HOUSE OF REPRESENTATIVES
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

H.B. NO. 1952

A BILL FOR AN ACT

RELATING TO INSURANCE.

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

SECTION 1. The legislature finds that consumers with health insurance who receive treatment from an out-of-network provider may receive a bill for the difference between an insurer's payments to a health care provider and the out-of-network provider's charges. These bills, known as balance bills or surprise bills, occur most often when consumers receive medical services from out-of-network providers. Out-of-network providers may not have a contracted rate with an insurer for services and therefore, the prices these providers may charge may be much greater than the price charged by in-network providers for similar services.

The legislature further finds that balance bills can be an unwelcome surprise to consumers who may not have knowingly decided to obtain health care outside of their provider network. Currently, there is no broad protection from surprise bills or balance bills at the federal level or in most states. In Hawaii, the restriction on balance billing applies to health

maintenance organizations and mutual benefit societies only, which must include a provision in provider contracts that states a subscriber or member will not be liable to the provider for amounts owed by the organization or society. The legislature also finds that additional consumer protections are necessary to increase transparency for patients billed for medical services and protect consumers from the need to pay balance bills.

Accordingly, the purpose of this Act is to

(1) Establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved;

(2) Specify disclosure requirements for health care professionals and health care facilities, including estimated costs for health care services and information on participating provider networks;

(3) Specify that an insured shall not be liable to a health care provider for any sums owed by an insurer;

(4) Specify that an insurer who receives emergency services from a nonparticipating provider shall not incur greater out-of-pocket costs for the emergency

services than the insured would have incurred with a participating provider;

(5) Specify additional disclosure requirements for health insurance plans, including payment methodologies and updated participating provider directories; and

(6) Require health insurance plans to provide at least one option for coverage for at least eighty per cent of the usual and customary cost of each out-of-network health care service in inadequate network situations.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new part to article 10 to be appropriately designated and to read as follows:

"**PART . EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS**

§431:10-A Definitions. As used in this part:

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

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

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

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of the person.

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

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

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

"Health care facility" means any institution, place, building, or agency, or portion thereof, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, rehabilitative, or preventive care to any person or persons.

"Health care plan" means a health insurance company, mutual benefit society governed by article 1 of chapter 432, health care service plan or health maintenance organization governed by chapter 432D, or any other entity delivering or issuing for delivery in the State accident and health or sickness insurance as defined in section 431:1-205.

"Health care provider" means an individual who is licensed or otherwise authorized by the State to provide health care services, including physicians and osteopathic physicians licensed under chapter 453, physician assistants licensed under chapter 453, and advanced practice registered nurses licensed under chapter 457.

"Hospital" means:

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

(2) A health facility under chapter 323F.

"Insured" means a patient covered under a health care plan's policy or contract.

"Nonparticipating" means not having a contract with a health care plan to provide health care services to an insured.

"Organized ambulatory health care facility" means a facility not part of a hospital, which is organized and operated to provide health services to outpatients.

"Participating" means having a contract with a health care plan to provide health care services to an insured.

"Patient" means a person who receives health care services, including emergency services, in the State.

"Surprise bill" means a bill for health care services, other than emergency services, received by:

(1) An insured for services rendered by a nonparticipating health care provider at a participating health care facility, hospital, or organized ambulatory health care facility, where:

(A) A participating health care provider is unavailable;

(B) A nonparticipating health care provider renders services without the insured's knowledge; or

(C) Unforeseen medical services arise at the time the health care services are rendered;

provided that a surprise bill shall not mean a bill received for health care services when a participating health care provider is available and the insured has elected to obtain services from a nonparticipating health care provider;

(2) An insured for services rendered by a nonparticipating health care provider, where the services were referred by a participating health care provider to the nonparticipating health care provider without the explicit written consent of the insured acknowledging that:

(A) The participating health care provider is referring the insured to a nonparticipating health care provider; and

(B) The referral may result in costs not covered by the health care plan; or

(3) A patient who is not an insured, for services rendered by a health care provider at a health care facility, hospital, or organized ambulatory health care facility, where the patient has not timely received

all of the disclosures required pursuant to section 321- .

