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# 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 for emergency  
21 services.



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 provider, health care facility, or hospital shall disclose  
6 the following information in writing to patients or prospective  
7 patients prior to the provision of non-emergency services that  
8 are not authorized by the patients' health care plan:

- 9 (1) That certain health care facility-based health care  
10 providers may be called upon to render care to a  
11 covered person during the course of treatment;
- 12 (2) That those health care facility-based health care  
13 providers may not have contracts with the covered  
14 person's health care plan and are therefore considered  
15 to be out-of-network providers;
- 16 (3) That the services provided will be on an out-of-  
17 network basis and the cost may be substantially higher  
18 than if the services were provided in-network;
- 19 (4) A notification that the covered person may either  
20 agree to accept and pay the charges for the out-of-  
21 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 provider, health care facility, or hospital 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 nonparticipating health  
15 care provider, health care facility, or hospital to the patient  
16 or prospective patient shall include notice in a twelve-point  
17 bold type stating that the communication is not a bill and  
18 informing the patient or prospective patient that the patient or  
19 prospective patient shall not pay any amount or estimated amount  
20 until the patient's or prospective patient's health care plan



1 informs the patient or prospective patient of any applicable  
2 cost-sharing.

3 (d) A nonparticipating health care provider, health care  
4 facility, or hospital that fails to comply with this section  
5 shall not bill or collect any amount from the patient or  
6 prospective patient in excess of the in-network cost-sharing  
7 owed by the patient or prospective patient that would be billed  
8 or collected for the same services rendered by a participating  
9 health care provider, health care facility, or hospital.

10 (e) For purposes of this section:

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

17 "Health care plan" means a policy, contract, plan, or  
18 agreement delivered or issued for delivery by a health insurance  
19 company governed by article 10A of chapter 431, mutual benefit  
20 society governed by article 1 of chapter 432, health maintenance  
21 organization governed by chapter 432D, or any other entity



1 delivering or issuing for delivery in the State accident and  
2 health or sickness insurance as defined in section 431:1-205,  
3 other than disability insurance that replaces lost income.

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

7 "Hospital" means:

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

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

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

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

20 "§431:10A-A Balance billing; hold harmless; emergency  
21 services. (a) Every contract between an insurer and a





1 participating provider of health care services shall be in  
2 writing and shall set forth that in the event the insurer fails  
3 to pay for health care services as set forth in the contract,  
4 the insured shall not be liable to the provider for any sums  
5 owed by the insurer.

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

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

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" shall have the same meaning as that  
12 term is defined in section 432E-1.

13 **§431:10A-B Balance billing; hold harmless; non-emergency**  
14 **services.** (a) No nonparticipating health care provider, health  
15 care facility, or hospital, or agent, trustee, or assignee  
16 thereof, may maintain any claim against an insured to collect  
17 sums in excess of the amount owed by the insured as a copayment,  
18 coinsurance, or deductible for similar services provided by a  
19 participating provider under the insured's policy of accident  
20 and health or sickness insurance.



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

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

11       "§431:14G-       Out-of-network or nonparticipating provider  
12 reimbursement; dispute resolution. (a) A managed care plan  
13 shall be responsible to fulfill its obligation to the enrollee  
14 and enter into negotiation with the nonparticipating provider.  
15 The managed care plan and nonparticipating provider shall come  
16 to an agreement through an independent dispute resolution  
17 process, as established by the commissioner. If no resolution  
18 is met, the managed care plan shall pay the nonparticipating  
19 provider the amount billed by the nonparticipating provider.  
20 The commissioner shall adopt rules pursuant to chapter 91 to  
21 establish an independent dispute resolution process.



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

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

12        "§432:1-        **Balance billing; hold harmless; emergency**  
13 services. (a) Every contract between a mutual benefit society  
14 and a participating provider of health care services shall be in  
15 writing and shall set forth that in the event the mutual benefit  
16 society fails to pay for health care services as set forth in  
17 the contract, the subscriber or member shall not be liable to  
18 the provider for any sums owed by the mutual benefit society.

19        (b) When a subscriber or member receives emergency  
20 services from a provider who is not a participating provider in  
21 the provider network of the subscriber or member, the subscriber



1 or member shall not incur greater out-of-pocket costs for  
2 emergency services than the subscriber or member would have  
3 incurred with a participating provider of health care services.

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

12 (d) For purposes of this section:

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

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

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



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

3       (4) Serious disfigurement of the person.

