
A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

1 SECTION 1. The legislature finds that the patients with
2 health insurance who receive treatment from an out-of-network
3 provider may be subject to the practice known as "balance
4 billing" or "surprise billing", where the provider bills the
5 patient for the difference between what the patient's health
6 insurance chooses to reimburse and what the provider chooses to
7 charge. These bills occur most often when patients
8 inadvertently receive medical services from out-of-network
9 providers, such as when a patient is undergoing surgery and is
10 not informed that a member of the medical team is not a
11 participating provider in the patient's health care plan, or
12 when a patient is in need of emergency services and is taken to
13 the nearest medical facility, regardless of the facility's or
14 its providers' network status. Out-of-network providers may not
15 have a contracted rate with a health insurer for services;
16 therefore, the prices these providers may charge may be much



1 greater than the price charged by in-network providers for
2 similar services.

3 The legislature further finds that balance bills or
4 surprise bills can be an unwelcome shock to patients who may
5 have unknowingly received health care services outside of their
6 provider network. These unexpected medical bills are a major
7 concern for Americans. According to a September 2018 Kaiser
8 Family Foundation poll, two-thirds of respondents said they
9 were "very worried" or "somewhat worried" that they or a
10 family member would receive a surprise bill. In fact, these
11 bills are the most-cited concern related to health care costs
12 and other household expenses. Furthermore, out-of-network
13 bills sent to health insurers or carriers from physicians can
14 be more than thirty times the average in-network rate for
15 those same services.

16 Currently, there is no comprehensive protection from
17 surprise bills or balance bills at the federal level and, while
18 there is a growing trend toward state action to protect patients
19 from surprise bills or balance bills, most state laws do not
20 provide comprehensive protections. However, the trend is
21 changing. At least nine states including California, Oregon,



1 Maryland, Connecticut, Illinois, New York, New Hampshire, New
2 Jersey, and Florida have enacted comprehensive approaches to end
3 balance billing and surprise bills. Similarly, New Mexico,
4 Texas, Washington, and Colorado passed new comprehensive laws in
5 2019. Hawaii patients continue to be at risk of being caught in
6 the middle of balance billing disputes between health insurers
7 and providers or being hit with significant surprise bills.

8 The purpose of this Act is to specify:

- 9 (1) Disclosure and consent requirements for health care
10 providers, health care facilities, and hospitals that
11 are nonparticipating providers in a patient's health
12 care plan;
- 13 (2) The circumstances in which a patient shall not be
14 liable to a health care provider for any sums owed by
15 an insurer, mutual benefit society, or health
16 maintenance organization; and
- 17 (3) That insurers, mutual benefit societies, and health
18 maintenance organizations shall enter into independent
19 dispute resolutions with nonparticipating providers to
20 resolve their outstanding obligations.



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

4 "§321- Disclosure and consent required. (a) A health
5 care plan shall disclose the following information in writing to
6 an insured prior to the provision of non-emergency services that
7 are not authorized by the patients' health care plan:

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

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

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

18 (4) A notification that the covered person may either
19 agree to accept and pay the charges for the out-of-
20 network services or rely on any other rights and



1 remedies that may be available under state or federal
2 law; and

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

9 (b) If a health care provider, health care facility, or
10 hospital is not a participating provider in a patient's or
11 prospective patient's health care plan network, and the patient
12 is receiving non-emergency health care services, the health care
13 plan shall:

14 (1) At least twenty-four hours prior to the provision of
15 non-emergency services, disclose to the patient or
16 prospective patient in writing and in compliance with
17 subsection (c), the amount or estimated amount that
18 the health care provider, health care facility, or
19 hospital will bill the patient or prospective patient
20 for non-emergency health care services provided or
21 anticipated to be provided to the patient or



1 prospective patient, not including unforeseen medical
2 circumstances that may arise when the health care
3 services are provided; and

4 (2) At least twenty-four hours prior to the provision of
5 non-emergency services, obtain the written consent of
6 the patient or prospective patient for provision of
7 services by the nonparticipating health care provider,
8 health care facility, or hospital in writing separate
9 from the document used to obtain the consent for any
10 other part of the care or procedure; provided that the
11 consent shall not be obtained at the time of admission
12 or at any time when the patient or prospective patient
13 is being prepared for surgery or any other procedure.

