HOUSE OF REPRESENTATIVES
THIRTIETH LEGISLATURE, 2019
STATE OF HAWAII

H.B. NO. 1086

A BILL FOR AN ACT

RELATING TO OUT-OF-NETWORK HEALTH CARE CHARGES.

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

1 SECTION 1. The Hawaii Revised Statutes is amended by
2 adding a new chapter to be appropriately designated and to read
3 as follows:

4 **"CHAPTER**

5 **OUT-OF-NETWORK HEALTH CARE CHARGES**

6 **§ -1 Definitions.** As used in this chapter, unless the
7 context dictates otherwise:

8 "Carrier" means an entity that contracts or offers to
9 contract to provide, deliver, arrange for, pay for, or reimburse
10 any of the costs of, health care services under a health
11 benefits plan, including:

12 (1) An accident and health or sickness insurer;
13 (2) A mutual benefit society;
14 (3) A health maintenance organization;
15 (4) The Hawaii employer-union health benefits trust fund;
16 and
17 (5) Any other entity providing a health benefits plan.

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1 "Carrier" does not include any other entity providing or
2 administering a self-funded health benefits plan.
3 "Commissioner" means the insurance commissioner.
4 "Covered person" means a person on whose behalf a carrier
5 is obligated to pay health benefits or provide health care
6 services.
7 "Department" means the department of commerce and consumer
8 affairs.
9 "Emergency or urgent basis" means all emergency and urgent
10 care services.
11 "Health benefits plan" means a benefits plan that pays or
12 provides hospital and medical expense benefits for covered
13 services, and is delivered or issued for delivery in this State
14 by or through a carrier.
15 A "health benefits plan" does not include the following
16 plans, policies or contracts:
17 (1) Med-QUEST, medicare, or medicare advantage;
18 (2) Accident only, credit, disability, long-term care,
19 TRICARE supplement coverage, workers' compensation,
20 motor vehicle; and
21 (3) Dental and hospital confinement indemnity.

"Health care facility" means a hospital or any other facility that performs ambulatory surgery.

"Health care professional" means an individual, acting within the scope of the individual's licensure or certification, who provides a covered service defined by the health benefits plan.

"Health care provider" or "provider" means a health care professional or a health care facility.

"Inadvertent out-of-network services" means health care services that are:

(1) Covered under a managed care health benefits plan that provides a network; and

(2) Provided by an out-of-network health care provider if the covered person uses an in-network health care facility for covered health care services; and

(3) In-network health care services are unavailable in that in-network health care facility.

"Inadvertent out-of-network services" includes laboratory testing ordered by an in-network health care provider and performed by an out-of-network bio-analytical laboratory.

1 "Knowingly, voluntarily, and specifically selected an out-
2 of-network provider" means that a covered person:
3 (1) Had an opportunity to be serviced by an in-network
4 provider;
5 (2) Chose the services of an out-of-network provider
6 specific provider; and
7 (3) Knew that the provider was out-of-network with respect
8 to the covered person's health benefits plan; provided
9 that the mere disclosure by a provider of the
10 provider's out-of-network status does not by itself
11 constitute "knowingly".
12 "Medical necessity" or "medically necessary" means or
13 describes a health care service that a health care provider,
14 exercising the provider's prudent clinical judgment, would
15 provide to a covered person for the purpose of evaluating,
16 diagnosing, or treating an illness, injury, disease, or its
17 symptoms and that is:
18 (1) In accordance with the generally accepted standards of
19 medical practice;
20 (2) Clinically appropriate, in terms of type, frequency,
21 extent, site, and duration;

