THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

S.B. NO. 2278 S.D. 2 H.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

1 PART I

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

1 providers may charge may be much greater than the price charged
2 by in-network providers for 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,

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

The purpose of this Act is to:

(1) Specify the circumstances under which a patient shall not be liable to a health care provider for any sums owed by an insurer, mutual benefit society, or health maintenance organization;

(2) Specify the rate at which a health insurance plan must reimburse a nonparticipating provider who provides health care to a patient, unless otherwise agreed to by the nonparticipating provider and the health insurance plan;

(3) Require health insurance payors to use a transparent, third-party database by which to calculate out-of-network provider reimbursements for emergency services; and

1 (4) Require mandatory mediation to resolve disputes
2 between insurers and providers to be overseen by the
3 insurance division of the department of commerce and
4 consumer affairs.

5 SECTION 2. Chapter 431, Hawaii Revised Statutes, is
6 amended by adding two new sections to article 10A to be
7 appropriately designated and to read as follows:

8 "**§431:10A-A Balance billing; hold harmless; emergency**
9 **services; mandatory mediation.** (a) Every contract between an
10 insurer and a participating provider of health care services
11 shall be in writing and shall set forth that in the event the
12 insurer fails to pay for health care services as set forth in
13 the contract, the insured shall not be liable to the provider
14 for any sums owed by the insurer.

15 (b) If a contract with a participating provider has not
16 been reduced to writing as required by subsection (a), or if a
17 contract fails to contain the required prohibition, the
18 participating provider shall not collect or attempt to collect
19 from the insured sums owed by the insurer. No participating
20 provider, or agent, trustee, or assignee thereof, may maintain
21 any action at law against an insured to:

1 (1) Collect sums owed by the insurer; or
2 (2) Collect sums in excess of the amount owed by the
3 insured as a copayment, coinsurance, or deductible
4 under the insured's policy of accident and health or
5 sickness insurance.
6 (c) 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. No nonparticipating provider, or agent, trustee, or
12 assignee thereof, may maintain any action at law against an
13 insured to collect sums in excess of the amount owed by the
14 insured as a copayment, coinsurance, or deductible under the
15 insured's policy of accident and health or sickness insurance.
16 (d) When an insured receives emergency services from a
17 provider who is not a participating provider in the provider
18 network of the insured, the insurer shall use data from a
19 transparent, third-party database by which to calculate out-of-
20 network reimbursements for emergency services.

1 (e) Any dispute between an insurer and provider that
2 arises pursuant to this section shall be submitted to mandatory
3 mediation to be overseen by the insurance division.
4 (f) For purposes of this section:
5 "Emergency condition" means a medical or behavioral
6 condition that manifests itself by acute symptoms of sufficient
7 severity, including severe pain, such that a prudent layperson,
8 possessing an average knowledge of medicine and health, could
9 reasonably expect the absence of immediate medical attention to
10 result in:
11 (1) Placing the health of the person afflicted with the
12 condition in serious jeopardy;
13 (2) Serious impairment to the person's bodily functions;
14 (3) Serious dysfunction of any bodily organ or part of the
15 person; or
16 (4) Serious disfigurement of the person.
17 "Emergency services" means, with respect to an emergency
18 condition:
19 (1) A medical screening examination as required under
20 section 1867 of the Social Security Act, title 42
21 United States Code section 1395dd; and

1 (2) Any further medical examination and treatment, as
2 required under section 1867 of the Social Security
3 Act, title 42 United States Code section 1395dd, to
4 stabilize the patient.
5 **§431:10A-B Balance billing; hold harmless; non-emergency**
6 **services.** No nonparticipating health care provider; health care
7 facility or hospital; or agent, trustee, or assignee thereof,
8 may maintain any action at law against an insured to collect
9 sums in excess of the amount owed by the insured as a copayment,
10 coinsurance, or deductible for similar services provided by a
11 participating provider under the insured's policy of accident
12 and health or sickness insurance."
13 SECTION 3. Chapter 431, Hawaii Revised Statutes, is
14 amended by adding a new section to article 14G to be
15 appropriately designated and to read as follows:
16 "**§431:14G- Out-of-network or nonparticipating provider**
17 **reimbursement; rate calculation.** (a) Notwithstanding section
18 431:10A-A or any contract to the contrary, a managed care plan
19 shall reimburse a nonparticipating provider the usual and
20 customary rate for similar services provided by a participating
21 provider under the enrollee's managed care plan.