14 (c) Any communication from the health care plan to the
15 insured shall include notice in a twelve-point bold type stating
16 that the communication is not a bill and informing the insured
17 that the insured shall not pay any amount or estimated amount
18 until the insured's health care plan informs the insured of any
19 applicable cost-sharing.

20 (d) A health care plan that fails to comply with this
21 section shall not bill or collect any amount from the insured in



1 excess of the in-network cost-sharing owed by the insured that
2 would be billed or collected for the same services rendered by a
3 participating health care provider, health care facility, or
4 hospital.

5 (e) For purposes of this section:

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

12 "Health care plan" means a policy, contract, plan, or
13 agreement delivered or issued for delivery by a health insurance
14 company, mutual benefit society governed by article 1 of chapter
15 432, health maintenance organization governed by chapter 432D,
16 or any other entity delivering or issuing for delivery in the
17 State accident and health or sickness insurance as defined in
18 section 431:1-205, other than disability insurance that replaces
19 lost income.



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

4 "Hospital" means:

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

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

10 "In-network cost-sharing" means the amount owed by a
11 covered person to a health care provider, health care facility,
12 or hospital that is a participating member of the covered
13 person's health care plan's network."

14 SECTION 3. Chapter 431, Hawaii Revised Statutes, is
15 amended by adding two new sections to article 10A be
16 appropriately designated and to read as follows:

17 "§431:10A-A Balance billing; hold harmless; emergency
18 services. (a) Every contract between an insurer and a
19 participating provider of health care services shall be in
20 writing and shall set forth that in the event the insurer fails
21 to pay for health care services as set forth in the contract,



1 the insured shall not be liable to the provider for any sums
2 owed by the insurer.

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

9 (c) When the insured received emergency services from a
10 provider who is not a participating provider in the provider
11 network of the insured, an insurer shall be responsible to
12 fulfill their obligation to the insured and shall enter into
13 negotiation with the provider who is not a participating
14 provider in the provider network of the insured to resolve any
15 sums owed by the insurer.

16 (d) For purposes of this section:

17 "Emergency condition" means a medical or behavioral
18 condition that manifests itself by acute symptoms of sufficient
19 severity, including severe pain, such that a prudent layperson,
20 possessing an average knowledge of medicine and health, could



1 reasonably expect the absence of immediate medical attention to
2 result in:

- 3 (1) Placing the health of the person afflicted with the
4 condition in serious jeopardy;
5 (2) Serious impairment to the person's bodily functions;
6 (3) Serious dysfunction of any bodily organ or part of the
7 person; or
8 (4) Serious disfigurement of the person.

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

- 11 (1) A medical screening examination as required under
12 section 1867 of the Social Security Act, title 42
13 United States Code section 1395dd; and
14 (2) Any further medical examination and treatment, as
15 required under section 1867 of the Social Security
16 Act, title 42 United States Code section 1395dd, to
17 stabilize the patient.

18 §431:10A-B Balance billing; hold harmless; non-emergency
19 services. (a) No nonparticipating health care provider, health
20 care facility, or hospital, or agent, trustee, or assignee
21 thereof, may maintain any action at law against an insured to



1 collect sums in excess of the amount owed by the insured as a
2 copayment, coinsurance, or deductible for similar services
3 provided by a participating provider under the insured's policy
4 of accident and health or sickness insurance.

5 (b) When the insured receives non-emergency services from
6 a provider who is not a participating provider in the provider
7 network of the insured, an insurer shall be responsible to
8 fulfill their obligation to the insured and shall enter into
9 negotiation with the provider who is not a participating
10 provider in the provider network of the insured to resolve any
11 sums owed by the insurer."

