

1 The term "active course of treatment" includes treatment of
2 a covered person on a regular basis by a provider being removed
3 from or leaving the network.

4 "Affordable Care Act" refers to the Patient Protection and
5 Affordable Care Act, 42 U.S.C. section 18001 (2010), as the same
6 may be amended, and its related regulations.

7 "Authorized representative" means:

- 8 (1) A person to whom a covered person has given express
9 written consent to represent the covered person;
- 10 (2) A person authorized by law to provide substituted
11 consent for a covered person; or
- 12 (3) The covered person's treating health care professional
13 only when the covered person or persons authorized
14 pursuant to paragraphs (1) and (2) of this definition
15 are unable to provide consent.

16 "Commissioner" means the insurance commissioner of the
17 State.

18 "Covered benefit" means those health care services to which
19 a covered person is entitled under the terms of a health benefit
20 plan.



1 "Covered person" means a policyholder, subscriber,
2 enrollee, or other individual participating in a health benefit
3 plan, offered or administered by a person or entity, including
4 but not limited to an insurer governed by this chapter, mutual
5 benefit society governed by chapter 432, and health maintenance
6 organization governed by chapter 432D.

7 "Essential community provider" means a provider that:

- 8 (1) Serves predominantly low-income, medically underserved
9 individuals, including a health care provider that is
10 a covered entity as defined in section 340B(a)(4) of
11 the Public Health Service Act; or
12 (2) Is described in section 1927(c)(1)(D)(i)(IV) of the
13 Social Security Act, as set forth by section 221 of
14 Public Law 111-8.

15 "Facility" means an institution providing health care
16 services or a health care setting, including hospitals and other
17 licensed inpatient centers, ambulatory surgical or treatment
18 centers, skilled nursing centers, residential treatment centers,
19 urgent care centers, diagnostic facilities, laboratories, and
20 imaging centers, and rehabilitation and other therapeutic health



1 settings licensed or certified by the department of health under
2 chapter 321.

3 "Health benefit plan" means a policy, contract,
4 certificate, or agreement entered into, offered, or issued by a
5 health carrier to provide, deliver, arrange for, pay for, or
6 reimburse any of the costs of health care services pursuant to
7 chapters 87A, 431, 432, or 432D.

8 "Health care professional" means a physician or other
9 health care practitioner licensed, accredited, or certified to
10 perform specified health care services consistent with the
11 practitioner's scope of practice under state law.

12 "Health care provider" or "provider" means a health care
13 professional, pharmacy, or facility.

14 "Health care services" means services for the diagnosis,
15 prevention, treatment, cure, or relief of a physical, mental, or
16 behavioral health condition, illness, injury, or disease,
17 including mental health and substance use disorders.

18 "Health carrier" or "carrier" means an entity subject to
19 the insurance laws and regulations of this State, or subject to
20 the jurisdiction of the commissioner, that contracts or offers
21 to contract, or enters into an agreement to provide, deliver,



1 arrange for, pay for, or reimburse any of the costs of health
2 care services, including a health insurance company, a health
3 maintenance organization, a hospital and health service
4 corporation, or any other entity providing a plan of health
5 insurance, health benefits, or health care services.

6 The term "health carrier" or "carrier" includes an accident
7 and health or sickness insurance plan that issues health benefit
8 plans under part I of article 10A of this chapter, a mutual
9 benefit society under article 1 of chapter 432, and a health
10 maintenance organization under chapter 432D.

11 "Integrated delivery system" means a health plan that
12 provides a majority of its members covered health care services
13 through physicians and non-physician practitioners employed by
14 the health benefit plan or through a single contracted medical
15 group.

16 "Intermediary" means a person authorized to negotiate and
17 execute provider contracts with health carriers on behalf of
18 health care providers or on behalf of a network, if applicable.

19 "Limited scope dental plan" means a plan that provides
20 coverage primarily for treatment of the mouth, including any
21 organ or structure within the mouth, under a separate policy,



1 certificate, or contract of insurance or is otherwise not an
2 integral part of a health benefit plan.

3 "Limited scope vision plan" means a plan that provides
4 coverage primarily for treatment of the eye through a separate
5 policy, certificate, or contract of insurance or is otherwise
6 not an integral part of a health benefit plan.

7 "Network" means the group or groups of participating
8 providers providing services under a network plan.

9 "Network plan" means a health benefit plan that either
10 requires a covered person to use, or creates incentives,
11 including financial incentives, for a covered person to use
12 health care providers managed, owned, under contract with, or
13 employed by the health carrier.

14 "Participating provider" means a provider who, under a
15 contract with the health carrier or with its contractor or
16 subcontractor, has agreed to provide health care services to
17 covered persons with an expectation of receiving payment, other
18 than coinsurance, copayments, or deductibles, directly or
19 indirectly from the health carrier.

20 "Person" means an individual, a corporation, a partnership,
21 an association, a joint venture, a joint stock company, a trust,



1 an unincorporated organization, any similar entity, or any
2 combination of the foregoing.

