THE SENATE
THIRTIETH LEGISLATURE, 2019
STATE OF HAWAII

S.B. NO. 1043 S.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH CARE.

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

1 SECTION 1. The legislature finds that Hawaii has long been
2 a leader in advancing reproductive rights, advocating the
3 importance of access to reproductive health care without
4 discrimination, and implementing forward thinking reproductive
5 health care policy. However, gaps in coverage and care still
6 exist, and Hawaii benefits and protections are constantly under
7 attack by a hostile federal administration bent on repealing or
8 undercutting the federal Patient Protection and Affordable Care
9 Act of 2010 and, in particular, access to sexual and
10 reproductive health care benefits and protections.
11 The legislature finds that access to reproductive health
12 care is critical for the health and economic security of all of
13 Hawaii's people. Research shows that for every one dollar in
14 public spending on reproductive health and family planning
15 services, states save seven dollars in medicaid costs for
16 pregnancy, labor and delivery, and children's health care.
17 Ensuring that Hawaii's people receive comprehensive client-

1 centered and culturally-sensitive sexual and reproductive health
2 care makes good economic sense and improves the overall health
3 of our communities and our State.
4 The legislature concludes that in order to safeguard access
5 to abortion, to solidify the essential health benefits that have
6 changed thousands of lives, and to improve overall access to
7 care, it is vital to preserve certain important aspects of the
8 Patient Protection and Affordable Care Act and expand access to
9 care for residents of Hawaii.
10 Accordingly, the purpose of this Act is to ensure
11 comprehensive coverage for the full spectrum of sexual and
12 reproductive health care services, including family planning,
13 abortion, and postpartum care, for all of Hawaii's people.
14 PART I
15 SECTION 2. Chapter 431, Hawaii Revised Statutes, is
16 amended by adding two new sections to part I of article 10A to
17 be appropriately designated and to read as follows:
18 "**§431:10A-A Preventive care; coverage; requirements.** (a)
19 Every individual policy of accident and health or sickness
20 insurance issued or renewed in this State shall provide coverage
21 for all of the following services, drugs, devices, products, and

1 procedures for the policyholder or any dependent of the
2 policyholder who is covered by the policy:
3 (1) Well-woman preventive care visit annually for women to
4 obtain the recommended preventive services that are
5 age and developmentally appropriate, including
6 preconception care and services necessary for prenatal
7 care. A well-woman visit, where appropriate, shall
8 include other preventive services as listed in this
9 section; provided that if several visits are needed to
10 obtain all necessary recommended preventive services,
11 depending upon a woman's health status, health needs,
12 and other risk factors, coverage shall apply to each
13 of the necessary visits;
14 (2) Counseling for sexually transmitted infections,
15 including human immunodeficiency virus and acquired
16 immune deficiency syndrome;
17 (3) Screening for: chlamydia; gonorrhea; hepatitis B;
18 hepatitis C; human immunodeficiency virus and acquired
19 immune deficiency syndrome; human papillomavirus;
20 syphilis; anemia; urinary tract infection; pregnancy;

1 Rh incompatibility; gestational diabetes;
2 osteoporosis; breast cancer; and cervical cancer;
3 (4) Screening to determine whether counseling and testing
4 related to the BRCA1 or BRCA2 genetic mutation is
5 indicated and genetic counseling and testing related
6 to the BRCA1 or BRCA2 genetic mutation, if indicated;
7 (5) Screening and appropriate counseling or interventions
8 for:
9 (A) Substance abuse, including tobacco and electronic
10 smoking devices, and alcohol; and
11 (B) Domestic and interpersonal violence;
12 (6) Screening and appropriate counseling or interventions
13 for mental health screening and counseling, including
14 depression;
15 (7) Folic acid supplements;
16 (8) Abortion;
17 (9) Breastfeeding comprehensive support, counseling, and
18 supplies;
19 (10) Breast cancer chemoprevention counseling;
20 (11) Any contraceptive supplies, as specified in section
21 431:10A-116.6;

1 (12) Voluntary sterilization, as a single claim or combined
2 with the following other claims for covered services
3 provided on the same day:
4 (A) Patient education and counseling on contraception
5 and sterilization; and
6 (B) Services related to sterilization or the
7 administration and monitoring of contraceptive
8 supplies, including:
9 (i) Management of side effects;
10 (ii) Counseling for continued adherence to a
11 prescribed regimen;
12 (iii) Device insertion and removal; and
13 (iv) Provision of alternative contraceptive
14 supplies deemed medically appropriate in the
15 judgment of the insured's health care
16 provider;
17 (13) Pre-exposure prophylaxis, post-exposure prophylaxis,
18 and human papillomavirus vaccination; and
19 (14) Any additional preventive services for women that must
20 be covered without cost sharing under title 42 United
21 States Code section 300gg-13, as identified by the