12 SECTION 4. Chapter 431, Hawaii Revised Statutes, is
13 amended by adding a new section to article 14G to be
14 appropriately designated and to read as follows:

15 "§431:14G- Out-of-network or nonparticipating provider
16 reimbursement; dispute resolution. (a) A managed care plan
17 shall be responsible to fulfill their obligation to the insured
18 and enter into negotiation with the nonparticipating provider.
19 The managed care plan and nonparticipating provider shall come
20 to an agreement through an independent dispute resolution
21 process, as established by the commissioner. If no resolution



1 is met, the managed care plan shall pay the nonparticipating
2 provider the amount billed by the nonparticipating provider.
3 The commissioner shall adopt rules pursuant to chapter 91 to
4 establish an independent dispute resolution process.

5 (b) Nothing in this section shall be construed to require
6 a managed care plan to cover services not required by law or by
7 the terms and conditions of the managed care plan. Nothing in
8 this section shall be construed to prohibit nonparticipating
9 providers from seeking the uncovered cost of services rendered
10 from enrollees who have consented to receive the health care
11 services provided by the nonparticipating provider in accordance
12 with section 321- ."

13 SECTION 5. Chapter 432, Hawaii Revised Statutes, is
14 amended by adding three new sections to article 1 to be
15 appropriately designated and to read as follows:

16 "§432:1- **Balance billing; hold harmless; emergency**
17 **services.** (a) Every contract between a mutual benefit society
18 and a participating provider of health care services shall be in
19 writing and shall set forth that in the event the mutual benefit
20 society fails to pay for health care services as set forth in



1 the contract, the subscriber or member shall not be liable to
2 the provider for any sums owed by the mutual benefit society.

3 (b) When a subscriber or member receives emergency
4 services from a provider who is not a participating provider in
5 the provider network of the subscriber or member, the subscriber
6 or member shall not incur greater out-of-pocket costs for
7 emergency services than the subscriber or member would have
8 incurred with a participating provider of health care services.

9 (c) When a subscriber or member receives emergency
10 services from a provider who is not a participating provider in
11 the provider network of the subscriber or member, the mutual
12 benefit society shall be responsible to fulfill their obligation
13 to the subscriber or member and shall enter into negotiation
14 with the provider who is not a participating provider in the
15 provider network of the subscriber or member, to resolve any
16 sums owed by the mutual benefit society.

17 (d) For purposes of this section:

18 "Emergency condition" means a medical or behavioral
19 condition that manifests itself by acute symptoms of sufficient
20 severity, including severe pain, such that a prudent layperson,
21 possessing an average knowledge of medicine and health, could



1 reasonably expect the absence of immediate medical attention to
2 result in:

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

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

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

8 (4) Serious disfigurement of the person.

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

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

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

18 §432:1- Balance billing; hold harmless; non-emergency

19 services. (a) No nonparticipating health care provider, health
20 care facility, or hospital, or agent, trustee, or assignee

21 thereof, may maintain any action at law against a subscriber or



1 member to collect sums in excess of the amount owed by the
2 subscriber or member as a copayment, coinsurance, or deductible
3 for similar services provided by a participating provider under
4 the subscriber's or member's plan contract.

5 (b) When a subscriber or member receives non-emergency
6 services from a provider who is not a participating provider in
7 the provider network of the subscriber or member, the mutual
8 benefit society shall be responsible to fulfill their obligation
9 to the subscriber or member and shall enter into negotiation
10 with the provider who is not a participating provider in the
11 provider network of the subscriber or member, to resolve any
12 sums owed by the mutual benefit society.