3 "Primary care" means health care services for a range of
4 common conditions provided by a physician or non-physician
5 primary care professional.

6 "Primary care professional" means a participating health
7 care professional designated by the health carrier to supervise,
8 coordinate, or provide initial care or continuing care to a
9 covered person, and who may be required by the health carrier to
10 initiate a referral for specialty care and maintain supervision
11 of health care services rendered to the covered person.

12 "Serious acute condition" means a disease or condition for
13 which the covered person is currently requiring complex ongoing
14 care, such as chemotherapy, post-operative visits, or radiation
15 therapy.

16 "Specialist" means a physician or non-physician health care
17 professional who focuses on a specific area of health care
18 services or on a group of patients and who has successfully
19 completed required training and is recognized by the State in
20 which the physician or non-physician health care professional
21 practices to provide specialty care.



1 The term "specialist" includes a subspecialist who has
2 additional training and recognition above and beyond the
3 subspecialist's specialty training.

4 "Specialty care" means advanced medically necessary care
5 and treatment of specific health conditions or health conditions
6 that may manifest themselves in particular ages or
7 subpopulations that are provided by a specialist, preferably in
8 coordination with a primary care professional or other health
9 care professional.

10 "Telehealth" means health care services provided through
11 telecommunications technology by a health care professional who
12 is at a location other than where the covered person is located.

13 "Tier" means specific groups of providers and facilities
14 identified by a network and to which different provider
15 reimbursement, covered person cost-sharing, provider access
16 requirements, or any combination thereof, apply for the same
17 services.

18 §431 -B **Applicability and scope.** (a) Except as
19 provided in subsection (b), this article applies to all health
20 carriers that offer fully insured network plans.



1 (b) The following provisions of this article shall not
2 apply to health carriers that offer network plans that consist
3 solely of limited scope dental plans or limited scope vision
4 plans:

- 5 (1) Section 431 -C(a) (2), on network adequacy;
- 6 (2) Section 431 -C(f) (7) (E), (f) (8) (B), and (f) (11), on
7 network adequacy;
- 8 (3) Paragraphs (1) and (3) of the definition of "active
9 course of treatment" under section 431 -A, on
10 definitions, and section 431 -D(1) (6) (C), on
11 requirements for health carriers and participating
12 providers;
- 13 (4) Section 431 -D, on disclosure and notice
14 requirements;
- 15 (5) Section 431 -E(a) (3) (B) and (C), on provider
16 directories; and
- 17 (6) Section 431 -E(a) (4) (A) (i) and (ii) and (a) (4) (B),
18 on provider directories.

19 (c) This article shall not apply to disability and
20 accident-only policies as provided in section 431:10A-102.5.



1 §431 -C Network adequacy. (a) Network adequacy
2 requirements shall be as set forth in this subsection:

3 (1) A health carrier providing a network plan shall
4 maintain a network that is sufficient in numbers and
5 appropriate types of providers, including those that
6 serve predominantly low-income, medically underserved
7 individuals, to assure that all covered services will
8 be accessible to covered persons, including children
9 and adults, without unreasonable travel or delay; and

10 (2) Covered persons shall have access to emergency
11 services twenty-four hours per day, seven days per
12 week.

13 (b) The commissioner shall determine sufficiency in
14 accordance with the requirements of this section by considering
15 any reasonable criteria, which may include, but shall not be
16 limited to:

- 17 (1) Provider to covered person ratios by specialty;
- 18 (2) Primary care professional to covered person ratios;
- 19 (3) Geographic accessibility of providers;
- 20 (4) Geographic variation and population dispersion;



- 1 (5) Waiting times for an appointment with participating
2 providers;
- 3 (6) Hours of operation;
- 4 (7) The ability of the network to meet the needs of
5 covered persons, which may include low-income persons,
6 children and adults with serious, chronic, or complex
7 health conditions or physical or mental disabilities,
8 or persons with limited English proficiency;
- 9 (8) Other health care service delivery system options,
10 such as telehealth, mobile clinics, centers of
11 excellence, integrated delivery systems, and other
12 ways of delivering care; and
- 13 (9) The volume of technologically advanced and specialty
14 care services available to serve the needs of covered
15 persons requiring technologically advanced or
16 specialty care services.
- 17 (c) A health carrier shall have process requirements as
18 set forth in this subsection:
- 19 (1) A health carrier shall have a process to ensure that a
20 covered person can obtain a covered benefit at an in-
21 network level of benefits, including an in-network



1 level of cost-sharing, from a non-participating
2 provider, or shall make other arrangements acceptable
3 to the commissioner when:

4 (A) The health carrier has a sufficient network but
5 does not have a type of participating provider
6 available to provide the covered benefit to the
7 covered person, or does not have a participating
8 provider available to provide the covered benefit
9 to the covered person without unreasonable travel
10 or delay; or

11 (B) The health carrier has an insufficient number or
12 type of participating providers available to
13 provide the covered benefit to the covered person
14 without unreasonable travel or delay;

