
A BILL FOR AN ACT

RELATING TO HEALTH CARE.

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

1 PART I

2 SECTION 1. The legislature finds that Hawaii has long been
3 a leader in advancing reproductive rights and advocating for
4 access to affordable and comprehensive sexual and reproductive
5 health care without discrimination. However, gaps in coverage
6 and care still exist, and Hawaii benefits and protections have
7 been threatened for years by a hostile federal administration
8 that has attempted to restrict and repeal the federal Patient
9 Protection and Affordable Care Act and limit access to sexual
10 and reproductive health care. The Trump administration made it
11 increasingly difficult for insurers to cover abortion care and
12 assembled a Supreme Court that restricted abortion access and
13 that may eliminate the Patient Protection and Affordable Care
14 Act in the near future.

15 The legislature further finds that a host of the Protection
16 and Affordable Care Act provisions could soon be eliminated,
17 including coverage of preventive care with no patient



1 cost-sharing. These changes would force people in Hawaii to pay
2 more health care costs out-of-pocket, delay or forego care, and
3 risk their health and economic security. The COVID-19 pandemic
4 has cost thousands of people their jobs and health insurance.
5 Forcing Hawaii residents to pay more for preventive care would
6 create a new public health crisis in the wake of a global
7 pandemic.

8 The legislature further finds that access to sexual and
9 reproductive health care is critical for the health and economic
10 security of all people in Hawaii, particularly during a
11 recession. Investing in no-cost preventive services will
12 ultimately save Hawaii money because providing preventive care
13 avoids the need for more expensive treatment and management in
14 the future. No-cost preventive services would also support
15 families in financial difficulty by helping people remain
16 healthy and plan their families in a way that is appropriate for
17 them. Ensuring that Hawaii's people receive comprehensive,
18 client-centered, and culturally-competent sexual and
19 reproductive health care is prudent economic policy that will
20 improve the overall health of our State's communities.



1 In order to guarantee essential health benefits, safeguard
2 access to abortion, limit out-of-pocket costs, and improve
3 overall access to care, the legislature finds that it is vital
4 to preserve certain aspects of the Patient Protection and
5 Affordable Care Act and ensure access to health care for
6 residents of Hawaii.

7 Accordingly, the purpose of this Act is to ensure
8 comprehensive coverage for sexual and reproductive health care
9 services, including family planning and abortion, for all people
10 in Hawaii.

11 PART II

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

15 "§431:10A-A Preventive care; coverage; requirements. (a)
16 Every individual policy of accident and health or sickness
17 insurance issued or renewed in this State shall provide coverage
18 for all of the following services, drugs, devices, products, and
19 procedures for the policyholder or any dependent of the
20 policyholder who is covered by the policy:



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



- 1 (4) Screening to determine whether counseling and testing
- 2 related to the BRCA1 or BRCA2 genetic mutation is
- 3 indicated and genetic counseling and testing related
- 4 to the BRCA1 or BRCA2 genetic mutation, if indicated;
- 5 (5) Screening and appropriate counseling or interventions
- 6 for:
- 7 (A) Substance abuse, including tobacco and electronic
- 8 smoking devices, and alcohol; and
- 9 (B) Domestic and interpersonal violence;
- 10 (6) Screening and appropriate counseling or interventions
- 11 for mental health screening and counseling, including
- 12 depression;
- 13 (7) Folic acid supplements;
- 14 (8) Abortion;
- 15 (9) Breastfeeding comprehensive support, counseling, and
- 16 supplies;
- 17 (10) Breast cancer chemoprevention counseling;
- 18 (11) Any contraceptive supplies, as specified in section
- 19 431:10A-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 United States Preventive Services Task Force or the
2 Health Resources and Services Administration of the
3 United States Department of Health and Human Services,
4 as of January 1, 2019.

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
13 high-deductible health plan, the insurer shall establish the
14 plan's cost-sharing for the coverage provided pursuant to this
15 section at the minimum level necessary to preserve the insured's
16 ability to claim tax-exempt contributions and withdrawals from
17 the insured's health savings account under title 26 United
18 States 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 2024
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, 2024.

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 431:10A-607.

