HOUSE OF REPRESENTATIVES
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

H.B. NO. 1789

A BILL FOR AN ACT

RELATING TO HEALTH CARE.

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

SECTION 1. Definitions. As used in this Act:

"Board" means the health care for all Hawaii board.

"Group practice" means a single legal entity consisting of individual providers organized as a partnership, professional corporation, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar association:

(1) In which each individual provider uses office space, facilities, equipment, and personnel shared with other individual providers to deliver medical care, consultation, diagnosis, treatment, or other services that the provider routinely delivers in the provider's practice;

(2) For which substantially all of the services delivered by the individual providers are delivered on behalf of the group practice and billed as services provided by the group practice;

(3) For which substantially all of the payments to the group practice are to reimburse the cost of services provided by the individual providers in the group practice;

(4) In which the overhead expenses of, and the income from, the group practice are shared among the individual providers in the group practice in accordance with methods agreed to by the individual providers who are members of the group practice; and

(5) That is a unified business with consolidated billing, accounting, and financial reporting and a centralized decision-making body that represents the individual providers who are members of the group practice.

"Individual provider" means a health care provider who is licensed, certified, or registered in the State or who is licensed, certified, or registered to provide care in another state or country.

"Institutional provider" means a single legal entity that is:

(1) A health care facility as defined in section 323D-2;

(2) A comprehensive outpatient rehabilitation facility;

(3) A home health agency; or

(4) A hospice program.

"Provider" means an individual provider, institutional provider, or group practice.

"Single payer health care financing system" means a universal system used by the State for paying the cost of health care services or goods in which:

(1) Institutional providers are paid directly for health care services or goods by the State or are paid by an administrator that does not bear risk in its contracts with the State;

(2) Group practices are paid directly for health care services or goods by the State or are paid by an administrator that does not bear risk in its contracts with the State; and

(3) Individual providers are paid directly for health care services or goods by the State, their employers, an administrator that does not bear risk in its contracts with the State, an institutional provider, or a group practice.

SECTION 2. Establishment of the health care for all Hawaii board; advisory committee. (a) There is established a health care for all Hawaii board, to be placed within the department of health for administrative purposes only, to design and recommend the health care for all Hawaii plan, a universal, equitable, affordable, and comprehensive health care system that is publicly funded and available to every resident of the State.

(b) The board shall consist of the following twenty members:

(1) Two members of the senate, including one member from the majority party and one member from the minority party, to be appointed by the senate president;

(2) Two members of the house of representatives, including one member from the majority party and one member from the minority party, to be appointed by the speaker of the house of representatives;

(3) Thirteen members appointed by the governor and with the advice and consent of the senate, who reside in the State and who:

(A) Demonstrate a commitment to achieving a universal, single-payer system, or as close to it as possible; and

(B) Possess expertise in health system design and health policy;

(4) The director of health, or the director's designee, who shall serve as an ex officio nonvoting member;

(5) The director of commerce and consumer affairs, or the director's designee, who shall serve as an ex officio nonvoting member; and

(6) A representative of the Hawaii State Association of Counties, who shall serve as a nonvoting member.

(c) In making appointments under subsection (b)(3), the governor shall ensure that there is no disproportionate influence by any individual, organization, government entity, industry, business, or profession in any decision-making by the board and no actual or potential conflicts of interest.

(d) A majority of the voting members of the board shall constitute a quorum to do business.

(e) Any official action by the board shall require the approval of a majority of the voting members of the board.

(f) The board shall elect a chairperson and a vice-chairperson from among its members.

(g) Any vacancy shall be filled in the same manner as the original appointment.

(h) The board shall meet at times and places as specified by the chairperson or a majority of the voting members of the board.

(i) The board may adopt rules pursuant to chapter 91, Hawaii Revised Statutes, necessary for the operation of the board.

