Disclosure and consent required.</u>** The amendments shifting disclosure and communication requirements to health care plans do not protect consumers and are inconsistent with current practices. A consumer is most at risk of unknowingly receiving out-of-network services at the point of service when presenting to a health care provider, health care facility or hospital. It is critical all disclosure and consent requirements in this section be reverted to the original language in HB2504 where a patient would be meaningfully presented with out-of-network status information by a nonparticipating health care provider, health care facility, or hospital and given the meaningful opportunity for consent in the specified form and manner of this section.

2. **Section 3:**

   a. **<u>§431:10A-A Balance billing; hold harmless; emergency services.</u>** The amendments removing certain provisions that prohibit court actions to collect balance sums against insurers undercut the intent of a comprehensive balance billing legislative solution. As amended, HB2504 HD1 fails to address or resolve the market failures that have led to excess billing practices in Hawaiʻi and would allow billed charges for emergency services to continue without limit. HB2504 must establish fair, predictable and reliable statutory parameters to resolve balance billing disputes between providers and insurers. As such, we urge the committee to strike all the language of Section 3 from HB2504 HD1 and revert to the language in Section 3 from HB2504, as introduced, found at §431:10A-A(b), (b)(1)-(2), and (c).

   b. **<u>§431:10A-B Balance billing; hold harmless; non-emergency services.</u>** The inclusion of new subsection (b) is problematic because it would allow for full billed charges for non-emergency services to continue without limit. Additionally, the notice and consent requirements need to be reinserted to this section because they are necessary to differentiate situations where a patient makes an informed decision to see an out-of-network provider and understands the financial consequences of that choice.

3. **Section 4:**

   a. **<u>§431:14G-   Out-of-network or nonparticipating provider reimbursement; dispute resolution.</u>**

      i. *Average contracted rate methodology.* Kaiser Permanente Hawaiʻi strongly opposes the removal of the average contracted rate methodology to

determine the usual and customary reimbursement rate amount. While we believe there should be an appropriate Medicare reimbursement level as a proxy for the average contracted rate, given ongoing discussions with stakeholders, we do not oppose the removal of a Medicare benchmark methodology in HB2504 so long as the average contracted rate methodology remains in the legislation. We believe the best and most comprehensive solution to resolving balance and surprise billing disputes in Hawai'i includes a predictable and reliable market-based benchmark rate based on the average contracted rate.

ii. *Independent dispute resolution.* While we do not oppose the concept of an independent dispute resolution process in the rare cases where the application of the average contracted rate methodology may be uncertain, Kaiser Permanente Hawai'i opposes the inclusion of the independent dispute resolution (IDR) process in HB2504 HD1. Any IDR process should not be substituted for a benchmark rate methodology, and likewise should not create a new opportunity to challenge the clear and uniform application of a benchmark rate methodology. As amended, the IDR process in HB2504 perpetuates market distortions by creating a statutory obligation for a managed care plan to pay a nonparticipating provider the full billed charges in cases where no resolution can be met. Such a provision would only further exacerbate existing market failures, undermining the goal of creating a fair and competitive market and leading to significantly higher costs for all Hawai'i residents.

4. **Section 5:**

Chapter 432:1-

a. **Balance billing; hold harmless; emergency services;**
b. **Balance billing; hold harmless; non-emergency services.**
c. **Out-of-network or nonparticipating provider reimbursement; dispute resolution.**

We recommend the same corresponding amendments to provisions governing a mutual benefit society as outlined above in §431:10A-A, §431:10A-B and §431:14G- .

5. **Section 6:**

Chapter 432D-

a. **Balance billing; hold harmless; emergency services;**
b. **Balance billing; hold harmless; non-emergency services;**
c. **Out-of-network or nonparticipating provider reimbursement; dispute resolution.**

We recommends the same corresponding amendments to provisions governing a health maintenance organization as outlined above in §431:10A-A, §431:10A-B and §431:14G- .

6. **Section 7:**

   a. **§432E- Dispute resolution.**

      i. As previously mentioned, Kaiser Permanente does not oppose the concept of an independent dispute resolution process in the rare cases where the application of the average contracted rate methodology may be uncertain. However, we oppose the inclusion of the independent dispute resolution (IDR) process as amended. Any IDR process should not be substituted for a benchmark rate methodology. Additionally, any IDR process to address balance and surprise billing disputes should have consistent application for insurers, health maintenance organizations, mutual benefit societies and managed care plans.

For these reasons we urge the committee to return HB2504 to its original language as specified in these comments. At the very minimum any legislative solution must include a fair and balanced market-based benchmark – we believe an average contracted rate would best accomplish this goal. This would ensure that for emergency situations and for situations where consumers go to an in-network hospital but see an out-of-network doctor, **the payment to the out-of-network doctor or hospital reasonably covers their costs without incentivizing other providers to stay out-of-network or driving up costs to the system, including healthcare premiums.** As a fully integrated system, which includes over 600 Hawaiʻi Permanente Medical Group physicians and providers, Kaiser Permanente Hawaiʻi understands that any benchmark rate in HB2504 needs to cover the cost of services provided.

By establishing a fair and balanced market-based benchmark for out-of-network reimbursement, patients can be protected from exorbitant bills.

