THE SENATE
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

S.B. NO. 2690

JAN 23 2026

A BILL FOR AN ACT

RELATING TO PRIMARY CARE.

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

PART I

SECTION 1. The legislature finds that a strong primary care system is the foundation of affordable, high-quality healthcare. Better access to, and utilization of, primary care improves chronic disease management, increases life expectancies, reduces avoidable healthcare visits, and lowers healthcare costs. However, the legislature recognizes that, Hawaii currently faces an acute primary care access crisis. According to the university of Hawaii's most recent workforce assessment, the State has a shortage of approximately seven hundred sixty-eight full-time equivalent providers, with the single largest shortage being in primary care. According to the assessment, approximately one hundred fifty-two additional primary care providers are needed statewide.

The legislature also recognizes that, while the costs of operating a business in Hawaii, including rent, staffing, overhead, and insurance, have increased significantly, primary

care reimbursements have remained stagnant. As a result, providers are leaving insurance networks, retiring early, or closing their practices due to unsustainable financial pressures.

The legislature believes that abusive insurance practices, such as blanket utilization reviews, downcoding, and restrictive prior authorization, undermine the sustainability of primary care practices and restrict patients' access to timely and necessary care.

Accordingly, the purpose of this Act is to strengthen and protect primary care in Hawaii by:

(1) Requiring each health carrier to allocate, initially, at least six per cent of the carrier's total medical expenditures directly to primary care providers, with the percentage increasing incrementally to twelve per cent;

(2) Ensuring that funds reach treating providers without being diverted through administrative mechanisms;

(3) Prohibiting downcoding and abusive utilization review practices;

(4) Requiring prompt reimbursement payments; and

(5) Expanding enforcement, transparency, data reporting, and rural access protections to stabilize the State's primary care workforce.

PART II

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

"ARTICLE

PRIMARY CARE PROTECTION ACT

PART I. GENERAL PROVISIONS

§431: -A Definitions. As used in this article:

"Commissioner" means the commissioner of insurance.

"Community access primary care site" means a clinic that offers same-day or episodic primary care services, maintains referral capability, and ensures documented follow-up care.

"Covered person" means a person enrolled in a health benefit plan offered or administered by a health carrier.

"Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered by, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services pursuant to

chapter 87A, 431, 432, or 432D; provided that "health benefit plan" does not include limited-benefit, dental-only, or vision-only plans.

"Health carrier" has the same meaning as defined in section 431:26-101.

"Primary care" means comprehensive health care services furnished by a primary care provider practicing in family medicine, internal medicine, pediatrics, geriatrics, obstetrics, or gynecology.

"Primary care access visit" means a guidelines-based primary care visit furnished in an urgent care, same-day, or walk-in setting to a covered person who has not designated a primary care provider.

"Primary care provider" or "provider" means a physician, advanced practice registered nurse, or physician's assistant who:

(1) Is designated by a covered person as the person's usual source of primary care;

(2) Provides a plurality of a covered person's care visits in a twenty-four-month lookback period; or

(3) Furnishes a primary care access visit to a covered person at a community access primary care site.

"Primary care spending" means payments for primary care services furnished by a primary care provider that are paid directly to the treating provider and are not reduced or diverted by administrative scoring, medical loss ratio adjustments, or intermediary entities. "Primary care spending" includes payments for primary care access visits provided at community access primary care sites.

"Total medical expenditures" means payments to reimburse physical and mental health care services, excluding expenditures for prescription drugs, vision care, and dental care.

§431: -B Applicability. Except as provided in part V, this article shall apply to all health carriers offering health benefit plans in the individual, small group, and large group fully insured markets and to the Hawaii employer-union health benefits trust fund.

PART II. PROVIDER PROTECTIONS

§431: -C Primary care investment requirement; direct allocation. (a) Beginning January 1, 2027, primary care spending shall comprise at least six per cent of each health carrier's total medical expenditures; provided that the required percentage shall increase to:

(1) Nine per cent by January 1, 2028; and

(2) Twelve per cent by January 1, 2029.

(b) The payments required by this section shall:

(1) Be paid directly to primary care providers, not allocated through intermediaries;

(2) Not be reduced by quality metrics, scoring, or shared savings programs;

(3) Not be diverted through wellness programs, unless the wellness program is directly supervised by a primary care provider;

(4) Not be counted as an administrative expense for medical loss ratio purposes; and

(5) If paid under the per member per month, capitation, or global budgets metrics, be no less than the fee-for-service equivalent.

