THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

JAN 17 2020

S.B. NO. 2278

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

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

1 Maryland, Connecticut, Illinois, New York, New Hampshire, New
2 Jersey, and Florida have enacted comprehensive approaches to end
3 balance billing and surprise bills. Similarly, New Mexico,
4 Texas, Washington, and Colorado passed new comprehensive laws in
5 2019. Hawaii patients continue to be at risk of being caught in
6 the middle of balance billing disputes between health insurers
7 and providers or being hit with significant surprise bills.
8 The purpose of this Act is to specify:
9 (1) Disclosure and consent requirements for health care
10 providers, health care facilities, and hospitals that
11 are nonparticipating providers in a patient's health
12 care plan;
13 (2) The circumstances in which a patient shall not be
14 liable to a health care provider for any sums owed by
15 an insurer, mutual benefit society, or health
16 maintenance organization; and
17 (3) The rate at which a health insurance plan must
18 reimburse a nonparticipating provider who provides
19 health care to a patient, unless otherwise agreed to
20 by the nonparticipating provider and the health
21 insurance plan.

1 SECTION 2. Chapter 321, Hawaii Revised Statutes, is
2 amended by adding a new section to be appropriately designated
3 and to read as follows:
4 "**§321- Disclosure and consent required.** (a) A health
5 care provider, health care facility, or hospital shall disclose
6 the following information in writing to patients or prospective
7 patients prior to the provision of non-emergency services that
8 are not authorized by the patients' health care plan:
9 (1) That certain health care facility-based health care
10 providers may be called upon to render care to a
11 covered person during the course of treatment;
12 (2) That those health care facility-based health care
13 providers may not have contracts with the covered
14 person's health care plan and are therefore considered
15 to be out-of-network providers;
16 (3) That the services provided will be on an out-of-
17 network basis and the cost may be substantially higher
18 than if the services were provided in-network;
19 (4) A notification that the covered person may either
20 agree to accept and pay the charges for the out-of-
21 network services or rely on any other rights and

1 remedies that may be available under state or federal
2 law; and
3 (5) A statement indicating that the covered person may
4 obtain from the covered person's health care plan a
5 list of health care facility-based health care
6 providers who are participating providers and the
7 covered person may request those participating
8 facility-based health care providers.
9 (b) If a health care provider, health care facility, or
10 hospital is not a participating provider in a patient's or
11 prospective patient's health care plan network, and the patient
12 is receiving non-emergency health care services, the health care
13 provider, health care facility, or hospital shall:
14 (1) At least twenty-four hours prior to the provision of
15 non-emergency services, disclose to the patient or
16 prospective patient in writing and in compliance with
17 subsection (c), the amount or estimated amount that
18 the health care provider, health care facility, or
19 hospital will bill the patient or prospective patient
20 for non-emergency health care services provided or
21 anticipated to be provided to the patient or

1 prospective patient, not including unforeseen medical
2 circumstances that may arise when the health care
3 services are provided; and
4 (2) At least twenty-four hours prior to the provision of
5 non-emergency services, obtain the written consent of
6 the patient or prospective patient for provision of
7 services by the nonparticipating health care provider,
8 health care facility, or hospital in writing separate
9 from the document used to obtain the consent for any
10 other part of the care or procedure; provided that the
11 consent shall not be obtained at the time of admission
12 or at any time when the patient or prospective patient
13 is being prepared for surgery or any other procedure.
14 (c) Any communication from the nonparticipating health
15 care provider, health care facility, or hospital to the patient
16 or prospective patient shall include notice in a twelve-point
17 bold type stating that the communication is not a bill and
18 informing the patient or prospective patient that the patient or
19 prospective patient shall not pay any amount or estimated amount
20 until the patient's or prospective patient's health care plan