(j) The board shall establish an advisory committee to provide input from a consumer perspective. The following qualifications shall be possessed by the members of the advisory committee such that:

(1) At least one member:

(A) Has experience in seeking or receiving health care in the State to address one or more serious medical conditions or disabilities;

(B) Is enrolled in a health benefits plan offered by the Hawaii employer-union health benefits trust fund;

(C) Is enrolled in employer-sponsored health insurance, group health insurance, or a self-insured health plan offered by an employer;

(D) Is enrolled in commercial insurance purchased without any employer contribution;

(E) Receives medical assistance;

(F) Is enrolled in medicare;

(G) Is a parent or guardian of a child enrolled in the children's health insurance program;

(H) Is enrolled in the federal employees health benefits program;

(I) Is enrolled in TRICARE;

(J) Receives care from the United States Department of Veteran Affairs Veterans Health Administration;

(K) Has an active license to provide health care in the State;

(L) Has an active license to provide mental or behavioral health care in the State;

(M) Has expertise, based on knowledge and experience, in advocating for health care equity; and

(N) Has personal experience in seeking and receiving health care in the State to treat complex or multiple chronic illnesses or disabilities; and

(2) To the greatest extent practicable, at least one member from each of the following constituencies:

(A) Diverse social identities, including but not limited to individuals who identify by geography, race, ethnicity, sex, gender nonconformance, sexual orientation, economic status, disability, or health status; and

(B) Diverse areas of expertise, based on knowledge and experience, including but not limited to patient advocacy, receipt of medical assistance, management of a business that offers health insurance to the business's employees, public health, organized labor, provision of health care, or owning a small business; and

(C) The following areas of expertise acquired by education, vocation, or personal experience:

(i) Rural health;

(ii) Quality assurance and health care accountability;

(iii) Fiscal management and change management;

(iv) Social services;

(v) Public health services;

(vi) Medical and surgical services;

(vii) Alternative therapy services;

(viii) Services for individuals with disabilities; or

(ix) Nursing services.

Members of the advisory committee shall serve without compensation but may be reimbursed for actual expenses, including travel expenses, incurred in the performance of their duties.

(k) The board may establish additional advisory or technical committees the board deems necessary. The committees may be continuing or temporary. The board shall determine the representation, membership, terms, and organization of the committees and shall appoint the members of the committees.

(l) The legislative reference bureau shall provide administrative support to the board.

(m) The board may apply for public or private grants from nonprofit organizations for the costs of research.

(n) Members of the legislature appointed to the board pursuant to subsection (b)(1) and (2) shall be nonvoting members of the board and shall act in an advisory capacity only.

(o) Members of the board shall serve without compensation but may be reimbursed for actual expenses, including travel expenses, incurred in the performance of their duties.

(p) Members of advisory or technical committees, other than the advisory committee established pursuant to subsection (j), shall serve without compensation but may be reimbursed for actual expenses, including travel expenses, incurred in the performance of their duties.

(q) When necessary and applicable, all state departments shall cooperate with and assist the board in the performance of its duties and, to the extent permitted by federal and state confidentiality laws, furnish information and provide advice as requested by the board.

SECTION 3. Purpose. The board shall produce findings and recommendations for a well-functioning single payer health care

financing system that is responsive to the needs and expectations of the residents of the State by:

(1) Improving the health status of individuals, families, and communities;

(2) Defending against threats to the health of the residents of the State;

(3) Protecting individuals from the financial consequences of ill health;

(4) Providing equitable access to person-centered care;

(5) Removing cost as a barrier to accessing health care;

(6) Removing any financial incentive for a health care provider to provide care to one patient rather an another;

(7) Making it possible for individuals to participate in decisions affecting their health and the health care system;

(8) Establishing measurable health care goals and guidelines that align with other federal and state health standards; and

(9) Promoting continuous quality improvement and fostering interorganizational collaboration.