17 (i) If the commissioner concludes that enforcement of this
18 section may adversely affect the allocation of federal funds to
19 the State, the commissioner may grant an exemption to the
20 requirements, but only to the minimum extent necessary to ensure
21 the continued receipt of federal funds.



1 (j) A bill or statement for services from any health care
2 provider or insurer shall be sent directly to the person
3 receiving the services.

4 (k) For purposes of this section, "contraceptive supplies"
5 shall have the same meaning as in section 431:10A-116.6.

6 **§431:10A-B Nondiscrimination; reproductive health care;**
7 **coverage.** (a) An individual, on the basis of actual or
8 perceived race, color, national origin, sex, gender identity,
9 sexual orientation, age, or disability, shall not be excluded
10 from participation in, be denied the benefits of, or otherwise
11 be subjected to discrimination in the coverage of, or payment
12 for, the services, drugs, devices, products, and procedures
13 covered by section 431:10A-A or 431:10A-116.6.

14 (b) Violation of this section shall be considered a
15 violation pursuant to chapter 489.

16 (c) Nothing in this section shall be construed to limit
17 any cause of action based upon any unfair or discriminatory
18 practices for which a remedy is available under state or federal
19 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 the policyholder or any dependent of the insured
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. For the purposes of this section and where
15 appropriate, a "well-woman visit" shall include other
16 preventive services as listed in this section;
17 provided that if several visits are needed to obtain
18 all necessary recommended preventive services,
19 depending upon a woman's health status, health needs,
20 and other risk factors, coverage shall apply to each
21 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 electronic
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 insured's dependent's health
2 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 United States Preventive Services Task Force or the
9 Health Resources and Services Administration of the
10 United States Department of Health and Human Services,
11 as of January 1, 2019.

12 (b) An insurer shall not impose any cost-sharing
13 requirements, including copayments, coinsurance, or deductibles,
14 on a policyholder 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
20 high-deductible health plan, the insurer shall establish the
21 plan's cost-sharing for the coverage provided pursuant to this



1 section at the minimum level necessary to preserve the insured's
2 ability to claim tax-exempt contributions and withdrawals from
3 the insured'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 insured 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 insured members and shall
15 be transmitted to insured members beginning with calendar year
16 2024 when annual information is made available to subscribers or
17 in any other mailing to subscribers, but in no case later than
18 December 31, 2024.

19 (h) This section shall not apply to policies that provide
20 coverage for specified diseases or other limited benefit health
21 insurance coverage, as provided pursuant to section 431:10A-607.



1 (i) If the commissioner concludes that enforcement of this
2 section may adversely affect the allocation of federal funds to
3 the State, the commissioner may grant an exemption to the
4 requirements, but only to the minimum extent necessary to ensure
5 the continued receipt of federal funds.

6 (j) A bill or statement for services from any health care
7 provider or insurer shall be sent directly to the person
8 receiving the services.

9 (k) For purposes of this section, "contraceptive supplies"
10 shall have the same meaning as in section 431:10A-116.6.

11 **§431:10A-D Nondiscrimination; reproductive health care;**

12 **coverage.** (a) An individual, on the basis of actual or
13 perceived race, color, national origin, sex, gender identity,
14 sexual orientation, age, or disability, shall not be excluded
15 from participation in, be denied the benefits of, or otherwise
16 be subjected to discrimination in the coverage of, or payment
17 for, the services, drugs, devices, products, and procedures
18 covered by section 431:10A-C or 431:10A-116.6.

19 (b) Violation of this section shall be considered a
20 violation pursuant to chapter 489.



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

8 "§432:1-A Preventive care; coverage; requirements. (a)
9 Every individual or group hospital or medical service plan
10 contract issued or renewed in this State shall provide coverage
11 for all of the following services, drugs, devices, products, and
12 procedures for the subscriber or member or any dependent of the
13 subscriber or member who is covered by the plan contract:

14 (1) Well-woman preventive care visit annually for women to
15 obtain the recommended preventive services that are
16 age and developmentally appropriate, including
17 preconception care and services necessary for prenatal
18 care. For the purposes of this section and where
19 appropriate, a "well-woman visit" shall include other
20 preventive services as listed in this section;
21 provided that if several visits are needed to obtain