"Usual and customary cost" means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area.

§431:10-B Dispute resolution process; established. (a) The commissioner shall establish a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved.

(b) The commissioner shall adopt rules pursuant to chapter 91 necessary to carry out the purposes of this part.

§431:10-C Applicability. This part shall not apply to health care services, including emergency services, where health care provider fees are subject to schedules or other monetary limitations under any other law, including chapter 386 and article 10C of chapter 431, and shall not preempt any such law.

§431:10-D Criteria for determining a reasonable fee. In determining the appropriate amount to pay for a health care service, an independent dispute resolution entity shall consider the following relevant factors:

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

(A) Fees paid to the involved health care provider for the same services rendered by the health care provider to other patients in health care plans in which the health care provider is nonparticipating; and

(B) In the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified nonparticipating health care providers for the same services in the same geographic region;

(2) The level of training, education, and experience of the health care provider;

(3) The health care provider's usual charge for comparable services to patients in health care plans where the health care provider is nonparticipating;

(4) The circumstances and complexity of the particular case, including time and place of the service;

(5) Individual patient characteristics; and

(6) The usual and customary cost of the service.

§431:10-E Dispute resolution for emergency services. (a) With regard to emergency services for an insured:

(1) When a health care plan receives a bill for emergency services from a nonparticipating health care provider, the health care plan shall pay an amount that the health care plan determines is reasonable for the emergency services rendered by the nonparticipating health care provider, except for the insured's copayment, coinsurance, or deductible, if any; provided that the insured shall incur no greater out-of-pocket costs for emergency services than the insured would have incurred with a participating health care provider pursuant to sections 432:1-407(d) and 432D-8(d);

(2) A nonparticipating health care provider or a health care plan may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity;

(3) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review; and

(4) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either the health care plan's payment or the nonparticipating health care provider's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section 431:10-D. If an independent dispute resolution entity determines, based on the health care plan's payment and the nonparticipating health care provider's fee, that a settlement between the health care plan and nonparticipating health care provider is reasonably likely, or that both the health care plan's payment and the nonparticipating health care provider's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and nonparticipating health care

provider may be granted up to ten business days for the negotiation, which shall run concurrently with the thirty day period for dispute resolution.

(b) With regard to emergency services for a patient that is not an insured:

(1) A patient that is not an insured or the patient's health care provider may submit a dispute regarding a fee for emergency services for review to an independent dispute resolution entity upon approval of the commissioner;

(2) An independent dispute resolution entity shall determine a reasonable fee for the services based upon the same conditions and factors set forth in section 431:10-D; and

(3) A patient that is not an insured shall not be required to pay the health care provider's fee in order to be eligible to submit the dispute for review to an independent dispute resolution entity.

(c) The determination of an independent dispute resolution entity shall be binding on the health care plan, health care provider, and patient, and shall be admissible in any court

proceeding between the health care plan, health care provider, or patient or in any administrative proceeding between the State and the health care provider.

§431:10-F Hold harmless; assignment of benefits; surprise bills. When an insured assigns benefits in writing for a surprise bill to a nonparticipating health care provider who knows the insured is an insured under a health care plan, the nonparticipating health care provider shall not bill the insured, except for any applicable copayment, coinsurance, or deductible that would be owed if the insured utilized a participating health care provider.