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

HAWAI'I PACIFIC HEALTH | PALI MOMI MEDICAL CENTER

Date: **Thursday, February 13, 2020**
Time: **2:00 p.m.**
Room: **Conference Room 329**

House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Gidget Ruscetta, Chief Operating Officer

Re: HB 2504 HD1 – Relating To Health Insurance
STRONG SUPPORT

My name is Gidget Ruscetta, Chief Operating Officer with Pali Momi Medical Center. With 118 beds and more than 500 physicians on its medical staff, Pali Momi offers a full range of services for the communities of Central and West Oʻahu. The hospital has delivered many medical firsts for the community, including Central and West Oʻahu's first and only interventional cardiac catheterization units to detect and treat heart disease and the largest comprehensive center for cancer care. Pali Momi is also designated as a Level III Trauma Center as well as a Primary Stroke Center, which recognizes its high quality care for stroke patients.

We are writing in strong support of HD 2504 HD1. HD 2504 HD1 which prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and requires the use of a dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider.

As a health care provider we believe that the patient should not be caught in the middle and suffer any financial harm in a dispute that arises between a health plan and health provider. We therefore agree that 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.

To address these concerns, we are in agreement with our Healthcare association provider members Queens Health System, Castle Medical Center, and Hawaiʻi Health System Corporation on language which have been incorporated in the HD1.

The HD1 as written is a significant improvement over the original HB 2504 as it removes statutory reimbursement rates tied to Medicare that are either not comprehensive enough or inapplicable to determine reimbursement for services provided to specific populations and procedures. Moreover, *any* statutorily stated reimbursement will unfairly handicap a party in the process of dispute resolution by artificially establishing a baseline floor of payment.

We also support the establishment of a dispute resolution process before a disinterested 3rd party as has been passed in other states. 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.

Thank you for your consideration of this important matter.

HAWAI'I PACIFIC HEALTH | STRAUB MEDICAL CENTER

Thursday, February 13, 2020 at 2:00 PM
Conference Room 329

House Committee on Consumer Protection & Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Travis Clegg
Chief Operating Officer

Re: Testimony in Support of HB 2504, HD1
Relating to Health Insurance

My name is Travis Clegg, and I am the Operating Officer of Straub Medical Center (Straub). Straub is an affiliate of Hawaii Pacific Health. Founded in 1921, Straub includes a 159-bed hospital in Honolulu, a network of neighborhood clinics and a visiting specialist program that reaches throughout the state of Hawai'i. With over 200 physicians who are leaders in their fields, Straub provides its patients with diagnoses and treatments for more than 32 different medical specialties, including bone and joint, heart, cancer, endocrinology/diabetes, family medicine, gastroenterology, geriatric medicine, internal medicine, vascular and urology.

I write in support of HB 2504, HD1 which establishes disclosure and consent requirements for health insurers where services are provided by nonparticipating health care providers, prohibits nonparticipating health care providers from balance billing patients in specific circumstances, and establishes a dispute resolution process between the insurer and nonparticipating provider to resolve payment disputes.

At Straub we have experience working with a variety of insurers and providers, and believe in maintaining the integrity of the contracting process between health providers and health insurers in determining fair and adequate reimbursement methodologies for health care services that have already been delivered to the patient or insured. As a provider organization, we also assume that both health care insurers and health care providers have a *shared* responsibility to protect patients from financial burdens to ensure access to medically necessary care.

We agree 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.

Thank you for the opportunity to testify.

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN

Date: **Thursday, February 13, 2020**
Time: **2:00 p.m.**
Room: **Conference Room 329**

House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Martha Smith, Chief Executive Officer, Kapiʻolani Medical Center

Re: HB 2504 HD1 – Relating To Health Insurance
TESTIMONY IN STRONG SUPPORT

My name is Martha Smith, Chief Executive Officer, Kapiʻolani Medical Center for Women & Children. Kapiʻolani is Hawaiʻi's only maternity, newborn and pediatric specialty hospital. It is well recognized as Hawaiʻi's leader in the care of women, infants and children. With 253 beds, our not-for-profit hospital delivers more than 6,000 babies a year, and is also a medical teaching and research facility. Specialty services for patients throughout Hawaiʻi and the Pacific region include intensive care for infants and children, 24-hour emergency pediatric and adult care, critical care air transport and high-risk perinatal care.

I am writing in strong support of HD 2504 HD1 which prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and requires the use of a dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider.

We share the belief that the patient should not be caught in the middle and suffer any financial harm in a dispute that arises between a health plan and health provider. We also agree that 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.

To address these concerns, we are in agreement with our Healthcare Association provider members Queens Health System, Castle Medical Center, and Hawaiʻi Health System Corporation on language which have been incorporated in the HD1.

The amendments adopted in the HB 2504 HD1 is a major improvement to the original bill. The amendments remove statutory reimbursement rates tied to Medicare that are either not comprehensive enough or inapplicable to determine reimbursement for services provided to specific populations and procedures.

For example, using Medicare reimbursement methodology as a basis for most pediatric procedures and for many services for women of child-rearing age who are not disabled is not calculable. For a facility specializing in pediatric and women's health services of child rearing

age, a reimbursement tied to Medicare is unworkable. Furthermore, Kapiolani is the only provider of a number of specialty services such as pediatric trauma and numerous subspecialty services for the entire State. In those circumstances, calculating reimbursement for services that an HMO does not currently provide or have a contract for services would also be incalculable if tied to a *usual and customary rate* "...in the general geographic region in which the services were rendered..." as proposed in the original bill.

We believe that the establishment of a dispute resolution process to incentive providers and plans to contract or work out a settlement in a timely manner would be fair to both parties in a dispute. The establishment of a binding mediation process will incentivize both plans and providers to contract and reach a settlement in a timely matter with knowledge of binding arbitration process as a default remedy.

Thank you for your consideration of this important matter.