1 federal Preventive Services Task Force or the Health
2 Resources and Services Administration of the federal
3 Department of Health and Human Services, as of
4 January 1, 2017.
5 (b) An insurer shall not impose any cost-sharing
6 requirements, including copayments, coinsurance, or deductibles,
7 on a policyholder or an individual covered by the policy with
8 respect to the coverage and benefits required by this section,
9 except to the extent that coverage of particular services
10 without cost-sharing would disqualify a high-deductible health
11 plan from eligibility for a health savings account pursuant to
12 title 26 United States Code section 223. For a qualifying high-
13 deductible health plan, the insurer shall establish the plan's
14 cost-sharing for the coverage provided pursuant to this section
15 at the minimum level necessary to preserve the insured's ability
16 to claim tax-exempt contributions and withdrawals from the
17 insured's health savings account under title 26 United States
18 Code section 223.
19 (c) A health care provider shall be reimbursed for
20 providing the services pursuant to this section without any

1 deduction for coinsurance, copayments, or any other cost-sharing
2 amounts.
3 (d) Except as otherwise authorized under this section, an
4 insurer shall not impose any restrictions or delays on the
5 coverage required under this section.
6 (e) This section shall not require a policy of accident
7 and health or sickness insurance to cover:
8 (1) Experimental or investigational treatments;
9 (2) Clinical trials or demonstration projects;
10 (3) Treatments that do not conform to acceptable and
11 customary standards of medical practice; or
12 (4) Treatments for which there is insufficient data to
13 determine efficacy.
14 (f) If services, drugs, devices, products, or procedures
15 required by this section are provided by an out-of-network
16 provider, the insurer shall cover the services, drugs, devices,
17 products, or procedures without imposing any cost-sharing
18 requirement on the policyholder if:
19 (1) There is no in-network provider to furnish the
20 service, drug, device, product, or procedure that

1 meets the requirements for network adequacy under
2 section 431:26-103; or
3 (2) An in-network provider is unable or unwilling to
4 provide the service, drug, device, product, or
5 procedure in a timely manner.
6 (g) Every insurer shall provide written notice to its
7 policyholders regarding the coverage required by this section.
8 The notice shall be in writing and prominently positioned in any
9 literature or correspondence sent to policyholders and shall be
10 transmitted to policyholders beginning with calendar year 2020
11 when annual information is made available to policyholders or in
12 any other mailing to policyholders, but in no case later than
13 December 31, 2020.
14 (h) This section shall not apply to policies that provide
15 coverage for specified diseases or other limited benefit health
16 insurance coverage, as provided pursuant to section
17 431:10A-102.5.
18 (i) If the commissioner concludes that enforcement of this
19 section may adversely affect the allocation of federal funds to
20 the State, the commissioner may grant an exemption to the

1 requirements, but only to the minimum extent necessary to ensure
2 the continued receipt of federal funds.
3 (j) A bill or statement for services from any health care
4 provider or insurer shall be sent directly to the person
5 receiving the services.
6 (k) For purposes of this section, "contraceptive supplies"
7 shall have the same meaning as in section 431:10A-116.6.
8 **§431:10A-B Nondiscrimination; reproductive health care;**
9 **coverage.** (a) An individual, on the basis of actual or
10 perceived race, color, national origin, sex, gender identity,
11 sexual orientation, age, or disability, shall not be excluded
12 from participation in, be denied the benefits of, or otherwise
13 be subjected to discrimination in the coverage of, or payment
14 for, the services, drugs, devices, products, and procedures
15 covered by section 431:10A-A or 431:10A-116.6.
16 (b) Violation of this section shall be considered a
17 violation pursuant to chapter 481.
18 (c) Nothing in this section shall be construed to limit
19 any cause of action based upon any unfair or discriminatory
20 practices for which a remedy is available under state or federal
21 law."