1 informs the patient or prospective patient of any applicable
2 cost-sharing.
3 (d) A nonparticipating health care provider, health care
4 facility, or hospital that fails to comply with this section
5 shall not bill or collect any amount from the patient or
6 prospective patient in excess of the in-network cost-sharing
7 owed by the patient or prospective patient that would be billed
8 or collected for the same services rendered by a participating
9 health care provider, health care facility, or hospital.
10 (e) For purposes of this section:
11 "Health care facility" means any institution, place,
12 building, or agency, or portion thereof, licensed or otherwise
13 authorized by the State, whether organized for profit or not,
14 used, operated, or designed to provide medical diagnosis,
15 treatment, or rehabilitative or preventive care to any person or
16 persons.
17 "Health care plan" means a policy, contract, plan, or
18 agreement delivered or issued for delivery by a health insurance
19 company, mutual benefit society governed by article 1 of chapter
20 432, health maintenance organization governed by chapter 432D,
21 or any other entity delivering or issuing for delivery in the

1 State accident and health or sickness insurance as defined in
2 section 431:1-205, other than disability insurance that replaces
3 lost income.
4 "Health care provider" means an individual who is licensed
5 or otherwise authorized by the State to provide health care
6 services.
7 "Hospital" means:
8 (1) An institution with an organized medical staff,
9 regulated under section 321-11(10), that admits
10 patients for inpatient care, diagnosis, observation,
11 and treatment; and
12 (2) A health facility under chapter 323F.
13 "In-network cost-sharing" means the amount owed by a
14 covered person to a health care provider, health care facility,
15 or hospital that is a participating member of the covered
16 person's health care plan's network."
17 SECTION 3. Chapter 431, Hawaii Revised Statutes, is
18 amended by adding two new sections to article 10A be
19 appropriately designated and to read as follows:
20 "**§431:10A-A Balance billing; hold harmless; emergency**
21 **services.** (a) Every contract between an insurer and a

1 participating provider of health care services shall be in
2 writing and shall set forth that in the event the insurer fails
3 to pay for health care services as set forth in the contract,
4 the insured shall not be liable to the provider for any sums
5 owed by the insurer.
6 (b) If a contract with a participating provider has not
7 been reduced to writing as required by subsection (a), or if a
8 contract fails to contain the required prohibition, the
9 participating provider shall not collect or attempt to collect
10 from the insured sums owed by the insurer. No participating
11 provider, or agent, trustee, or assignee thereof, may maintain
12 any action at law against an insured to:
13 (1) Collect sums owed by the insurer; or
14 (2) Collect sums in excess of the amount owed by the
15 insured as a copayment, coinsurance, or deductible
16 under the insured's policy of accident and health or
17 sickness insurance.
18 (c) When an insured receives emergency services from a
19 provider who is not a participating provider in the provider
20 network of the insured, the insured shall not incur greater out-
21 of-pocket costs for emergency services than the insured would

1 have incurred with a participating provider of health care
2 services. No nonparticipating provider, or agent, trustee, or
3 assignee thereof, may maintain any action at law against an
4 insured to collect sums in excess of the amount owed by the
5 insured as a copayment, coinsurance, or deductible under the
6 insured's policy of accident and health or sickness insurance.
7 (d) For purposes of this section:
8 "Emergency condition" means a medical or behavioral
9 condition that manifests itself by acute symptoms of sufficient
10 severity, including severe pain, such that a prudent layperson,
11 possessing an average knowledge of medicine and health, could
12 reasonably expect the absence of immediate medical attention to
13 result in:
14 (1) Placing the health of the person afflicted with the
15 condition in serious jeopardy;
16 (2) Serious impairment to the person's bodily functions;
17 (3) Serious dysfunction of any bodily organ or part of the
18 person; or
19 (4) Serious disfigurement of the person.
20 "Emergency services" means, with respect to an emergency
21 condition:

1 (1) A medical screening examination as required under
2 section 1867 of the Social Security Act, title 42
3 United States Code section 1395dd; and
4 (2) Any further medical examination and treatment, as
5 required under section 1867 of the Social Security
6 Act, title 42 United States Code section 1395dd, to
7 stabilize the patient.
8 **§431:10A-B Balance billing; hold harmless; non-emergency**
9 **services.** Absent a signed consent form as required under
10 section 321- , no nonparticipating health care provider,
11 health care facility, or hospital, 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 for similar
15 services provided by a participating provider under the
16 insured's policy of accident and health or sickness insurance."
17 SECTION 4. Chapter 431, Hawaii Revised Statutes, is
18 amended by adding a new section to article 14G to be
19 appropriately designated and to read as follows:
20 "**§431:14G- Out-of-network or nonparticipating provider**
21 **reimbursement; rate calculation.** (a) Absent a signed consent