1 (3) Considered effective for the covered person's illness,
2 injury, or disease;
3 (4) Not primarily for the convenience of the covered
4 person or the health care provider; and
5 (5) Not more costly than an alternative service or
6 sequence of services at least as likely to produce
7 equivalent therapeutic or diagnostic results as to the
8 diagnosis or treatment of that covered person's
9 illness, injury, or disease.
10 "Self-funded health benefits plan" or "self-funded plan"
11 means a self-insured health benefits plan governed by the
12 federal Employee Retirement Income Security Act of 1974, 29
13 U.S.C. section 1001 et seq.
14 **§ -2 Disclosures by health care facility.** (a) Prior to
15 scheduling an appointment with a covered person for a non-
16 emergency or elective procedure, a health care facility shall:
17 (1) Disclose to the covered person whether the health care
18 facility is in-network or out-of-network with respect
19 to the covered person's health benefits plan;
20 (2) Advise the covered person to check with the physician
21 arranging the facility services to determine whether

1 or not that physician is in-network or out-of-network
2 with respect to the covered person's health benefits
3 plan and provide information about how to determine
4 the health plans participated in by any physician who
5 is reasonably anticipated to provide services to the
6 covered person;
7 (3) Advise the covered person that, at a health care
8 facility that is in-network, with respect to the
9 person's health benefits plan:
10 (A) The covered person will have a financial
11 responsibility applicable to an in-network
12 procedure and not in excess of the covered
13 person's copayment, deductible, or coinsurance as
14 provided in the covered person's health benefits
15 plan;
16 (B) Unless the covered person, at the time of the
17 disclosure required pursuant to this section, has
18 knowingly, voluntarily, and specifically selected
19 an out-of-network provider to provide services,
20 the covered person will not incur any out-of-

1 pocket costs in excess of the charges applicable
2 to an in-network procedure;
3 (C) Any bills, charges, or attempts to collect by the
4 facility, or any health care professional
5 involved in the procedure, in excess of the
6 covered person's copayment, deductible, or
7 coinsurance as provided in the covered person's
8 health benefits plan in violation of subparagraph
9 (B) should be reported to the covered person's
10 carrier and the commissioner; and
11 (D) That if the covered person's coverage is provided
12 through an entity providing or administering a
13 self-funded health benefits plan that does not
14 elect to be subject to section -8, that:
15 (i) Certain health care services may be provided
16 on an out-of-network basis, including those
17 services associated with the health care
18 facility;
19 (ii) The covered person may have a financial
20 responsibility applicable to health care
21 services provided by an out-of-network

1 provider that is in excess of the covered
2 person's copayment, deductible, or
3 coinsurance, and the covered person may be
4 responsible for any costs in excess of those
5 allowed by the person's self-funded health
6 benefits plan; and
7 (iii) The covered person should contact the
8 covered person's self-funded health benefits
9 plan sponsor for further consultation on
10 those costs; and
11 (4) Advise the covered person that at a health care
12 facility that is out-of-network with respect to the
13 covered person's health benefits plan:
14 (A) Certain health care services may be provided on
15 an out-of-network basis, including those health
16 care services associated with the health care
17 facility;
18 (B) The covered person may have a financial
19 responsibility applicable to health care services
20 provided at an out-of-network facility, in excess
21 of the covered person's copayment, deductible, or

1 coinsurance, and the covered person may be
2 responsible for any costs in excess of those
3 allowed by their health benefits plan; and
4 (C) That the covered person should contact the
5 covered person's carrier for further consultation
6 on those costs.
7 (b) A health care facility shall make available to the
8 public a list of the facility's standard charges for items and
9 services provided by the facility.
10 (c) A health care facility shall post on the facility's
11 website:
12 (1) The health benefits plans in which the facility is a
13 participating provider;
14 (2) A statement that:
15 (A) Physician services provided in the facility are
16 not included in the facility's charges;
17 (B) Physicians who provide services in the facility
18 may or may not participate with the same health
19 benefits plans as the facility;
20 (C) The covered person is advised to check with the
21 physician arranging for the facility services to

1 determine the health benefits plans in which the
2 physician participates; and
3 (D) The covered person is advised to contact their
4 carrier for further consultation on those costs;
5 (3) The name, mailing address, and telephone number of the
6 hospital-based physician groups that the facility has
7 contracted with to provide services including
8 anesthesiology, pathology, and radiology; and
9 (4) The name, mailing address, and telephone number of
10 physicians employed by the facility and whose services
11 may be provided at the facility, and the health
12 benefits plans in which they participate.
13 (d) If, between the time the notice required pursuant to
14 subsection (a) is provided to the covered person and the time
15 the procedure takes place, the network status of the facility
16 changes as it relates to the covered person's health benefits
17 plan, the facility shall notify the covered person within ten
18 days.
19 (e) The department of health shall establish in further
20 detail the content and design of the disclosure form and the
21 manner in which the form shall be provided.