1 SECTION 3. Chapter 431, Hawaii Revised Statutes, is
2 amended by adding two new sections to part II of article 10A to
3 be appropriately designated and to read as follows:

4 "**§431:10A-C Preventive care; coverage; requirements.** (a)
5 Every group policy of accident and health or sickness insurance
6 issued or renewed in this State shall provide coverage for all
7 of the following services, drugs, devices, products, and
8 procedures for any subscriber or any dependent of the subscriber
9 who is covered by the policy:

10 (1) Well-woman preventive care visit annually for women to
11 obtain the recommended preventive services that are
12 age and developmentally appropriate, including
13 preconception care and services necessary for prenatal
14 care. A well-woman visit, where appropriate, shall
15 include other preventive services as listed in this
16 section; provided that if several visits are needed to
17 obtain all necessary recommended preventive services,
18 depending upon a woman's health status, health needs,
19 and other risk factors, coverage shall apply to each
20 of the necessary visits;

1 (2) Counseling for sexually transmitted infections,
2 including human immunodeficiency virus and acquired
3 immune deficiency syndrome;
4 (3) Screening for: chlamydia; gonorrhea; hepatitis B;
5 hepatitis C; human immunodeficiency virus and acquired
6 immune deficiency syndrome; human papillomavirus;
7 syphilis; anemia; urinary tract infection; pregnancy;
8 Rh incompatibility; gestational diabetes;
9 osteoporosis; breast cancer; and cervical cancer;
10 (4) Screening to determine whether counseling and testing
11 related to the BRCA1 or BRCA2 genetic mutation is
12 indicated and genetic counseling and testing related
13 to the BRCA1 or BRCA2 genetic mutation, if indicated;
14 (5) Screening and appropriate counseling or interventions
15 for:
16 (A) Substance abuse, including tobacco and electric
17 smoking devices, and alcohol; and
18 (B) Domestic and interpersonal violence;
19 (6) Screening and appropriate counseling or interventions
20 for mental health screening and counseling, including
21 depression;

1 (7) Folic acid supplements;

2 (8) Abortion;

3 (9) Breastfeeding comprehensive support, counseling, and

4 supplies;

5 (10) Breast cancer chemoprevention counseling;

6 (11) Any contraceptive supplies, as specified in section

7 431:10A-116.6;

8 (12) Voluntary sterilization, as a single claim or combined

9 with the following other claims for covered services

10 provided on the same day:

11 (A) Patient education and counseling on contraception

12 and sterilization; and

13 (B) Services related to sterilization or the

14 administration and monitoring of contraceptive

15 supplies, including:

16 (i) Management of side effects;

17 (ii) Counseling for continued adherence to a

18 prescribed regimen;

19 (iii) Device insertion and removal; and

20 (iv) Provision of alternative contraceptive

21 supplies deemed medically appropriate in the

1 judgment of the subscriber's or dependent's
2 health care provider;
3 (13) Pre-exposure prophylaxis, post-exposure prophylaxis,
4 and human papillomavirus vaccination; and
5 (14) Any additional preventive services for women that must
6 be covered without cost sharing under title 42 United
7 States Code section 300gg-13, as identified by the
8 federal Preventive Services Task Force or the Health
9 Resources and Services Administration of the federal
10 Department of Health and Human Services, as of
11 January 1, 2017.
12 (b) An insurer shall not impose any cost-sharing
13 requirements, including copayments, coinsurance, or deductibles,
14 on a subscriber or an individual covered by the policy with
15 respect to the coverage and benefits required by this section,
16 except to the extent that coverage of particular services
17 without cost-sharing would disqualify a high-deductible health
18 plan from eligibility for a health savings account pursuant to
19 title 26 United States Code section 223. For a qualifying high-
20 deductible health plan, the insurer shall establish the plan's
21 cost-sharing for the coverage provided pursuant to this section

1 at the minimum level necessary to preserve the subscriber's
2 ability to claim tax-exempt contributions and withdrawals from
3 the subscriber's health savings account under title 26 United
4 States Code section 223.
5 (c) A health care provider shall be reimbursed for
6 providing the services pursuant to this section without any
7 deduction for coinsurance, copayments, or any other cost-sharing
8 amounts.
9 (d) Except as otherwise authorized under this section, an
10 insurer shall not impose any restrictions or delays on the
11 coverage required under this section.
12 (e) This section shall not require a policy of accident
13 and health or sickness insurance to cover:
14 (1) Experimental or investigational treatments;
15 (2) Clinical trials or demonstration projects;
16 (3) Treatments that do not conform to acceptable and
17 customary standards of medical practice; or
18 (4) Treatments for which there is insufficient data to
19 determine efficacy.
20 (f) If services, drugs, devices, products, or procedures
21 required by this section are provided by an out-of-network