SECTION 4. Values. The board, in developing its recommendations for the health care for all Hawaii plan, shall consider, at a minimum, the following values:

(1) Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means, similar to public education, public safety, and other public infrastructure;

(2) Access to a distribution of health care resources and services according to each individual's needs and location within the State should be available. Race; color; national origin; age; disability; wealth; income; citizenship status; primary language use; genetic conditions; previous or existing medical conditions; religion; sex, including sex stereotyping, gender identity, and sexual orientation; and pregnancy and related medical conditions, including termination of pregnancy, should not create any barriers to health care or disparities in health outcomes due to access to care;

(3) The components of the single payer health care financing system should be accountable and fully transparent to the public with regard to information, decision-making, and management through meaningful public participation in decisions affecting people's health care; and

(4) Funding for the health care for all Hawaii plan should be a public trust and any savings or excess revenue should be returned to the trust.

SECTION 5. Principles. The board, in developing its recommendations for the health care for all Hawaii plan, shall consider, at a minimum, the following principles:

(1) A participant in the plan may choose any individual provider who is licensed, certified, or registered in the State or any group practice;

(2) The plan shall not discriminate against any individual provider who is licensed, certified, or registered in the State to provide services covered by the plan and who is acting within the individual provider's scope of practice;

(3) A participant and the participant's provider shall determine, within the scope of services covered within each category of care and within the plan's parameters for standards of care and requirements for prior authorization, whether a treatment is medically necessary or medically appropriate for that participant; and

(4) The plan shall cover services from birth to death, based on evidence-informed decisions as determined by the director of health.

SECTION 6. Scope of design of the health care for all Hawaii plan. (a) The design of the health care for all Hawaii plan recommended by the board shall:

(1) Adhere to the values and principles described under sections 4 and 5 of this Act, respectively;

(2) Be a single payer health care financing system;

(3) Ensure that individuals who receive services from the United States Department of Veterans Affairs Veterans Health Administration may be enrolled in the plan while continuing to receive services from the Veterans Health Administration;

(4) Equitably and uniformly include all state residents in the plan without decreasing the ability of any individual to obtain affordable health care coverage if the individual moves out of the State by obtaining a waiver of federal requirements that pose barriers to achieving the goal or by adopting other approaches; and

(5) Preserve the coverage of health services currently required by medicare; medicaid; the children's health insurance program; the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010; and any other federal or state program.

(b) In designing the plan, the board shall:

(1) Develop cost estimates for the plan, including but not limited to cost estimates for:

(A) The approach recommended for achieving the result described in subsection (a)(4); and

(B) The payment method designed by the board under section 7(b) in designing the plan;

(2) Consider the plan's impact on the structure of existing state and county boards and commissions and the counties, as well as its impact on the federal government and other states;

(3) Investigate other states' attempts at providing universal coverage and using single payer health care financing systems, including the outcomes of the attempts; and

(4) Consider the work by existing health care provider boards and commissions and include important aspects of the work of these boards and commissions in its recommendations.

(c) In developing recommendations for the plan, the board shall engage in a public process to solicit public input on the elements of the plan. The public process shall:

(1) Ensure input from individuals in rural and underserved communities and individuals in communities that experience health care disparities;

(2) Solicit public comments statewide while providing the public with evidence-based information developed by the board about the health care costs of a single

payer health care financing system, including the cost estimates developed under subsection (b), as compared to the current system; and

(3) Solicit the perspectives of:

(A) Individuals throughout the range of communities that experience health care disparities;

(B) A range of businesses, based on industry and employer size;

(C) Individuals whose insurance coverage represents a range of current insurance types and individuals who are uninsured or underinsured; and

(D) Individuals with a range of health care needs, including individuals needing disability services and long-term care services who have experienced the financial and social effects of policies requiring them to exhaust a large portion of their resources before qualifying for long-term care services paid for by federal or state assistance programs.

