A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The legislature finds that the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) has resulted in an estimated 20,000,000 Americans gaining health insurance coverage. The provisions under the Affordable Care Act that afforded coverage to the uninsured include the medicaid expansion, health insurance marketplace coverage, and changes in private insurance that permit young adults to remain on their parent's health insurance plans and require health insurance plans to cover people with preexisting health conditions.

According to a report from the United States Department of Health and Human Services, 6,100,000 uninsured young adults ages nineteen to twenty-five have gained health insurance coverage thanks to the Affordable Care Act. This is especially important as young adults were particularly likely to be uninsured before the law went into effect.

The federal Department of Health and Human Services recently reported that since the enactment of the Affordable
Care Act, 54,000 residents of Hawaii have gained health insurance coverage. In addition to residents who would otherwise be uninsured, hundreds of thousands of Hawaii residents with employer, medicaid, individual market, or medicare coverage have also benefited from new protections under the Affordable Care Act. Even with the robust coverage of Hawaii's Prepaid Health Care Act, the benefits of the Affordable Care Act in Hawaii have been widespread. The Act expanded medicaid eligibility and strengthened the program for those already eligible. The State has saved millions in uncompensated care costs and has been able to improve behavioral health outcomes for various beneficiaries. For Hawaii residents, individual market coverage is now dramatically better than before the enactment of the Affordable Care Act.

Unfortunately, the future of the Affordable Care Act is now uncertain. The incoming Presidential Administration campaigned on the promise to repeal the Affordable Care Act. Republicans in Congress have also backed the incoming President-Elect's promise to repeal and replace the Affordable Care Act. On January 12, 2017, Senate Republicans took their first major step toward repealing the Affordable Care Act, when they approved a
budget blueprint that would allow Republicans to gut the Affordable Care Act without the threat of a Democratic filibuster.

The repeal of the Affordable Care Act will have widespread ramifications. According to recent data from the Urban Institute, 86,000 fewer people in Hawaii would have health insurance in 2019 if the Affordable Care Act is repealed. States are poised to lose significant federal funds if marketplace subsidies and the medicaid expansion end. For Hawaii, a repeal of the Affordable Care Act means the loss of $47,000,000 in federal marketplace spending in 2019 and a loss of $532,000,000 between 2019 and 2028. Hawaii would also lose $306,000,000 in federal medicaid funding in 2019 and $3,700,000,000 between 2019 and 2028.

The legislature further finds that repealing the Affordable Care Act would destabilize the individual insurance market, due to a combination of several factors, including the pending loss of subsidies, elimination of the requirement to buy health insurance, and the requirement that insurers sell to all purchasers. Such factors will likely cause individual insurance
prices to rise and may cause healthier individuals to drop health insurance coverage.

The Urban Institute estimates that repealing the Affordable Care Act without an adequate replacement plan that ensures affordable coverage would take health insurance coverage away from 29,800,000 people nationwide by 2019, more than doubling the total number of uninsured to 58,700,000.

As of January 2017, there is not yet a firm plan or agreement regarding the future of the Affordable Care Act. However, the President-Elect has demanded Congress immediately repeal and replace the Act. The legislature concludes that due to the uncertainty over the Affordable Care Act, it is important to preserve certain important aspects of the Act for residents in Hawaii.

Accordingly, the purpose of this Act is to ensure certain benefits under the Affordable Care Act, which may not otherwise be available under the State's Prepaid Health Care Act, remain available under Hawaii law, including:

(1) Preserving the individual mandate that requires taxpayers to have qualified health insurance coverage throughout the year or pay a penalty;
(2) Ensuring all health insurers, mutual benefit societies, and health maintenance organizations in the State, including health benefits plans under chapter 87A, Hawaii Revised Statutes, include ten essential health care benefits, plus additional contraception and breastfeeding coverage benefits;

(3) Extending dependent coverage for adult children until the children turn twenty-six years of age;

(4) Prohibiting health insurance entities from imposing a preexisting condition exclusion; and

(5) Prohibiting health insurance entities from using an individual's gender to determine premiums or contributions.

SECTION 2. Chapter 235, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"§235- Qualifying health insurance coverage. (a) For each month beginning after December 31, 2017, an individual shall ensure that the individual, and any dependent of the individual, is covered with qualifying health insurance coverage for the month."
(b) If a taxpayer, or a dependent for whom the taxpayer is liable under paragraph (2), fails to meet the requirement of subsection (a) for one or more months, then a penalty shall be imposed on the taxpayer in an amount determined pursuant to subsection (c); provided that:

(1) Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under section 235-92 for the taxable year which includes that month; and

(2) If a penalty is imposed for any month on an individual and the individual:

   (A) Is a dependent of another taxpayer for the other taxpayer's taxable year, the other taxpayer shall be liable for the penalty; or

   (B) Files a joint return for the taxable year, the individual and the spouse of the individual shall be jointly liable for such penalty.