1 provider, the insurer shall cover the services, drugs, devices,
2 products, or procedures without imposing any cost-sharing
3 requirement on the subscriber if:
4 (1) There is no in-network provider to furnish the
5 service, drug, device, product, or procedure that
6 meets the requirements for network adequacy under
7 section 431:26-103; or
8 (2) An in-network provider is unable or unwilling to
9 provide the service, drug, device, product, or
10 procedure in a timely manner.
11 (g) Every insurer shall provide written notice to its
12 subscribers regarding the coverage required by this section.
13 The notice shall be in writing and prominently positioned in any
14 literature or correspondence sent to subscribers and shall be
15 transmitted to subscribers beginning with calendar year 2020
16 when annual information is made available to subscribers or in
17 any other mailing to subscribers, but in no case later than
18 December 31, 2020.
19 (h) This section shall not apply to policies that provide
20 coverage for specified diseases or other limited benefit health

1 insurance coverage, as provided pursuant to section
2 431:10A-102.5.
3 (i) If the commissioner concludes that enforcement of this
4 section may adversely affect the allocation of federal funds to
5 the State, the commissioner may grant an exemption to the
6 requirements, but only to the minimum extent necessary to ensure
7 the continued receipt of federal funds.
8 (j) A bill or statement for services from any health care
9 provider or insurer shall be sent directly to the person
10 receiving the services.
11 (k) For purposes of this section, "contraceptive supplies"
12 shall have the same meaning as in section 431:10A-116.6.
13 **§431:10A-D Nondiscrimination; reproductive health care;**
14 **coverage.** (a) An individual, on the basis of actual or
15 perceived race, color, national origin, sex, gender identity,
16 sexual orientation, age, or disability, shall not be excluded
17 from participation in, be denied the benefits of, or otherwise
18 be subjected to discrimination in the coverage of, or payment
19 for, the services, drugs, devices, products, and procedures
20 covered by section 431:10A-C or 431:10A-116.6.

1 (b) Violation of this section shall be considered a
2 violation pursuant to chapter 481.
3 (c) Nothing in this section shall be construed to limit
4 any cause of action based upon any unfair or discriminatory
5 practices for which a remedy is available under state or federal
6 law."
7 SECTION 4. Chapter 432, Hawaii Revised Statutes, is
8 amended by adding two new sections to article 1 to be
9 appropriately designated and to read as follows:
10 "**§432:1-A Preventive care; coverage; requirements.** (a)
11 Every individual or group hospital or medical service plan
12 contract issued or renewed in this State shall provide coverage
13 for all of the following services, drugs, devices, products, and
14 procedures for the subscriber or member or any dependent of the
15 subscriber or member who is covered by the plan contract:
16 (1) Well-woman care, as prescribed by the commissioner by
17 rule consistent with guidelines published by the
18 federal Health Resources and Services Administration;
19 (2) Counseling for sexually transmitted infections,
20 including human immunodeficiency virus and acquired
21 immune deficiency syndrome;

1 (3) Screening for: chlamydia; gonorrhea; hepatitis B;
2 hepatitis C; human immunodeficiency virus and acquired
3 immune deficiency syndrome; human papillomavirus;
4 syphilis; anemia; urinary tract infection; pregnancy;
5 Rh incompatibility; gestational diabetes;
6 osteoporosis; breast cancer; and cervical cancer;
7 (4) Screening to determine whether counseling and testing
8 related to the BRCA1 or BRCA2 genetic mutation is
9 indicated and genetic counseling and testing related
10 to the BRCA1 or BRCA2 genetic mutation, if indicated;
11 (5) Screening and appropriate counseling or interventions
12 for:
13 (A) Substance abuse, including tobacco and electronic
14 smoking devices, and alcohol; and
15 (B) Domestic and interpersonal violence;
16 (6) Screening and appropriate counseling or interventions
17 for mental health screening and counseling, including
18 depression;
19 (7) Folic acid supplements;
20 (8) Abortion;

1 (9) Breastfeeding comprehensive support, counseling, and
2 supplies;
3 (10) Breast cancer chemoprevention counseling;
4 (11) Any contraceptive supplies, as specified in section
5 431:10A-116.6;
6 (12) Voluntary sterilization, as a single claim or combined
7 with the following other claims for covered services
8 provided on the same day:
9 (A) Patient education and counseling on contraception
10 and sterilization; and
11 (B) Services related to sterilization or the
12 administration and monitoring of contraceptive
13 supplies, including:
14 (i) Management of side effects;
15 (ii) Counseling for continued adherence to a
16 prescribed regimen;
17 (iii) Device insertion and removal; and
18 (iv) Provision of alternative contraceptive
19 supplies deemed medically appropriate in the
20 judgment of the subscriber's or member's
21 health care provider;