1 § -4 **Disclosures by health care professional.** (a)
2 Except as provided in subsection (f), a health care professional
3 shall disclose to a covered person, in writing or through an
4 internet website, the health benefits plans in which the health
5 care professional is a participating provider and the facilities
6 with which the health care professional is affiliated prior to
7 providing non-emergency services, and verbally or in writing, at
8 the time of an appointment. If a health care professional does
9 not participate in the network of the covered person's health
10 benefits plan, the health care professional shall:
11 (1) Prior to scheduling a non-emergency procedure, inform
12 the covered person that the professional is out-of-
13 network and that the amount or estimated amount the
14 health care professional will bill the covered person
15 for the services is available upon request;
16 (2) Upon receipt of a request from a covered person for
17 the service and the current procedural terminology
18 codes associated with that service, disclose to the
19 covered person in writing the amount or estimated
20 amount that the health care professional will bill the
21 covered person for the service, and the current

1 procedural terminology codes associated with that
2 service; provided that disclosure under this paragraph
3 shall not apply to unforeseen medical circumstances
4 that may arise when the health care service is
5 provided;
6 (3) Inform the covered person that the covered person will
7 have a financial responsibility applicable to health
8 care services provided by an out-of-network
9 professional, in excess of the covered person's
10 copayment, deductible, or coinsurance, and the covered
11 person may be responsible for any costs in excess of
12 those allowed by their health benefits plan; and
13 (4) Advise the covered person to contact the covered
14 person's carrier for further consultation on those
15 costs.
16 (b) A health care professional who is a physician shall
17 provide the covered person, to the extent the information is
18 available, with the name, practice name, mailing address, and
19 telephone number of any health care provider scheduled to
20 perform anesthesiology, laboratory, pathology, radiology, or
21 assistant surgeon services in connection with care to be

provided in the physician's office for the covered person or coordinated or referred by the physician for the covered person at the time of referral to, or coordination of, services with that provider. The physician shall provide instructions as to how to determine the health benefits plans in which the health care provider participates and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

(c) A physician, for a covered person's scheduled facility admission or scheduled outpatient facility services, shall provide the covered person and the facility with the name, practice name, mailing address, and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission, testing, registration, or admission at the time the non-emergency services are scheduled, and information as to how to determine the health benefits plans in which the physician participates, and recommend that the covered person should contact the covered person's carrier for further consultation on costs associated with these services.

1 (d) The receipt or acknowledgement by any covered person
2 of any disclosure required pursuant to this section shall not
3 waive or otherwise affect any protection under existing statutes
4 or rules regarding in-network health benefits plan coverage
5 available to the covered person or created under this chapter.
6 (e) If, between the time the notice required pursuant to
7 subsection (a) is provided to the covered person and the time
8 the procedure takes place, the network status of the
9 professional changes as it relates to the covered person's
10 health benefits plan, the professional shall notify the covered
11 person within ten days.
12 (f) If a primary care physician or internist performs an
13 unscheduled procedure in that provider's office, the notice
14 required pursuant this section may be made verbally at the time
15 of the service.
16 (g) The appropriate board within the professional and
17 vocational licensing division of the department shall establish
18 in further detail the content and design of the disclosure form
19 and the manner in which the form shall be provided.
20 **§ -5 Website updates of addition or termination of**
21 **provider from carrier's network; disclosure to covered persons.**

