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



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

14           Currently, there is no comprehensive protection from  
15 surprise bills or balance bills at the federal level and, while  
16 there is a growing trend toward state action to protect patients  
17 from surprise bills or balance bills, most state laws do not  
18 provide comprehensive protections. However, the trend is  
19 changing. At least nine states including California, Oregon,  
20 Maryland, Connecticut, Illinois, New York, New Hampshire, New  
21 Jersey, and Florida have enacted comprehensive approaches to end



1 balance billing and surprise bills. Similarly, New Mexico,  
2 Texas, Washington, and Colorado passed new comprehensive laws in  
3 2019. Hawaii patients continue to be at risk of being caught in  
4 the middle of balance billing disputes between health insurers  
5 and providers or being hit with significant surprise bills.

6 The purpose of this Act is to:

- 7 (1) Specify the circumstances in which a patient shall not  
8 be liable to a health care provider for any sums owed  
9 by an insurer, mutual benefit society, or health  
10 maintenance organization;
- 11 (2) Specify the rate at which a health insurance plan must  
12 reimburse a nonparticipating provider who provides  
13 health care to a patient, unless otherwise agreed to  
14 by the nonparticipating provider and the health  
15 insurance plan;
- 16 (3) Require health insurance payors to use a transparent,  
17 third-party database on which to calculate out-of-  
18 network provider reimbursements for emergency  
19 services; and
- 20 (4) Require mandatory mediation to resolve disputes  
21 between insurers and providers to be overseen by the



1 insurance division of the department of commerce and  
2 consumer affairs.

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

6 "§431:10A-A Balance billing; hold harmless; emergency  
7 services; mandatory mediation. (a) Every contract between an  
8 insurer and a participating provider of health care services  
9 shall be in writing and shall set forth that in the event the  
10 insurer fails to pay for health care services as set forth in  
11 the contract, the insured shall not be liable to the provider  
12 for any sums owed by the insurer.

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

20 (1) Collect sums owed by the insurer; or



1       (2) Collect sums in excess of the amount owed by the  
2       insured as a copayment, coinsurance, or deductible  
3       under the insured's policy of accident and health or  
4       sickness insurance.

5       (c) When an insured receives emergency services from a  
6       provider who is not a participating provider in the provider  
7       network of the insured, the insured shall not incur greater out-  
8       of-pocket costs for emergency services than the insured would  
9       have incurred with a participating provider of health care  
10      services. No nonparticipating provider, or agent, trustee, or  
11      assignee thereof, may maintain any action at law against an  
12      insured to collect sums in excess of the amount owed by the  
13      insured as a copayment, coinsurance, or deductible under the  
14      insured's policy of accident and health or sickness insurance.

15      (d) When an insured receives emergency services from a  
16      provider who is not a participating provider in the provider  
17      network of the insured, the insurer shall use data from a  
18      transparent, third-party database upon which to calculate out-  
19      of-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 greater of:



1       (1) The usual and customary rate for similar services  
2               provided by a participating provider under the  
3               insured's managed care plan; or

4       (2) \_\_\_\_\_ per cent of the amount medicare reimburses on a  
5               fee-for-service basis for the same or similar services  
6               in the general geographic region in which the services  
7               were rendered.

8       (b) Nothing in this section shall be construed to require  
9       a managed care plan to cover services not required by law or by  
10       the terms and conditions of the managed care plan.

11       (c) For purposes of this section "usual and customary  
12       rate" shall mean the managed care plan's average contracted  
13       rate."

14       SECTION 4. Chapter 432, Hawaii Revised Statutes, is  
15       amended by adding three new sections to article 1 to be  
16       appropriately designated and to read as follows:

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





1 care services as set forth in the contract, the subscriber or  
2 member shall not be liable to the provider for any sums owed by  
3 the mutual benefit society.

4 (b) If a contract with a participating provider has not  
5 been reduced to writing as required by subsection (a), or if a  
6 contract fails to contain the required prohibition, the  
7 participating provider shall not collect or attempt to collect  
8 from the subscriber or member sums owed by the mutual benefit  
9 society. No participating provider, or agent, trustee, or  
10 assignee thereof, may maintain any action at law against a  
11 subscriber or member to:

12 (1) Collect sums owed by the mutual benefit society; or  
13 (2) Collect sums in excess of the amount owed by the  
14 subscriber or member as a copayment, coinsurance, or  
15 deductible under the subscriber's or member's plan  
16 contract.

17 (c) When a subscriber or member receives emergency  
18 services from a provider who is not a participating provider in  
19 the provider network of the subscriber or member, the subscriber  
20 or member shall not incur greater out-of-pocket costs for  
21 emergency services than the subscriber or member would have



1 incurred with a participating provider of health care services.  
2 No nonparticipating provider, or agent, trustee, or assignee  
3 thereof, may maintain any action at law against a subscriber or  
4 member to collect sums in excess of the amount owed by the  
5 subscriber or member as a copayment, coinsurance, or deductible  
6 under the subscriber's or member's plan contract.