4       "Emergency services" shall have the same meaning as that  
5 term is defined in 432E-1.

6       §432:1- Balance billing; hold harmless; non-emergency  
7 services. (a) No nonparticipating health care provider, health  
8 care facility, or hospital, or agent, trustee, or assignee  
9 thereof, may maintain any claim against a subscriber or member  
10 to collect sums in excess of the amount owed by the subscriber  
11 or member as a copayment, coinsurance, or deductible for similar  
12 services provided by a participating provider under the  
13 subscriber's or member's plan contract.

14       (b) When a subscriber or member receives non-emergency  
15 services from a provider who is not a participating provider in  
16 the provider network of the subscriber or member, the mutual  
17 benefit society shall be responsible to fulfill its obligation  
18 to the subscriber or member and shall enter into negotiation  
19 with the provider who is not a participating provider in the  
20 provider network of the subscriber or member, to resolve any  
21 sums owed by the mutual benefit society.



1        §432:1-        Out-of-network or nonparticipating provider  
2 reimbursement; dispute resolution. (a) A health care plan  
3 shall be responsible for fulfilling its obligation to the  
4 subscriber or member and shall enter into negotiation with the  
5 nonparticipating provider. If no resolution is met within  
6 thirty days, the mutual benefit society shall pay the  
7 nonparticipating provider the amount billed by the  
8 nonparticipating provider.

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

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

16        "§432D-        Balance billing; hold harmless; emergency  
17 services. (a) Every contract between a health maintenance  
18 organization and a participating provider of health care  
19 services shall be in writing and shall set forth that in the  
20 event the health maintenance organization fails to pay for  
21 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 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 health  
13 maintenance organization shall be responsible to fulfill their  
14 obligation to the subscriber or enrollee and shall enter into  
15 negotiation with the provider who is not a participating  
16 provider in the provider network of the subscriber or enrollee,  
17 to resolve any sums owed by the health maintenance organization.

18 (d) For purposes of this section:

19 "Emergency condition" means a medical or behavioral  
20 condition that manifests itself by acute symptoms of sufficient  
21 severity, including severe pain, such that a prudent layperson,





1 possessing an average knowledge of medicine and health, could  
2 reasonably expect the absence of immediate medical attention to  
3 result in:

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

10 "Emergency services" shall have the same meaning as that  
11 term is defined in section 432E-1.

12 §432D- Balance billing; hold harmless; non-emergency  
13 services. No nonparticipating health care provider, health care  
14 facility, or hospital, or agent, trustee, or assignee thereof,  
15 may maintain any claim against a subscriber or enrollee to  
16 collect sums in excess of the amount owed by the subscriber or  
17 enrollee as a copayment, coinsurance, or deductible for similar  
18 services provided by a participating provider under the  
19 subscriber's or enrollee's policy, contract, plan, or agreement.

20 §432D- Out-of-network or nonparticipating provider  
21 reimbursement; dispute resolution. (a) A health maintenance



1 organization shall be responsible to fulfill its obligation to  
2 the subscriber or enrollee and enter into negotiation with the  
3 nonparticipating provider. The health maintenance organization  
4 and nonparticipating provider shall come to an agreement through  
5 an independent dispute resolution process, as established by the  
6 commissioner. If no resolution is met, the health maintenance  
7 organization shall pay the nonparticipating provider the amount  
8 billed by the nonparticipating provider. The commissioner shall  
9 adopt rules pursuant to chapter 91 to establish an independent  
10 dispute resolution process.

11 (b) Nothing in this section shall be construed to require  
12 a health maintenance organization to cover services not required  
13 by law or by the terms and conditions of the policy, contract,  
14 plan, or agreement. Nothing in this section shall be construed  
15 to prohibit nonparticipating providers from seeking the  
16 uncovered cost of services rendered from subscribers or  
17 enrollees who have consented to receive the health care services  
18 provided by the nonparticipating provider in accordance with  
19 section 321- ."



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

4 "§432E- Dispute resolution. (a) When the  
5 nonparticipating health care provider and the managed care plan  
6 are unable to reach an agreement as to the amount to be paid for  
7 the services provided by the nonparticipating provider of  
8 emergency services, the matter shall be submitted to the  
9 commissioner for binding arbitration or mediation.