15 (2) The health carrier shall specify and inform covered
16 persons of the process a covered person may use to
17 request access to obtain a covered benefit from a non-
18 participating provider as provided in paragraph (1)
19 when:



- 1 (A) The covered person is diagnosed with a condition
2 or disease that requires specialized health care
3 services or medical services; and
- 4 (B) The health carrier:
- 5 (i) Does not have a participating provider of
6 the required specialty with the professional
7 training and expertise to treat or provide
8 health care services for the condition or
9 disease; or
- 10 (ii) Cannot provide reasonable access to a
11 participating provider with the required
12 specialty and who possesses the professional
13 training and expertise to treat or provide
14 health care services for the condition or
15 disease without unreasonable travel or
16 delay;
- 17 (3) The health carrier shall treat the health care
18 services the covered person receives from a non-
19 participating provider pursuant to paragraph (2) as if
20 the services were provided by a participating
21 provider, including counting the covered person's



1 cost-sharing for those services toward the maximum
2 out-of-pocket limit applicable to services obtained
3 from participating providers under the health benefit
4 plan;

5 (4) The process described in paragraphs (1) and (2) shall
6 ensure that requests to obtain a covered benefit from
7 a non-participating provider are addressed in a timely
8 fashion appropriate to the covered person's condition;

9 (5) The health carrier shall establish and maintain a
10 system that documents all requests to obtain a covered
11 benefit from a non-participating provider under this
12 subsection and shall provide this information to the
13 commissioner upon request;

14 (6) The process established in this subsection is not
15 intended to be used by health carriers as a substitute
16 for establishing and maintaining a sufficient provider
17 network in accordance with this article nor is it
18 intended to be used by covered persons to circumvent
19 the use of covered benefits available through a health
20 carrier's network delivery system options; and



1 (7) This section does not prevent a covered person from
2 exercising the rights and remedies available under
3 applicable state or federal law relating to internal
4 and external claims grievance and appeals processes.

5 (d) The health carrier shall be subject to adequate
6 arrangement requirements as set forth in this subsection:

7 (1) A health carrier shall establish and maintain adequate
8 arrangements to ensure covered persons have reasonable
9 access to participating providers located near their
10 home or business address. In determining whether the
11 health carrier has complied with this paragraph, the
12 commissioner shall give due consideration to the
13 relative availability of health care providers with
14 the requisite expertise and training in the service
15 area under consideration; and

16 (2) A health carrier shall monitor, on an ongoing basis,
17 the ability, clinical capacity, and legal authority of
18 its participating providers to furnish all contracted
19 covered benefits to covered persons.

20 (e) A health carrier shall meet the following access plan
21 requirements:



- 1 (1) Beginning on the effective date of this Act, a health
2 carrier shall file with the commissioner for approval,
3 prior to or at the time it files a newly offered
4 network plan, in a manner and form defined by rule of
5 the commissioner, an access plan meeting the
6 requirements of this article;
- 7 (2) The health carrier may request the commissioner to
8 deem sections of the access plan as proprietary,
9 competitive, or trade secret information that shall
10 not be made public. Information is proprietary,
11 competitive, or a trade secret if disclosure of the
12 information would cause the health carrier's
13 competitors to obtain valuable business information.
14 The health carrier shall make the access plans, absent
15 proprietary, competitive, or trade secret information,
16 available online, at its business premises, and to any
17 person upon request; and
- 18 (3) The health carrier shall prepare an access plan prior
19 to offering a new network plan and shall notify the
20 commissioner of any material change to any existing
21 network plan within fifteen business days after the



1 change occurs. The carrier shall include in the
2 notice to the commissioner a reasonable timeframe
3 within which the carrier will submit to the
4 commissioner for approval or file with the
5 commissioner, as appropriate, an update to an existing
6 access plan.

7 (f) In addition to subsection (e), the access plan shall
8 describe or contain at least the following:

9 (1) The health carrier's network, including how telehealth
10 or other technology may be used to meet network access
11 standards, if applicable;

12 (2) The health carrier's procedures for making and
13 authorizing referrals within and outside its network,
14 if applicable;

15 (3) The health carrier's process for monitoring and
16 assuring on an ongoing basis the sufficiency of the
17 network to meet the health care needs of populations
18 that enroll in network plans;

19 (4) The factors the health carrier uses to build its
20 provider network, including a description of the
21 network and the criteria used to select providers;



- 1 (5) The health carrier's efforts to address the needs of
2 covered persons, including children and adults, and
3 persons with limited English proficiency, illiteracy,
4 diverse cultural or ethnic backgrounds, physical or
5 mental disabilities, and serious, chronic, or complex
6 medical conditions. Information required under this
7 paragraph shall include the carrier's efforts, when
8 appropriate, to include various types of essential
9 community providers in the carrier's network. A
10 health carrier that is subject to the Affordable Care
11 Act alternative standard shall demonstrate to the
12 commissioner that the health carrier meets that
13 standard;
- 14 (6) The health carrier's methods for assessing the health
15 care needs of covered persons and their satisfaction
16 with services;
- 17 (7) The health carrier's method of informing covered
18 persons of the plan's covered services and features,
19 including:
- 20 (A) The plan's grievance and appeals procedures;



