THE SENATE
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

S.B. NO. 2668 S.D. 2 H.D. 1

A BILL FOR AN ACT

RELATING TO INSURANCE.

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

SECTION 1. The legislature finds that consumers with health insurance who receive treatment from an out-of-network provider may receive a bill for the difference between an insurer's payments to a health care provider and the out-of-network provider's charges. These bills, known as balance bills or surprise bills, occur most often when consumers receive medical services from out-of-network providers. Out-of-network providers may not have a contracted rate with an insurer for services; therefore, the prices these providers may charge may be much greater than the price charged by in-network providers for similar services.

The legislature further finds that balance bills can be an unwelcome surprise to consumers who may not have knowingly decided to obtain health care outside of their provider network. Currently, there is no broad protection from surprise bills or balance bills at the federal level or in most states. In Hawaii, the restriction on balance billing, which applies to

health maintenance organizations and mutual benefit societies only, requires the inclusion of a provision in provider contracts which states that a subscriber or member will not be liable to the provider for amounts owed by the organization or society. The legislature also finds that additional consumer protections are necessary to increase transparency for patients billed for medical services and protect consumers from the need to pay balance bills.

Accordingly, the purpose of this Act is to specify:

(1) Disclosure requirements for health care providers, health care facilities, and hospitals that are nonparticipating providers in a patient's health care plan;

(2) That an insured shall not be liable to a health care provider for any sums owed by an insurer; and

(3) That an insured who receives emergency services from a nonparticipating provider shall not incur greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating provider; and

(4) Additional disclosure requirements for health insurance plans.

SECTION 2. Chapter 321, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§321- Disclosure required.** (a) A health care provider, health care facility, or hospital shall disclose the following information in writing to patients or prospective patients prior to the provision of nonemergency services that are not authorized by the patients' health care plan:

(1) That certain health care facility-based providers may be called upon to render care to a covered person during the course of treatment;

(2) That those health care facility-based providers may not have contracts with the covered person's health care plan and are therefore considered to be out-of-network providers;

(3) That the services will therefore be provided on an out-of-network basis and the cost may be substantially higher than if the services were provided in-network;

(4) A notification that the covered person may either agree to accept and pay the charges for the out-of-network services, contact the covered person's health care plan for additional assistance, or rely on any other rights and remedies that may be available under state or federal law; and

(5) A statement indicating that the covered person may obtain from the covered person's health care plan a list of health care facility-based providers that are participating providers and the covered person may request those participating facility-based providers.

(b) If a health care provider, health care facility, or hospital is not a participating provider in a patient's or prospective patient's health care plan network, the health care provider, health care facility, or hospital shall:

(1) Inform a patient or prospective patient of the amount or estimated amount the health care provider, health care facility, or hospital will bill the patient or prospective patient for health care services prior to the provision of non-emergency services; and

(2) Disclose to the patient or prospective patient in writing the amount or estimated amount that the health care provider, health care facility, or hospital will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient, not including unforeseen medical circumstances that may arise when the health care services are provided.

(c) For purposes of this section:

"Health care facility" means any institution, place, building, or agency, or portion thereof, licensed or otherwise authorized by the State, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, or rehabilitative or preventive care to any person or persons.

"Health care plan" means a health insurance company, mutual benefit society governed by article 1 of chapter 432, health care service plan or health maintenance organization governed by chapter 432D, or any other entity delivering or issuing for delivery in the State accident and health or sickness insurance

as defined in section 431:1-205, other than disability insurance that replaces lost income.

"Health care provider" means an individual who is licensed or otherwise authorized by the State to provide health care services.

"Hospital" means:

(1) An institution with an organized medical staff, regulated under section 321-11(10), that admits patients for inpatient care, diagnosis, observation, and treatment; and

(2) A health facility under chapter 323F."

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 10A to be appropriately designated and to read as follows:

"**§431:10A- Balance billing; hold harmless; emergency services.** (a) Every contract between an insurer and a participating provider of health care services shall be in writing and shall set forth that in the event the insurer fails to pay for health care services as set forth in the contract, the insured shall not be liable to the provider for any sums owed by the insurer.

(b) When an insured receives emergency services from a provider that is not a participating provider in the provider network of an insurer, the insured shall not incur greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating provider of health care services.

(c) If a contract with a participating provider has not been reduced to writing as required by this section, or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the insured sums owed by the insurer. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against an insured to collect sums owed by the insurer.

(d) When an insured receives emergency services from a provider that is not a participating provider in the provider network of the insured, the insurer shall make certain that the insured shall incur no greater out-of-pocket costs for emergency services than the insured would have incurred with a participating provider of health care services.

(e) For purposes of this section:

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

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

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

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

(4) Serious disfigurement of the person.