(c) No health carrier shall raise premiums to meet the requirements of this section.

§431: -D Downcoding and inappropriate claim modification; prohibited. (a) No health carrier shall alter, reduce, reclassify, or downcode any claim submitted by a primary care provider unless the health carrier:

(1) Demonstrates that the modification is supported by clear, contemporaneous clinical evidence that is documented in the medical record;

(2) Provides written notice to the primary care provider within five days of the modification; and

(3) Cites in the notice to the primary care provider the specific clinical guidelines or standards justifying the modification.

(b) The health carrier shall have the burden of proof in justifying any modification of the claim.

(c) A claim may not be downcoded based on:

(1) The documentation format or style, if the clinical elements are present;

(2) The omission of templated language;

(3) The use of telehealth if telehealth is clinically appropriate; or

(4) Any automated scoring systems or algorithmic criteria without clinician oversight.

(d) Each downcoded claim shall be subject to expedited external review and a final determination shall be issued within fifteen calendar days.

(e) Health carriers shall maintain an auditable record of each downcoded claim, including the:

(1) Original and final codes;

(2) Provider and patient identifiers;

(3) Financial impact of the modification;

(4) Rationale for the modification; and

(5) Final outcome, if the modification was appealed or overturned.

(f) Each health carrier shall provide to the commissioner quarterly reports on downcoding volumes, overturn rates, and financial impacts.

(g) Violation of this section shall constitute unfair or deceptive acts and shall be subject to penalties under section 431: -K.

§431: -E Prompt payments; required. (a) All health carriers shall pay:

(1) Electronically-submitted claims within fifteen business days of the claim's approval; and

(2) Claims submitted on paper within thirty business days of the claim's approval.

(b) Late payments shall accrue interest at a rate of:

(1) Ten per cent annually; and

(2) $25 per day after thirty business days.

(c) Each health carrier shall submit a quarterly report to the commissioner detailing the carrier's payment times.

§431: -F Retaliation; prohibited. (a) No health carrier shall engage in retaliatory conduct against a primary care provider who:

(1) Files a complaint;

(2) Appeals a claim;

(3) Challenges downcoding;

(4) Advocates for patient care; or

(5) Requests an audit.

(b) For purposes of this section, retaliatory conduct shall include:

(1) Reducing reimbursements;

(2) Terminating the provider;

(3) Causing credentialing delays;

(4) Engaging in selective auditing; or

(5) Narrowing the provider's network.

§431: -G Fair contracting standards. (a) No contract between a health carrier and a primary care provider shall include:

(1) A confidentiality or non-disclosure agreement;

(2) Provisions requiring arbitration for any dispute arising under this article;

(3) Any waiver of the provider's rights; or

(4) Any provisions allowing the health carrier to unilaterally modify the contract.

(b) Providers shall receive at least thirty days' notice before any rate change or contract change.

PART III. TRANSPARENCY AND ENFORCEMENT

§431: -H Annual reporting requirements; health carriers. (a) Each health carrier shall submit to the commissioner no later than March 31 of each year a primary care transparency report.

(b) The report shall be filed in a form determined by the commissioner and shall include, for the preceding calendar year, the health carrier's:

(1) Total medical expenditures;

(2) Total primary care expenditures;

(3) Percentage of total medical expenditures allocated to primary care;

(4) Total amounts paid for primary care access visits and care received at community access primary care sites;

(5) Number and percentage of claims downcoded;

(6) Downcoding reversal rates;

(7) Prior authorization requests, denials, approvals, and appeals;

(8) Average turnaround times for prior authorization requests;

(9) Average payment times for claims submitted electronically and on paper;

(10) Number of late-paid claims, by month;

(11) Provider contracts terminated, and the reason for each termination;

(12) Provider network participation rates, by island; and

(13) Primary care provider entry and exit counts.

(c) Data provided in the report shall be stratified by:

(1) Island;

(2) County;

(3) Provider type; and

(4) Rural or urban designation.

§431: -I Standardized public reporting format. (a) The commissioner shall establish a standardized public reporting format, including digital templates, for the health carriers' annual primary care transparency reports.