(d) The board's recommendations shall be succinct statements and include actions and timelines, the degree of

consensus, and the priority of each recommendation, based on urgency and importance. The report shall include but not be limited to the following:

(1) The governance and leadership of the board, specifically:

(A) The composition and representation of the membership of the board, appointed or otherwise selected using an open and equitable selection process;

(B) The statutory authority of the board to establish policies, guidelines, mandates, incentives, and enforcement needed to develop a highly effective and responsive single payer health care financing system;

(C) The ethical standards and the enforcement of the ethical standards for members of the board to ensure the most rigorous protections and prohibitions from actual or perceived economic conflicts of interest; and

(D) The steps for ensuring that there is no disproportionate influence by any individual,

organization, government, industry, business, or profession in any decision-making by the board;

(2) A list of federal and state laws and rules, state contracts or agreements, and court actions or decisions that may facilitate, constrain, or prevent implementation of the plan and an explanation of how the federal or state laws and rules, state contracts or agreements, and court actions or decisions may facilitate or constrain or prevent implementation;

(3) The plan's economic sustainability, operational efficiency, and cost control measures that include but shall not be limited to the following:

(A) A financial governance system supported by relevant legislation, financial audit and public expenditure reviews, and clear operational rules to ensure efficient use of public funds; and

(B) Cost control features such as multistate purchasing;

(4) Features of the plan that are necessary to continue to receive federal funding that is currently available to

the State and estimates of the amount of the federal funding that will be available;

(5) Fiduciary requirements for the revenue generated to fund the plan, including but not limited to the following:

(A) A dedicated fund, separate and distinct from the general fund, that is held in trust for the residents of the State;

(B) Restrictions to be authorized by the board on the use of the trust fund;

(C) A process for creating a reserve fund by retaining moneys in the trust fund if, over the course of a year, revenue exceeds costs; and

(D) Required accounting methods that eliminate the potential for misuse of public funds, detect inaccuracies in provider reimbursement, and use the most rigorous generally accepted accounting principles, including annual external audits and audits at the time of each transition in the board's executive management;

(6) Requirements for the purchase of reinsurance;

(7) Bonding authority that may be necessary;

(8) The board's role in workforce recruitment, retention, and development;

(9) A process for the board to develop statewide goals, objectives, and ongoing review;

(10) The appropriate relationship between the board and regional or local authorities regarding oversight of health activities, health care systems, and providers to promote community health reinvestment, equity, and accountability;

(11) Criteria to guide the board in determining which health care services are necessary for the maintenance of health, prevention of health problems, treatment or rehabilitation of health conditions, and long-term and respite care. Criteria may include but shall not be limited to the following:

(A) Whether the services are cost-effective and based on evidence from multiple sources;

(B) Whether the services are currently covered by the health benefit plans offered by the Hawaii employer-union health benefits trust fund;

(C) Whether the services are designated as effective by the United States Preventive Services Task Force; Advisory Committee on Immunization Practices; Bright Futures Program of the United States Department of Health and Human Services, Health Resources and Services Administration; or Institute of Medicine Committee on Preventive Services for Women; and

(D) Whether the evidence on the effectiveness of services comes from peer-reviewed medical literature, existing assessments and recommendations from federal and state boards and commissions, and other peer-reviewed sources;

(12) A process to track and resolve complaints, grievances, and appeals, including establishing an office of the patient advocate;

(13) Options for transition planning, including an impact analysis on existing health systems, providers, and patient relationships;

(14) Options for incorporating cost containment measures such as prior approval and prior authorization

requirements and the effect of such measures on equitable access to quality diagnosis and care;

(15) The methods of reimbursing providers for the cost of care as described in section 7(b) and recommendations regarding the appropriate reimbursement for the cost of services provided to plan participants when they are traveling outside of the State; and

(16) Recommendations for long-term care services and supports that are tailored to each individual's needs based on an assessment. The services and supports may include:

(A) Long-term nursing services provided by an institutional provider or in a community-based setting;

(B) A broad spectrum of long-term services and supports, including home and community-based settings or other noninstitutional settings;

(C) Services that meet the physical, mental, and social needs of individuals while allowing them maximum possible autonomy and maximum civic, social, and economic participation;

(D) Long-term services and supports that are not based on the individual's type of disability, level of disability, service needs, or age;

(E) Services provided in the least restrictive setting appropriate to the individual's needs;

(F) Services provided in a manner that allows individuals with disabilities to maintain their independence, self-determination, and dignity;

(G) Services and supports that are of equal quality and accessibility in every geographic region of the State; and

(H) Services and supports that give the individual the opportunity to direct the services.