- 1 (B) The plan's process for choosing and changing
- 2 providers;
- 3 (C) The plan's process for updating its provider
- 4 directories for each of its network plans;
- 5 (D) A statement of health care services offered,
- 6 including those services offered through the
- 7 preventive care benefit, if applicable; and
- 8 (E) The plan's procedures for covering and approving
- 9 emergency, urgent, and specialty care, if
- 10 applicable;
- 11 (8) The health carrier's system for ensuring the
- 12 coordination and continuity of care:
- 13 (A) For covered persons referred to specialty
- 14 physicians; and
- 15 (B) For covered persons using ancillary services,
- 16 including social services and other community
- 17 resources, if applicable;
- 18 (9) The health carrier's process for enabling covered
- 19 persons to change primary care professionals, if
- 20 applicable;



1 (10) The health carrier's proposed plan for providing
 2 continuity of care if a contract termination occurs
 3 between the health carrier and any of its
 4 participating providers or in the event of the health
 5 carrier's insolvency or other inability to continue
 6 operations. Information required under this paragraph
 7 shall explain how covered persons will be notified of
 8 the contract termination, or the health carrier's
 9 insolvency or other cessation of operations, and
 10 transitioned to other providers in a timely manner;
 11 and

12 (11) Any other information required by the commissioner to
 13 determine compliance with this article.

14 **§431 -D Requirements for health carriers and**
 15 **participating providers.** (a) A health carrier shall establish
 16 a mechanism by which participating providers shall be notified
 17 on an ongoing basis of the specific covered health care services
 18 for which the provider will be responsible, including any
 19 limitations or conditions on services.

20 (b) Every contract between a health carrier and a
 21 participating provider shall set forth a hold-harmless provision



1 specifying protection for covered persons. This subsection
2 shall be met by including a provision substantially similar to
3 the following:

4 "Provider agrees that in no event, including but not
5 limited to nonpayment by the health carrier or
6 intermediary, insolvency of the health carrier or
7 intermediary, or breach of this agreement, shall the
8 provider bill, charge, collect a deposit from, seek
9 compensation, remuneration, or reimbursement from, or have
10 any recourse against a covered person or a person (other
11 than the health carrier or intermediary, as applicable)
12 acting on behalf of the covered person for services
13 provided pursuant to this agreement. This agreement does
14 not prohibit the provider from collecting coinsurance,
15 deductibles, or copayments, as specifically provided in the
16 evidence of coverage, or fees for uncovered services
17 delivered on a fee-for-service basis to covered persons;
18 provided that a provider shall not bill or collect from a
19 covered person or a person acting on behalf of a covered
20 person any charges for non-covered services or services
21 that do not meet the criteria in section 432E-1.4, Hawaii



1 Revised Statutes, unless an agreement of financial
2 responsibility specific to the service is signed by the
3 covered person or a person acting on behalf of the covered
4 person is obtained prior to the time services are rendered.
5 This agreement does not prohibit a provider, except for a
6 health care professional who is employed full-time on the
7 staff of a health carrier and who has agreed to provide
8 services exclusively to that health carrier's covered
9 persons and no others, and a covered person from agreeing
10 to continue services solely at the expense of the covered
11 person; provided that the provider has clearly informed the
12 covered person that the health carrier may not cover or
13 continue to cover a specific service or services. Except
14 as provided herein, this agreement does not prohibit the
15 provider from pursuing any available legal remedy."

16 (c) Every contract between a health carrier and a
17 participating provider shall provide that in the event of a
18 health carrier or intermediary insolvency or other cessation of
19 operations, the provider's obligation to deliver covered
20 services to covered persons without balance billing will
21 continue until the earlier of:



- 1 (1) The termination of the covered person's coverage under
2 the network plan, including any extension of coverage
3 provided under the contract terms or applicable state
4 or federal law for covered persons who are in an
5 active course of treatment or totally disabled; or
6 (2) The date the contract between the carrier and the
7 provider, including any required extension for covered
8 persons in an active course of treatment, would have
9 terminated if the carrier or intermediary had remained
10 in operation.
- 11 (d) Contract provisions required by subsections (b) and
12 (c) shall be construed in favor of the covered person, shall
13 survive the termination of the contract regardless of the reason
14 for termination, including the insolvency of the health carrier,
15 and shall supersede any oral or written contrary agreement
16 between a provider and a covered person or the representative of
17 a covered person if the contrary agreement is inconsistent with
18 the hold-harmless and continuation-of-covered services
19 provisions required by subsections (b) and (c).



1 (e) In no event shall a participating provider collect or
2 attempt to collect from a covered person any money owed to the
3 provider by the health carrier.