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

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

18 (1) Whether there is a gross disparity between the fee  
19 charged by the health care provider or hospital for  
20 services rendered as compared to:



- 1           (A) The fees paid to the involved health care  
2           provider or hospital for the same services  
3           rendered by the health care provider or hospital  
4           to other patients in managed care plans in which  
5           the health care provider or hospital is not  
6           participating; and
- 7           (B) In the case of a dispute involving a managed care  
8           plan, fees paid by the managed care plan to  
9           reimburse similarly qualified health care  
10           providers or hospitals for the same services in  
11           the same region who are not participating with  
12           the managed care plan;
- 13           (2) The level of training, education, and experience of  
14           the provider, and in the case of a hospital, the  
15           teaching staff, scope of services, and case mix;
- 16           (3) The provider's usual billed charge for comparable  
17           services with regard to patients in managed care plans  
18           in which the health care provider or hospital is not  
19           participating;
- 20           (4) The circumstances and complexity of the particular  
21           case, including time and place service;



- 1        (5) Individual patient characteristics;
- 2        (6) The eightieth percentile of billed charges for similar  
3        services in the same geozip area determined by an  
4        independent, third party benchmarking database; and
- 5        (7) The fiftieth percentile of rates for the service or  
6        supply paid to participating providers in the same or  
7        similar specialty and provided in the same geozip area  
8        by an independent, third-party benchmarking database.
- 9        (d) A provider may bundle multiple claims in a single  
10      mediation if the disputed charges involve:
- 11       (1) The identical managed care plan or issuer and  
12       provider;
- 13       (2) Claims with the same or related current procedural  
14       codes; and
- 15       (3) Claims that occur within one hundred eighty days of  
16       each other.
- 17       (e) A patient that is not insured or the patient's  
18      provider may submit a dispute regarding a fee for emergency  
19      services for binding arbitration or mediation upon approval of  
20      the commissioner.



1       (f) For disputes involving an enrollee, when the dispute  
2 resolution entity determines the managed care plan's payment is  
3 reasonable, payment for the dispute resolution process shall be  
4 the responsibility of the nonparticipating provider. When the  
5 dispute resolution entity determines the nonparticipating  
6 provider's fee is reasonable, payment for the dispute resolution  
7 process shall be the responsibility of the managed care plan.  
8 When a good faith negotiation directed by the dispute resolution  
9 entity results in a settlement between the managed care plan and  
10 nonparticipating provider, the managed care plan and the  
11 nonparticipating provider shall evenly divide and share the  
12 prorated cost for dispute resolution.

13       (g) For disputes involving a patient that is not an  
14 enrollee, when the dispute resolution entity determines the  
15 provider's fee is reasonable, payment for the dispute resolution  
16 process shall be the responsibility of the patient unless  
17 payment for the dispute resolution process would pose a hardship  
18 to the patient. The commissioner shall adopt rules pursuant to  
19 chapter 91 to determine payment for the dispute resolution  
20 process in cases of hardship. When the dispute resolution  
21 entity determines the health care provider's fee is



1 unreasonable, payment for the dispute resolution process shall  
2 be the responsibility of the provider.

3 (h) The mediator shall issue a decision on a submitted  
4 case with thirty days of commencement of binding arbitration or  
5 mediation process."

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

8 "[~~+~~] §431:10-109 [~~+~~] ~~Disclosure of [health care coverage and~~  
9 ~~benefits.] information. (a) In order to ensure that all~~  
10 individuals understand their health care options and are able to  
11 make informed decisions, all insurers shall provide current and  
12 prospective insureds with written disclosure of [~~coverages and~~  
13 ~~benefits, including information on coverage principles and any~~  
14 ~~exclusions or restrictions on coverage.] the following  
15 information:~~

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

19 (2) With regard to out-of-network coverage examples of  
20 anticipated out-of-pocket costs for frequently billed  
21 out-of-network health care services; and



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

8       (b) The information provided shall be current,  
9       understandable, and available prior to the issuance of a policy,  
10      and upon request after the policy has been issued[-]; provided  
11      that nothing in this section shall prevent an insurer from  
12      changing or updating the materials that are made available to  
13      insureds.

14      (c) For purposes of this section:  
15      "Emergency condition" means a medical or behavioral  
16      condition that manifests itself by acute symptoms of sufficient  
17      severity, including severe pain, such that a prudent layperson,  
18      possessing an average knowledge of medicine and health, could  
19      reasonably expect the absence of immediate medical attention to  
20      result in:





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

7        "Emergency services" shall have the same meaning as that  
8 term is defined in section 432E-1."

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

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

15        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. (HD2)

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