1 (13) Pre-exposure prophylaxis, post-exposure prophylaxis,
2 and human papillomavirus vaccination; and
3 (14) Any additional preventive services for women that must
4 be covered without cost sharing under title 42 United
5 States Code section 300gg-13, as identified by the
6 federal Preventive Services Task Force or the Health
7 Resources and Services Administration of the federal
8 Department of Health and Human Services, as of
9 January 1, 2017.
10 (b) A mutual benefit society shall not impose any cost-
11 sharing requirements, including copayments, coinsurance, or
12 deductibles, on a subscriber or member or an individual covered
13 by the plan contract with respect to the coverage and benefits
14 required by this section, except to the extent that coverage of
15 particular services without cost-sharing would disqualify a
16 high-deductible health plan from eligibility for a health
17 savings account pursuant to title 26 United States Code section
18 223. For a qualifying high-deductible health plan, the mutual
19 benefit society shall establish the plan's cost-sharing for the
20 coverage provided pursuant to this section at the minimum level
21 necessary to preserve the subscriber's or member's ability to

1 claim tax-exempt contributions and withdrawals from the
2 subscriber's or member's health savings account under title 26
3 United States Code section 223.
4 (c) A health care provider shall be reimbursed for
5 providing the services pursuant to this section without any
6 deduction for coinsurance, copayments, or any other cost-sharing
7 amounts.
8 (d) Except as otherwise authorized under this section, a
9 mutual benefit society shall not impose any restrictions or
10 delays on the coverage required under this section.
11 (e) This section shall not require an individual or group
12 hospital or medical service plan contract to cover:
13 (1) Experimental or investigational treatments;
14 (2) Clinical trials or demonstration projects;
15 (3) Treatments that do not conform to acceptable and
16 customary standards of medical practice; or
17 (4) Treatments for which there is insufficient data to
18 determine efficacy.
19 (f) If services, drugs, devices, products, or procedures
20 required by this section are provided by an out-of-network
21 provider, the mutual benefit society shall cover the services,

1 drugs, devices, products, or procedures without imposing any
2 cost-sharing requirement on the subscriber or member if:
3 (1) There is no in-network provider to furnish the
4 service, drug, device, product, or procedure that
5 meets the requirements for network adequacy under
6 section 431:26-103; or
7 (2) An in-network provider is unable or unwilling to
8 provide the service, drug, device, product, or
9 procedure in a timely manner.
10 (g) Every mutual benefit society shall provide written
11 notice to its subscribers or members regarding the coverage
12 required by this section. The notice shall be in writing and
13 prominently positioned in any literature or correspondence sent
14 to subscribers or members and shall be transmitted to
15 subscribers or members beginning with calendar year 2020 when
16 annual information is made available to subscribers or members
17 or in any other mailing to subscribers or members, but in no
18 case later than December 31, 2020.
19 (h) This section shall not apply to plan contracts that
20 provide coverage for specified diseases or other limited benefit

1 health insurance coverage, as provided pursuant to section
2 431:10A-102.5.
3 (i) If the commissioner concludes that enforcement of this
4 section may adversely affect the allocation of federal funds to
5 the State, the commissioner may grant an exemption to the
6 requirements, but only to the minimum extent necessary to ensure
7 the continued receipt of federal funds.
8 (j) A bill or statement for services from any health care
9 provider or mutual benefit society shall be sent directly to the
10 person receiving the services.
11 (k) For purposes of this section, "contraceptive supplies"
12 shall have the same meaning as in section 431:10A-116.6.
13 **§432:1-B Nondiscrimination; reproductive health care;**
14 **coverage.** (a) An individual, on the basis of actual or
15 perceived race, color, national origin, sex, gender identity,
16 sexual orientation, age, or disability, shall not be excluded
17 from participation in, be denied the benefits of, or otherwise
18 be subjected to discrimination in the coverage of, or payment
19 for, the services, drugs, devices, products, or procedures
20 covered by section 432:1-A or 432:1-604.5.

