THE SENATE
THIRTY-SECOND LEGISLATURE, 2023
STATE OF HAWAII

JAN 2 0 2023

S.B. NO. 893

A BILL FOR AN ACT

RELATING TO HEALTH CARE.

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

PART I

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

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

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

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

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

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

PART II

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

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

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

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

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

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

(5) Screening and appropriate counseling or interventions for:

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

(B) Domestic and interpersonal violence;

(6) Screening and appropriate counseling or interventions for mental health screening and counseling, including depression;

(7) Folic acid supplements;

(8) Abortion;

(9) Breastfeeding comprehensive support, counseling, and supplies;

(10) Breast cancer chemoprevention counseling;

(11) Any contraceptive supplies, as specified in section 431:10A-116.6;

(12) Voluntary sterilization, as a single claim or combined with the following other claims for covered services provided on the same day:

(A) Patient education and counseling on contraception and sterilization; and

(B) Services related to sterilization or the administration and monitoring of contraceptive supplies, including:

(i) Management of side effects;

(ii) Counseling for continued adherence to a prescribed regimen;

(iii) Device insertion and removal; and

(iv) Provision of alternative contraceptive supplies deemed medically appropriate in the judgment of the insured's health care provider;

(13) Pre-exposure prophylaxis, post-exposure prophylaxis, and human papillomavirus vaccination; and

(14) Any additional preventive services for women that must be covered without cost sharing under title 42 United States Code section 300gg-13, as identified by the

United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services, as of January 1, 2019.

(b) An insurer shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on a policyholder or an individual covered by the policy with respect to the coverage and benefits required by this section, except to the extent that coverage of particular services without cost-sharing would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to title 26 United States Code section 223. For a qualifying high-deductible health plan, the insurer shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the insured's ability to claim tax-exempt contributions and withdrawals from the insured's health savings account under title 26 United States Code section 223.

(c) 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.

(d) Except as otherwise authorized under this section, an insurer shall not impose any restrictions or delays on the coverage required under this section.

(e) This section shall not require a policy of accident and health or sickness insurance to cover:

(1) Experimental or investigational treatments;

(2) Clinical trials or demonstration projects;

(3) Treatments that do not conform to acceptable and customary standards of medical practice; or

(4) Treatments for which there is insufficient data to determine efficacy.

(f) If services, drugs, devices, products, or procedures required by this section are provided by an out-of-network provider, the insurer shall cover the services, drugs, devices, products, or procedures without imposing any cost-sharing requirement on the policyholder if:

(1) There is no in-network provider to furnish the service, drug, device, product, or procedure that

meets the requirements for network adequacy under section 431:26-103; or

(2) An in-network provider is unable or unwilling to provide the service, drug, device, product, or procedure in a timely manner.

(g) Every insurer shall provide written notice to its policyholders regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to policyholders and shall be transmitted to policyholders beginning with calendar year 2024 when annual information is made available to policyholders or in any other mailing to policyholders, but in no case later than December 31, 2024.

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

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

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

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

§431:10A-B 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, and procedures covered by section 431:10A-A or 431:10A-116.6.

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

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

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

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

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

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

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

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

(5) Screening and appropriate counseling or interventions for:

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

(B) Domestic and interpersonal violence;

(6) Screening and appropriate counseling or interventions for mental health screening and counseling, including depression;

(7) Folic acid supplements;

(8) Abortion;

(9) Breastfeeding comprehensive support, counseling, and supplies;

(10) Breast cancer chemoprevention counseling;

(11) Any contraceptive supplies, as specified in section 431:10A-116.6;

(12) Voluntary sterilization, as a single claim or combined with the following other claims for covered services provided on the same day:

(A) Patient education and counseling on contraception and sterilization; and

(B) Services related to sterilization or the administration and monitoring of contraceptive supplies, including:

(i) Management of side effects;

(ii) Counseling for continued adherence to a prescribed regimen;

(iii) Device insertion and removal; and

(iv) Provision of alternative contraceptive supplies deemed medically appropriate in the

judgment of the insured's dependent's health care provider;

(13) Pre-exposure prophylaxis, post-exposure prophylaxis, and human papillomavirus vaccination; and

(14) Any additional preventive services for women that must be covered without cost sharing under title 42 United States Code section 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services, as of January 1, 2019.