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Date: **Thursday, February 13, 2020**
Time: **2:00 p.m.**
Room: **Conference Room 329**

House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

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

Re: HB 2504 HD1 – Relating To Health Insurance
STRONG SUPPORT with a Single Amendment

My name is Michael Robinson, Vice President, Government Relations and Community Affairs at Hawaiʻi Pacific Health (HPH). Hawaiʻi Pacific Health is a not-for-profit health care system comprised of its four medical centers – Kapiʻolani, Pali Momi, Straub and Wilcox and over 70 locations statewide with a mission of creating a healthier Hawaiʻi.

HPH is in strong support of HD 2504 HD1 which prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and requires the use of a dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider.

As a non-profit health care system, we assume that both healthcare insurers and healthcare providers have a *shared* responsibility to protect patients from financial burdens related to accessing medically necessary care. The patient should not be caught in the middle and suffer any financial harm in a dispute that arises between a health plan and health provider. 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.

This *shared* responsibility between health insurer and health provider also requires that a fair and equitable environment for contracting for services is maintained to the benefit of both parties. Balance billing fundamentally results from a failure between healthcare insurer and healthcare provider to come to an agreement to contract for services or arrive at a settlement for reimbursement on services already rendered.

To address these concerns, we are in agreement with our Healthcare association provider members Queens Health System, Castle Medical Center, and Hawaiʻi Health System Corporation on language which have been incorporated in the HD1.

The amendments adopted in the HB 2504 HD1 is a significant improvement to the original bill.

First, the amendments remove any statutory reimbursement rates tied to Medicare that are either not comprehensive enough or inapplicable to determine reimbursement for services provided to specific populations and procedures for good reason. For example, there is no applicable Medicare reimbursement methodology for most pediatric procedures and many services for women of child-rearing age who are not disabled. Under Medicare there are no reimbursement methodologies for pediatric specialty and certain women's health services delivered at Kapiʻolani Medical Center and Wilcox on Kauaʻi as proposed under the original version of this bill. Similarly, a "usual and customary" rate – which for an HMO that is both a plan and provider would equate to the *reimbursement it pays itself for the same service* – would be incalculable in situations where an HMO does not provide that service within its network"...in the general geographic region in which the services were rendered..." as proposed in the original bill.

Most importantly, the removal of statutory terms provides the right and fair incentivizes to force 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.

Second, the HD1 also incorporates the establishment of a binding dispute resolution process to incentive providers and plans to contract or work out a settlement in a timely manner. The establishment of such a process would additionally incentivize both plans and providers to reach a settlement with knowledge that a binding arbitration process would be in the .

We do propose 1 amendment and request that Section 2 pertaining to consent and disclosure requirements provider network status be removed entirely. The requirements under Sections 3, Section 5, Section 6 requiring that the patient be held harmless and kept out of the middle of a billing dispute, renders the disclosure and consent requirements in Section 2 unnecessary. Requiring health providers to still provide disclosure and consent under Section 2 would only serve to increase patient anxiety and may result in appointment cancellations due to the uncessary ambiguity that process would introduce at the point of care.

Thank you for your consideration of this important matter.

Date: **Thursday, February 13, 2020**
Time: **2:00 p.m.**
Room: **Conference Room 329**

House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Jen Chahanovich
President & CEO, Wilcox Medical Center,
CEO, Kaua'i Medical Clinic

Re: **HB 2504 HD1 – Relating To Health Insurance**
STRONG SUPPORT

My name is Jen Chahanovich, President and CEO of Wilcox Medical Center and CEO of Kaua'i Medical Clinic. Founded in 1938, Wilcox Medical Center is a not-for-profit medical center dedicated to providing the Kaua'i community with accessible quality health care. The largest medical center on Kaua'i, it is a state-of-the-art acute care facility with a full suite of services offering 30 specialties and programs, including cardiology, emergency medicine, family practice, gastroenterology, health management, internal medicine, neurology, OB-GYN, oncology, orthopedics, pediatrics and urology. Its 20-bed emergency department serves as the island's Primary Stroke Center. The medical center also has four birthing suites, seven intensive care beds and 20 same-day surgery beds. Wilcox is the first American College of Surgeons-verified Level III Trauma Center in the state of Hawai'i

We are writing in strong support of HD 2504 HD1 which prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and requires the use of a dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider.

We share the belief that the patient should not be caught in the middle and suffer any financial harm in a dispute that arises between a health plan and health provider. We therefore agree that 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.

To address these concerns, we are in agreement with our Healthcare association provider members Queens Health System, Castle Medical Center, and Hawai'i Health System Corporation on language which have been incorporated in the HD1.

The amendments adopted in the HB 2504 HD1 is an improvement to the original bill. The amendments remove statutory reimbursement rates tied to Medicare that are either not

comprehensive enough or inapplicable to determine reimbursement for services provided to specific populations and procedures.

For example, there is no applicable Medicare reimbursement methodology for most pediatric procedures and for many services for women of child-rearing age who are not disabled. Pediatric cases for services Wilcox provides on Kauai would be incalculable under a reimbursement rate based on Medicare. Furthermore, Wilcox is the only provider of a number of specialty services such as trauma and neurological services for the entire island of Kauai. In those circumstances, calculating reimbursement for services that an HMO does not currently provide would be incalculable if relied upon a usual and customary rate…in the general geographic region in which the services were rendered" as proposed in the original bill.

We also support the establishment of a dispute resolution process to incentive providers and plans to contract or work out a settlement in a timely manner. 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.

Thank you for your consideration of this important matter.