§431:10-G Dispute resolution for surprise bills. (a) When an insured who assigns benefits receives a surprise bill, the following shall apply:

(1) If an insured assigns benefits to a nonparticipating health care provider, the health care plan shall pay the nonparticipating health care provider in accordance with paragraphs (2) and (3);

(2) The nonparticipating health care provider may bill the health care plan for the health care services rendered and the health care plan shall:

(A) Pay the nonparticipating health care provider the billed amount; or

(B) Attempt to negotiate reimbursement with the nonparticipating health care provider;

(3) If the health care plan's attempts to negotiate reimbursement for health care services provided by a nonparticipating health care provider does not result in a resolution of the payment dispute between the nonparticipating health care provider and the health care plan, the health care plan shall pay the nonparticipating health care provider an amount the health care plan determines is reasonable for the health care services rendered, except for the insured's co-payment, coinsurance, or deductible;

(4) Either the health care plan or the nonparticipating health care provider may submit the dispute regarding the surprise bill for review to an independent dispute resolution entity; provided that the health care plan may not submit the dispute unless it has first complied with the requirements of paragraphs (1), (2), and (3);

(5) The independent dispute resolution entity shall make a determination within thirty days of receipt of the dispute for review; and

(6) When determining a reasonable fee for the services rendered, the independent dispute resolution entity shall select either the health care plan's payment or the nonparticipating health care provider's fee. An independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in section 431:10-D. If an independent dispute resolution entity determines, based on the health care plan's payment and the nonparticipating health care provider's fee, that a settlement between the health care plan and nonparticipating health care provider is reasonably likely, or that both the health care plan's payment and the nonparticipating health care provider's fee represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The health care plan and nonparticipating health care

provider may be granted up to ten business days for the negotiation, which shall run concurrently with the thirty day period for dispute resolution.

(b) When an insured who has not assigned benefits receives a surprise bill or a patient who is not an insured receives a surprise bill, the following shall apply:

(1) An insured who has not assigned benefits in accordance with subsection (a) or a patient who is not an insured who receives a surprise bill may submit a dispute regarding the surprise bill for review to an independent dispute resolution entity;

(2) The independent dispute resolution entity shall determine a reasonable fee for the services rendered based upon the conditions and factors set forth in section 431:10-D; and

(3) An insured who has not assigned benefits in accordance with subsection (a) or a patient who is not an insured shall not be required to pay the health care provider's fee to be eligible to submit the dispute for review to the independent dispute entity.

(c) The determination of an independent dispute resolution entity shall be binding on the patient, health care provider, and health care plan and shall be admissible in any court proceeding between the patient or insured, health care provider, or health care plan or in any administrative proceeding between the State and the health care provider.

§431:10-H Payment for independent dispute resolution entity. (a) For disputes involving an insured, when:

(1) The independent dispute resolution entity determines the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the nonparticipating health care provider;

(2) The independent dispute resolution entity determines the nonparticipating health care provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan; and

(3) A good faith negotiation directed by the independent dispute resolution entity pursuant to section 431:10-E(a)(4) or 431:10-G(a)(6) results in a settlement

between the health care plan and nonparticipating health care provider, the health care plan and the nonparticipating health care provider shall evenly divide and share the prorated cost for dispute resolution.

(b) For disputes involving a patient that is not an insured, when:

(1) The independent dispute resolution entity determines the health care provider's fee is reasonable, payment for the dispute resolution process shall be the responsibility of the patient unless payment for the dispute resolution process would pose a hardship to the patient; provided that the commissioner shall adopt rules pursuant to chapter 91 to determine payment for the dispute resolution process in cases of hardship; and

(2) The independent dispute resolution entity determines the health care provider's fee is unreasonable, payment for the dispute resolution process shall be the responsibility of the health care provider."

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

"**§321- Disclosure required.** (a) A health care provider, health care facility, or hospital shall disclose to patients or prospective patients in writing or through an internet website the health care plans in which the health care provider, health care facility, or hospital is a participating provider and the hospitals with which the health care provider is affiliated prior to the provision of nonemergency services and verbally at the time an appointment is scheduled.