(c) The amount of the penalty imposed by this section on any taxpayer for any taxable year pursuant to subsection (b) shall be equal to the sum of the monthly penalty amounts
determined under subsection (d) for months in the taxable year
during which one or more such failures occurred.

(d) The monthly penalty amount with respect to any
taxpayer for any month during which any failure described
pursuant to subsection (b) occurred is an amount equal to one-
twelfth of the greater of the following amounts:

(1) A flat rate of $695; or

(2) 2.5 per cent of the excess of the taxpayer's household
income for the taxable year over the amount of gross
income with respect to the taxpayer for the taxable
year.

(e) If an individual has not attained the age of eighteen
as of the beginning of a month, the applicable dollar amount for
the penalty with respect to such individual for the month shall
be equal to one-half of the applicable dollar amount for the
calendar year in which the month occurs.

(f) For every calendar year beginning after December 31,
2018, the applicable dollar amount for the penalty under
subsection (d)(1) shall be $695, increased by an amount equal to
$695 multiplied by the cost of living adjustment determined
pursuant to title 26 United States Code section 1(f)(3).
(g) For purposes of this section, "qualifying health insurance coverage" means any plan, policy, contract, certificate, or agreement, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits."

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

"§431:10A- Essential health care benefits. (a) Every policy of accident and health or sickness insurance issued or renewed in this State shall include at least the following essential health care benefits:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization benefits;
(4) Pregnancy, maternity, and newborn care;

(5) Mental health and substance use disorder services, including behavioral health treatment, mental and behavioral health inpatient services, and substance use disorder treatment;

(6) Prescription drug coverage;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care.

(b) Policies of accident and health or sickness insurance delivered or issued for delivery in this State shall also include the following additional benefits:

(1) Contraceptive coverage; including contraceptive methods and counseling, as prescribed by a health care provider; and

(2) Breastfeeding coverage, including breastfeeding support, counseling, and equipment for the duration of breastfeeding;
provided that a health insurer shall not impose any cost-sharing
requirements, including copayments, coinsurance, or deductibles,
on a policyholder or individual with respect to the benefits
covered under this subsection.

(c) This section shall not apply to policies that provide
coverage for specified diseases or other limited benefit
coverage, as provided pursuant to section 431:10A-102.5.

§431:10A- Extension of dependent coverage. A group
accident and health or sickness insurance policy and a health
insurer offering group or individual accident and health or
sickness insurance coverage that provides dependent coverage of
children shall continue to make such coverage available for an
adult child until the child turns twenty-six years of age.
Nothing in this section shall require a policy or health insurer
to make coverage available for a child of a child receiving
dependent coverage.

§431:10A- Prohibition of preexisting condition
exclusions. (a) An accident and health or sickness insurance
policy issued or renewed in this State shall not impose any
preexisting condition exclusion.
(b) For purposes of this section, a "preexisting condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual accident and health or sickness insurance policy, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day and includes any condition.

The term "preexisting condition exclusion" includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual accident and health or sickness insurance policy, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.
§431:10A- Prohibited discrimination in premiums or contributions. A group accident and health or sickness insurance policy and a health insurer offering group or individual accident and health or sickness insurance coverage issued or renewed in this State shall not require an individual, as a condition of enrollment or continued enrollment under the policy, to pay a premium or contribution based on the individual's gender that is greater than the premium or contribution for a similarly situated individual of the opposite gender who is covered under the same policy."

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

"§432:1- Essential health care benefits. (a) Every hospital or medical service plan contract issued or renewed in this State shall include at least the following essential health care benefits:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization benefits;
4. Pregnancy, maternity, and newborn care;
(5) Mental health and substance use disorder services, including behavioral health treatment, mental and behavioral health inpatient services, and substance use disorder treatment;

(6) Prescription drug coverage;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care.

(b) Hospital or medical service plan contracts delivered or issued for delivery in this State shall also include the following additional benefits:

(1) Contraceptive coverage; including contraceptive methods and counseling, as prescribed by a health care provider; and

(2) Breastfeeding coverage, including breastfeeding support, counseling, and equipment for the duration of breastfeeding;

provided that a mutual benefit society shall not impose any cost-sharing requirements, including copayments, coinsurance, or
deductibles, on a member or subscriber with respect to the
benefits covered under this subsection.

(c) This section shall not apply to policies that provide
coverage for specified diseases or other limited benefit
coverage, as provided pursuant to section 431:10A-102.5.