4 (f) Selection standards shall be developed pursuant to the
5 following:

6 (1) Health carrier selection standards for selecting and
7 tiering, as applicable, participating providers shall
8 be developed for providers and each health care
9 professional specialty;

10 (2) The standards shall be used in determining the
11 selection of participating providers by the health
12 carrier and the intermediaries with which the health
13 carrier contracts. The standards shall meet
14 requirements developed by the commissioner through
15 rules adopted pursuant to chapter 91 relating to
16 health care professional credentialing verification;

17 (3) Selection criteria shall not be established in a
18 manner:

19 (A) That would allow a health carrier to discriminate
20 against high risk populations by excluding
21 providers because they are located in geographic



1 areas that contain populations or providers
2 presenting a risk of higher than average claims,
3 losses, or health care services utilization;
4 (B) That would exclude providers because they treat
5 or specialize in treating populations presenting
6 a risk of higher than average claims, losses, or
7 health care services utilization; or
8 (C) That would discriminate with respect to
9 participation under the health benefit plan
10 against any provider who is acting within the
11 scope of the provider's license or certification
12 under applicable state law or regulations. This
13 subparagraph shall not be construed to require a
14 health carrier to contract with any provider who
15 is willing to abide by the terms and conditions
16 for participation established by the carrier;
17 (4) Paragraph (3) shall not prohibit a carrier from
18 declining to select a provider who fails to meet the
19 other legitimate selection criteria of the carrier
20 developed in compliance with this article; and



1 (5) This article shall not require a health carrier, its
2 intermediaries, or the provider networks with which
3 the carrier and its intermediaries contract, to employ
4 specific providers acting within the scope of their
5 license or certification under applicable state law
6 that may meet the selection criteria of the carrier,
7 or to contract with or retain more providers acting
8 within the scope of their license or certification
9 under applicable state law than are necessary to
10 maintain a sufficient provider network.

11 (g) A health carrier shall make its standards for
12 selecting participating providers available for review and
13 approval by the commissioner. A description in plain language
14 of the selection standards of the health carrier shall be made
15 available to the public.

16 (h) A health carrier shall notify participating providers
17 of the providers' responsibilities with respect to the health
18 carrier's applicable administrative policies and programs,
19 including but not limited to:

20 (1) Payment terms;

21 (2) Utilization review;



- 1 (3) Quality assessment and improvement programs;
- 2 (4) Credentialing; grievance and appeals procedures;
- 3 (5) Requirements for reporting data and for timely notice
- 4 of changes in practice, such as discontinuance of
- 5 accepting new patients;
- 6 (6) Confidentiality requirements; and
- 7 (7) Any applicable federal or state programs.
- 8 (i) A health carrier shall not offer an inducement to a
- 9 provider that would encourage or otherwise motivate the provider
- 10 not to provide medically necessary services to a covered person.
- 11 (j) A health carrier shall not prohibit a participating
- 12 provider from discussing any specific or all treatment options
- 13 with covered persons irrespective of the health carrier's
- 14 position on the treatment options, or from advocating on behalf
- 15 of covered persons within the utilization review or grievance or
- 16 appeals processes established by the carrier or a person
- 17 contracting with the carrier or in accordance with any rights or
- 18 remedies available under applicable state or federal law.
- 19 (k) Every contract between a health carrier and a
- 20 participating provider shall require the provider to make health
- 21 records available to appropriate state and federal authorities



1 involved in assessing the quality of care or investigating the
2 grievances or complaints of covered persons, and to comply with
3 the applicable state and federal laws related to the
4 confidentiality of medical and health records and the covered
5 person's right to see, obtain copies of, or amend their medical
6 and health records.

7 (1) The departure of a provider from a network shall be
8 subject to the following requirements:

9 (1) A health carrier and participating provider shall
10 provide at least sixty days' written notice to each
11 other before the provider is removed or leaves the
12 network without cause;

13 (2) The health carrier shall make a good faith effort to
14 provide written notice of a provider's removal or
15 leaving the network within thirty days of receipt or
16 issuance of a notice provided in accordance with
17 paragraph (1) to all covered persons who are patients
18 seen on a regular basis by the provider being removed
19 or leaving the network, irrespective of whether it is
20 for cause or without cause;



- 1 (3) When the provider being removed or leaving the network
2 is a primary care professional, all covered persons
3 who are patients of that primary care professional
4 shall also be notified. When the provider either
5 gives or receives the notice in accordance with
6 paragraph (1), the provider shall supply the health
7 carrier with a list of those patients of the provider
8 that are covered by a plan of the health carrier;
- 9 (4) When a covered person's provider leaves or is removed
10 from the network, a health carrier shall establish
11 reasonable procedures to transition the covered
12 person, who is in an active course of treatment, to a
13 participating provider in a manner that provides for
14 continuity of care;
- 15 (5) The health carrier shall provide the notice required
16 under paragraph (1) and shall make available to the
17 covered person a list of available participating
18 providers in the same geographic area who are of the
19 same provider type and information about how the
20 covered person may request continuity of care as
21 provided under paragraph (6);