(b) If a health care provider, health care facility, or hospital is not a participating provider in a patient's or prospective patient's health care plan network, the health care provider, health care facility, or hospital shall:

(1) Inform a patient or prospective patient that the amount or estimated amount the health care provider will bill the patient for health care services is available upon request, prior to the provision of non-emergency services; and

(2) Upon request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount or estimated amount that the health care provider, health care facility, or hospital will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient, absent unforeseen medical circumstances that may arise when the health care services are provided.

(c) A health care provider who is a physician shall provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated or referred by the physician for the patient at the time of referral to or coordination of services with that provider.

(d) A health care provider who is a physician shall, for a patient's scheduled hospital admission or scheduled outpatient hospital services, provide a patient and the hospital with the

name, practice name, mailing address, and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the preadmission testing, registration or admission at the time nonemergency services are scheduled and information on how to determine the health care plans in which the physician participates.

(e) A hospital shall establish, update, and make public through posting on the hospital's website, to the extent required by federal guidelines, a list of the hospital's standard charges for items and services provided by the hospital.

(f) The following information shall be posted on a hospital's website:

(1) The health care plans in which the hospital is a participating provider;

(2) A statement that:

(A) Health care provider services provided in the hospital are not included in the hospital's charges;

(B) Health care providers who provide services in the hospital may or may not participate with the same health care plans as the hospital; and

(C) The prospective patient should check with a health care provider who arranges for the hospital services to determine the health care plans in which the health care provider participates;

(3) As applicable, the name, mailing address, and telephone number of the medical groups that the hospital has contracted with to provide services including anesthesiology, pathology, or radiology and instructions on how to contact the medical groups to determine the health care plan participation of the physicians in the groups; and

(4) As applicable, the name, mailing address, and telephone number of health care providers employed by the hospital and whose services may be provided at the hospital and the health care plans in which they participate.

(g) A hospital shall include the following in registration or admission materials provided in advance of non-emergency hospital services:

(1) A recommendation that the patient or prospective patient should check with a health care provider arranging the hospital services to determine:

(A) The name, practice name, mailing address, and telephone number of any other health care provider whose services will be arranged by the health care provider; and

(B) Whether the services of physicians who are employed or contracted by the hospital to provide services including anesthesiology, pathology, or radiology are reasonably anticipated to be provided to the patient; and

(2) Information for patients or prospective patients on how to timely determine the health care plans participated in by health care providers who are reasonably anticipated to provide services to the patient at the hospital, as determined by the health care provider arranging the patient's hospital

services, and who are employees of the hospital or who are contracted by the hospital to provide services including anesthesiology, radiology, or pathology.

(h) For purposes of this section:

"Health care facility" means any institution, place, building, or agency, or portion thereof, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, rehabilitative, or preventive care to any person or persons.

"Health care plan" means a health insurance company, mutual benefit society governed by article 1 of chapter 432, health care service plan or health maintenance organization governed by chapter 432D, or any other entity delivering or issuing for delivery in the State accident and health or sickness insurance as defined in section 431:1-205.

"Health care provider" means an individual who is licensed or otherwise authorized by the State to provide health care services, including physicians and osteopathic physicians licensed under chapter 453, physician assistants licensed under chapter 453, and advanced practice registered nurses licensed under chapter 457.

"Hospital" means:

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

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

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

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

(b) When a policyholder receives emergency services from a provider that is not a participating provider in the provider network of an insurer, the policyholder shall not incur greater out-of-pocket costs for the emergency services than the

policyholder would have incurred with a participating provider of health care services.

(c) If a contract with a participating provider has not been reduced to writing as required by this section, or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the policyholder sums owed by the insurer. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a policyholder to collect sums owed by the insurer.

(d) For purposes of this subsection, "emergency services" shall have the same meaning as in section 431:10-A."

