SENATE . . . . . No. 2204

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

SENATE, Monday, November 6, 2017

The committee on Financial Services to whom was referred the petition (accompanied by bill, Senate, No. 499) of Harriette L. Chandler, Robert M. Koczera, Jennifer E. Benson, Sarah K. Peake and other members of the General Court for legislation relative to women's health and economic equity,- reports the accompanying bill (Senate, No. 2204).

For the committee,
James B. Eldridge

SENATE . . . . . No. 2204

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(2017-2018)

An Act relative to advancing contraceptive coverage and economic security in our state (ACCESS).

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 32A of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting after section 27 the following section:

Section 28. (a) Any coverage offered by the commission to any active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for all of the following services and contraceptive methods:

(1) all Food and Drug Administration (”FDA”)-approved contraceptive drugs, devices and other products; provided that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs with no therapeutic equivalent. The following apply:

(i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, the Commission is not required to include all such therapeutically equivalent versions in its formulary, as long as at least one is included and covered without cost-sharing and in accordance with this section; and

(ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, the Commission may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost-sharing; provided that if an individual's attending provider recommends a particular FDA-approved contraceptive, based on a medical determination with respect to that individual, the insurer shall provide coverage, subject to the Commission's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost-sharing.

(2) all FDA-approved emergency contraception available over-the-counter, either with a prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

(3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled in a plan or policy under this chapter at the time the prescription contraceptive was first dispensed; provided, however, that the insured may not fill more than one 12-month prescription in a single dispensing per plan year;

(4) voluntary female sterilization procedures;

(5) patient education and counseling on contraception; and

(6) follow-up services related to the drugs, devices, products and procedures covered under this subsection, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(b) (1) Coverage provided under this subsection shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement, except as provided in paragraph (a)(1)(i)-(ii) or as otherwise required under federal law. Any coverage offered under this section shall not impose any unreasonable restrictions or delays in the coverage; provided that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Benefits for an enrollee under this section shall also be provided for such enrollee's covered spouse and covered dependents.

(3) Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures as prescribed by a provider for reasons other than contraceptive purposes, such as for decreasing the risk of ovarian cancer or eliminating symptoms of menopause or for contraception that is necessary to preserve the life or health of such enrollee, or such enrollee's covered spouse, and/or covered dependents.

(4) The group insurance commission shall ensure plan compliance with this chapter.

(5) Nothing in this section shall be construed to require the commission to cover experimental or investigational treatments.

(c) For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

"Provider", an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice acting within the scope of that license.

Contraceptive drugs, devices, or products classified as "therapeutic equivalents" means (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; provided further that to be considered a "therapeutic equivalent", the contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence code by the FDA.

SECTION 2. Chapter 118E of the General Laws, as so appearing, is hereby amended by inserting after section 10I the following section:

10J (a) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall provide coverage for all of the following services and contraceptive methods:

(1) all FDA-approved contraceptive drugs, devices and other products, provided that coverage shall not be required for male condoms or FDA-approved oral contraceptives with no therapeutic equivalent. The following apply:

(i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, the division is not required to include all such

therapeutically equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing in accordance with this section;

(ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, the division may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive, based on a medical determination with respect to that individual, the division shall provide coverage, subject to the division's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost-sharing; and

(iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-approved contraceptive drug, device, or other product without cost-sharing shall be subject to the grievance process laid out in section 47 of chapter 118E;

(2) all FDA-approved emergency contraception available over-the-counter, either with a prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

(3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled with the division at the time the prescription contraceptive was first dispensed; provided, however, that the insured may not fill more than one 12-month prescription in a single dispensing per plan year;

(4) voluntary female sterilization procedures;

(5) patient education and counseling on contraception; and

(6) follow-up services related to the drugs, devices, products and procedures covered under this subsection, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(b) (1) Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement, except as provided for in paragraph (a)(1)(i)-(ii), or as otherwise required under federal law. Any coverage provided under this section shall not impose any unreasonable restrictions or delays in the coverage; provided that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Benefits for an enrollee under this section shall be the same for such enrollee's covered spouse and covered dependents.

(3) Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures prescribed by a provider for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause or for contraception that is necessary to preserve the life or health of such enrollee, or such enrollee's covered spouse and/or covered dependents.

(4) Nothing in this section shall be construed to deny or restrict in any way the division of medical assistance's authority to ensure its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party

administrators under contract to a Medicaid managed care organization or primary care clinician plan are in compliance with this chapter.