1 all necessary recommended preventive services,
2 depending upon a woman's health status, health needs,
3 and other risk factors, coverage shall apply to each
4 of the necessary visits;

5 (2) Counseling for sexually transmitted infections,
6 including human immunodeficiency virus and acquired
7 immune deficiency syndrome;

8 (3) Screening for: chlamydia; gonorrhea; hepatitis B;
9 hepatitis C; human immunodeficiency virus and acquired
10 immune deficiency syndrome; human papillomavirus;
11 syphilis; anemia; urinary tract infection; pregnancy;
12 Rh incompatibility; gestational diabetes;
13 osteoporosis; breast cancer; and cervical cancer;

14 (4) Screening to determine whether counseling and testing
15 related to the BRCA1 or BRCA2 genetic mutation is
16 indicated and genetic counseling and testing related
17 to the BRCA1 or BRCA2 genetic mutation, if indicated;

18 (5) Screening and appropriate counseling or interventions
19 for:

20 (A) Substance abuse, including tobacco and electronic
21 smoking devices, and alcohol; and



- 1 (B) Domestic and interpersonal violence;
- 2 (6) Screening and appropriate counseling or interventions
- 3 for mental health screening and counseling, including
- 4 depression;
- 5 (7) Folic acid supplements;
- 6 (8) Abortion;
- 7 (9) Breastfeeding comprehensive support, counseling, and
- 8 supplies;
- 9 (10) Breast cancer chemoprevention counseling;
- 10 (11) Any contraceptive supplies, as specified in section
- 11 431:10A-116.6;
- 12 (12) Voluntary sterilization, as a single claim or combined
- 13 with the following other claims for covered services
- 14 provided on the same day:
- 15 (A) Patient education and counseling on contraception
- 16 and sterilization; and
- 17 (B) Services related to sterilization or the
- 18 administration and monitoring of contraceptive
- 19 supplies, including:
- 20 (i) Management of side effects;



- 1 (ii) Counseling for continued adherence to a
2 prescribed regimen;
- 3 (iii) Device insertion and removal; and
- 4 (iv) Provision of alternative contraceptive
5 supplies deemed medically appropriate in the
6 judgment of the subscriber's or member's
7 health care provider;
- 8 (13) Pre-exposure prophylaxis, post-exposure prophylaxis,
9 and human papillomavirus vaccination; and
- 10 (14) Any additional preventive services for women that must
11 be covered without cost sharing under title 42 United
12 States Code section 300gg-13, as identified by the
13 United States Preventive Services Task Force or the
14 Health Resources and Services Administration of the
15 United States Department of Health and Human Services,
16 as of January 1, 2019.
- 17 (b) A mutual benefit society shall not impose any
18 cost-sharing requirements, including copayments, coinsurance, or
19 deductibles, on a subscriber or member or an individual covered
20 by the plan contract with respect to the coverage and benefits
21 required by this section, except to the extent that coverage of



1 particular services without cost-sharing would disqualify a
2 high-deductible health plan from eligibility for a health
3 savings account pursuant to title 26 United States Code section
4 223. For a qualifying high-deductible health plan, the mutual
5 benefit society shall establish the plan's cost-sharing for the
6 coverage provided pursuant to this section at the minimum level
7 necessary to preserve the subscriber's or member's ability to
8 claim tax-exempt contributions and withdrawals from the
9 subscriber's or member's health savings account under title 26
10 United States Code section 223.

11 (c) A health care provider shall be reimbursed for
12 providing the services pursuant to this section without any
13 deduction for coinsurance, copayments, or any other cost-sharing
14 amounts.

15 (d) Except as otherwise authorized under this section, a
16 mutual benefit society shall not impose any restrictions or
17 delays on the coverage required under this section.