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.
4 (c) For purposes of this section "usual and customary
5 rate" shall mean the managed care plan's average contracted
6 rate."
7 SECTION 4. Chapter 432, Hawaii Revised Statutes, is
8 amended by adding three new sections to article 1 to be
9 appropriately designated and to read as follows:
10 "**§432:1-A Balance billing; hold harmless; emergency**
11 **services; mandatory mediation.** (a) Every contract between a
12 mutual benefit society and a participating provider of health
13 care services shall be in writing and shall set forth that in
14 the event the mutual benefit society fails to pay for health
15 care services as set forth in the contract, the subscriber or
16 member shall not be liable to the provider for any sums owed by
17 the mutual benefit society.
18 (b) If a contract with a participating provider has not
19 been reduced to writing as required by subsection (a), or if a
20 contract fails to contain the required prohibition, the
21 participating provider shall not collect or attempt to collect

1 from the subscriber or member sums owed by the mutual benefit
2 society. No participating provider, or agent, trustee, or
3 assignee thereof, may maintain any action at law against a
4 subscriber or member to:
5 (1) Collect sums owed by the mutual benefit society; or
6 (2) Collect sums in excess of the amount owed by the
7 subscriber or member as a copayment, coinsurance, or
8 deductible under the subscriber's or member's plan
9 contract.
10 (c) When a subscriber or member receives emergency
11 services from a provider who is not a participating provider in
12 the provider network of the subscriber or member, the subscriber
13 or member shall not incur greater out-of-pocket costs for
14 emergency services than the subscriber or member would have
15 incurred with a participating provider of health care services.
16 No nonparticipating provider, or agent, trustee, or assignee
17 thereof, may maintain any action at law against a subscriber or
18 member to collect sums in excess of the amount owed by the
19 subscriber or member as a copayment, coinsurance, or deductible
20 under the subscriber's or member's plan contract.

1 (d) When a subscriber or member receives emergency
2 services from a provider who is not a participating provider in
3 the provider network of the subscriber or member, the mutual
4 benefit society shall use data from a transparent, third-party
5 database by which to calculate out-of-network reimbursements for
6 emergency services.
7 (e) Any dispute between a mutual benefit society and
8 provider that arises pursuant to this section shall be submitted
9 to mandatory mediation to be overseen by the insurance division.
10 (f) For purposes of this section:
11 "Emergency condition" means a medical or behavioral
12 condition that manifests itself by acute symptoms of sufficient
13 severity, including severe pain, such that a prudent layperson,
14 possessing an average knowledge of medicine and health, could
15 reasonably expect the absence of immediate medical attention to
16 result in:
17 (1) Placing the health of the person afflicted with the
18 condition in serious jeopardy;
19 (2) Serious impairment to the person's bodily functions;
20 (3) Serious dysfunction of any bodily organ or part of the
21 person; or

1 (4) Serious disfigurement of the person.
2 "Emergency services" means, with respect to an emergency
3 condition:
4 (1) A medical screening examination as required under
5 section 1867 of the Social Security Act, title 42
6 United States Code section 1395dd; and
7 (2) Any further medical examination and treatment, as
8 required under section 1867 of the Social Security
9 Act, title 42 United States Code section 1395dd, to
10 stabilize the patient.
11 **§432:1-B Balance billing; hold harmless; non-emergency**
12 **services.** No nonparticipating health care provider; health care
13 facility or hospital; or agent, trustee, or assignee thereof,
14 may maintain any action at law against a subscriber or member to
15 collect sums in excess of the amount owed by the subscriber or
16 member as a copayment, coinsurance, or deductible for similar
17 services provided by a participating provider under the
18 subscriber's or member's plan contract.
19 **§432:1-C Out-of-network or nonparticipating provider**
20 **reimbursement; rate calculation.** (a) Notwithstanding section
21 432:1-A, and absent any contract to the contrary, a mutual

benefit society shall reimburse a nonparticipating provider the usual and customary rate for similar services provided by a participating provider under the subscriber's or member's plan contract.

(b) Nothing in this section shall be construed to require a mutual benefit society to cover services not required by law or by the terms and conditions of the plan contract.

(c) For purposes of this section "usual and customary rate" shall mean the mutual benefit society's average contracted rate."

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

"**§432D-A Balance billing; hold harmless; emergency services; mandatory mediation.** (a) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the carrier or health maintenance organization.

(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to:

(1) Collect sums owed by the health maintenance organization; or

(2) Collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible under the subscriber's or enrollee's policy, contract, plan, or agreement.