(5) Nothing in this section shall be construed to require the division to cover experimental or investigational treatments.

(c) For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

"Provider", an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice acting within the scope of that licensure.

Contraceptive drugs, devices, or products classified as "therapeutic equivalents" means (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; provided further that to be considered a "therapeutic equivalent", the contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence code by the FDA.

SECTION 3. Chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after section 47W(c) the following:

(d) An individual policy of accident and sickness insurance issued pursuant to section 108 that provides hospital expense and surgical expense and any group blanket policy of accident and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical

expense insurance, delivered, issued or renewed by agreement between the insurer and the policyholder, within or without the Commonwealth, (hereinafter "policy") shall provide benefits for residents of the Commonwealth and all group members having a principal place of employment within the Commonwealth coverage for all of the following services and contraceptive methods:

(1) all FDA-approved contraceptive drugs, devices and other products, provided that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs with no therapeutic equivalent. The following apply:

(i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, a policy is not required to include all such therapeutically equivalent versions in its formulary, as long as at least one is included and covered without cost-sharing and in accordance with this section;

(ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, a policy may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive, based on a medical determination with respect to that individual, the policy shall provide coverage, subject to that policy's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost-sharing; and

(iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-approved contraceptive drug, device, or other product without cost-sharing shall be subject to the expedited grievance process under section 13 of chapter 176O;

(2) all FDA-approved emergency contraception available over-the-counter, either with a prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

(3) prescription contraceptives intended to last for: (i) up to a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled in the policy at the time the prescription was first dispensed; provided, however, that a corporation shall not be required to provide coverage for more than one 12-month prescription in a single dispensing per plan year;

(4) voluntary female sterilization procedures;

(5) patient education and counseling on contraception; and

(6) follow-up services related to the drugs, devices, products and procedures covered under this section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(e) (1) Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement, except as provided for un paragraph (d)(1)(i)-(ii) or as otherwise required under federal law. Any covered offered under this section shall not impose any unreasonable restrictions or delays on the coverage, in

accordance with the requirements of chapter 176O; provided that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Benefits for an enrollee shall be the same for such enrollee's covered spouse and covered dependents.

(f) (1) This section may not apply to a policy if such policy is purchased by an employer that is a church or qualified church-controlled organization, at the request of the employer.

(2) A church or qualified church-controlled organization that invokes the exemption provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care methods and services such employer refuses to cover for religious reasons.

(g) Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures prescribed by a provider for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause or for contraception that is necessary to preserve the life or health of an enrollee.

(h) The commissioner of insurance shall ensure compliance with this chapter.

(i) Nothing in this section shall be construed to require an individual or group policy of accident or sickness to cover experimental or investigational treatments.

(j) For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

"Church", a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

"Provider", an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice acting within the scope of that licensure.

"Qualified church-controlled organization", described in section 501(c)(3) of the Internal Revenue Code, other than an organization which--

(i) offers goods, services, or facilities for sale, other than on an incidental basis, to the general public, other than goods, services, or facilities which are sold at a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(ii) normally receives more than 25 percent of its support from either (I) governmental sources, or (II) receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

Contraceptive drugs, devices, or products classified as "therapeutic equivalents" means (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; provided further that to be considered a "therapeutic equivalent", the contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence code by the FDA.

SECTION 4. Chapter 176A of the General Laws, as so appearing, is hereby amended by inserting after section 8W(c) the following:

(d) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the Commonwealth and that provides benefits for outpatient services shall provide to all individual subscribers and members within the Commonwealth and to all group members having a principal place of employment within the Commonwealth coverage for all of the following services and contraceptive methods:

(1) all FDA-approved contraceptive drugs, devices and other products, provided that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs with no therapeutic equivalent. The following apply:

(i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, an individual or group hospital service plan is not required to include all such therapeutically equivalent versions in its formulary, as long as at least one is included and covered without cost-sharing and in accordance with this section;

(ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, an individual or group hospital service plan may provide coverage for more than one drug, device, or other product and may impose cost-sharing requirements as long as at least one drug, device, or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive, based on a medical determination with respect to that

individual, the insurer shall provide coverage, subject to a plan's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost-sharing; and

(iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-approved contraceptive drug, device or other product without cost sharing shall be subject to the expedited grievance process under section 13 of chapter 176O;