18 (e) This section shall not require an individual or group
19 hospital or medical service plan contract to cover:

20 (1) Experimental or investigational treatments;

21 (2) Clinical trials or demonstration projects;



- 1 (3) Treatments that do not conform to acceptable and
2 customary standards of medical practice; or
- 3 (4) Treatments for which there is insufficient data to
4 determine efficacy.
- 5 (f) If services, drugs, devices, products, or procedures
6 required by this section are provided by an out-of-network
7 provider, the mutual benefit society shall cover the services,
8 drugs, devices, products, or procedures without imposing any
9 cost-sharing requirement on the subscriber or member if:
- 10 (1) There is no in-network provider to furnish the
11 service, drug, device, product, or procedure that
12 meets the requirements for network adequacy under
13 section 431:26-103; or
- 14 (2) An in-network provider is unable or unwilling to
15 provide the service, drug, device, product, or
16 procedure in a timely manner.
- 17 (g) Every mutual benefit society shall provide written
18 notice to its subscribers or members regarding the coverage
19 required by this section. The notice shall be in writing and
20 prominently positioned in any literature or correspondence sent
21 to subscribers or members and shall be transmitted to



1 subscribers or members beginning with calendar year 2024 when
2 annual information is made available to subscribers or members
3 or in any other mailing to subscribers or members, but in no
4 case later than December 31, 2024.

5 (h) This section shall not apply to plan contracts that
6 provide coverage for specified diseases or other limited benefit
7 health insurance coverage, as provided pursuant to section
8 431:10A-607.

9 (i) If the commissioner concludes that enforcement of this
10 section may adversely affect the allocation of federal funds to
11 the State, the commissioner may grant an exemption to the
12 requirements, but only to the minimum extent necessary to ensure
13 the continued receipt of federal funds.

14 (j) A bill or statement for services from any health care
15 provider or mutual benefit society shall be sent directly to the
16 person receiving the services.

17 (k) For purposes of this section, "contraceptive supplies"
18 shall have the same meaning as in section 431:10A-116.6.

19 **§432:1-B Nondiscrimination; reproductive health care;**
20 **coverage.** (a) An individual, on the basis of actual or
21 perceived race, color, national origin, sex, gender identity,



1 sexual orientation, age, or disability, shall not be excluded
2 from participation in, be denied the benefits of, or otherwise
3 be subjected to discrimination in the coverage of, or payment
4 for, the services, drugs, devices, products, and procedures
5 covered by section 432:1-A or 432:1-604.5.

6 (b) Violation of this section shall be considered a
7 violation pursuant to chapter 489.

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

12 SECTION 5. Chapter 432D, Hawaii Revised Statutes, is
13 amended by adding a new section to be appropriately designated
14 and to read as follows:

15 **"§432D-A Nondiscrimination; reproductive health care;**
16 **coverage.** (a) An individual, on the basis of actual or
17 perceived race, color, national origin, sex, gender identity,
18 sexual orientation, age, or disability, shall not be excluded
19 from participation in, be denied the benefits of, or otherwise
20 be subjected to discrimination in the coverage of, or payment



1 for, the services, drugs, devices, products, and procedures
2 covered by section 431:10-A or 431:10A-116.6.

3 (b) Violation of this section shall be considered a
4 violation pursuant to chapter 489.

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

9 SECTION 6. Section 431:10A-116.6, Hawaii Revised Statutes,
10 is amended to read as follows:

11 **"§431:10A-116.6 Contraceptive services. (a)**

12 Notwithstanding any provision of law to the contrary, each
13 employer group policy of accident and health or sickness
14 [~~policy, contract, plan, or agreement~~] insurance issued or
15 renewed in this State on or after January 1, [~~2000,~~] 2024, shall
16 [~~cease to exclude~~] provide coverage for contraceptive services
17 or contraceptive supplies for the [~~subscriber~~] insured or any
18 dependent of the [~~subscriber~~] insured who is covered by the
19 policy, subject to the exclusion under section 431:10A-116.7 and
20 the exclusion under section 431:10A-607[-



1 ~~(b) Except as provided in subsection (c), all policies,~~
2 ~~contracts, plans, or agreements under subsection (a) that~~
3 ~~provide contraceptive services or supplies or prescription drug~~
4 ~~coverage shall not exclude any prescription contraceptive~~
5 ~~supplies or impose any unusual copayment, charge, or waiting~~
6 ~~requirement for such supplies.~~