1 (b) Violation of this section shall be considered a
2 violation pursuant to chapter 481.
3 (c) Nothing in this section shall be construed to limit
4 any cause of action based upon any unfair or discriminatory
5 practices for which a remedy is available under state or federal
6 law."
7 SECTION 5. Chapter 432D, Hawaii Revised Statutes, is
8 amended by adding a new section to be appropriately designated
9 and to read as follows:
10 "**§432D-A Nondiscrimination; reproductive health care;**
11 **coverage.** (a) An individual, on the basis of actual or
12 perceived race, color, national origin, sex, gender identity,
13 sexual orientation, age, or disability, shall not be excluded
14 from participation in, be denied the benefits of, or otherwise
15 be subjected to discrimination in the coverage of, or payment
16 for, the services, drugs, devices, products, and procedures
17 covered by section 431:10A-A or 431:10A-116.6.
18 (b) Violation of this section shall be considered a
19 violation pursuant to chapter 481.
20 (c) Nothing in this section shall be construed to limit
21 any cause of action based upon any unfair or discriminatory

1 practices for which a remedy is available under state or federal
2 law."
3 SECTION 6. Section 431:10A-116.6, Hawaii Revised Statutes,
4 is amended to read as follows:
5 **"§431:10A-116.6 Contraceptive services.** (a)
6 Notwithstanding any provision of law to the contrary, each
7 employer group policy of accident and health or sickness
8 [~~policy, contract, plan, or agreement~~] insurance issued or
9 renewed in this State on or after January 1, 2000, shall [~~cease~~
10 ~~to exclude~~] provide coverage for contraceptive services or
11 contraceptive supplies for the [~~subscriber~~] insured or any
12 dependent of the [~~subscriber~~] insured who is covered by the
13 policy, subject to the exclusion under section 431:10A-116.7 and
14 the exclusion under section 431:10A-102.5[~~.~~]; provided that:
15 (1) If there is a therapeutic equivalent of a
16 contraceptive supply approved by the federal Food and
17 Drug Administration, an insurer may provide coverage
18 for either the requested contraceptive supply or for
19 one or more therapeutic equivalents of the requested
20 contraceptive supply;

1 (2) If a contraceptive supply covered by the policy is
2 deemed medically inadvisable by the insured's health
3 care provider, the policy shall cover an alternative
4 contraceptive supply prescribed by the health care
5 provider;
6 (3) An insurer shall pay pharmacy claims for reimbursement
7 of all contraceptive supplies available for over-
8 the-counter sale that are approved by the federal Food
9 and Drug Administration; and
10 (4) An insurer may not infringe upon an insured's choice
11 of contraceptive supplies and may not require prior
12 authorization, step therapy, or other utilization
13 control techniques for medically-appropriate covered
14 contraceptive supplies.
15 [~~(b) Except as provided in subsection (c), all policies,~~
16 ~~contracts, plans, or agreements under subsection (a), that~~
17 ~~provide contraceptive services or supplies, or prescription drug~~
18 ~~coverage, shall not exclude any prescription contraceptive~~
19 ~~supplies or impose any unusual copayment, charge, or waiting~~
20 ~~requirement for such supplies.~~

~~(c) Coverage for oral contraceptives shall include at least one brand from the monophasic, multiphasic, and the progestin-only categories. A member shall receive coverage for any other oral contraceptive only if:~~

~~(1) Use of brands covered has resulted in an adverse drug reaction; or~~

~~(2) The member has not used the brands covered and, based on the member's past medical history, the prescribing health care provider believes that use of the brands covered would result in an adverse reaction.~~

~~(d)~~] (b) An insurer shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on an insured with respect to the coverage required under this section. A health care provider shall be reimbursed for providing the services pursuant to this section without any deduction for coinsurance, copayments, or any other cost-sharing amounts.

(c) Except as otherwise provided by this section, an insurer shall not impose any restrictions or delays on the coverage required by this section.

1 (d) Coverage required by this section shall not exclude
2 coverage for contraceptive supplies prescribed by a health care
3 provider, acting within the provider's scope of practice, for:
4 (1) Reasons other than contraceptive purposes, such as
5 decreasing the risk of ovarian cancer or eliminating
6 symptoms of menopause; or
7 (2) Contraception that is necessary to preserve the life
8 or health of an insured.
9 (e) Coverage required by this section shall include
10 reimbursement to a prescribing health care provider or
11 dispensing entity for prescription contraceptive supplies
12 intended to last for up to a twelve-month period for an insured.
13 [~~(e)~~] (f) Coverage required by this section shall include
14 reimbursement to a prescribing and dispensing pharmacist who
15 prescribes and dispenses contraceptive supplies pursuant to
16 section 461-11.6.
17 (g) Nothing in this section shall be construed to extend
18 the practice or privileges of any health care provider beyond
19 that provided in the laws governing the provider's practice and
20 privileges.
21 [~~(f)~~] (h) For purposes of this section:

1 "Contraceptive services" means physician-delivered,
2 physician-supervised, physician assistant-delivered, advanced
3 practice registered nurse-delivered, nurse-delivered, or
4 pharmacist-delivered medical services intended to promote the
5 effective use of contraceptive supplies or devices to prevent
6 unwanted pregnancy.