HB-2504-HD-1
Submitted on: 2/12/2020 9:26:17 AM
Testimony for CPC on 2/13/2020 2:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Diane Ware	Individual	Support	No

Comments:

Dear Commitee Chair and Members,

I am a 72 year old resident of rural Ka'u and I am very anxious about health care costs. I do not have Part D Medicare due to basic cost now of medical and dental near 20% of my income. I am so anxious that I might avoid certain treatments or medications or going to the hospital for fear of bankruptcy.

Please support this bill for the peace of mind of lower income and middle class residents. Consumers should have the right to know what costs will be charged beforehand as we have with all other purchases.

Sincerely,

Diane Ware, Volcano HI

HB2504 HD1

CPC HEARING
02/13/20 @ 2:00 PM

Various Individuals (23) - IN SUPPOR	
1	Jonathan Aki, MD
2	Ricky Amii, MD
3	Rodney Boychuk, MD
4	Kathryn Cherefko, MD
5	Tiffany Coleman-Satterfield, MD
6	Peter Di Rocco, MD
7	Paul J. Eakin, MD
8	Robert Canonico, DO
9	Timothy Curlett, MD
10	Travis KF Hong, MD
11	Misha Kassel, MD
12	Torey Kikukawa, MD
13	Andy Lee, MD
14	Jannet Lee-Jayaram, MD
15	Sidney Lee, MD
16	Kersten Milligan, MD
17	Thinh Nguyen, MD
18	Masafumi Sato, MD
19	Andrew Summersgill, MD
20	Brian A. Tobe, MD
21	Jamie Tom, MD
22	Loren G. Yamamoto, MD
23	Lynnette Young, MD

To: House Committee on Consumer Protection and Commerce
Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

Re: HB 2504 HD1 – Relating To Medical Service Billing
IN SUPPORT FOR BILL AS WRITTEN

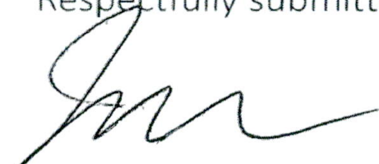
My name is Dr. Jonathan Aki. I am an emergency medicine physician in Hawai'i and I am in strong support of HB 2504 HD1.

I support this legislation because I agree a patient should not be responsible for charges when the patient is not able to make a choice about a network provider due to their medical circumstances.

I also am in support of this bill's incentives to encourage insurers to work with health care providers to resolve any sums owed by the patient and to create a dispute resolution process. This is more fair to the patient, as well as the providers.

I also am happy that any reference to statutory reimbursement rates tied to Medicare or "usual and customary rates" have been removed from this bill, as I am opposed to establishing any reimbursement rates by law.

Respectfully submitted,



Jonathan Aki, MD

To: Rep. Roy Takumi, Chair
Rep. Linda Ichiyama, Vice Chair
House Committee on Consumer Protection and Commerce

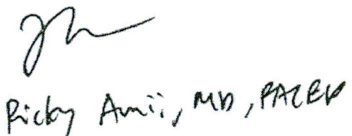
From: Ricky Amii, MD

I am writing to state my strong support for HB 2504 HD1.

As an emergency room physician, I support this bill to limit balance billing and encourage resolution of any charges between the insurer and health care provider.

I believe the bill offers important protections for patients who are unable to make a choice about whether their provider is in their health plan's network. Establishing a dispute resolution process for providers and insurers to negotiate their differences would be fair to both patients and the provider.

Thank you for the opportunity to testify.



House Committee on Consumer Protection and Commerce

From: Rodney Boychuk, MD

To: Rep. Roy Takumi, Chair; Rep Linda Ichiyama, Vice Chair

STRONG SUPPORT FOR HB 2504 HD1

I am Rod Boychuk, MD and am board certified in pediatrics, neonatology and pediatric emergency medicine.

As a Hawai'i pediatric specialty physician I am in strong support of HB 2504 HD1 as written.

I along with my colleagues believe that the patient should not be caught in the middle and suffer harm in a dispute between a health plan and health provider. This is especially true in an emergency room setting.

The HD1 is much better written than the original HB 2504. The original bill contained reimbursement rates tied to pay Medicare or other payment methodologies that frankly would make no sense for specialized pediatric care.

I also support the establishment of a dispute resolution process that is binding. Creating such a process would both protect patient while encouraging both providers and insurers to come to the table and negotiate their differences.

Thank you for the opportunity to testify.

Rodney B Boychuk MD
(BOYCHUK.

To: Hawai'i State House of Representatives
CPC Committee
Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Kathryn Cherefko, MD

Re: Please Pass HB 2504 HD1

I am in support of this bill as written because it protects patients from being caught in a billing dispute while creating a process to resolve such disputes between the insurer and the provider.

I also support this version of the bill because it does not include statutorily set reimbursement rates. Reimbursing physicians based on rates stated in statute would be unfair to all parties and will not provide the right incentives for plans and providers to come to the table and contract with one another.

I therefore am in strong support of passing HB 2504 HD1 as written.

Thank you.

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair
House Committee on Consumer Protection and Commerce

From: Dr. Tiffany Coleman-Satterfield, M.D.

Re: HB 2504 HD1
Relating To Medical Service Billing
IN SUPPORT

I am writing in strong support of HB 2504 HD1 as written.

As an emergency room physician, I support this bill's disclosure and consent requirements for nonparticipating health care providers; balance billing restrictions; and dispute resolution processes for nonparticipating provider reimbursements.

The patient should not be caught in the middle of a dispute between a health insurance plan and health care provider. When a patient choice is not possible because medical necessity eliminates the opportunity for a patient to choose an in-network provider, the patient should not be responsible for charges.

Balance billing is fundamentally a failure between a plan and provider to come to an agreement on contract terms on payment for medical services already rendered. We therefore support the establishment of a dispute resolution process before a disinterested third party as has been passed in other states. Setting up such a process would incentivize both plans and providers to reach a settlement with knowledge of binding arbitration being a possible remedy.