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

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

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

SECTION 4. Section 431:10-109, Hawaii Revised Statutes, is amended to read as follows:

"[~~[~~]§431:10-109[~~]~~] **Disclosure of [~~health care coverage and benefits.~~] information.** (a) In order to ensure that all individuals understand their health care options and are able to make informed decisions, all insurers shall provide current and prospective insureds with written disclosure of [~~coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage.~~] the following information:

(1) A description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(2) A description of all prior authorization or other requirements for treatments and services;

(3) A description prepared annually of the types of methodologies the insurer uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse

for the provision of particular types of services; provided that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between an insurer and a health care provider;

(4) An explanation of an insured's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges; annual limits on an insured's financial responsibility; caps on payments for covered services; and financial responsibility for non-covered health care procedures, treatments, or services;

(5) Where applicable, an explanation of an insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network of providers or by any provider without required authorization, or when a procedure, treatment, or service is not a covered benefit;

(6) A description of the procedure for obtaining emergency services; provided that the description shall include

a definition of emergency services; notice that emergency services shall not be subject to prior approval; and shall specify the insured's financial and other responsibilities regarding obtaining emergency services;

(7) Where applicable, a description of procedures for insureds to select and access the insurer's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(8) Where applicable, a description of the procedures for changing primary and specialty care providers within the insurer's network of providers;

(9) Where applicable, notice that an insured enrolled in a managed care plan that utilizes a network of providers offered by the insurer may obtain a referral or preauthorization for a health care provider outside of the insurer's network when the insurer does not have a health care provider who is geographically accessible to the insured and who has the appropriate training and experience in the network to meet the particular

health care needs of the insured and the procedure by which the insured can obtain the referral or preauthorization;

(10) Where applicable, notice that an insured, who is enrolled in a managed care plan that utilizes a network of providers offered by the insurer and who has a condition that requires ongoing care from a specialist, may request a standing referral to the specialist and the procedure for requesting and obtaining a standing referral;

(11) Where applicable, notice that an insured, who is enrolled in a managed care plan that utilizes a network of providers offered by the insurer and who has a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining a specialist;

(12) Notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization;

(13) Where applicable, a listing by specialty, which may be in a separate document that is updated annually, of:

(A) The name, address, and telephone number of all participating providers, including facilities;

(B) The name, address, telephone number, board certification, languages spoken, and any affiliations with participating hospitals of all participating physicians;

provided that the listing shall be posted on the insurer's website and shall be updated within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

(14) A description of the method by which an insured may submit a claim for health care services;

(15) With regards to out-of-network coverage:

(A) A clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(B) The amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

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

(16) Information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

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

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

(c) For purposes of this section:

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

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

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

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

(4) Serious disfigurement of the person.

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

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

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

"Managed care plan" means any plan, policy, contract, certificate, or agreement, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:

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

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

"Usual and customary cost" means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area."

SECTION 5. Section 432:1-407, Hawaii Revised Statutes, is amended by amending subsection (d) to read as follows:

"(d) Every contract between a mutual benefit society and a participating provider of health care services shall be in writing and shall set forth that in the event the society fails to pay for health care services as set forth in the contract, the subscriber or member shall not be liable to the provider for any sums owed by the society. When a subscriber or member receives emergency services from a provider that is not a participating provider in the provider network of the mutual benefit society, the mutual benefit society shall ensure that the subscriber or member shall incur no greater out-of-pocket costs for emergency services than the subscriber or member would have incurred with a participating provider of health care

services. If a contract with a participating provider has not been reduced to writing as required by this subsection, or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or member sums owed by the society. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums owed by the society.

For purposes of this subsection, "emergency services" shall have the same meaning as in section 431:10A- ."

SECTION 6. Section 432D-8, Hawaii Revised Statutes, is amended by amending subsection (d) to read as follows:

"(d) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization. When a subscriber or enrollee receives emergency services from a provider that is not a participating provider in the provider

network of the health maintenance organization, the health maintenance organization shall ensure that the subscriber or enrollee shall incur no greater out-of-pocket costs for emergency services than the subscriber or enrollee would have incurred with a participating provider of health care services. In the event that a contract with a participating provider has not been reduced to writing as required by this subsection or that a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

For purposes of this subsection, "emergency services" shall have the same meaning as in section 431:10A- ."

SECTION 7. (a) The insurance commissioner shall establish and convene a working group for the purpose of evaluating the issue of balance billing in the State.

(b) The working group shall examine the following:

(1) The extent of balance billing in the State;

(2) Any data concerning and specific cases of balance billing in the State; and

(3) State and national efforts related to mitigating balancing billing.

(c) The working group shall determine the appropriate amount that can be billed by a non-participating healthcare provider to a patient for services performed without prior or subsequent authorization from a patient's health care plan and what amount should be paid by an insurer to a nonparticipating provider.

(d) The working group shall submit a report of its findings and recommendations to the legislature no later than twenty days prior to the convening of the regular session of 2017, including an explanation of the methodologies used to reach its conclusions.

(e) The working group shall cease to exist on June 30, 2017.

SECTION 8. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 9. This Act shall take effect on July 1, 2112.

S.B. NO. 2668 S.D. 2 H.D. 1

Report Title:
Insurance; Out-of-Network Providers; Balance Bills; Surprise Bills; Disclosure; Emergency Services; Health Care Providers; Health Care Facilities; Hospitals

Description:
Specifies disclosure requirements for health care providers, health care facilities, and hospitals who are nonparticipating providers in a patient's health care plan. Specifies that an insured who receives emergency services from a nonparticipating provider shall not incur greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating provider. Specifies additional disclosure requirements for health insurance plans. Establishes a working group to examine balance billing. (SB2668 HD1)

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