7 "Contraceptive supplies" means all United States Food and
8 Drug Administration-approved contraceptive drugs [~~or~~], devices,
9 or products used to prevent unwanted pregnancy[~~.~~], regardless of
10 whether they are to be used by the insured or the partner of the
11 insured, and regardless of whether they are to be used for
12 contraception or exclusively for the prevention of sexually
13 transmitted infections.

14 [~~(g) Nothing in this section shall be construed to extend~~
15 ~~the practice or privileges of any health care provider beyond~~
16 ~~that provided in the laws governing the provider's practice and~~
17 ~~privileges.~~]"

18 SECTION 7. Section 431:10A-116.7, Hawaii Revised Statutes,
19 is amended by amending subsection (g) to read as follows:

20 "(g) For purposes of this section:

"Contraceptive services" means physician-delivered, physician-supervised, physician assistant-delivered, advanced practice registered nurse-delivered, nurse-delivered, or pharmacist-delivered medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.

"Contraceptive supplies" means all United States Food and Drug Administration-approved contraceptive drugs [~~or~~], devices, or products used to prevent unwanted pregnancy[~~.~~], regardless of whether they are to be used by the insured or the partner of the insured, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections."

SECTION 8. Section 432:1-604.5, Hawaii Revised Statutes, is amended to read as follows:

"**§432:1-604.5 Contraceptive services.** (a) Notwithstanding any provision of law to the contrary, each employer group [~~health policy, contract, plan, or agreement~~] hospital or medical service plan contract issued or renewed in this State on or after January 1, 2000, shall [~~cease to exclude~~] provide coverage for contraceptive services or contraceptive

1 supplies, and contraceptive prescription drug coverage for the
2 subscriber or member or any dependent of the subscriber or
3 member who is covered by the policy, subject to the exclusion
4 under section 431:10A-116.7[-]; provided that:
5 (1) If there is a therapeutic equivalent of a
6 contraceptive supply approved by the federal Food and
7 Drug Administration, a mutual benefit society may
8 provide coverage for either the requested
9 contraceptive supply or for one or more therapeutic
10 equivalents of the requested contraceptive supply;
11 (2) If a contraceptive supply covered by the plan contract
12 is deemed medically inadvisable by the subscriber's or
13 member's health care provider, the plan contract shall
14 cover an alternative contraceptive supply prescribed
15 by the health care provider;
16 (3) A mutual benefit society shall pay pharmacy claims for
17 reimbursement of all contraceptive supplies available
18 for over-the-counter sale that are approved by the
19 federal Food and Drug Administration; and
20 (4) A mutual benefit society shall not infringe upon a
21 subscriber's or member's choice of contraceptive

1 supplies and shall not require prior authorization,
2 step therapy, or other utilization control techniques
3 for medically-appropriate covered contraceptive
4 supplies.
5 [(b) Except as provided in subsection (c), all policies,
6 contracts, plans, or agreements under subsection (a), that
7 provide contraceptive services or supplies, or prescription drug
8 coverage, shall not exclude any prescription contraceptive
9 supplies or impose any unusual copayment, charge, or waiting
10 requirement for such drug or device.
11 (c) Coverage for contraceptives shall include at least one
12 brand from the monophasic, multiphasic, and the progestin-only
13 categories. A member shall receive coverage for any other oral
14 contraceptive only if:
15 (1) Use of brands covered has resulted in an adverse drug
16 reaction; or
17 (2) The member has not used the brands covered and, based
18 on the member's past medical history, the prescribing
19 health care provider believes that use of the brands
20 covered would result in an adverse reaction.