I also support HD1 as written because it removes statutory reimbursement rates tied to Medicare. Any statutorily stated reimbursement would unfairly handicap a party in the process of dispute resolution by artificially establishing a baseline floor of payment.

Thank you for your time and consideration.

From: Peter Di Rocco, M.D.

To: House Committee on Consumer Protection and Commerce
Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

SUPPORT FOR HB 2504 HD1

As a physician, I am expressing strong support of HD 2504 HD1 as written.

I agree that the patient should not be caught in the middle and suffer harm in a dispute between health plan and health provider. Where a patient can't make a choice about their provider's network status with a health plan due to their medical situation, the patient should not be responsible for charges.

The HD1 as written is an improvement over the original HB 2504 as it removes statutory reimbursement rates tied to Medicare or other methodologies that are unfairly insurer friendly (ie. "usual and customary rates").

Fair reimbursement for a provider – especially for commercial plan arrangement which this bill would mostly effect – should best be achieved through contracting and negotiation. Statutory rates would not be fair to providers.

I also like the mediation and arbitration provisions which would incentive plans to negotiate with providers.

Thank you. Please pass this bill.

House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Paul J. Eakin, MD

Re: Support for HB 2504 HD1 – Relating To Medical Service Billing

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My name is Paul J. Eakin MD, a Hawai'i Pediatric Emergency Medicine Physician. **I am writing in strong support of HD 2504 HD1.**

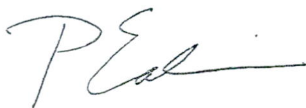
As a physician, I believe that the patient should not be caught in the middle between health plan and health provider. Where medical necessity eliminates the opportunity for a patient to make a choice based on a provider's network status with a health plan, the patient should not be responsible for charges where patient choice is not possible.

I support legislation that encourages insurers to fulfill their obligation to their members and work in good faith with health care providers to negotiate and resolve any payment disputes on behalf of their members. I would expect the same from my health plan.

The HD1 is much better than the original HB 1881 as it removes statutory reimbursement rates tied to Medicare which would unfairly handicap a party in the process of dispute resolution by artificially establishing a baseline floor of payment. I would be opposed to any statement of reimbursement by law and therefore am very pleased that the language has been removed.

I also think the creation of some type of dispute resolution process – either binding arbitration or mediation is a good thing. Lawsuits are expensive and can keep things in limbo. An arbitration or mediation process would be fair and most importantly encourage plans and providers to work out their differences.

Thank you for your consideration of this important matter.



Paul J. Eakin, MD, FAAP, FACEP

Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair
House Committee on Consumer Protection and Commerce
Hawai'i State Legislature

Dear Representatives Takumi and Ichiyama:

My name is Robert Canonico, DO. I am a Hawai'i emergency medicine physician and I am writing to express my strong support for passage of HB 2504 HD1 – Relating to Medical Service Billing.

As a physician, I believe this legislation is fair to patients who are unable choose their network provider due to medical urgency. The patient should not be on the hook for excess medical costs because their insurer and provider could not come to an agreement. Therefore, I also support this bill's requirement to create a process for dispute resolution to resolve billing issues between the insurer and provider.

I believe HB 2504 HD1 as written is also fair to providers while providing patients with protections, therefore I support passage of this bill as written.

Respectfully submitted,

Robert Canonico, DO

House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Timothy Curlett, MD

Re: Support for HB 2504 HD1 – Relating To Medical Service Billing

My name is Dr. Timothy Curlett, a Hawai'i emergency medicine physician. I am in strong support of HB 2504 HD1.

I support this legislation because it requires insurers to work with health care providers directly to resolve any payment disputes on behalf of their members. I agree that patients should not be balance billed, especially in situations where medical necessity takes away a patient's opportunity to choose their network provider.

In addition, an arbitration or mediation process as required in this bill would be fair and encourage plans and providers to work out their differences without the patient being caught in the middle.

Please pass this bill. Thank you.

House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Travis K.F. Hong, MD

Re: HB 2504 HD1 – Relating To Medical Service Billing
STRONG SUPPORT FOR BILL AS WRITTEN

I am writing in support of HD 2504 HD1 which establishes disclosure and consent requirements for nonparticipating health care providers; prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and requires the use of a dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider.

As a physician, I believe that the patient should not be caught in the middle between a plan and provider in situations involving balance billing. Balance billing does not happen often in Hawai'i compared to the mainland. However when it does it occur, it is usually temporary when a provider and plan cannot come to agreement.

I support the establishment of a dispute resolution process before a disinterested third party as has been passed in other states. The establishment of such a process would incentivize both plans and providers to reach a settlement. Thank you for your consideration of this important matter.

I am also pleased to see that the bill makes no reference to setting a reimbursement rate by law. Doing so would be unfair to either party especially if pegged to Medicare.

Sincerely,

Travis K.F. Hong, MD

House of Representatives
Committee on Consumer Protection and Commerce

To: Rep Roy Takumi, Chair
Rep Linda Ichiyama, Vice Chair

From: Misha Kassel, MD

Re: Support HB 2504 HD1

I am writing in strong support of HD 2504 HD1.

This bill encourages insurers and providers to negotiate fairly to resolve billing disputes.

I much prefer the HD1 than the original HB 2504 as it removes mention of any statutory reimbursement rates tied to Medicare or other payment method which would unfairly penalize and handicap providers in any negotiation.

I would have opposed to any statement of reimbursement by law and glad to see that has now been removed.