1 (a) A carrier shall update the carrier's website within twenty
2 days of the addition or termination of a provider from the
3 carrier's network or a change in a physician's affiliation with
4 a facility; provided that for a change in a physician's
5 affiliation, the facility or the physician shall notify the
6 carrier of the change in the physician's affiliation within ten
7 days.
8 (b) With respect to out-of-network services, for each
9 health benefits plan offered, a carrier shall provide a covered
10 person with:
11 (1) A clear and understandable description of the plan's
12 out-of-network health care benefits, including the
13 methodology used by the carrier to determine the
14 allowed amount for out-of-network services;
15 (2) The allowed amount that the plan will reimburse under
16 that methodology and, in situations in which a covered
17 person requests allowed amounts associated with a
18 specific current procedural terminology code, the
19 portion of the allowed amount the plan will reimburse
20 and the portion of the allowed amount that the covered
21 person will pay, including an explanation that the

1 covered person will be required to pay the difference
2 between the allowed amount as defined by the carrier's
3 plan and the charges billed by an out-of-network
4 provider;
5 (3) Examples of anticipated out-of-pocket costs for
6 frequently billed out-of-network services;
7 (4) Information in writing and through an internet website
8 that reasonably permits a covered person or
9 prospective covered person to calculate the
10 anticipated out-of-pocket cost for out-of-network
11 services in a geographical region or zip code based
12 upon the difference between the amount the carrier
13 will reimburse for out-of-network services and the
14 usual and customary cost of out-of-network services;
15 (5) Information in response to a covered person's request,
16 concerning whether a health care provider is an in-
17 network provider;
18 (6) Any other information that the commissioner determines
19 appropriate and necessary to ensure that a covered
20 person receives sufficient information necessary to
21 estimate the person's out-of-pocket cost for an out-

1 of-network service and make a well-informed health
2 care decision; and
3 (7) Access to a telephone hotline that shall be operated
4 no less than sixteen hours per day for consumers to
5 call with questions about network status and out-of-
6 pocket costs.
7 (c) If a carrier authorizes a covered health care service
8 to be performed by an in-network health care provider with
9 respect to any health benefits plan, and the provider or
10 facility status changes to out-of-network before the authorized
11 service is performed, the carrier shall notify the covered
12 person as soon as practicable that the provider or facility is
13 no longer in-network. If the carrier fails to provide the
14 notice at least thirty days prior to the authorized service
15 being performed, the covered person's financial responsibility
16 shall be limited to the financial responsibility the covered
17 person would have incurred had the provider been in-network with
18 respect to the covered person's health benefits plan.
19 (d) A carrier shall incorporate into the explanation of
20 benefits and all reimbursement correspondence to the consumer
21 and the provider clear and concise notification that inadvertent

1 and involuntary out-of-network charges are not subject to
2 balance billing above and beyond the financial responsibility
3 incurred under the terms of the contract for in-network service.
4 The notification shall also specify that any attempt by the
5 provider to collect, bill, or invoice funds should be promptly
6 reported to the carrier's customer service department at the
7 phone number that the carrier shall provide on the explanation
8 of benefits and all reimbursement correspondence to the
9 consumer.

10 (e) A carrier, and any other entity providing or
11 administering a self-funded health benefits plan that elects to
12 be subject to section -8, shall issue a health insurance
13 identification card to the primary insured under a health
14 benefits plan. In a form and manner to be prescribed by the
15 commissioner, the card shall indicate whether the plan is
16 insured or, if the plan is a self-funded plan that elects to be
17 subject to section -8, whether the plan is self-funded and
18 whether the plan elected is to be subject to this chapter.

19 (f) A carrier shall include in the carrier's annual
20 filing, exhibit, or report under section 431:3-301, 432:1-404,
21 or 432D-5, as applicable, and in a manner to be determined by

1 the commissioner, the number of claims submitted by health care
2 providers to the carrier that are denied or down coded by the
3 carrier and the reason for the denial or down coding
4 determination.
5 **§ -6 Billing for emergency, urgent care; facility.** (a)
6 Subject to subsection (e), if a covered person receives
7 medically necessary services at any health care facility on an
8 emergency or urgent basis, the facility shall not bill the
9 covered person in excess of any deductible, copayment, or
10 coinsurance amount applicable to in-network services pursuant to
11 the covered person's health benefits plan.
12 (b) Subject to subsection (e), if a covered person
13 receives medically necessary services at an out-of-network
14 health care facility on an emergency or urgent basis, and the
15 carrier and facility cannot agree on the final offer as a
16 reimbursement rate for these services pursuant to section -8,
17 the carrier, health care facility, or covered person, as
18 applicable, may initiate binding arbitration pursuant to chapter
19 658A.
20 (c) If a health care facility is in-network with respect
21 to any health benefits plan, the facility shall ensure that all