(b) The commissioner shall maintain and update at least annually a publicly accessible website summarizing each health carrier's:

(1) Primary care spending;

(2) Downcoding activities;

(3) Prior authorization performance;

(4) Prompt payment performance;

(5) Community access primary care site and primary care access visit utilization; and

(6) Rural network adequacy measurements.

§431: -J Audit authority. (a) The commissioner shall provide oversight of health carriers and may conduct:

(1) Random audits;

(2) Targeted audits based on complaints or anomalies;

(3) Investigations of downcoding practices;

(4) Reviews of prior authorization systems;

(5) Evaluations of payment timelines; and

(6) Inspections of health carrier offices or delegated entities.

(b) Each health carrier shall provide, within ten business days of the commissioner's request, the health carrier's:

(1) Claims adjudication records;

(2) Downcoding algorithms or any automated decision tools used by the health carrier;

(3) Internal guidelines;

(4) Utilization review criteria;

(5) Credentialing files;

(6) Financial data, as necessary to verify compliance; or

(7) Any other data requested by the commissioner.

§431: -K Enforcement; penalties. (a) For violations of this article, the commissioner may impose fines of up to:

(1) $5,000 per violation for initial noncompliance;

(2) $10,000 per violation for repeated or aggravated violations; and

(3) Up to $500,000 per year for systemic violations.

(b) For severe or repeated violations, in addition to imposing fines pursuant to subsection (a), the commissioner may:

(1) Require corrective action plans;

(2) Implement monitoring requirements;

(3) Restrict new plan approvals;

(4) Suspend rate filings; or

(5) Refer the case to the attorney general for further investigation.

(c) All fines collected under this section shall be deposited into the primary care stabilization special fund established under section §431: -L.

§431: -L Primary care stabilization special fund; established. (a) There is established a primary care stabilization special fund within the treasury of the State into which shall be deposited:

(1) Fines collected under section §431: -K;

(2) Appropriations made by the legislature to the fund;

(3) Donations to the fund; and

(4) Federal grants deposited into the fund;

provided that all interest accrued by the revenues of the fund shall become part of the fund.

(b) Moneys in the primary care stabilization special fund may be used for:

(1) Stabilizing and expanding access to primary care services in rural areas;

(2) Expanding community access primary care sites;

(3) Supporting workforce development initiatives and workforce retention efforts for primary care providers, including medicaid workforce development initiatives; and

(4) Updating and expanding the State's telehealth infrastructure.

§431: -M Public posting of enforcement actions. (a) The commissioner shall maintain and make publicly available a database of enforcement actions taken against health carriers, including any:

(1) Violations;

(2) Penalties;

(3) Corrective actions; and

(4) Post-violation compliance statuses.

(b) Records posted pursuant to subsection (a) shall remain publicly available for five years.

PART IV. RURAL ACCESS TO PRIMARY CARE SERVICES

§431: -N Primary care access visits. (a) Primary care access visits shall be recognized as covered primary care services regardless of:

(1) Attribution status;

(2) Care setting; or

(3) Whether the services were provided at a community access primary care site.

(b) Health carriers shall reimburse primary care access visits at parity with standard primary care services.

(c) No health carrier shall require prior authorization for any primary care access visit.

(d) Primary care access visits shall not be subject to:

(1) Reduced reimbursement rates;

(2) Differential documentation standards; or

(3) Enhanced utilization review requirements.

§431: -O Community access primary care sites. (a) A community access primary care site shall be recognized as a covered primary care delivery site if the site:

(1) Provides same-day or walk-in primary care services;

(2) Maintains referral pathways;

(3) Documents follow-up care;

(4) Provides guideline-based care; and

(5) Ensures continuity of care.

(b) Community access primary care sites shall not be subject to:

(1) Reduced reimbursement rates;

(2) Differential documentation standards; or

(3) Enhanced utilization review requirements.

(c) Health carriers shall reimburse services offered at community access primary care sites at parity with reimbursements for standard primary care services.

§431: -P Attribution standards. A covered person who visits a primary care provider two or more times within a twelve-month period shall be provisionally attributed to that primary care provider unless the patient elects otherwise; provided that attribution shall not be used to:

(1) Deny a claim;

(2) Reduce a reimbursement; or

(3) Restrict the covered person's access to a primary care access visit or community access primary care site.