13 §432:1- Out-of-network or nonparticipating provider
14 reimbursement; dispute resolution. (a) A mutual benefit
15 society shall be responsible to fulfill their obligation to the
16 subscriber or member and enter into negotiation with the
17 nonparticipating provider. The mutual benefit society and
18 nonparticipating provider shall come to an agreement through an
19 independent dispute resolution process, as established by the
20 commissioner. If no resolution is met, the mutual benefit
21 society shall pay the nonparticipating provider the amount



1 billed by the nonparticipating provider. The commissioner shall
2 adopt rules pursuant to chapter 91 to establish an independent
3 dispute resolution process.

4 (b) Nothing in this section shall be construed to require
5 a mutual benefit society to cover services not required by law
6 or by the terms and conditions of the plan contract. Nothing in
7 this section shall be construed to prohibit nonparticipating
8 providers from seeking the uncovered cost of services rendered
9 from subscribers or members who have consented to receive the
10 health care services provided by the nonparticipating provider
11 in accordance with section 321- ."

12 SECTION 6. Chapter 432D, Hawaii Revised Statutes, is
13 amended by adding three new sections to be appropriately
14 designated and to read as follows:

15 "§432D- **Balance billing; hold harmless; emergency**
16 **services.** (a) Every contract between a health maintenance
17 organization and a participating provider of health care
18 services shall be in writing and shall set forth that in the
19 event the health maintenance organization fails to pay for
20 health care services as set forth in the contract, the



1 subscriber or enrollee shall not be liable to the provider for
2 any sums owed by the carrier or health maintenance organization.

3 (b) When a subscriber or enrollee receives emergency
4 services from a provider who is not a participating provider in
5 the provider network of the subscriber or enrollee, the
6 subscriber or enrollee shall not incur greater out-of-pocket
7 costs for emergency services than the subscriber or enrollee
8 would have incurred with a participating provider of health care
9 services.

10 (c) When a subscriber or enrollee receives emergency
11 services from a provider who is not a participating provider in
12 the provider network of the subscriber or enrollee, the carrier
13 or health maintenance organization shall be responsible to
14 fulfill their obligation to the subscriber or enrollee and shall
15 enter into negotiation with the provider who is not a
16 participating provider in the provider network of the subscriber
17 or enrollee, to resolve any sums owed by the carrier or health
18 maintenance organization.

19 (d) For purposes of this section:

20 "Emergency condition" means a medical or behavioral
21 condition that manifests itself by acute symptoms of sufficient



1 severity, including severe pain, such that a prudent layperson,
2 possessing an average knowledge of medicine and health, could
3 reasonably expect the absence of immediate medical attention to
4 result in:

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

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

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

10 (4) Serious disfigurement of the person.

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

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

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

20 §432D- Balance billing; hold harmless; non-emergency

21 services. No nonparticipating health care provider, health care



1 facility, or hospital, or agent, trustee, or assignee thereof,
2 may maintain any action at law against a subscriber or enrollee
3 to collect sums in excess of the amount owed by the subscriber
4 or enrollee as a copayment, coinsurance, or deductible for
5 similar services provided by a participating provider under the
6 subscriber's or enrollee's policy, contract, plan, or agreement.

7 §432D- Out-of-network or nonparticipating provider
8 reimbursement; dispute resolution. (a) A health maintenance
9 organization shall be responsible to fulfill their obligation to
10 the subscriber or enrollee and enter into negotiation with the
11 nonparticipating provider. The health maintenance organization
12 and nonparticipating provider shall come to an agreement through
13 an independent dispute resolution process, as established by the
14 commissioner. If no resolution is met, the health maintenance
15 organization shall pay the nonparticipating provider the amount
16 billed by the nonparticipating provider. The commissioner shall
17 adopt rules pursuant to chapter 91 to establish an independent
18 dispute resolution process.

19 (b) Nothing in this section shall be construed to require
20 a health maintenance organization to cover services not required
21 by law or by the terms and conditions of the policy, contract,



1 plan, or agreement. Nothing in this section shall be construed
2 to prohibit nonparticipating providers from seeking the
3 uncovered cost of services rendered from subscribers or
4 enrollees who have consented to receive the health care services
5 provided by the nonparticipating provider in accordance with
6 section 321- ____."