The development of a dispute resolution process makes sense and is the right thing to do for both plans and providers. We appreciate the work done in this draft.

Thank you for the opportunity to provide testimony.

State of Hawai'i House of Representatives
Committee on Consumer Protection and Commerce

Re: Testimony In Support of HB 2504 HD1

To: Rep Roy Takumi, Chair
Rep Linda Ichiyama, Vice Chair

From: Torey Kikukawa, MD

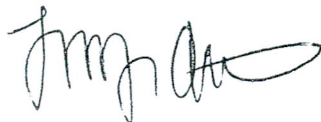
My name is Dr. Torey Kikukawa, an emergency medicine physician, and I am writing in strong support of HB 2504 HD1 as written.

The HD1 is an improvement over the original HB 2504. I support this bill because it removes statutory reimbursement rates tied to Medicare or arrangements that could result in no reimbursement when based upon "usual and customary rates" where the insurer does not have a contract for that service.

This bill version is drafted more fairly than the original HB 2504 which would have been placed providers at a disadvantage when negotiating with insurers.

I also support the addition of a mediation or arbitration type process. Having such a process will ensure that both parties come to the table and resolve their differences.

Thank you.



House of Representatives – CPC Committee

To: Rep Roy Takumi, Chair; Rep Linda Ichiyama, Vice-Chair

From: Andy Lee, MD

Re: HB 2504 HD1
STRONG SUPPORT

I support HD 2504 HD1. Please pass this bill as drafted.

Reimbursing physicians based on Medicare rates - does not make sense and will not provide the right incentives for plans and providers to come to the table and contract with one another.

We appreciate this HD1 does not unfairly title the balance of negotiations in favor of either party by removing mention of rates pegged to Medicare or a "usual and customary rate".

Further, this bill provides a patient that protection in cases of billing disputes through a mediation or arbitration process.
This is a much improved bill from the original. Please pass this bill as drafted.

To: House Committee on Consumer Protection and Commerce
Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Jannet Lee-Jayaram, MD

Re: Support for HB 2504 HD1

My name is Jannet Lee-Jayaram, MD. As a Hawai'i pediatric emergency medicine physician, I strongly support HB 2504 HD1 – Relating to Medical Service Billing.

I support the establishment of a dispute resolution process as required in the bill. The establishment of such a process would incentivize both plans and providers to reach a settlement so that the patient is not caught in the middle between a health plan and health provider. The patient should not be responsible for charges where patient choice is not possible. Therefore I believe that legislation should require insurers to fulfill their obligation to their members and work in good faith with health care providers to negotiate and resolve any sums owed on behalf of the insured patient.

HB 2504 HD1 as written is a significant improvement over the original HB 1881 which tied payment to Medicare other type of payment standard. This bill is much fairer to providers while providing patients with protections.

Therefore, I strongly support passage of HB 1881 HD1 as written.

Sincerely,

Jannet Lee-Jayaram, MD
Associate Director, SimTiki Simulation Center
Assistant Professor, Pediatrics, John A Burns School of Medicine
Pediatric Emergency Physician, Kapiolani Medical Center for Women and Children

State of Hawai'i House of Representatives
Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Sidney Lee, MD

Re: Testimony In Support of HB 2504 HD1

My name is Dr. Sidney Lee, an emergency medicine physician, and I am writing in strong support of HB 2504 HD1 as written.

The HD1 is an improvement over the original HB 2504 as it removes statutory reimbursement rates tied to Medicare that are either not sufficient and or inapplicable to determine reimbursement for services provided to specific populations such as women and children. In examples where an HMO does not provide that services, the reimbursement could be zero based on "usual and customary rates".

More importantly any statutorily stated reimbursement will have the unintended consequence of unfairly handicapping a party in the process of dispute resolution by making it too easy for insurers to decide not to contract with providers.

I applaud what this bill tries to achieve. Compared to the original HB 1881 which would have been unfair to physicians and provider organizations this is much better. The addition of a mediation or arbitration type process will also be good to encourage plans and providers to resolve disputes while keeping patients harmless.

Thank you.

House Committee on Consumer Protection and Commerce

From: Kersten Milligan, MD

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

IN STRONG SUPPORT FOR HB 2504 HD1

I am writing in strong support of HD 2504 HD1.

I agree that patients should not be caught in the middle and suffer during a dispute between the health plan and health provider. Fortunately in Hawai'i balance billing is not the issue that it is in the mainland.

It's always better to have plans and insurers work out their differences with a process that is fair to both parties. Insurers have to be incentive to contract with plans which is why establishing payment at a Medicare rate or what plans consider "usual and customary" is not a viable option that is fair to providers.

The establishment of some type of dispute resolution process as proposed in this bill could work. It would support both sides reaching a settlement with knowledge of binding arbitration being a possible remedy. Thank you for your consideration of this important matter.

Please pass this bill. It is such an improvement over the original bill that was introduced!

2-11-20

Kersten Milligan, MD

Testimony in support of HB 2504 HD1

From: Thinh Nguyen, MD

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair
Committee on Consumer Protection and Commerce

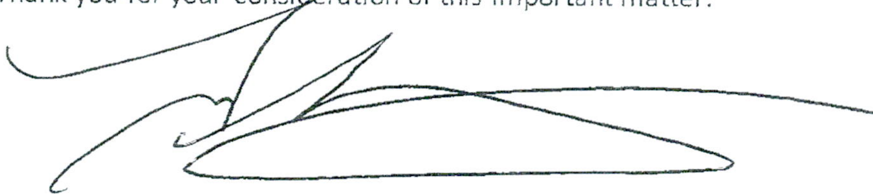
My name is Dr. Thinh Nguyen, MD. I'm an emergency room physician. I support HB 2504 HD1.