§431: -Q Telehealth; parity. (a) A telehealth primary care visit shall be reimbursed at parity with in-person primary care services.

(b) Health carriers may not apply to telehealth visits:

(1) Additional prior authorization requirements;

(2) Lower reimbursement rates; or

(3) More restrictive modality rules.

(c) Telehealth visits shall be credited equally for purposes of:

(1) Attribution; and

(2) Primary care spending requirements.

§431: -R Travel and access barriers. For residents of islands or regions without adequate access to primary care services, health carriers shall:

(1) Cover medically necessary inter-island transportation;

(2) Not deny travel for a lack of local access; and

(3) Allow a community access primary care site or primary care provider to certify access necessity.

§431: -S Nondiscriminatory contracting in rural areas. (a) Health carriers shall not pay rural primary care providers less than they pay urban primary care providers for equivalent services.

(b) Health carriers may consider the primary care provider's geographic location for purposes of geographic adjustment factors and other adjustments that benefit rural primary care providers.

§431: -T Rural access performance. (a) Each health carrier shall maintain adequate primary care access standards on a per-island and per-region basis.

(b) If a health carrier's primary care access standards are not met, the carrier shall:

(1) Submit to the commissioner an access remediation plan;

(2) Increase rates;

(3) Contract with a community access primary care site;

(4) Expand access to telehealth; or

(5) Expand access to primary care access visits.

(c) A health carrier's persistent failure to meet primary care access standards shall constitute a violation of this article.

PART V. MED-QUEST IMPLEMENTATION

§431: -U Alignment of med-QUEST. The med-QUEST division of the department of human services shall implement this article to the extent permitted by federal law by:

(1) Adopting, according to the increments provided in section 431: -C(a), the twelve per cent primary care spending requirement;

(2) Enforcing the direct allocation of payments to primary care providers;

(3) Applying downcoding prohibitions;

(4) Enforcing prompt payment requirements; and

(5) Incorporating these provisions into all contracts with medicaid managed care organizations.

§431: -V Federal approvals and waiver authority. (a) The med-QUEST division of the department of human services shall seek any federal approvals necessary to implement this part, including:

(1) State plan amendments;

(2) Modifications to demonstration waivers under section 1115 of the Social Security Act; and

(3) Any updates required to actuarial certifications.

(b) The med-QUEST division may implement interim compliance measures while awaiting federal approval, as permitted by federal guidelines.

§431: -W Medicaid primary care access stabilization. The med-QUEST division of the department of human services shall ensure geographically reasonable access to primary care in the State by:

(1) Requiring managed care organizations to maintain adequate networks of primary care providers;

(2) Supporting telehealth parity;

(3) Ensuring the statewide availability of primary care access visits and community access primary care sites; and

(4) Reimbursing medically necessary inter-island travel when appropriate.

§431: -X Payment protections for medicaid primary care providers. (a) Medicaid managed care organizations shall reimburse primary care evaluation and management codes at rates at least equivalent to medicare rates.

(b) The med-QUEST division of the department of human services may implement supplemental payment programs supporting:

(1) Rural primary care providers;

(2) Community access primary care sites;

(3) Primary care access visit expansions; or

(4) Providers treating high-risk or underserved populations.

(c) Managed care organizations shall not reduce primary care providers' reimbursements to offset compliance with the spending requirement in section 431: -U(1).

§431: -Y Medicaid workforce retention. (a) The med-QUEST division of the department of human services shall support:

(1) Loan repayment programs for primary care providers;

(2) Incentives for primary care providers to practice in rural and underserved regions;

(3) Recruitment programs for physicians, advanced practice registered nurses, and physician's assistants; and

(4) The coordination of health care workforce development strategies with the department of health and university of Hawaii.

(b) Moneys from the primary care stabilization special fund established in section 431: -L may be used to support medicaid workforce development initiatives.

§431: -Z Enforcement for medicaid managed care organizations. The med-QUEST division of the department of human services shall coordinate with the commissioner to provide joint oversight of medicaid managed care organizations and, to the extent permitted by federal law, may enforce this article by:

(1) Requiring corrective action plans;

(2) Freezing enrollments;

(3) Withholding payments;

(4) Implementing civil penalties; and

(5) Declining contract renewals."

PART III

SECTION 3. (a) The insurance commissioner, department of human services med-QUEST division, and department of health shall adopt rules pursuant to chapter 91, Hawaii Revised Statutes, as necessary to implement and enforce this Act.