7 SECTION 7. Chapter 432E, Hawaii Revised Statutes, is
8 amended by adding a new section to be appropriately designated
9 and to read as follows:

10 "§432E- ____ Dispute resolution. (a) When the
11 nonparticipating health care provider and the managed care plan
12 are unable to reach an agreement as to the amount to be billed
13 for the services provided by the nonparticipating provider, the
14 matter shall be submitted to the commissioner for binding
15 arbitration or mediation.

16 (b) The nonparticipating provider and managed care plan
17 shall agree on whether the matter shall be subject to binding
18 arbitration or mediation within forty-five days of notification
19 by the managed care plan to the nonparticipating provider that
20 the managed care plan disagrees with the amount billed for the
21 services rendered to the enrollee. The commissioner shall issue



1 a decision on a submitted case within forty-five days of the
2 commencement of the binding arbitration or mediation process.

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

5 (d) This section shall apply to emergency and non-emergency
6 services provided by a nonparticipating provider."

7 SECTION 8. Section 431:10-109, Hawaii Revised Statutes, is
8 amended to read as follows:

9 " ~~[+] §431:10-109 [+~~ **Disclosure of ~~[health care coverage and~~**
10 **~~benefits.]~~ information. (a) In order to ensure that all
11 individuals understand their health care options and are able to
12 make informed decisions, all insurers shall provide current and
13 prospective insureds with written disclosure of ~~[coverages and~~
14 ~~benefits, including information on coverage principles and any~~
15 ~~exclusions or restrictions on coverage.]~~ the following
16 information:**

17 (1) Coverages and benefits, including information on
18 coverage principles and any exclusions or restrictions
19 on coverage;

20 (2) With regard to out-of-network coverage:



- 1 (A) For non-emergency services where the insured has
2 consented to services provided by an out-of-
3 network provider in accordance with section
4 321- , the amount that the insurer will
5 reimburse under the rate calculation for out-of-
6 network health care specified in section
7 431:14G- ; and
- 8 (B) Examples of anticipated out-of-pocket costs for
9 frequently billed out-of-network health care
10 services; and
- 11 (3) Information in writing and through an internet website
12 that reasonably permits an insured or prospective
13 insured to estimate the anticipated out-of-pocket cost
14 for out-of-network health care services in a
15 geographical area based upon the difference between
16 what the insurer will reimburse for out-of-network
17 health care services and the rate calculation
18 specified in section 431:14G- for out-of-network
19 health care services.
- 20 (b) The information provided shall be current,
21 understandable, and available prior to the issuance of a policy,



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

5 (c) For purposes of this section:

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

- 12 (1) Placing the health of the person afflicted with the
13 condition in serious jeopardy;
14 (2) Serious impairment to the person's bodily functions;
15 (3) Serious dysfunction of any bodily organ or part of
16 such person; or
17 (4) Serious disfigurement of the person.

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



- 1 (1) A medical screening examination as required under
2 section 1867 of the Social Security Act, title 42
3 United States Code section 1395dd; and
4 (2) Any further medical examination and treatment, as
5 required under section 1867 of the Social Security
6 Act, title 42 United States Code section 1395dd, to
7 stabilize the patient."

8 SECTION 9. In codifying the new sections added by section
9 3 of this Act, the revisor of statutes shall substitute
10 appropriate section numbers for the letters used in designating
11 the new sections in this Act.

12 SECTION 10. Statutory material to be repealed is bracketed
13 and stricken. New statutory material is underscored.

14 SECTION 11. This Act shall take effect on July 1, 2050.



Report Title:

Balance Billing; Surprise Billing; Prohibitions; Health Insurance; Nonparticipating Providers; Dispute Resolution

Description:

Establishes disclosure and consent requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Requires the use of dispute resolution when a dispute exists as to the reimbursement of a nonparticipating provider. Effective 7/1/2050. (HD1)

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