- 1 (6) The procedures for patient transfer shall provide
2 that:
- 3 (A) Any request for continuity of care shall be made
4 to the health carrier by the covered person or
5 the covered person's authorized representative;
- 6 (B) Requests for continuity of care shall be reviewed
7 by the health carrier's medical director after
8 consultation with the treating provider for
9 patients who are under the care of a provider who
10 has not been removed or left the network for
11 cause and who meet the criteria specified under
12 the definition of:
- 13 (i) Active course of treatment;
14 (ii) Life-threatening health condition; or
15 (iii) Serious acute condition;
- 16 (C) Any decisions made with respect to a request for
17 continuity of care shall be subject to the health
18 benefit plan's internal and external grievance
19 and appeal processes in accordance with
20 applicable state or federal law or regulations;



- 1 (D) The continuity of care period for covered persons
2 who are in their second or third trimester of
3 pregnancy shall extend through the postpartum
4 period; and
- 5 (E) The continuity of care period for covered persons
6 who are undergoing an active course of treatment
7 shall extend through the earliest of:
- 8 (i) The termination of the course of treatment
9 by the covered person or the treating
10 provider;
- 11 (ii) Ninety days, unless the medical director
12 determines that a longer period is
13 necessary;
- 14 (iii) The date that care is successfully
15 transitioned to a participating provider;
- 16 (iv) The date that benefit limitations under the
17 plan are met or exceeded; or
- 18 (v) The date that care is not medically
19 necessary; and
- 20 (7) A continuity of care request shall only be granted
21 when:



1 (A) The provider agrees in writing to accept the same
2 payment from and abide by the same terms and
3 conditions with respect to the health carrier for
4 that patient as provided in the original provider
5 contract; and

6 (B) The provider agrees in writing not to seek any
7 payment from the covered person for any amount
8 for which the covered person would not have been
9 responsible if the physician or provider were
10 still a participating provider.

11 (m) The rights and responsibilities under a contract
12 between a health carrier and a participating provider shall not
13 be assigned or delegated by either party without the prior
14 written consent of the other party.

15 (n) A health carrier is responsible for ensuring that a
16 participating provider furnishes covered benefits to all covered
17 persons without regard to the covered person's enrollment in the
18 plan as a private purchaser of the plan or as a participant in
19 publicly financed programs of health care services. This
20 subsection shall not apply to circumstances when the provider



1 should not render services due to limitations arising from lack
2 of training, experience, skill, or licensing restrictions.

3 (o) A health carrier shall notify participating providers
4 of their obligations, if any, to collect applicable coinsurance,
5 copayments, or deductibles from covered persons pursuant to the
6 evidence of coverage, or of the providers' obligations, if any,
7 to notify covered persons of their personal financial
8 obligations for non-covered services.

9 (p) A health carrier shall not penalize a provider because
10 the provider, in good faith, reports to state or federal
11 authorities any act or practice by the health carrier that
12 jeopardizes patient health or welfare.

13 (q) A health carrier shall establish procedures for
14 resolution of administrative, payment, or other disputes between
15 providers and the health carrier.

16 (r) A contract between a health carrier and a provider
17 shall not contain provisions that conflict with the network plan
18 or this article.

19 (s) A contract between a health carrier and a provider
20 shall be subject to the following requirements:



- 1 (1) At the time the contract is signed, the health carrier
2 and, if appropriate, the intermediary shall timely
3 notify the participating provider of all provisions
4 and other documents incorporated by reference in the
5 contract;
- 6 (2) While the contract is in force, the carrier shall
7 timely notify the participating provider of any
8 changes to those provisions or documents that would
9 result in material changes in the contract;
- 10 (3) The health carrier shall timely inform the provider of
11 the provider's network participation status on any
12 health benefit plan in which the carrier has included
13 the provider as a participating provider; and
- 14 (4) For purposes of this subsection, the contract shall
15 define what is considered timely notice and what is
16 considered a material change.
- 17 **§431 -E Provider directories.** (a) A health carrier
18 shall post electronically a current and accurate provider
19 directory for each of the carrier's network plans with the
20 information and search functions described in paragraphs (3) and
21 (4) and:



- 1 (1) The health carrier shall ensure that the general
2 public is able to view all current providers for a
3 plan through an identifiable link or tab and without
4 creating or accessing an account or entering a policy
5 or contract number;
- 6 (2) The health carrier shall update each network plan
7 provider directory at least monthly and shall
8 periodically audit a reasonable sample size of its
9 provider directories for accuracy and retain
10 documentation of such an audit to be made available to
11 the commissioner upon request;
- 12 (3) For each network plan, the health carrier shall make
13 available the following information in a searchable
14 format:
 - 15 (A) For health care professionals:
 - 16 (i) Name;
 - 17 (ii) Gender;
 - 18 (iii) Participating office locations;
 - 19 (iv) Specialty, if applicable;
 - 20 (v) Medical group affiliations, if applicable;
 - 21 (vi) Facility affiliations, if applicable;