SECTION 5. Section 431:10-109, Hawaii Revised Statutes, is 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) A description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(2) A description of all prior authorization or other requirements for treatments and services;

(3) A description prepared annually of the types of methodologies the insurer uses to reimburse providers specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between an insurer and a health care provider;

(4) An explanation of an insured's financial responsibility for payment of premiums, coinsurance,

copayments, deductibles, and any other charges; annual limits on an insured's financial responsibility; caps on payments for covered services; and financial responsibility for non-covered health care procedures, treatments, or services;

(5) Where applicable, an explanation of an insured's financial responsibility for payment when services are provided by a health care provider who is not part of the insurer's network of providers or by any provider without required authorization, or when a procedure, treatment, or service is not a covered benefit;

(6) A description of the procedure for obtaining emergency services; provided that the description shall include a definition of emergency services; notice that emergency services shall not be subject to prior approval; and shall specify the insured's financial and other responsibilities regarding obtaining emergency services;

(7) Where applicable, a description of procedures for insureds to select and access the insurer's primary and specialty care providers, including notice of how

to determine whether a participating provider is accepting new patients;

(8) Where applicable, a description of the procedures for changing primary and specialty care providers within the insurer's network of providers;

(9) Where applicable, notice that an insured enrolled in a managed care plan that utilizes a network of providers offered by the insurer may obtain a referral or preauthorization for a health care provider outside of the insurer's network when the insurer does not have a health care provider who is geographically accessible to the insured and who has the appropriate training and experience in the network to meet the particular health care needs of the insured and the procedure by which the insured can obtain the referral or preauthorization;

(10) Where applicable, notice that an insured, who is enrolled in a managed care plan that utilizes a network of providers offered by the insurer and who has a condition that requires ongoing care from a specialist, may request a standing referral to the

specialist and the procedure for requesting and obtaining a standing referral;

(11) Where applicable, notice that an insured, who is enrolled in a managed care plan that utilizes a network of providers offered by the insurer and who has a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining a specialist;

(12) Notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization;

(13) Where applicable, a listing by specialty, which may be in a separate document that is updated annually, of:

(A) The name, address, and telephone number of all participating providers, including facilities;

(B) The name, address, telephone number, board certification, languages spoken, and any

affiliations with participating hospitals of all participating physicians;

provided that the listing shall be posted on the insurer's website and shall be updated within fifteen days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliation;

(14) A description of the method by which an insured may submit a claim for health care services;

(15) With regards to out-of-network coverage:

(A) A clear description of the methodology used by the insurer to determine reimbursement for out-of-network health care services;

(B) The amount that the insurer will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual and customary cost for out-of-network health care services; and

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

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

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

(c) For purposes of this section:

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

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

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

(3) Serious dysfunction of any bodily organ or part of such person; or

(4) Serious disfigurement of the person.

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

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

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

"Managed care plan" means any plan, policy, contract, certificate, or agreement, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a

point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:

(1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and

(2) Financial incentives for enrollees to use participating providers and procedures provided by a plan.

"Usual and customary cost" means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area."

SECTION 6. Section 432:1-407, Hawaii Revised Statutes, is amended by amending subsection (d) to read as follows:

"(d) Every contract between a mutual benefit society and a participating provider of health care services shall be in writing and shall set forth that in the event the society fails to pay for health care services as set forth in the contract,

the subscriber or member shall not be liable to the provider for any sums owed by the society. When a subscriber or member receives emergency services from a provider that is not a participating provider in the provider network of the mutual benefit society, the mutual benefit society shall ensure that the subscriber or member shall incur no greater out-of-pocket costs for emergency services than the subscriber or member would have incurred with a participating provider of health care services. If a contract with a participating provider has not been reduced to writing as required by this subsection, or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or member sums owed by the society. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums owed by the society.

For purposes of this subsection, "emergency services" shall have the same meaning as in section 431:10-A."