(b) An insurer shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on a policyholder or an individual covered by the policy with respect to the coverage and benefits required by this section, except to the extent that coverage of particular services without cost-sharing would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to title 26 United States Code section 223. For a qualifying high-deductible health plan, the insurer shall establish the plan's cost-sharing for the coverage provided pursuant to this

section at the minimum level necessary to preserve the insured's ability to claim tax-exempt contributions and withdrawals from the insured's health savings account under title 26 United States Code section 223.

(c) 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.

(d) Except as otherwise authorized under this section, an insurer shall not impose any restrictions or delays on the coverage required under this section.

(e) This section shall not require a policy of accident and health or sickness insurance to cover:

(1) Experimental or investigational treatments;

(2) Clinical trials or demonstration projects;

(3) Treatments that do not conform to acceptable and customary standards of medical practice; or

(4) Treatments for which there is insufficient data to determine efficacy.

(f) If services, drugs, devices, products, or procedures required by this section are provided by an out-of-network

provider, the insurer shall cover the services, drugs, devices, products, or procedures without imposing any cost-sharing requirement on the insured if:

(1) There is no in-network provider to furnish the service, drug, device, product, or procedure that meets the requirements for network adequacy under section 431:26-103; or

(2) An in-network provider is unable or unwilling to provide the service, drug, device, product, or procedure in a timely manner.

(g) Every insurer shall provide written notice to its subscribers regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to insured members and shall be transmitted to insured members beginning with calendar year 2024 when annual information is made available to subscribers or in any other mailing to subscribers, but in no case later than December 31, 2024.

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

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

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

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

§431:10A-D 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, and procedures covered by section 431:10A-C or 431:10A-116.6.

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

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

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

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

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

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

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

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

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

(5) Screening and appropriate counseling or interventions for:

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

(B) Domestic and interpersonal violence;

(6) Screening and appropriate counseling or interventions for mental health screening and counseling, including depression;

(7) Folic acid supplements;

(8) Abortion;

(9) Breastfeeding comprehensive support, counseling, and supplies;

(10) Breast cancer chemoprevention counseling;

(11) Any contraceptive supplies, as specified in section 431:10A-116.6;

(12) Voluntary sterilization, as a single claim or combined with the following other claims for covered services provided on the same day:

(A) Patient education and counseling on contraception and sterilization; and

(B) Services related to sterilization or the administration and monitoring of contraceptive supplies, including:

(i) Management of side effects;

(ii) Counseling for continued adherence to a prescribed regimen;

(iii) Device insertion and removal; and

(iv) Provision of alternative contraceptive supplies deemed medically appropriate in the judgment of the subscriber's or member's health care provider;

(13) Pre-exposure prophylaxis, post-exposure prophylaxis, and human papillomavirus vaccination; and

(14) Any additional preventive services for women that must be covered without cost sharing under title 42 United States Code section 300gg-13, as identified by the United States Preventive Services Task Force or the Health Resources and Services Administration of the United States Department of Health and Human Services, as of January 1, 2019.

(b) A mutual benefit society shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on a subscriber or member or an individual covered by the plan contract with respect to the coverage and benefits required by this section, except to the extent that coverage of

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

(c) 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.

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

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

(1) Experimental or investigational treatments;

(2) Clinical trials or demonstration projects;

(3) Treatments that do not conform to acceptable and customary standards of medical practice; or

(4) Treatments for which there is insufficient data to determine efficacy.