- 1 (vii) Participating facility affiliations, if
- 2 applicable;
- 3 (viii) Languages spoken other than English, if
- 4 applicable; and
- 5 (ix) Whether accepting new patients;
- 6 (B) For hospitals:
- 7 (i) Hospital name;
- 8 (ii) Hospital type, such as acute,
- 9 rehabilitation, children's, or cancer;
- 10 (iii) Participating hospital location; and
- 11 (iv) Hospital accreditation status; and
- 12 (C) For facilities, other than hospitals, by type:
- 13 (i) Facility name;
- 14 (ii) Facility type;
- 15 (iii) Type of services performed; and
- 16 (iv) Participating facility locations; and
- 17 (4) In addition to the information in paragraph (3), a
- 18 health carrier shall make available the following
- 19 information for each network plan:
- 20 (A) For health care professionals:
- 21 (i) Contact information;



- 1 (ii) Board certifications; and
- 2 (iii) Languages spoken other than English by
- 3 clinical staff, if applicable; and

4 (B) For hospitals and facilities other than

5 hospitals: telephone number.

6 (b) Upon the request of a covered person or prospective

7 covered person, a health carrier shall provide a print copy of a

8 current provider directory or of the requested directory

9 information as follows:

10 (1) The following provider directory information for the

11 applicable network plan shall be included:

12 (A) For health care professionals:

- 13 (i) Contact information;
- 14 (ii) Participating office locations;
- 15 (iii) Specialty, if applicable;
- 16 (iv) Languages spoken other than English, if
- 17 applicable; and
- 18 (v) Whether accepting new patients;

19 (B) For hospitals:

- 20 (i) Hospital name;



- 1 (ii) Hospital type, such as acute,
- 2 rehabilitation, children's, or cancer; and
- 3 (iii) Participating hospital location and
- 4 telephone number;

5 (C) For facilities, other than hospitals, by type:

- 6 (i) Facility name;
- 7 (ii) Facility type;
- 8 (iii) Types of services performed; and
- 9 (iv) Participating facility locations and
- 10 telephone number; and

11 (2) The health carrier shall include a disclosure in the
12 provider directory that the information in paragraph
13 (1) included in the directory is accurate as of the
14 date of printing and that covered persons or
15 prospective covered persons should consult the
16 carrier's electronic provider directory on its website
17 or call customer service to obtain current directory
18 information.

19 (c) For both electronic and print provider directories, a
20 health carrier shall indicate the following information:

21 (1) For each network plan:



- 1 (A) A description of the criteria the carrier has
- 2 used to build its provider network;
- 3 (B) If applicable, a description of the criteria the
- 4 carrier has used to tier providers;
- 5 (C) If applicable, the method by which the carrier
- 6 designates the different provider tiers or levels
- 7 in the network and identifies, for each specific
- 8 provider, hospital, or other type of facility in
- 9 the network, the tier in which each is placed,
- 10 such as by name, symbols, or grouping, so that a
- 11 covered person or prospective covered person may
- 12 identify the provider tier; and
- 13 (D) If applicable, that authorization or referral may
- 14 be required to access some providers;
- 15 (2) The provider directory applicable to a network plan,
- 16 such as inclusion of the specific name of the network
- 17 plan as marketed and issued in this State; and
- 18 (3) A customer service email address and telephone number
- 19 or electronic link that covered persons or the general
- 20 public may use to notify the health carrier of
- 21 inaccurate provider directory information.



1 (d) For the information required by subsections (a) (3),
2 (a) (4), and (b) (1) in a provider directory pertaining to a
3 health care professional, hospital, or facility other than a
4 hospital, the health carrier shall make available through
5 electronic and print provider directories the source of the
6 information and any limitations, if applicable.

7 (e) The electronic and print provider directories shall
8 accommodate the communication needs of individuals with
9 disabilities and include a link to or information regarding
10 available assistance for persons with limited English
11 proficiency.

12 **§431 -F Intermediaries.** (a) Intermediaries and
13 participating providers with whom they contract shall comply
14 with all the applicable requirements of section 431 -D.

15 (b) A health carrier's statutory responsibility to monitor
16 the offering of covered benefits to covered persons shall not be
17 delegated or assigned to the intermediary.

18 (c) A health carrier shall have the right to approve or
19 disapprove participation status of a subcontracted provider in
20 the carrier's own network or a contracted network for the



1 purpose of delivering covered benefits to the carrier's covered
2 persons.

3 (d) A health carrier shall maintain copies of all
4 intermediary health care subcontracts at its principal place of
5 business in the State or ensure that the carrier has access to
6 all intermediary subcontracts, including the right to make
7 copies to facilitate regulatory review, upon twenty days prior
8 written notice from the health carrier.

9 (e) If applicable, an intermediary shall transmit
10 utilization documentation and claims paid documentation to the
11 health carrier. The carrier shall monitor the timeliness and
12 appropriateness of payments made to providers and health care
13 services received by covered persons.