(2) all FDA-approved emergency contraception available over-the-counter, either with a prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

(3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; provided, however, that a corporation shall not be required to provide coverage for more than one 12-month prescription in a single dispensing per plan year;

(4) voluntary female sterilization procedures;

(5) patient education and counseling on contraception; and

(6) follow-up services related to the drugs, devices, products and procedures covered under this subsection, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(e) (1) Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any cost-sharing requirement, except as provided for in paragraph

(d)(1), or as otherwise required under federal law. Any coverage offered under this section shall not impose any unreasonable restrictions or delays in the coverage, in accordance with the requirements of Chapter 176O; provided that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Benefits for an enrollee under this subsection shall be the same for an enrollee's covered spouse and covered dependents.

(f) (1) The requirements of subsection (d) may not apply to a contract between a subscriber and a corporation under an individual or group hospital service plan that is delivered, issued, or renewed within or without the Commonwealth that is purchased by an employer that is a church or qualified church-controlled organization, at the request of the employer.

(2) A church or qualified church-controlled organization that invokes the exemption provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care methods and services such employer refuses to cover for religious reasons.

(g) Nothing in this subsection shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures prescribed by a provider for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause or for contraception that is necessary to preserve the life or health of an enrollee.

(h) The commissioner of insurance shall ensure compliance with this chapter.

(i) Nothing in this section shall be construed to require a contract to cover experimental or investigational treatments.

(j) For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

"Church", a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

"Provider", an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice acting within the scope of that licensure.

"Qualified church-controlled organization", described in section 501(c)(3) of the Internal Revenue Code, other than an organization which--

(i) offers goods, services, or facilities for sale, other than on an incidental basis, to the general public, other than goods, services, or facilities which are sold at a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(ii) normally receives more than 25 percent of its support from either (I) governmental sources, or (II) receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

Contraceptive drugs, devices, or products classified as "therapeutic equivalents" means (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that

they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence code by the FDA.

SECTION 5. Chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after section 4W(c) the following:

(d) Any subscription certificate under an individual or group medical service agreement that is delivered, issued or renewed within or without the Commonwealth and that provides benefits for outpatient services shall provide to all individual subscribers and members within the Commonwealth and to all group members having a principal place of employment within the Commonwealth coverage for all of the following services and contraceptive methods:

(1) all FDA-approved contraceptive drugs, devices and other products, provided that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs with no therapeutic equivalent. The following apply:

(i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, an individual or group hospital service plan is not required to include all such therapeutically equivalent versions in its formulary, as long as at least one is included and covered without cost-sharing and in accordance with this section;

(ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, an individual or group hospital service plan may provide coverage for more than one drug, device, or other product and may impose cost-sharing

requirements as long as at least one drug, device, or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive, based on a medical determination with respect to that individual, the insurer shall provide coverage, subject to a plan's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost-sharing; and

(iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-approved contraceptive drug, device or other product without cost sharing shall be subject to the expedited grievance process under section 13 of chapter 176O;

(2) all FDA-approved emergency contraception available over-the-counter, either with a prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

(3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-month period for any subsequent dispensing of the same prescription, which may be furnished or dispensed all at once or over the course of the 12 months, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; provided, however, that a corporation shall not be required to provide coverage for more than one 12-month prescription in a single dispensing per plan year;

(4) voluntary female sterilization procedures;

(5) patient education and counseling on contraception; and

(6) follow-up services related to the drugs, devices, products and procedures covered under this subsection, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(e) (1) Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement, except as provided for in subsection (d)(1)(i) and (ii), or otherwise as required under federal law. Any coverage offered under this section shall not impose any unreasonable restrictions or delays in the coverage, in accordance with the requirements of Chapter 176O; provided that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Benefits for an enrollee under this subsection shall be the same for such enrollee's covered spouse and covered dependents.

(f) (1) The requirements of this subsection may not apply to a medical service agreement that is delivered, issued, or renewed within or without the Commonwealth that is purchased by an employer that is a church or qualified church-controlled organization, at the request of the employer.

(2) A church or qualified church-controlled organization that invokes the exemption provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care methods and services the employer refuses to cover for religious reasons.

(g) Nothing in this subsection shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures prescribed by a provider for reasons other than

contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause or for contraception that is necessary to preserve the life or health of an enrollee.