7 (d) When a subscriber or member receives emergency  
8 services from a provider who is not a participating provider in  
9 the provider network of the subscriber or member, the mutual  
10 benefit society shall use data from a transparent, third-party  
11 database upon which to calculate out-of-network reimbursements  
12 for emergency services.

13 (e) Any dispute between a mutual benefit society and  
14 provider that arises pursuant to this section shall be submitted  
15 to mandatory mediation to be overseen by the insurance 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 **§432:1-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 member to**



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

5 §432:1-C Out-of-network or nonparticipating provider  
6 reimbursement; rate calculation. (a) Notwithstanding section  
7 432:1-A, and absent any contract to the contrary, a mutual  
8 benefit society shall reimburse a nonparticipating provider the  
9 greater of:

10 (1) The usual and customary rate for similar services  
11 provided by a participating provider under the  
12 subscriber's or member's plan contract; or

13 (2) \_\_\_\_\_ per cent of the amount medicare reimburses on a  
14 fee-for-service basis for the same or similar services  
15 in the general geographic region in which the services  
16 were rendered.

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



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

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

7        **"§432D-A Balance billing; hold harmless; emergency**  
8 **services; mandatory mediation.** (a) Every contract between a  
9 health maintenance organization and a participating provider of  
10 health care services shall be in writing and shall set forth  
11 that in the event the health maintenance organization fails to  
12 pay for health care services as set forth in the contract, the  
13 subscriber or enrollee shall not be liable to the provider for  
14 any sums owed by the carrier or health maintenance organization.

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 subscriber or enrollee sums owed by the health  
20 maintenance organization. No participating provider, or agent,



1 trustee, or assignee thereof, may maintain any action at law  
2 against a subscriber or enrollee to:

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

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

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



1        (d) When a subscriber or enrollee receives emergency  
2 services from a provider who is not a participating provider in  
3 the provider network of the subscriber or enrollee, the health  
4 maintenance organization shall use data from a transparent,  
5 third-party database upon which to calculate out-of-network  
6 reimbursements for emergency services.

7        (e) Any dispute between a health maintenance organization  
8 and provider that arises pursuant to this section shall be  
9 submitted to mandatory mediation to be overseen by the insurance  
10 division.

11        (f) For purposes of this section:

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

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

20        (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" means, with respect to an emergency  
5       condition:

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

9       (2) Any further medical examination and treatment, as  
10           required under section 1867 of the Social Security  
11           Act, title 42 United States Code section 1395dd, to  
12           stabilize the patient.

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





1           §432D-C Out-of-network or nonparticipating provider  
2 reimbursement; rate calculation. (a) Notwithstanding section  
3 432D-A or any contract to the contrary, a health maintenance  
4 organization shall reimburse a nonparticipating provider the  
5 greater of:

6           (1) The usual and customary rate for similar services  
7 provided by a participating provider under the  
8 subscriber's or enrollee's policy, contract, plan, or  
9 agreement; or

10           (2) \_\_\_\_\_ per cent of the amount medicare reimburses on a  
11 fee-for-service basis for the same or similar services  
12 in the general geographic region in which the services  
13 were rendered.

14           (b) Nothing in this section shall be construed to require  
15 a health maintenance organization to cover services not required  
16 by law or by the terms and conditions of the policy, contract,  
17 plan, or agreement.

18           (c) For purposes of this section "usual and customary  
19 rate" shall mean the carrier or health maintenance  
20 organization's average contracted rate."



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

3 "~~[+] §431:10-109 [.]~~ Disclosure of ~~[health care coverage and~~  
4 ~~benefits.]~~ information. (a) In order to ensure that all  
5 individuals understand their health care options and are able to  
6 make informed decisions, all insurers shall provide current and  
7 prospective insureds with written disclosure of ~~[coverages and~~  
8 ~~benefits, including information on coverage principles and any~~  
9 ~~exclusions or restrictions on coverage.]~~ the following  
10 information:

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

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

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

19 (B) Examples of anticipated out-of-pocket costs for  
20 frequently billed out-of-network health care  
21 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 and the rate calculation  
8       specified in section 431:14G- for out-of-network  
9       health care services.

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

16       (c) 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  
7 such 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 SECTION 7. In codifying the new sections added by sections  
19 2, 4, and 5 of this Act, the revisor of statutes shall  
20 substitute appropriate section numbers for the letters used in  
21 designating the new sections in this Act.



1 SECTION 8. Statutory material to be repealed is bracketed  
2 and stricken. New statutory material is underscored.

3 SECTION 9. This Act shall take effect on January 2, 2050,  
4 and shall be repealed on January 2, 2025; provided that section  
5 431:10-109 shall be reenacted in the form in which it read on  
6 the day before this effective date of this Act.



S.B. NO. 2278  
S.D. 2

**Report Title:**

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

**Description:**

Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers. Repeals January 2, 2025. Effective 1/2/2050. (SD2)

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