(c) When a subscriber or enrollee receives emergency services from a provider who is not a participating provider in the provider network of the subscriber or enrollee, the subscriber or enrollee shall not incur greater out-of-pocket costs for emergency services than the subscriber or enrollee would have incurred with a participating provider of health care services. No nonparticipating provider, or agent, trustee, or

1 assignee thereof, may maintain any action at law against a
2 subscriber or enrollee to collect sums in excess of the amount
3 owed by the subscriber or enrollee as a copayment, coinsurance,
4 or deductible under the subscriber's or enrollee's policy,
5 contract, plan, or agreement.
6 (d) When a subscriber or enrollee receives emergency
7 services from a provider who is not a participating provider in
8 the provider network of the subscriber or enrollee, the health
9 maintenance organization shall use data from a transparent,
10 third-party database by which to calculate out-of-network
11 reimbursements for emergency services.
12 (e) Any dispute between a health maintenance organization
13 and provider that arises pursuant to this section shall be
14 submitted to mandatory mediation to be overseen by the insurance
15 division.
16 (f) 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 **§432D-B Balance billing; hold harmless; non-emergency**
19 **services.** No nonparticipating health care provider; health care
20 facility or hospital; or agent, trustee, or assignee thereof,
21 may maintain any action at law against a subscriber or enrollee

1 to collect sums in excess of the amount owed by the subscriber
2 or enrollee as a copayment, coinsurance, or deductible for
3 similar services provided by a participating provider under the
4 subscriber's or enrollee's policy, contract, plan, or agreement.
5 **§432D-C Out-of-network or nonparticipating provider**
6 **reimbursement; rate calculation.** (a) Notwithstanding section
7 432D-A or any contract to the contrary, a health maintenance
8 organization shall reimburse a nonparticipating provider the
9 usual and customary rate for similar services provided by a
10 participating provider under the subscriber's or enrollee's
11 policy, contract, plan, or agreement.
12 (b) Nothing in this section shall be construed to require
13 a health maintenance organization to cover services not required
14 by law or by the terms and conditions of the policy, contract,
15 plan, or agreement.
16 (c) For purposes of this section "usual and customary
17 rate" shall mean the carrier or health maintenance
18 organization's average contracted rate."
19 SECTION 6. Section 431:10-109, Hawaii Revised Statutes, is
20 amended to read as follows:

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

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

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

(A) For non-emergency services, the amount that the insurer will reimburse under the rate calculation for out-of-network health care specified in section 431:14G- ; and

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

(3) Information in writing and through an internet website that reasonably permits an insured or prospective

1 insured to estimate the anticipated out-of-pocket cost
2 for out-of-network health care services in a
3 geographical area based upon the difference between
4 what the insurer will reimburse for out-of-network
5 health care services and the rate calculation
6 specified in section 431:14G- 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" means, with respect to an emergency
8 condition:
9 (1) A medical screening examination as required under
10 section 1867 of the Social Security Act, title 42
11 United States Code section 1395dd; and
12 (2) Any further medical examination and treatment, as
13 required under section 1867 of the Social Security
14 Act, title 42 United States Code section 1395dd, to
15 stabilize the patient."
16 PART II
17 SECTION 7. Chapter 432E, Hawaii Revised Statutes, is
18 amended by a new section to be appropriately designated and to
19 read as follows:
20 "**§432E- Balance billing; hold harmless; emergency**
21 **services; binding arbitration.** (a) When an enrollee receives

1 emergency services from a nonparticipating provider, the
2 enrollee shall not incur greater out-of-pocket costs for the
3 emergency services than the enrollee would have incurred with a
4 participating provider. A nonparticipating provider, or agent,
5 trustee, or assignee thereof, shall not attempt to collect sums
6 in excess of the amount owed by the enrollee as a copayment,
7 coinsurance, or deductible under the enrollee's health benefit
8 plan.
9 (b) When an enrollee receives emergency services from a
10 nonparticipating provider, the health carrier that issued the
11 enrollee's health benefit plan shall pay an amount to the
12 nonparticipating provider that the health carrier determines is
13 reasonable and equal to at least ________ as payment for the
14 emergency services.
15 (c) The health carrier and nonparticipating provider may
16 consult an independent, third-party database as part of their
17 negotiations to determine a reasonable payment amount.
18 (d) If there is a disagreement between a health carrier
19 and nonparticipating provider that arises from a reimbursement
20 under subsection (b) and the disagreement is not resolved within
21 forty-five days of the nonparticipating provider's notifying the