§432:1- Extension of dependent coverage. A group
hospital or medical service plan contract and a mutual benefit
society offering group or individual hospital and medical
service plan contracts that provides dependent coverage of
children shall continue to make such coverage available for an
adult child until the child turns twenty-six years of age.

Nothing in this section shall require a plan contract to make
coverage available for a child of a child receiving dependent
coverage.

§432:1- Prohibition of preexisting condition exclusions.

(a) A hospital or medical service plan contract issued or
renewed in this State shall not impose any preexisting condition
exclusion.

(b) For purposes of this section, a "preexisting condition
exclusion" means a limitation or exclusion of benefits
(including a denial of coverage) based on the fact that the
condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual hospital and medical service plan contract, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day and includes any condition.

The term "preexisting condition exclusion" includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual hospital and medical service plan contract, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

PROHIBITED DISCRIMINATION IN PREMIUMS OR CONTRIBUTIONS. A group hospital or medical service plan contract and a mutual benefit society offering group or individual hospital and medical service plan contracts issued or renewed in this State shall not require an individual, as a
condition of enrollment or continued enrollment under the plan contract, to pay a premium or contribution based on the individual's gender that is greater than the premium or contribution for a similarly situated individual of the opposite gender who is covered under the same plan contract."

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

"§432D- Essential health care benefits. (a) Every health maintenance organization policy, contract, plan, or agreement issued or renewed in this State shall include at least the following essential health care benefits:

(1) Ambulatory patient services;
(2) Emergency services;
(3) Hospitalization benefits;
(4) Pregnancy, maternity, and newborn care;
(5) Mental health and substance use disorder services, including behavioral health treatment, mental and behavioral health inpatient services, and substance use disorder treatment;
(6) Prescription drug coverage;
(7) Rehabilitative and habilitative services and devices;
(8) Laboratory services;
(9) Preventive and wellness services and chronic disease management; and
(10) Pediatric services, including oral and vision care.

(b) Every health maintenance organization policy, contract, plan, or agreement delivered or issued for delivery in this State shall also include the following additional benefits:

(1) Contraceptive coverage; including contraceptive methods and counseling, as prescribed by a health care provider; and

(2) Breastfeeding coverage, including breastfeeding support, counseling, and equipment for the duration of breastfeeding;

provided that a health maintenance organization shall not impose any cost-sharing requirements, including copayments, coinsurance, or deductibles, on an enrollee or subscriber with respect to the benefits covered under this subsection.

(c) This section shall not apply to policies that provide coverage for specified diseases or other limited benefit coverage, as provided pursuant to section 431:10A-102.5.
§432D— Extension of dependent coverage. A group contract and a health maintenance organization offering group or individual policies, contracts, plans, or agreements that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns twenty-six years of age. Nothing in this section shall require a policy, contract, plan, or agreement to make coverage available for a child of a child receiving dependent coverage.

§432D— Prohibition of preexisting condition exclusions.
(a) A health maintenance organization policy, contract, plan, or agreement issued or renewed in this State shall not impose any preexisting condition exclusion.
(b) For purposes of this section, a "preexisting condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual health maintenance organization policy, contract, plan, or agreement, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day and includes any condition.
The term "preexisting condition exclusion" includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group or individual health maintenance organization policy, contract, plan, or agreement, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

§432D- Prohibited discrimination in premiums or contributions. A group contract and a health maintenance organization offering group or individual policies, contracts, plans, or agreements issued or renewed in this State shall not require an individual, as a condition of enrollment or continued enrollment under a policy, contract, plan, or agreement, to pay a premium or contribution based on the individual's gender that is greater than the premium or contribution for a similarly situated individual of the opposite gender who is covered under the same policy, contract, plan, or agreement."
SECTION 6. Notwithstanding any other law to the contrary, the requirements for essential health care benefits, extension of dependent coverage, and prohibition of preexisting condition exclusions required under sections 3, 4, and 5 of this Act shall apply to all health benefits plans under chapter 87A, Hawaii Revised Statutes, issued, renewed, modified, altered, or amended on or after the effective date of this Act.

SECTION 7. New statutory material is underscored.

SECTION 8. This Act shall take effect upon its approval.
Report Title:
Health Insurance; Individual Mandate; Essential Benefits; Covered Services; Extended Coverage; Preexisting Conditions

Description:
Ensures certain benefits under the federal Affordable Care Act are preserved under Hawaii law, including: preserving the individual health insurance mandate for taxpayers; requiring all health insurance entities, including health benefits plans under chapter 87A, HRS, to include ten essential health care benefits, plus additional contraception and breastfeeding coverage benefits; extending dependent coverage for adult children until the children turn twenty-six years of age; prohibiting health insurance entities from imposing a preexisting condition exclusion; and prohibiting health insurance entities from using an individual's gender to determine premiums or contributions.

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