SECTION 7. Section 432D-8, Hawaii Revised Statutes, is amended by amending subsection (d) to read as follows:

"(d) 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 health maintenance organization. When a subscriber or enrollee receives emergency services from a provider that is not a participating provider in the provider network of the health maintenance organization, the health maintenance organization shall ensure that the subscriber or enrollee shall incur no greater out-of-pocket costs for emergency services than the subscriber or enrollee would have incurred with a participating provider of health care services. In the event that a contract with a participating provider has not been reduced to writing as required by this subsection or that 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 collect sums owed by the health maintenance organization.

For purposes of this subsection, "emergency services" shall have the same meaning as in section 431:10-A."

SECTION 8. Section 432F-2, Hawaii Revised Statutes, is amended to read as follows:

"[~~+~~]§432F-2[~~+~~] **Health care provider network adequacy.** (a) On or before January 1 of each calendar year, each managed care plan shall demonstrate the adequacy of its provider network to the commissioner. A provider network shall be considered adequate if it provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay, after taking into consideration geography. The commissioner shall also consider any applicable federal standards on network adequacy. A certification from a national accreditation organization shall create a rebuttable presumption that the network of a managed care plan is adequate. This presumption may be rebutted by evidence submitted to, or collected by, the commissioner.

(b) A managed care plan that does not have a certification from a national accreditation organization may submit to the

commissioner a plan to become accredited by a national accreditation organization within a period of two years if the managed care plan has provided sufficient evidence that its network is reasonably adequate at the time of submission of the plan. The commissioner shall also consider any applicable federal standards on network adequacy. The commissioner may extend the period of time for accreditation.

(c) The commissioner shall approve or disapprove a managed care plan's annual filing on network adequacy. If the commissioner deems the filing incomplete, additional information and supporting documentation may be requested. A managed care plan shall have sixty days to appeal an adverse decision by the commissioner in an administrative hearing pursuant to chapter 91.

(d) To enable the commissioner to determine the network adequacy for qualified health plans to be listed with the Hawaii health connector under section 435H-11, the commissioner may request that a managed care plan demonstrate the adequacy of its provider network at the time that it files its health plan benefit document with the commissioner.

(e) A managed care plan that issues a group contract or policy that covers out-of-network health care services shall make available and, if requested by the policy holder or contract holder, provide at least one option for coverage for at least eighty per cent of the usual and customary cost of each out-of-network health care service after imposition of a deductible or any permissible benefit maximum; provided that this subsection shall not apply to emergency department services.

(f) If there is no coverage available pursuant to subsection (a) in a geographic area, the commissioner may require a managed care plan issues a group contract or policy in the geographic region, to make available and, if requested by the policy holder or contract holder, provide at least one option for coverage of eighty per cent of the usual and customary cost of each out-of-network health care service after imposition of any permissible deductible or benefit maximum; provided that this subsection shall not apply to emergency department services.

[~~(e)~~] (g) This section shall apply to any managed care plan qualified as a prepaid health care plan pursuant to chapter 393.

(h) For purposes of this section, "usual and customary cost" means the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area."

SECTION 9. In codifying the new sections added by section 2 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

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

SECTION 11. This Act shall take effect on July 1, 2016.

INTRODUCED BY:

JAN 2 2 2016

H.B. NO. 1952

Report Title:
Insurance; Out-of-Network Providers; Balance Bills; Surprise Bills; Independent Dispute Resolution; Emergency Services; Health Care Providers; Health Care Facilities; Disclosure; Network Adequacy

Description:
Establishes a dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. Specifies disclosure requirements for health care professionals and health care facilities, including estimated costs for health care services and information on participating provider networks. Specifies that an insured shall not be liable to a health care provider for any sums owed by an insurer. Specifies that an insurer who receives emergency services from a nonparticipating provider shall not incur greater out-of-pocket costs for the emergency services than the insured would have incurred with a participating provider. Specifies additional disclosure requirements for health insurance plans, including payment methodologies and updated participating provider directories. Requires health insurance plans to provide at least one option for coverage for at least eighty per cent of the usual and customary cost of each out-of-network health care service in inadequate network situations.

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