(e) In developing recommendations for long-term care services and supports for the plan under subsection (d)(16), the board shall convene an advisory committee that includes:

(1) Individuals with disabilities who receive long-term care services and supports;

(2) Older adults who receive long-term care services and supports;

(3) Individuals representing individuals with disabilities and older adults;

(4) Members of groups that represent the diversity, including by gender, race, and economic status, of individuals with disabilities;

(5) Providers of long-term care services and supports, including in-home care providers who are represented by organized labor, and family attendants and caregivers who provide long-term care services and supports; and

(6) Academics and researchers in relevant fields of study.

(f) Notwithstanding subsection (d)(16), the board may explore the effects of excluding long-term care services from the plan, including but not limited to the social, financial, and administrative costs.

(g) The board's report to the legislature shall include the following:

(1) The waivers of federal laws and other federal approval that will be necessary to enable a person who is a resident of the State and who has coverage that is not subject to state regulation to enroll in the plan

without jeopardizing eligibility for the other coverage if the person moves out of the State;

(2) Estimates of the savings and expenditure increases under the plan, relative to the current health care system, including but not limited to:

(A) Savings from eliminating waste in the current system and administrative simplification, fraud reduction, monopsony power, simplification of electronic documentation, and other factors that the board identifies;

(B) Savings from eliminating the cost of insurance that currently provides medical benefits that would be provided through the plan; and

(C) Increased costs due to providing better health care to more individuals than under the current health care system;

(3) Estimates of the expected health care expenditures under the plan, compared to the current health care system, reported in categories similar to the National Health Expenditure Accounts compiled by the Centers

for Medicare and Medicaid Services, including, at a minimum:

(A) Personal health care expenditures;

(B) Health consumption expenditures; and

(C) State health expenditures;

(4) Estimates of how much of the expenditures on the plan will be made from moneys currently spent on health care in the State from federal and state sources and redirected or utilized, in an equitable and comprehensive manner, to the plan;

(5) Estimates of the amount, if any, of additional state revenue that will be required;

(6) Results of the board's evaluation of the impact on individuals, communities, and the State if the current level of health care spending continues without implementing the plan, using existing reports and analysis where available; and

(7) A description of how the board or another entity may enhance:

(A) Access to comprehensive, high quality, patient-centered, patient-empowered, equitable and publicly funded health care for all individuals;

(B) Financially sustainable and cost-effective health care for the benefit of businesses, families, individuals, and state and county governments;

(C) Regional and community-based systems integrated with community programs to contribute to the health of individuals and communities;

(D) Regional planning for cost-effective, reasonable capital expenditures that promote regional equity;

(E) Funding for the modernization of public health as an integral component of cost efficiency in an integrated health care system; and

(F) An ongoing and deepening collaboration with other organizations providing health care that will not be under the authority of the board.

(h) The board's findings and recommendations regarding revenue for the plan, including redirecting existing health care moneys under subsection (g)(4), shall be ranked according to

explicit criteria, including the degree to which an individual, class of individuals, or organization would experience an increase or decrease in the direct or indirect financial burden or whether they would experience no change. Revenue options may include but shall not be limited to the following:

(1) The redirection of current public agency expenditures;

(2) An employer payroll tax based on progressive principles that protect small businesses and tend to preserve or enhance federal tax expenditures for Hawaii employers that pay the costs of their employees' health care; and

(3) A dedicated revenue stream based on progressive taxes that do not impose a burden on individuals who would otherwise qualify for medical assistance.

(i) The board may explore the effect of means-tested copayments or deductibles, including but not limited to the effect of increased administrative complexity and the resulting costs that cause patients to delay getting necessary care, resulting in more severe consequences for their health.