The proposed language is fair and most importantly protects the patient from financial concerns which we all agree must happen

I believe that a mediation or arbitration process is also fair. I am relieved that there is no payment reimbursement stated in the statute tied to Medicare. That would be unfair – to any provider to be forced to receive Medicare payment for what would typically be reimbursed at a commercial rate.

An arbitration or mediation process would be fair and force insurers and providers to settle their dispute in a reasonable amount of time. This is a much better solution than litigation.

Thank you for your consideration of this important matter.



Re: Testimony in support of HB 2504 HD1 – Relating To Medical Service Billing

From: Masafumi Sato, MD

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair
Committee on Consumer Protection and Commerce

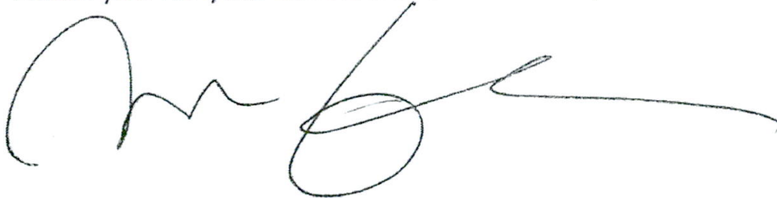
My name is Dr. Masafumi Sato. I'm an emergency room physician and I am in strong support of HB 2504 HD1.

As a physician, this proposed language is fair and most importantly protects the patient from financial concerns.

I believe that a mediation or arbitration process is also fair. I am relieved that there is no payment reimbursement stated in the statute. That would be unfair – particularly for physicians like myself who take care of pediatric patients. Pegging reimbursement to Medicare would make no sense for our patients like ourselves.

Please pass this bill as drafted.

Thank you for your consideration of this important matter.



House Committee on Consumer Protection and Commerce

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

SUPPORT FOR HB 2504 HD1

My name is Andrew Summersgill, MD. I am an emergency medicine physician. I am in strong support of HD 2504 HD1.

In situations where a patient is unable to make a choice on a provider's network status with a health plan due to their medical situation, the patient should not be responsible for charges – I agree that a patient should not be caught in the middle.

This bill is much improved to the original bill – HB 1881 which would enable insurers to pay providers a Medicare rate for out of network providers. If rates are established that low by statute, then what incentive would an insurer have to create a network when they would only have to reimburse out of network providers at such a low rate?

Please pass this bill.

Thank you.

Sincerely

Andrew Summersgill, M.D..

House of Representatives – CPC Committee

To: Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair

From: Brian A. Tobe, MD

Re: HB 2504 HD1
STRONG SUPPORT

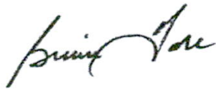
I support HD 2504 HD1! Please pass this bill as drafted.

Reimbursing physicians based on rates stated in statute does not make sense and will not provide the right incentives for plans and providers to come to the table and contract with one another. This version of the bill makes no reference to setting a reimbursement rate by law. Doing so would be unfair to either party especially if pegged to Medicare or a "usual and customary rate" – which I do not have full confidence in.

I believe that a patient should not be kept in the middle of a billing dispute. The bill provides a patient that protection while creating an arbitration and mediation process to resolve disputes that does not involve the patient.

Please pass this bill as drafted.

Sincerely,



Brian A. Tobe, MD

House of Representatives
Committee on Consumer Protection and Commerce

To: Rep Roy Takumi, Chair
Rep Linda Ichiyama, Vice Chair

From: Jamie Tom, MD

Re: Support for HB 2504 HD1: Relating To Medical Service Billing

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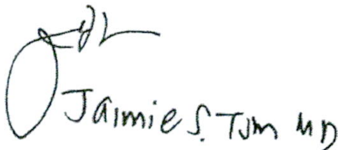
My name is Dr. Jamie Tom. I am writing in strong support of HD 2504 HD1.

This bill encourages insurers and providers to negotiate fairly to resolve billing disputes.

I much prefer the HD1 than the original HB 2504 as it removes mention of any statutory reimbursement rates tied to Medicare or other payment method which would unfairly penalize and handicap providers in any negotiation. I would have opposed to any statement of reimbursement by law and glad to see that has now been removed.

I also think the creation of some type of dispute resolution process makes sense. Some type of binding arbitration or mediation would be a step in the right direction.

Thank you!



Honorable Roy Takumi, Chair
Honorable Linda Ichiyama, Vice Chair
House Committee on Consumer Protection and Commerce

Re: In Support of HB 2504 HD1

Dear Representative Takumi and Representative Ichiyama:

My name is Dr. Loren Yamamoto. As a pediatric emergency medicine physician, I strongly support HB 2501 HD1 because it will help protect patients from being unfairly caught in a billing dispute between their health care provider and their insurer.

A patient should not be responsible for charges where patient choice is not possible. I believe this bill's disclosure and consent requirements, limits on balance billing, and dispute resolution process are fair and appropriate means to resolve such charges and provide important patient protections.

Sincerely,

Loren G. Yamamoto, MD

To: House Committee on Consumer Protection and Commerce
Honorable Roy Takumi, Chair
Honorable Linda Ichiyama, Vice Chair

I SUPPORT HB 2504 HD1

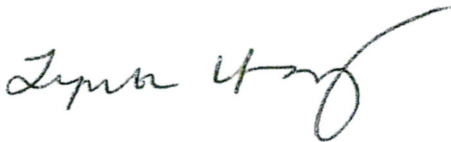
My name is Lynnette Young, MD. I am a pediatric emergency medicine physician.
I write today in strong support of HD 2504 HD1.