1 health carrier of the disagreement, either party may elect to
2 enter into binding arbitration under subsection (d).
3 (e) If a health carrier and a nonparticipating provider
4 are unable to reach an agreement to resolve a disagreement
5 within forty-five days of the nonparticipating provider's
6 notifying the health carrier of the disagreement under
7 subsection (c), either party may submit the matter to the
8 commissioner, who shall refer the matter to an independent
9 dispute resolution entity for binding arbitration.
10 (f) In determining the appropriate amount to pay a
11 nonparticipating provider for emergency services, the
12 independent dispute resolution entity shall consider all
13 relevant factors, including:
14 (1) Whether there is a gross disparity between the fee
15 charged by the nonparticipating provider for services
16 rendered as compared to:
17 (A) The fees paid to the nonparticipating provider
18 for the same services rendered to enrollees in
19 other health benefit plans issued by health
20 carriers with which the nonparticipating provider

1 is not subject to a written agreement governing
2 the provision of emergency services; and
3 (B) Fees paid by the health carrier to reimburse
4 similarly qualified nonparticipating providers
5 for the same emergency services in the same
6 region;
7 (2) The level of training, education, and experience of
8 the nonparticipating provider, and in the case of a
9 facility, any teaching staff, scope of services, and
10 case mix;
11 (3) The nonparticipating provider's usual billed charge
12 for comparable services with regard to enrollees in
13 health benefit plans issued by carriers with which the
14 nonparticipating provider is not subject to a written
15 agreement governing the provision of emergency
16 services;
17 (4) The circumstances and complexity of the particular
18 case, including the time and place of the emergency
19 services; and
20 (5) Individual patient characteristics.

(g) Either party may submit multiple disagreements in a single request for dispute resolution if the disputed charges involve:

(1) The same health carrier and nonparticipating provider;

(2) Claims with the same or related current procedural codes; and

(3) Claims that occur within one hundred eighty days of each other.

(h) If the independent dispute resolution entity determines the health carrier's payment under subsection (b) is reasonable, payment for the binding arbitration process shall be the responsibility of the nonparticipating provider. If the independent dispute resolution entity determines the nonparticipating provider's fee is reasonable, payment for the binding arbitration process shall be the responsibility of the health carrier. If the independent dispute resolution entity does not determine that the health carrier's payment is reasonable or that the nonparticipating provider's fee is reasonable, the health carrier and the nonparticipating provider shall evenly divide and share the total cost for binding arbitration.

1 (i) The independent dispute resolution entity shall issue
2 a decision on a submitted case no later than forty-five days
3 from the commencement of binding arbitration.
4 (j) Nothing in this section shall be construed to prohibit
5 nonparticipating providers from seeking the uncovered cost of
6 services rendered from enrollees who have consented to receive
7 out-of-network health care services provided by a
8 nonparticipating provider."
9 SECTION 8. Section 432E-1, Hawaii Revised Statutes is
10 amended by adding the following definition to be appropriately
11 inserted to read:
12 ""Nonparticipating provider" means a facility, health care
13 provider, or health care professional that is not subject to a
14 written agreement with the health carrier that issued the
15 enrollee's health benefit plan that governs the provision of
16 emergency services."
17 SECTION 9. Section 432E-8, Hawaii Revised Statutes, is
18 amended to read as follows:
19 **§432E-8 Enforcement.** All remedies, penalties, and
20 proceedings in articles 2 and 13 of chapter 431 made applicable
21 hereby to managed care plans, health benefit plans, health

1 carriers, and nonparticipating providers shall be invoked and
2 enforced solely and exclusively by the commissioner.

3 PART III

4 SECTION 10. In codifying the new sections added by
5 sections 2, 4, and 5 of this Act, the revisor of statutes shall
6 substitute appropriate section numbers for the letters used in
7 designating the new sections in this Act.

8 SECTION 11. Statutory material to be repealed is bracketed
9 and stricken. New statutory material is underscored.

10 SECTION 12. This Act shall take effect on January 2, 2050,
11 and shall be repealed on January 2, 2025; provided that sections
12 431:10-109 and 432E-8, Hawaii Revised Statues, shall be
13 reenacted in the form in which they read on the day before the
14 effective date of this Act.

Report Title:
Balance Billing; Surprise Billing; Prohibitions; Health Insurance; Nonparticipating Providers; Binding Arbitration

Description:
Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers. Requires the insurance commissioner to refer certain disputes between insurers and non-participating providers to an independent dispute resolution entity for binding arbitration. Repeals 1/2/2025. Effective 1/2/2050. (HD1)

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