(b) Rulemaking shall include the establishment of:

(1) Reporting templates for health carriers and medicaid managed care organizations;

(2) Standards for rural access to primary care;

(3) Audit procedures and submission formats;

(4) Guidelines for enforcing downcoding restrictions;

(5) Reporting standards for primary care access visits and community access primary care sites; and

(6) Alignment requirements for medicaid capitation and contract compliance.

(c) The agencies may issue interim rules prior to adopting permanent rules.

SECTION 4. The insurance commissioner, department of human services med-QUEST division, and department of health shall coordinate to:

(1) Conduct joint audits;

(2) Exchange compliance data;

(3) Monitor statewide access to primary care;

(4) Evaluate network adequacy reports;

(5) Identify counties or regions in crisis; and

(6) Propose additional reforms as needed;

provided that all information sharing shall comply with state and federal confidentiality laws.

SECTION 5. (a) The insurance commissioner, department of human services med-QUEST division, and department of health shall jointly develop educational materials informing primary care providers of:

(1) The providers' rights under this Act;

(2) Procedures for challenging downcoding;

(3) Procedures for filing prior authorization appeals;

(4) Procedures for reporting health carrier violations; and

(5) Community access primary care site and primary care access visit billing requirements.

(b) The educational materials shall be made available through:

(1) Online modules;

(2) Webinars;

(3) Rural community training programs; and

(4) Provider associations.

SECTION 6. No later than one hundred eighty days after the effective date of this Act, each health carrier shall submit to the insurance commissioner a compliance plan:

(1) Identifying the health carrier's designated primary care compliance officer;

(2) Confirming that all contract provisions prohibited by this Act have been removed;

(3) Detailing any changes the health carrier has made to its systems and procedures in compliance with this Act, including systems and procedures for:

(A) Downcoding reviews;

(B) Claims adjudications; and

(C) The submission of quarterly and annual reports.

SECTION 7. The insurance commissioner shall submit a report to the legislature no later than twenty days prior to the convening of each regular session, beginning with the regular session of 2027. The med-QUEST division of the department of human services shall submit a parallel report annually by the same date regarding the application of this Act to medicaid managed care organizations. Each report shall include for the prior year:

(1) Each health carrier's primary care spending percentages;

(2) Each health carrier's downcoding volumes and overturn rates;

(3) Each health carrier's prior authorization denial and approval metrics;

(4) Each health carrier's compliance rates with prompt payment requirements;

(5) Analyses of rural access to primary care;

(6) Community access primary care site and primary care access visit utilization by island;

(7) Enforcement actions taken; and

(8) Any other findings or recommendations, including any proposed legislation.

SECTION 8. The auditor shall conduct an independent evaluation of the implementation of this Act three years after the measure's effective date. The evaluation shall include an assessment of the impact of the Act on:

(1) Primary care provider retention;

(2) Clinic closure rates;

(3) Rural access to primary care;

(4) Waiting times for primary care;

(5) Health carrier compliance with the requirement to spend twelve per cent of total medical expenditures on primary care; and

(6) The State's overall health care system.

PART IV

SECTION 9. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 10. 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 11. This Act shall take effect upon its approval; provided that section 2 shall take effect on July 1, 2026.

INTRODUCED BY:

S.B. NO. 2690

Report Title:
DHS; Health Carriers; Primary Care Providers; Primary Care Access Visits; Community Access Primary Care Sites; Downcoding; MED-QUEST; Prohibitions; Reports; Special Fund

Description:
Requires all health carriers to allocate, initially, not less than 6% of the carrier's total medical expenditures to primary care providers, with the percentage increasingly incrementally to 12%. Requires health carriers to pay primary care providers directly, rather than through administrative mechanisms. Places restrictions on downcoding and claim modifications. Requires health carriers to ensure access to primary care in rural areas, including access to Primary Care Access Visits and Community Access Primary Care Sites. Requires Insurance Commissioner to administer requirements established in bill. Requires the Department of Human Services Med-QUEST Division to apply the Act, to the extent permitted by federal law and subject to any federal approvals, to Medicaid managed care organizations. Requires reports. Requires the Auditor to evaluate the impact of the Act on various metrics 3 years after the measure's effective date. Establishes the primary care stabilization special fund.

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