(f) If services, drugs, devices, products, or procedures required by this section are provided by an out-of-network provider, the mutual benefit society shall cover the services, drugs, devices, products, or procedures without imposing any cost-sharing requirement on the subscriber or member if:

(1) There is no in-network provider to furnish the service, drug, device, product, or procedure that meets the requirements for network adequacy under section 431:26-103; or

(2) An in-network provider is unable or unwilling to provide the service, drug, device, product, or procedure in a timely manner.

(g) Every mutual benefit society shall provide written notice to its subscribers or members regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to subscribers or members and shall be transmitted to

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

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

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

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

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

§432:1-B 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, and procedures covered by section 432:1-A or 432:1-604.5.

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

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

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

"**§432D-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, and procedures covered by section 431:10-A or 431:10A-116.6.

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

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

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

"**§431:10A-116.6 Contraceptive services.** (a) Notwithstanding any provision of law to the contrary, each employer group policy of accident and health or sickness [~~policy, contract, plan, or agreement~~] insurance issued or renewed in this State on or after January 1, [~~2000,~~] 2024, shall [~~cease to exclude~~] provide coverage for contraceptive services or contraceptive supplies for the [~~subscriber~~] insured or any dependent of the [~~subscriber~~] insured who is covered by the policy, subject to the exclusion under section 431:10A-116.7 and the exclusion under section 431:10A-607[~~.~~

~~(b) Except as provided in subsection (c), all policies, contracts, plans, or agreements under subsection (a) that provide contraceptive services or supplies or prescription drug coverage shall not exclude any prescription contraceptive supplies or impose any unusual copayment, charge, or waiting 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)~~]; provided that:

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

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

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

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

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

(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.

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

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

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

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

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

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

(h) 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.

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

"(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,~~] 2024, shall [~~cease to exclude~~] provide coverage for contraceptive services or contraceptive supplies, and contraceptive prescription drug coverage for the subscriber or member, or any dependent of the subscriber or member who is covered by the policy, subject to the exclusion under section 431:10A-116.7[~~.~~

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

~~(c) Coverage for 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)~~]; provided that:

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

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

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

for over-the-counter sale that are approved by the United States Food and Drug Administration; and

(4) A mutual benefit society shall not infringe upon a subscriber's or member's choice of contraceptive supplies and shall not require prior authorization, step therapy, or other utilization control techniques for medically-appropriate covered contraceptive supplies.

(b) A mutual benefit society shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on a subscriber or member 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, a mutual benefit society shall not impose any restrictions or delays on the coverage required by this section.

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

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

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

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

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

(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.

(h) 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 Food and Drug Administration-approved contraceptive drugs or devices used to prevent unwanted pregnancy[~~.~~

~~(f) 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.~~], regardless of whether they are to 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."

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."

PART III

SECTION 10. 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 489.

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

PART IV

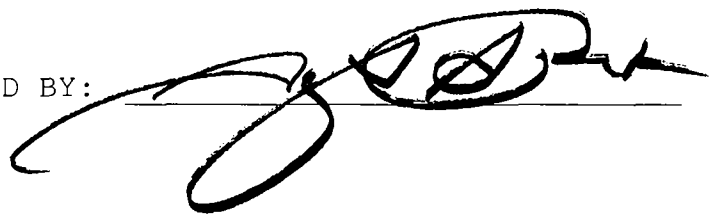
SECTION 11. No later than twenty days prior the convening of the regular session of 2025, the insurance division of the department of commerce and consumer affairs shall submit a report to the legislature on the degree of compliance by insurers, mutual benefit societies, and health maintenance organizations regarding the implementation of this Act, and of any actions taken by the insurance commissioner to enforce compliance with this Act.

SECTION 12. In codifying the new sections added by sections 2, 3, 4, 5, and 10 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 13. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 14. This Act shall take effect on January 1, 2024, and shall apply to all plans, policies, contracts, and

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

INTRODUCED BY: 

S.B. NO. 893

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.