14 (f) If applicable, an intermediary shall maintain the
15 books, records, financial information, and documentation of
16 services provided to covered persons at its principal place of
17 business in the State and preserve them for the time period
18 required by law in a manner that facilitates regulatory review.

19 (g) An intermediary shall allow the commissioner access to
20 the intermediary's books, records, financial information, and



1 any documentation of services provided to covered persons, as
2 necessary to determine compliance with this article.

3 (h) If an intermediary is insolvent, a health carrier may
4 require the assignment to the health carrier of the provisions
5 of a provider's contract addressing the provider's obligation to
6 furnish covered services. If a health carrier requires
7 assignment, the health carrier shall remain obligated to pay the
8 provider for furnishing covered services under the same terms
9 and conditions as the intermediary prior to the insolvency.

10 (i) Notwithstanding any other provision of this section,
11 to the extent the health carrier delegates its responsibilities
12 to the intermediary, the carrier shall retain full
13 responsibility for the intermediary's compliance with this
14 article.

15 **§431 -G Filing requirements and state administration.**

16 (a) At the time a health carrier files its access plan, the
17 health carrier shall file with the commissioner sample contract
18 forms proposed for use with its participating providers and
19 intermediaries.

20 (b) A health carrier shall submit material changes to a
21 contract that would affect any provision required by this



1 article or by rules adopted by the commissioner pursuant to this
2 article to the commissioner at least thirty days prior to
3 initial use of the contract.

4 (c) The health carrier shall maintain provider and
5 intermediary contracts at its principal place of business in the
6 State or shall have access to all contracts and shall provide
7 copies of any contracts requested to facilitate regulatory
8 review to the commissioner upon twenty days prior written notice
9 by the commissioner.

10 **§431 -H Contracting.** (a) The execution of a contract
11 by a health carrier shall not relieve the carrier of its
12 liability to any person with whom it has contracted for the
13 provision of services or of its responsibility for compliance
14 with any applicable law, rule, or regulation.

15 (b) All contracts shall be in writing and subject to
16 review.

17 (c) All contracts shall comply with applicable
18 requirements of law, rules, and regulations.

19 **§431 -I Enforcement.** (a) If the commissioner
20 determines that:



- 1 (1) A health carrier has not contracted with a sufficient
2 number of participating providers to ensure that
3 covered persons have accessible health care services
4 in a geographic area;
- 5 (2) A health carrier's network access plan does not ensure
6 reasonable access to covered benefits;
- 7 (3) A health carrier has entered into a contract that does
8 not comply with this article; or
- 9 (4) A health carrier has not complied with this article,
10 the commissioner shall require a modification to the access
11 plan, institute a corrective action plan that shall be followed
12 by the health carrier, or use any of the commissioner's other
13 enforcement powers to obtain the health carrier's compliance
14 with this article.
- 15 (b) The commissioner shall not arbitrate, mediate, or
16 settle disputes regarding a decision not to include a provider
17 in a network plan or provider network or regarding any other
18 dispute between a health carrier, its intermediaries, or one or
19 more providers arising under a provider contract or its
20 termination.



1 §431 -J Regulations. The commissioner may adopt rules
2 pursuant to chapter 91 to carry out this article.

3 §431 -K Penalties. A violation of this article shall
4 result in penalties as provided in this chapter.

5 §431 -L Severability. If any provision of this article
6 or the application of any provision to a person or circumstance
7 shall be held invalid, the remainder of this article and the
8 application of the provision to a person or circumstance, other
9 than those to which it is held invalid, shall not be affected."

10 SECTION 2. Chapter 432F, Hawaii Revised Statutes, is
11 repealed.

12 SECTION 3. In codifying the new sections added by section
13 1 of this Act, the revisor of statutes shall substitute
14 appropriate section numbers for the letters used in designating
15 the new sections in this Act.

16 SECTION 4. This Act shall take effect on July 1, 2090 and
17 shall apply to plan filings made in 2018 for health benefit
18 plans with a plan year that commences on or after January 1,
19 2019; provided that:

20 (1) Section 2 shall be effective on December 31, 2091;



- 1 (2) All provider and intermediary contracts in effect on
2 June 30, 2090 shall comply with this Act no later than
3 eighteen months after the effective date of this Act;
4 provided that the insurance commissioner may extend
5 the period of compliance for an additional period not
6 to exceed six months if the health carrier
7 demonstrates good cause for an extension;
- 8 (3) A new provider or intermediary contract that is issued
9 or put in force on or after July 1, 2090 shall comply
10 with this as of that date; and
- 11 (4) A provider contract or intermediary contract that is
12 not described in paragraphs (1) or (2) shall comply
13 with this Act no later than December 31, 2091.



Report Title:

Health Insurance; Network Access and Adequacy

Description:

Requires a health carrier with a network plan to maintain a network that provides sufficient practitioners and services to meet the needs of the enrollees or members. (HB914 HD1)

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