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

- 11 ~~(1) Use of brands covered has resulted in an adverse drug~~
12 ~~reaction; or~~
- 13 ~~(2) The member has not used the brands covered and, based~~
14 ~~on the member's past medical history, the prescribing~~
15 ~~health care provider believes that use of the brands~~
16 ~~covered would result in an adverse reaction.~~

17 ~~(d)]~~; provided that:

- 18 (1) If there is a therapeutic equivalent of a
19 contraceptive supply approved by the United States
20 Food and Drug Administration, an insurer may provide
21 coverage for either the requested contraceptive supply



1 or for one or more therapeutic equivalents of the
2 requested contraceptive supply;

3 (2) If a contraceptive supply covered by the policy is
4 deemed medically inadvisable by the insured's health
5 care provider, the policy shall cover an alternative
6 contraceptive supply prescribed by the health care
7 provider;

8 (3) An insurer shall pay pharmacy claims for reimbursement
9 of all contraceptive supplies available for
10 over-the-counter sale that are approved by the United
11 States Food and Drug Administration; and

12 (4) An insurer may not infringe upon an insured's choice
13 of contraceptive supplies and may not require prior
14 authorization, step therapy, or other utilization
15 control techniques for medically-appropriate covered
16 contraceptive supplies.

17 (b) An insurer shall not impose any cost-sharing
18 requirements, including copayments, coinsurance, or deductibles,
19 on an insured with respect to the coverage required under this
20 section. A health care provider shall be reimbursed for
21 providing the services pursuant to this section without any



1 deduction for coinsurance, copayments, or any other cost-sharing
2 amounts.

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

6 (d) Coverage required by this section shall not exclude
7 coverage for contraceptive supplies prescribed by a health care
8 provider, acting within the provider's scope of practice, for:

9 (1) Reasons other than contraceptive purposes, such as
10 decreasing the risk of ovarian cancer or eliminating
11 symptoms of menopause; or

12 (2) Contraception that is necessary to preserve the life
13 or health of an insured.

14 (e) Coverage required by this section shall include
15 reimbursement to a prescribing health care provider or
16 dispensing entity for prescription contraceptive supplies
17 intended to last for up to a twelve-month period for an insured.

18 ~~(e)~~ (f) Coverage required by this section shall include
19 reimbursement to a prescribing and dispensing pharmacist who
20 prescribes and dispenses contraceptive supplies pursuant to
21 section 461-11.6.



1 (g) Nothing in this section shall be construed to extend
2 the practices or privileges of any health care provider beyond
3 that provided in the laws governing the provider's practice and
4 privileges.

5 (h) For purposes of this section:

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

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

19 ~~[(f) Nothing in this section shall be construed to extend~~
20 ~~the practice or privileges of any health care provider beyond~~



1 ~~that provided in the laws governing the provider's practice and~~
2 ~~privileges.]"~~

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

5 "(g) For purposes of this section:

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

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

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



1 "§432:1-604.5 Contraceptive services. (a)

2 Notwithstanding any provision of law to the contrary, each
3 employer group [~~health policy, contract, plan, or agreement~~]
4 hospital or medical service plan contract issued or renewed in
5 this State on or after January 1, [~~2000,~~] 2024, shall [~~cease to~~
6 ~~exclude~~] provide coverage for contraceptive services or
7 contraceptive supplies, and contraceptive prescription drug
8 coverage for the subscriber or member, or any dependent of the
9 subscriber or member who is covered by the policy, subject to
10 the exclusion under section 431:10A-116.7[-

11 ~~(b) Except as provided in subsection (c), all policies,~~
12 ~~contracts, plans, or agreements under subsection (a), that~~
13 ~~provide contraceptive services or supplies or prescription drug~~
14 ~~coverage shall not exclude any prescription contraceptive~~
15 ~~supplies or impose any unusual copayment, charge, or waiting~~
16 ~~requirement for such drug or device.~~

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

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

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

7 ~~(d)]~~; provided that:

8 (1) If there is a therapeutic equivalent of a
9 contraceptive supply approved by the United States
10 Food and Drug Administration, a mutual benefit society
11 may provide coverage for either the requested
12 contraceptive supply or for one or more therapeutic
13 equivalents of the requested contraceptive supply;

14 (2) If a contraceptive supply covered by the plan contract
15 is deemed medically inadvisable by the subscriber's or
16 member's health care provider, the plan contract shall
17 cover an alternative contraceptive supply prescribed
18 by the health care provider;

19 (3) A mutual benefit society shall pay pharmacy claims for
20 reimbursement of all contraceptive supplies available



1 for over-the-counter sale that are approved by the
2 United States Food and Drug Administration; and
3 (4) A mutual benefit society shall not infringe upon a
4 subscriber's or member's choice of contraceptive
5 supplies and shall not require prior authorization,
6 step therapy, or other utilization control techniques
7 for medically-appropriate covered contraceptive
8 supplies.