1 form as required under section 321- or any contract to the
2 contrary, a managed care plan shall reimburse a nonparticipating
3 provider the greater of:
4 (1) The usual and customary rate for similar services
5 provided by a participating provider under the
6 insured's managed care plan; or
7 (2) per cent of the amount medicare reimburses on a
8 fee-for-service basis for the same or similar services
9 in the general geographic region in which the services
10 were rendered.
11 (b) Nothing in this section shall be construed to require
12 a managed care plan to cover services not required by law or by
13 the terms and conditions of the managed care plan. Nothing in
14 this section shall be construed to prohibit nonparticipating
15 providers from seeking the uncovered cost of services rendered
16 from enrollees who have consented to receive the health care
17 services provided by the nonparticipating provider in accordance
18 with section 321- .
19 (c) For purposes of this section "usual and customary
20 rate" shall mean the managed care plan's average contracted
21 rate."

1 SECTION 5. Chapter 432, Hawaii Revised Statutes, is
2 amended by adding three new sections to article 1 to be
3 appropriately designated and to read as follows:
4 "**§432:1- Balance billing; hold harmless; emergency**
5 **services.** (a) Every contract between a mutual benefit society
6 and a participating provider of health care services shall be in
7 writing and shall set forth that in the event the mutual benefit
8 society fails to pay for health care services as set forth in
9 the contract, the subscriber or member shall not be liable to
10 the provider for any sums owed by the mutual benefit society.
11 (b) If a contract with a participating provider has not
12 been reduced to writing as required by subsection (a), or if a
13 contract fails to contain the required prohibition, the
14 participating provider shall not collect or attempt to collect
15 from the subscriber or member sums owed by the mutual benefit
16 society. No participating provider, or agent, trustee, or
17 assignee thereof, may maintain any action at law against a
18 subscriber or member to:
19 (1) Collect sums owed by the mutual benefit society; or
20 (2) Collect sums in excess of the amount owed by the
21 subscriber or member as a copayment, coinsurance, or

1 deductible under the subscriber's or member's plan
2 contract.
3 (c) When a subscriber or member receives emergency
4 services from a provider who is not a participating provider in
5 the provider network of the subscriber or member, the subscriber
6 or member shall not incur greater out-of-pocket costs for
7 emergency services than the subscriber or member would have
8 incurred with a participating provider of health care services.
9 No nonparticipating provider, or agent, trustee, or assignee
10 thereof, may maintain any action at law against a subscriber or
11 member to collect sums in excess of the amount owed by the
12 subscriber or member as a copayment, coinsurance, or deductible
13 under the subscriber's or member's plan contract.
14 (d) 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 the
5 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 **§432:1- Balance billing; hold harmless; non-emergency**
17 **services.** Absent a signed consent form as required under
18 section 321- , no nonparticipating health care provider,
19 health care facility, or hospital, or agent, trustee, or
20 assignee thereof, may maintain any action at law against a
21 subscriber or member to collect sums in excess of the amount

1 owed by the subscriber or member as a copayment, coinsurance, or
2 deductible for similar services provided by a participating
3 provider under the subscriber's or member's plan contract.
4 **§432:1- Out-of-network or nonparticipating provider**
5 **reimbursement; rate calculation.** (a) Absent a signed consent
6 form as required under section 321- or any contract to the
7 contrary, a mutual benefit society shall reimburse a
8 nonparticipating provider the greater of:
9 (1) The usual and customary rate for similar services
10 provided by a participating provider under the
11 subscriber's or member's plan contract; or
12 (2) ____ per cent of the amount medicare reimburses on a
13 fee-for-service basis for the same or similar services
14 in the general geographic region in which the services
15 were rendered.
16 (b) Nothing in this section shall be construed to require
17 a mutual benefit society to cover services not required by law
18 or by the terms and conditions of the plan contract. Nothing in
19 this section shall be construed to prohibit nonparticipating
20 providers from seeking the uncovered cost of services rendered
21 from subscribers or members who have consented to receive the

