THE SENATE
THIRTIETH LEGISLATURE, 2020
STATE OF HAWAII

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

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that patients with health insurance who receive treatment from an out-of-network provider may be subject to the practice known as "balance billing" or "surprise billing", where the provider bills the patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge. These bills occur most often when patients inadvertently receive medical services from out-of-network providers, such as when a patient is undergoing surgery and is not informed that a member of the medical team is not a participating provider in the patient's health insurance's provider network, or when a patient is in need of emergency services and is taken to the nearest medical facility, regardless of the facility's or its providers' network status. Out-of-network providers may not have a contracted rate with a health insurer for services; 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 or surprise bills can be an unwelcome shock to patients who may have unknowingly received health care services outside of their provider network. These unexpected medical bills are a major concern for Americans. According to a September 2018 Kaiser Family Foundation poll, two-thirds of respondents said they were "very worried" or "somewhat worried" that they or a family member would receive a surprise bill. In fact, these bills are the most-cited concern related to health care costs and other household expenses. Furthermore, out-of-network bills sent to health insurers or carriers from physicians can be more than thirty times the average in-network rate for those same services.

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

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

The purpose of this Act is to:

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

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

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

(4) Require mandatory mediation to resolve disputes between insurers and providers to be overseen by the

insurance division of the department of commerce and consumer affairs.

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

"**§431:10A-A Balance billing; hold harmless; emergency services; mandatory mediation.** (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 insured shall not be liable to the provider for any sums owed by the insurer.

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

(1) Collect sums owed by the insurer; or

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

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

(d) When an insured receives emergency services from a provider who is not a participating provider in the provider network of the insured, the insurer shall use data from a transparent, third-party database upon which to calculate out-of-network reimbursements for emergency services.

(e) Any dispute between an insurer and provider that arises pursuant to this section shall be submitted to mandatory mediation to be overseen by the insurance division.

(f) 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 the 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, title 42 United States Code section 1395dd; and

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

§431:10A-B Balance billing; hold harmless; non-emergency services. No nonparticipating health care provider; health care facility or hospital; or agent, trustee, or assignee thereof, may maintain any action at law against an insured to collect sums in excess of the amount owed by the insured as a copayment, coinsurance, or deductible for similar services provided by a participating provider under the insured's policy of accident and health or sickness insurance."

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 14G to be appropriately designated and to read as follows:

"**§431:14G- Out-of-network or nonparticipating provider reimbursement; rate calculation.** (a) Notwithstanding section 431:10A-A or any contract to the contrary, a managed care plan shall reimburse a nonparticipating provider the greater of:

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

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

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

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

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

"**§432:1-A Balance billing; hold harmless; emergency services; mandatory mediation.** (a) 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 mutual benefit 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 mutual benefit society.

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

(1) Collect sums owed by the mutual benefit society; or

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

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

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

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

(e) Any dispute between a mutual benefit society and provider that arises pursuant to this section shall be submitted to mandatory mediation to be overseen by the insurance division.

(f) 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 the 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, title 42 United States Code section 1395dd; and

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

§432:1-B Balance billing; hold harmless; non-emergency services. 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 member to

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

§432:1-C Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) Notwithstanding section 432:1-A, and absent any contract to the contrary, a mutual benefit society 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 member's plan contract; or

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

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

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

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

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

(b) If a contract with a participating provider has not been reduced to writing as required by subsection (a), or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent,

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

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

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

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

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

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

(f) 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 the 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, title 42 United States Code section 1395dd; and

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

§432D-B Balance billing; hold harmless; non-emergency services. 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-C Out-of-network or nonparticipating provider reimbursement; rate calculation. (a) Notwithstanding section 432D-A 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

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

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

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

SECTION 6. 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) Coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage;

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

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

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

(3) Information in writing and through an internet website that reasonably permits an insured or prospective 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 rate calculation specified in section 431:14G- 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, title 42 United States Code section 1395dd; and

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

SECTION 7. In codifying the new sections added by sections 2, 4, and 5 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 8. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 9. This Act shall take effect on January 2, 2050, and shall be repealed on January 2, 2025; provided that section 431:10-109 shall be reenacted in the form in which it read on 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.