9 (b) A mutual benefit society shall not impose any
10 cost-sharing requirements, including copayments, coinsurance, or
11 deductibles, on a subscriber or member with respect to the
12 coverage required under this section. A health care provider
13 shall be reimbursed for providing the services pursuant to this
14 section without any deduction for coinsurance, copayments, or
15 any other cost-sharing amounts.

16 (c) Except as otherwise provided by this section, a mutual
17 benefit society shall not impose any restrictions or delays on
18 the coverage required by this section.

19 (d) Coverage required by this section shall not exclude
20 coverage for contraceptive supplies prescribed by a health care
21 provider, acting within the provider's scope of practice, for:



1 (1) Reasons other than contraceptive purposes, such as
2 decreasing the risk of ovarian cancer or eliminating
3 symptoms of menopause; or

4 (2) Contraception that is necessary to preserve the life
5 or health of a subscriber or member.

6 (e) Coverage required by this section shall include
7 reimbursement to a prescribing health care provider or
8 dispensing entity for prescription contraceptive supplies
9 intended to last for up to a twelve-month period for a member.

10 ~~(e)~~ (f) Coverage required by this section shall include
11 reimbursement to a prescribing and dispensing pharmacist who
12 prescribes and dispenses contraceptive supplies pursuant to
13 section 461-11.6.

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 (h) For purposes of this section:

19 "Contraceptive services" means physician-delivered,
20 physician-supervised, physician assistant-delivered, advanced
21 practice registered nurse-delivered, nurse-delivered, or



1 pharmacist-delivered medical services intended to promote the
2 effective use of contraceptive supplies or devices to prevent
3 unwanted pregnancy.

4 "Contraceptive supplies" means all Food and Drug
5 Administration-approved contraceptive drugs or devices used to
6 prevent unwanted pregnancy[-

7 ~~(f) 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.], regardless of whether they are to be used by the
11 subscriber or member or the partner of the subscriber or member,
12 and regardless of whether they are to be used for contraception
13 or exclusively for the prevention of sexually transmitted
14 infections."~~

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

17 "**§432D-23 Required provisions and benefits.**

18 Notwithstanding any provision of law to the contrary, each
19 policy, contract, plan, or agreement issued in the State after
20 January 1, 1995, by health maintenance organizations pursuant to
21 this chapter, shall include benefits provided in sections



1 431:10-212, 431:10A-115, 431:10A-115.5, 431:10A-116,
2 431:10A-116.2, 431:10A-116.5, 431:10A-116.6, 431:10A-119,
3 431:10A-120, 431:10A-121, 431:10A-122, 431:10A-125, 431:10A-126,
4 431:10A-132, 431:10A-133, 431:10A-134, 431:10A-140, and
5 [~~431:10A-134~~] 431:10A-A, and chapter 431M."

6 PART III

7 SECTION 10. Chapter 346, Hawaii Revised Statutes, is
8 amended by adding a new section to be appropriately designated
9 and to read as follows:

10 **"§346-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, or procedures
17 covered by section 432:1-A or 432:1-604.5 or in the receipt of
18 medical assistance as that term is defined under section 346-1.
19 (b) Violation of this section shall be considered a
20 violation pursuant to chapter 489.



1 agreements of health insurance issued or renewed by a health
2 insurer, mutual benefit society, or health maintenance
3 organization on or after January 1, 2024.

4

INTRODUCED BY:



JAN 24 2023



H.B. NO. 1179

Report Title:

Health Care; Insurance

Description:

Requires health insurance coverage for various sexual and reproductive health care services.

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