1 ~~(d)~~] (b) A mutual benefit society shall not impose any
2 cost-sharing requirements, including copayments, coinsurance, or
3 deductibles, on a subscriber or member with respect to the
4 coverage required under this section. A health care provider
5 shall be reimbursed for providing the services pursuant to this
6 section without any deduction for coinsurance, copayments, or
7 any other cost-sharing amounts.
8 (c) Except as otherwise provided by this section, a mutual
9 benefit society shall not impose any restrictions or delays on
10 the coverage required by this section.
11 (d) Coverage required by this section shall not exclude
12 coverage for contraceptive supplies prescribed by a health care
13 provider, acting within the provider's scope of practice, for:
14 (1) Reasons other than contraceptive purposes, such as
15 decreasing the risk of ovarian cancer or eliminating
16 symptoms of menopause; or
17 (2) Contraception that is necessary to preserve the life
18 or health of a subscriber or member.
19 (e) Coverage required by this section shall include
20 reimbursement to a prescribing health care provider or

1 dispensing entity for prescription contraceptive supplies
2 intended to last for up to a twelve-month period for a member.
3 [~~(e)~~] (f) Coverage required by this section shall include
4 reimbursement to a prescribing and dispensing pharmacist who
5 prescribes and dispenses contraceptive supplies pursuant to
6 section 461-11.6.
7 (g) Nothing in this section shall be construed to extend
8 the practice or privileges of any health care provider beyond
9 that provided in the laws governing the provider's practice and
10 privileges.
11 [~~(f)~~] (h) For purposes of this section:
12 "Contraceptive services" means physician-delivered,
13 physician-supervised, physician assistant-delivered, advanced
14 practice registered nurse-delivered, nurse-delivered, or
15 pharmacist-delivered medical services intended to promote the
16 effective use of contraceptive supplies or devices to prevent
17 unwanted pregnancy.
18 "Contraceptive supplies" means all Food and Drug
19 Administration-approved contraceptive drugs or devices used to
20 prevent unwanted pregnancy[~~.~~], regardless of whether they are to
21 be used by the subscriber or member or the partner of the

subscriber or member, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections.

[~~(g) Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the provider's practice and privileges.~~]"

SECTION 9. Section 432D-23, Hawaii Revised Statutes, is amended to read as follows:

"**§432D-23 Required provisions and benefits.** Notwithstanding any provision of law to the contrary, each policy, contract, plan, or agreement issued in the State after January 1, 1995, by health maintenance organizations pursuant to this chapter, shall include benefits provided in sections 431:10-212, 431:10A-115, 431:10A-115.5, 431:10A-116, 431:10A-116.2, 431:10A-116.5, 431:10A-116.6, 431:10A-119, 431:10A-120, 431:10A-121, 431:10A-122, 431:10A-125, 431:10A-126, 431:10A-132, 431:10A-133, 431:10A-134, 431:10A-140, and [~~431:10A-134,~~] 431:10A-A, and chapter 431M."

SECTION 10. The insurance division of the department of commerce and consumer affairs shall submit a report to the

legislature on the degree of compliance by insurers, mutual benefit societies, and health maintenance organizations regarding the implementation of this part, and of any actions taken by the insurance commissioner to enforce compliance with this part no later than twenty days prior to the convening of the regular session of 2020.

PART II

SECTION 11. Chapter 346, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§346-A Nondiscrimination; reproductive health care; coverage.** (a) An individual, on the basis of actual or perceived race, color, national origin, sex, gender identity, sexual orientation, age, or disability, shall not be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination in the coverage of, or payment for, the services, drugs, devices, products, or procedures covered by section 432:1-A or 432:1-604.5 or in the receipt of medical assistance as that term is defined under section 346-1.

(b) Violation of this section shall be considered a violation pursuant to chapter 481.

1 (c) Nothing in this section shall be construed to limit
2 any cause of action based upon any unfair or discriminatory
3 practices for which a remedy is available under state or federal
4 law."

5 PART III

6 SECTION 12. In codifying the new sections added by
7 sections 2, 3, 4, 5, and 11 of this Act, the revisor of statutes
8 shall substitute appropriate section numbers for the letters
9 used in designating the new sections in this Act.

10 SECTION 13. Statutory material to be repealed is bracketed
11 and stricken. New statutory material is underscored.

12 SECTION 14. This Act shall take effect on July 1, 2020,
13 and shall apply to all plans, policies, contracts, and
14 agreements of health insurance issued or renewed by a health
15 insurer, mutual benefit society, or health maintenance
16 organization on or after January 1, 2020.

S.B. NO. 1043 S.D. 1

Report Title:
Health Insurance; Required Benefits; Covered Benefits; Reproductive Health Care

Description:
Requires health insurers, mutual benefit societies, and health maintenance organizations to provide coverage for a comprehensive category of reproductive health services, drugs, devices, products, and procedures. Prohibits discrimination in the provision of reproductive health care services. (SD1)

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