1 health care services provided by the nonparticipating provider
2 in accordance with section 321-   .
3 (c) For purposes of this section "usual and customary
4 rate" shall mean the mutual benefit society's average contracted
5 rate."
6 SECTION 6. Chapter 432D, Hawaii Revised Statutes, is
7 amended by adding three new sections to be appropriately
8 designated and to read as follows:
9 "**§432D-   Balance billing; hold harmless; emergency**
10 **services.** (a) Every contract between a health maintenance
11 organization and a participating provider of health care
12 services shall be in writing and shall set forth that in the
13 event the health maintenance organization fails to pay for
14 health care services as set forth in the contract, the
15 subscriber or enrollee shall not be liable to the provider for
16 any sums owed by the carrier or health maintenance organization.
17 (b) If a contract with a participating provider has not
18 been reduced to writing as required by subsection (a), or if a
19 contract fails to contain the required prohibition, the
20 participating provider shall not collect or attempt to collect
21 from the subscriber or enrollee sums owed by the health

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

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

Act, title 42 United States Code section 1395dd, to stabilize the patient.

§432D- Balance billing; hold harmless; non-emergency services. Absent a signed consent form as required under section 321- , no nonparticipating health care provider, health care facility, or hospital, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums in excess of the amount owed by the subscriber or enrollee as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the subscriber's or enrollee's policy, contract, plan, or agreement.

§432D- Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) Absent a signed consent form as required under section 321- or any contract to the contrary, a health maintenance organization shall reimburse a nonparticipating provider the greater of:

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

1 (2) ___. per cent of the amount medicare reimburses on a
2 fee-for-service basis for the same or similar services
3 in the general geographic region in which the services
4 were rendered.
5 (b) Nothing in this section shall be construed to require
6 a health maintenance organization to cover services not required
7 by law or by the terms and conditions of the policy, contract,
8 plan, or agreement. Nothing in this section shall be construed
9 to prohibit nonparticipating providers from seeking the
10 uncovered cost of services rendered from subscribers or
11 enrollees who have consented to receive the health care services
12 provided by the nonparticipating provider in accordance with
13 section 321- .
14 (c) For purposes of this section "usual and customary
15 rate" shall mean the carrier or health maintenance
16 organization's average contracted rate."
17 SECTION 7. Section 431:10-109, Hawaii Revised Statutes, is
18 amended to read as follows:
19 "[[]§431:10-109[]] **Disclosure of** [~~**health care coverage and**~~
20 ~~**benefits.**~~] **information.** (a) In order to ensure that all
21 individuals understand their health care options and are able to

1 make informed decisions, all insurers shall provide current and
2 prospective insureds with written disclosure of [~~coverages and~~
3 ~~benefits, including information on coverage principles and any~~
4 ~~exclusions or restrictions on coverage.~~] the following
5 information:
6 (1) Coverages and benefits, including information on
7 coverage principles and any exclusions or restrictions
8 on coverage;
9 (2) With regard to out-of-network coverage:
10 (A) For non-emergency services where the insured has
11 consented to services provided by an out-of-
12 network provider in accordance with section
13 321- , the amount that the insurer will
14 reimburse under the rate calculation for out-of-
15 network health care specified in section
16 431:14G- ; and
17 (B) Examples of anticipated out-of-pocket costs for
18 frequently billed out-of-network health care
19 services; and
20 (3) Information in writing and through an internet website
21 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 SECTION 8. In codifying the new sections added by section
17 3 of this Act, the revisor of statutes shall substitute
18 appropriate section numbers for the letters used in designating
19 the new sections in this Act.
20 SECTION 9. Statutory material to be repealed is bracketed
21 and stricken. New statutory material is underscored.

S.B. NO. 2278

1 SECTION 10. This Act shall take effect upon its approval.

2

INTRODUCED BY: ______________________

S.B. NO. 2278

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

Description:
Establishes disclosure and consent requirements for nonparticipating health care providers. Prohibits nonparticipating health care providers from balance billing patients in specific circumstances. Establishes rate calculation requirements for reimbursement of nonparticipating providers.

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

SB HMS 2020-0003