1 providers providing services in the facility on an emergency or
2 inadvertent basis are provided notification of the requirements
3 of this chapter and information as to each health benefits plan
4 with which the facility has a contract to be in-network.

5 (d) A health care facility that contracts with a carrier
6 to be in-network with respect to any health benefits plan shall
7 annually report to the department of health the health benefits
8 plans with which the facility has an agreement to be in-network.

9 (e) Subsections (a) and (b) shall apply only to providers
10 providing services to members of entities providing or
11 administering a self-funded health benefits plan and its plan
12 members if the entity elects to be subject to section -8
13 pursuant to paragraph (5) of section -8.

14 (f) The department of health shall make the information
15 collected pursuant to subsection (d) available to the department
16 of commerce and consumer affairs.

17 **§ -7 Coverage for inadvertent out-of-network emergency**
18 **services; professional.** (a) If a covered person receives
19 inadvertent out-of-network services or medically necessary
20 services at an in-network or out-of-network health care facility
21 on an emergency or urgent basis, the health care professional

performing those services shall not bill the covered person in
excess of any deductible, copayment, or coinsurance amount:

(1) If the out-of-network services are inadvertent; and

(2) Applicable to in-network services pursuant to the covered person's health benefits plan, if services are provided on an emergency or urgent basis.

(b) If the carrier and the professional cannot agree on a reimbursement rate for the services provided pursuant to subsection (a), then the carrier, professional, or covered person, as applicable, may initiate binding arbitration pursuant to chapter 658A.

(c) This section shall not apply to providers providing services to members of entities providing or administering a self-funded health benefits plan and its plan members unless the entity elects to be subject to section -8.

§ -8 Responsibilities of carrier relative to inadvertent out-of-network services. Notwithstanding any law to the contrary:

(1) With respect to a carrier, if a covered person receives inadvertent out-of-network services, or services at an in-network or out-of-network health

1 care facility on an emergency or urgent basis, the
2 carrier shall ensure that the covered person incurs no
3 greater out-of-pocket costs than the covered person
4 would have incurred with an in-network health care
5 provider for covered services. Pursuant to
6 sections -6 and -7, the out-of-network provider
7 shall not bill the covered person, except for
8 applicable deductible, copayment, or coinsurance
9 amounts that would apply if the covered person used an
10 in-network health care provider for the covered
11 services. If services are provided to a member of a
12 self-funded plan that does not elect to be subject to
13 this section, the provider may bill the covered person
14 in excess of the applicable deductible, copayment, or
15 coinsurance amounts;
16 (2) With respect to inadvertent out-of-network services,
17 or services at an in-network or out-of-network health
18 care facility on an emergency or urgent basis,
19 benefits provided by a carrier that the covered person
20 receives for health care services shall be assigned to
21 the out-of-network health care provider, which shall

1 require no action on the part of the covered person.
2 Once the benefit is assigned as provided in this
3 paragraph:
4 (A) Any reimbursement paid by the carrier shall be
5 paid directly to the out-of-network provider; and
6 (B) The carrier shall provide the out-of-network
7 provider with a written remittance of payment
8 that specifies the proposed reimbursement and the
9 applicable deductible, copayment, or coinsurance
10 amounts owed by the covered person;
11 (3) An entity providing or administering a self-funded
12 health benefits plan that elects to participate in
13 this section shall comply with paragraph (2);
14 (4) If inadvertent out-of-network services or services
15 provided at an in-network or out-of-network health
16 care facility on an emergency or urgent basis are
17 performed in accordance with paragraph (1), the out-
18 of-network provider may bill the carrier for the
19 services rendered. The carrier may pay the billed
20 amount or the carrier shall determine within twenty
21 days from the date of the receipt of the claim for the