I agree with my physician colleagues that a patient should not be balanced billed. When a patient is unable to make a choice on a provider's network status with a health plan due to their medical situation, the patient should not be responsible for charges.

The establishment of a dispute resolution process party would make sense to ensure patient protections and an improvement to the original bill which tied payment to Medicare or what a plan pays others.. As a physician treating pediatric patients, either payment benchmark would not have made sense.

Thank you for considering my testimony.

Sincerely,



Lynnette Young, M.D.

DAVID Y. IGE
GOVERNOR

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STATE OF HAWAII
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
201 MERCHANT STREET, SUITE 1700
HONOLULU, HAWAII 96813
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

ADMINISTRATOR
DEREK M. MIZUNO

ASSISTANT ADMINISTRATOR
DONNA A. TONAKI

TESTIMONY BY DEREK MIZUNO
ADMINISTRATOR, HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE
ON HOUSE BILL NO. 2504 H.D. 1

February 13, 2020
2:00 p.m.
Room 329

RELATING TO HEALTH INSURANCE

Chair Takumi, Vice Chair Ichiyama, and Members of the Committee:

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) Board of Trustees has not been able to take a position on this bill. Their next meeting is scheduled for February 18, 2020. The EUTF staff would like to provide comments on the proposed bill that limits individual liability from “balance billing” but could potentially increase EUTF plan medical costs significantly.

The EUTF staff is concerned with the possible impact on EUTF plan medical costs and the resulting impact to be borne by the State, counties, employees and retirees through higher premiums. H.D. 1 requires negotiation between the insurer and nonparticipating provider to determine the insurer’s (and resulting EUTF plan) liability. If negotiations do not result in a settlement, the insurer (EUTF plan) “shall pay the nonparticipating provider the amount billed by the nonparticipating provider.” This predetermined result removes any incentive for the nonparticipating provider to

negotiate in good faith. It also incentivizes participating providers to leave the network since reimbursements from the insurer/plans are seemingly unlimited. The original draft of the bill provided a more reasonable and balanced approach to resolving these difficult situations.

Thank you for the opportunity to testify.

Representative Roy Takumi, Chair
Representative Linda Ichiyama, Vice Chair
Members of the House Committee on Consumer Protection

RE: Testimony of Michael Rembis, CEO
February 13, 2020

Aloha Chair Takumi, Vice Chair Ichiyama and members of the committee,

My name is Michael Rembis, and I am the Chief Executive Officer of Maui Health Systems ("MHS"). I am writing in support of H.B. 2504, HD1. This measure establishes disclosure and consent requirements for nonparticipating health care providers; prohibits nonparticipating health care providers from balance billing patients in specific circumstances; and requires the use of a dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider.

MHS believes that the patient should not be caught in the middle and suffer harm in a dispute between health plan and health provider. Where a medical emergency 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.

We also believe that legislation should serve to incentivize insurers to fulfill their obligation to their members and be required to work in good faith with health care providers to negotiate a contract and settlement to resolve any sums owed on behalf of their insured.

The HD1 as written is a significant improvement over the original HB 2504, as it removes the problematic rate setting provisions. Statutory reimbursement rates tied to benchmarks are either not comprehensive enough or are often inapplicable to determine reimbursement for services provided to specific populations. This is particularly true on the neighbor islands. Moreover, any statutorily stated reimbursement will unfairly handicap a party in the process of dispute resolution by artificially establishing a baseline floor of payment.

Finally, we strongly support the establishment of a dispute resolution process before a disinterested 3rd party as has been passed in other states. 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. Thank you for your consideration of this important matter.

Mahalo for your consideration,

Michael A. Rembis, FACHE
Chief Executive Officer

1132 Bishop Street, #1920 | Honolulu, HI 96813
1-866-295-7282 | Fax: 808-537-2288 | TTY: 1-877-434-7598
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facebook.com/AARPHawaii

HOUSE OF REPRESENTATIVES
Committee on Consumer Protection and Commerce
Thursday, February 13, 2020
2:00 p.m.
Conference Room 329

To: Representative Roy Takumi, Chair
Re: HB 2504, HD1 Relating to Health Insurance

Dear Chair Takumi, Vice-Chair Ichiyama, and Members of the Committee,

My name is Keali'i Lopez, and I am the State Director for AARP Hawai'i. AARP is a membership organization of people age fifty and over, with nearly 145,000 members in Hawai'i. AARP advocates for issues that matter to Hawai'i families, including the high cost of long-term care; access to affordable, quality health care for all generations; and serving as a reliable information source on issues critical to people over the age of fifty.

AARP Hawai'i **supports HB 2504, HD1 with comments**. This bill establishes disclosure and consent requirements for nonparticipating health providers; prohibits nonparticipating health care providers from balance billing patients in specific circumstances.

AARP supports efforts to protect consumers against surprise bills from nonparticipating providers who provide services without the consumer's knowledge or consent in an otherwise in-networking setting. We particularly support provisions that prevent these unexpected bills when a person needs to use emergency services, and requiring insurers to notify enrollees by mail and websites of their rights and potential costs for out-of-network procedures.

To clarify and further strengthen this bill, the Committee may want to address a few additional issues:

- Provisions for enforcement
- Consumer reimbursement if a consumer pays a bill they weren't supposed to pay
- Extending the 24 hour timeframe to disclose the requirements of a nonparticipating provider in advance. (e.g. People may have taken time off from work, or traveled from neighbor islands and cannot easily change their decision if a disclosure is given only 24 hours in advance)

Thank you very much for the opportunity to support HB 2504,HD1, and to provide comments.