(j) The board's recommendations shall ensure:

(1) Public access to state and county reports and forecasts of revenue expenditures;

(2) That the reports and forecasts are accurate, timely, of sufficient detail, and presented in a way that is understandable to the public to inform policy making and the allocation or relocation of public resources; and

(3) That the information can be used to evaluate programs and policies, while protecting patient confidentiality.

SECTION 7. General nature of the system to be evaluated. (a) The health care for all Hawaii plan designed by the board shall allow participation by any individual who:

(1) Resides in the State;

(2) Is a nonresident who works full-time in the State and contributes to the plan; or

(3) Is a nonresident who is a dependent of an individual described in paragraph (1) or (2).

(b) Providers shall be paid as follows, or using an alternative method that is similarly equitable and cost-effective:

(1) Individual providers licensed in the State shall be paid:

(A) On a fee-for-services basis; or

(B) As employees of institutional providers or members of group practices that are reimbursed with global budgets;

(2) Institutional providers shall be paid with global budgets that include separate capital budgets, determined through regional planning, and operational budgets; and

(3) Budgets shall be determined for individual hospitals and not for entities that own multiple hospitals, clinics, or other providers of health care services or goods.

(c) The board's recommendations shall address issues related to the provision of services to nonresidents who receive services in the State and plan participants who receive services outside the State.

(d) The board's recommendations for the duties of the board and the details of the health care for all Hawaii plan

shall consider the following to ensure that patients are empowered to protect their health, rights, and privacy:

(1) Access to patient advocates who are responsible to the patient and maintain patient confidentiality and whose responsibilities include but are not limited to addressing concerns about providers and helping patients navigate the process of obtaining medical care;

(2) Access to culturally and linguistically appropriate care and service;

(3) A patient's ability to obtain needed care when a treating provider is unable or unwilling to provide the care;

(4) Paying providers to complete forms or perform other administrative functions to assist patients in qualifying for disability benefits, family medical leave, or other income supports; and

(5) Patient access to and control of medical records, including:

(A) Empowering patients to control access to their medical records and obtain independent second

opinions, unless there are clear medical reasons not to do so;

(B) Requiring that a patient or the patient's designee be provided a complete copy of the patient's health records promptly after every interaction or visit with a provider;

(C) Ensuring that the copy of the health records provided to a patient includes all data used in the care of that patient; and

(D) Requiring that the patient or the patient's designee provide approval before any forwarding of the patient's data to, or access of the patient's data by, family members, caregivers, other providers, or researchers;

provided that patient access to and control of medical records shall be limited to competent patients; provided further that if a patient's competency is in question, the patient shall be subject to a medical or psychological evaluation to determine competency and, if deemed incompetent, then the rights to records

shall be delegated to the patient's conservator, guardian, or other authorized legal representative.

SECTION 8. Board timeline. (a) The members of the board shall be appointed no later than August 31, 2026.

(b) No later than October 31, 2026, the legislative research bureau shall begin preparing a work plan for the board.

(c) The board shall submit a report of its findings and recommendations for the design of the health care for all Hawaii plan, including any proposed legislation, to the legislature no later than twenty days prior to the convening of the regular session of 2027.

SECTION 9. There is appropriated out of the general revenues of the State of Hawaii the sum of $ or so much thereof as may be necessary for fiscal year 2026-2027 to establish and operate the board pursuant to this Act.

The sum appropriated shall be expended by the department of health for the purposes of this Act.

SECTION 10. This Act shall take effect on July 1, 2026, and shall be repealed on June 30, 2027.

H.B. NO. 1789

INTRODUCED BY: _____

JAN 2 2 2026

H.B. NO. 1789

Report Title:
Health Care for All Hawaii Board; Health Care for All Hawaii Plan; Advisory Committee; Recommendations; Report; Appropriation

Description:
Establishes a Health Care for All Hawaii Board to design and recommend the Health Care for All Hawaii plan that is publicly funded and available to every resident of the State. Establishes values and principles for the board in developing its plan, designates the scope of the plan, requires the board to establish an advisory committee to provide consumer perspective input, and requires the board to submit the plan to the Legislature. Appropriates funds. Repeals 6/30/2027.

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