1 services whether the carrier considers the claim to be
2 excessive, and if so, the carrier shall notify the
3 provider of this determination within twenty days of
4 the receipt of the claim. If the carrier provides
5 this notification, the carrier and the provider shall
6 have thirty days from the date of this notification to
7 negotiate a settlement. The carrier may attempt to
8 negotiate a final reimbursement amount with the out-
9 of-network health care provider that differs from the
10 amount paid by the carrier pursuant to this paragraph.
11 If there is no settlement reached after the thirty
12 days, the carrier shall pay the provider their final
13 offer for the services. If the carrier and provider
14 cannot agree on the final offer as a reimbursement
15 rate for these services, the carrier, provider, or
16 covered person, as applicable, may initiate binding
17 arbitration within thirty days of the final offer,
18 pursuant to chapter 658A;
19 (5) With respect to an entity providing or administering a
20 self-funded health benefits plan and its plan members,
21 this section shall only apply if the plan elects to be

1 subject to this section. To elect to be subject to
2 this section, the self-funded plan shall provide
3 notice, on an annual basis, to the department, on a
4 form and in a manner prescribed by the department,
5 attesting to the plan's participation and agreeing to
6 be bound by this section. The self-funded plan shall
7 amend the employee benefit plan, coverage policies,
8 contracts, and any other plan documents to reflect
9 that the benefits of this section shall apply to the
10 plan's members.
11 § -9 **Payment disputes, binding arbitration.** If attempts
12 to negotiate reimbursement for services provided by an out-of-
13 network health care provider, pursuant to section -8, do not
14 result in a resolution of the payment dispute, the carrier, out-
15 of-network health care provider, or plan member, as applicable,
16 may initiate binding arbitration to determine payment for the
17 services pursuant to chapter 658A.
18 § -10 **Notice of protections provided.** (a) A carrier
19 shall provide a written notice, in a form and manner to be
20 prescribed by the commissioner, to each covered person of the
21 protections provided to covered persons pursuant to this

chapter. The notice shall include information on how a consumer can contact the department or the appropriate regulatory agency to report and dispute an out-of-network charge. The notice required pursuant to this section shall be posted on the carrier's website.

(b) The commissioner shall provide a notice on the website of the department's insurance division containing information for consumers relating to the protections provided by this chapter, information on how consumers can report and file complaints with the insurance division relating to any out-of-network charges, and information and guidance for consumers regarding arbitrations filed pursuant to section -9.

§ -11 Inducements. It shall be a violation of this chapter if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. A pattern of waiving, rebating,

giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be deemed an inducement.

§ -12 Violations; penalties. (a) A person or entity who violates this chapter, or the rules adopted thereunder, shall be liable to a penalty as provided in this section.

(b) A health care facility or carrier that violates this chapter shall be fined not more than $1,000 for each violation. Every day that the violation continues shall be considered a separate violation, but no facility or carrier shall be fined more than $25,000 for each occurrence.

(c) A person or entity not covered by subsection (b) that violates this chapter shall be fined not more than $100 for each violation. Each day that a violation continues shall be considered a separate violation, but no person or entity shall be fined more than $2,500 for each occurrence.

§ -13 Rules. The commissioner may adopt rules, pursuant to chapter 91, to effectuate the purposes of this chapter."

SECTION 2. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

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1 SECTION 3. This Act shall take effect on January 1, 2020.

2

INTRODUCED BY: ______________________

JAN 23 2019

H.B. NO. 1086

Report Title:
Health Care Charges; Out-of-Network Providers; Disclosures

Description:
Requires health care facilities and health care professionals to disclose to patients whether they are in-network or out-of-network providers with respect to the patients' health benefits plans and the financial implications to the patients of that status. Protects patients from charges in excess of any deductibles, copayment, or coinsurance when treated for medically necessary services on an emergency or urgent basis by any health care professional and at any health care facility.

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