(h) The commissioner of insurance shall ensure compliance with this chapter.

(i) Nothing in this subsection shall be construed to require an individual or group medical service agreement to cover experimental or investigational treatments.

(j) For purposes of this section, the following definitions shall apply, unless the context clearly requires otherwise:

"Church", a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

"Provider", an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice, acting within the scope of that licensure.

"Qualified church-controlled organization", described in section 501(c)(3) of the Internal Revenue Code, other than an organization which--

(i) offers goods, services, or facilities for sale, other than on an incidental basis, to the general public, other than goods, services, or facilities which are sold at a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(ii) normally receives more than 25 percent of its support from either (I) governmental sources, or (II) receipts from admissions, sales of merchandise, performance of

services, or furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence code by the FDA.

SECTION 6. Chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after section 4O(c) the following:

(d) Any individual or group health maintenance contract that is issued, renewed or delivered within or without the Commonwealth and that provides benefits for outpatient prescription drugs or devices shall provide to residents of the Commonwealth and to persons having a principal place of employment within the Commonwealth coverage for all of the following services and contraceptive methods:

(1) all FDA-approved contraceptive drugs, devices and other products, provided that coverage shall not be required for male condoms or FDA-approved contraceptive drugs with no therapeutic equivalent. The following apply:

(i) Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, a health maintenance contract is not required to include

all such therapeutically equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this section;

(ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-approved contraceptive method, a health maintenance plan may provide coverage for more than one drug, device, or other product for that method and may impose cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive, based on a medical determination with respect to that individual, the health maintenance plan shall provide coverage, subject to the plan's utilization management procedures, for the prescribed contraceptive drug, device or product without cost-sharing; and

(iii) Appeals of an adverse determination of a request for coverage of an alternative FDA-approved contraceptive drug, device, or other product without cost-sharing shall be subject to the expedited grievance process under section 13 of chapter 176O;

(2) all FDA-approved emergency contraception available over-the-counter, either with a prescription, or dispensed consistent with the requirements of section 19A of chapter 94C;

(3) prescription contraceptives intended to last: (i) for up to a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (ii) for up to a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled in the plan at the time the prescription contraceptive was first dispensed; provided, however, that a corporation shall not be required to provide coverage for more than one 12-month prescription in a single dispensing per plan year;

(4) voluntary female sterilization procedures;

(5) patient education and counseling on contraception; and

(6) follow-up services related to the drugs, devices, products and procedures covered under this section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(e) (1) Coverage provided under this section shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement, except as provided for in paragraph (d)(1)(i)-(ii) or as otherwise required under federal law. Any coverage offered under this section shall not impose any unreasonable restrictions or delays in the coverage, in accordance with the requirements of chapter 176O; provided that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods.

(2) Benefits for an enrollee under this section shall be the same for such enrollee's covered spouse and covered dependents.

(f) (1) The requirements of this subsection may not apply to a health maintenance contract if that policy is purchased by an employer that is a church or qualified church-controlled organization, at the request of the employer.

(2) A church or qualified church-controlled organization that invokes the exemption provided under subsection (f)(1) shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(g) Nothing in this subsection shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures as prescribed by a provider for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause or for contraception that is necessary to preserve the life or health of an enrollee.

(h) The commissioner of insurance shall ensure compliance with this chapter.

(i) Nothing in this subsection shall be construed to require an individual or group health maintenance contract to cover experimental or investigational treatments.

(j) For purposes of this section, the following words shall have the following meanings, unless the context clearly requires otherwise:

"Church", a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

"Provider", an individual or facility licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice acting within the scope of that licensure.

"Qualified church-controlled organization", described in section 501(c)(3) of the Internal Revenue Code, other than an organization which--

(i) offers goods, services, or facilities for sale, other than on an incidental basis, to the general public, other than goods, services, or facilities which are sold at a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(ii) normally receives more than 25 percent of its support from either (I) governmental sources, or (II) receipts from admissions, sales of merchandise, performance of services, or furnishing of facilities, in activities which are not unrelated trades or businesses, or both.

Contraceptive drugs, devices, or products classified as “therapeutic equivalents” means (1) they are approved as safe and effective; and (2) they are pharmaceutical equivalents in that they (a) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration, and (b) meet compendial or other applicable standards of strength, quality, purity, and identity; provided further that to be considered a “therapeutic equivalent”, the contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence code by the FDA.

SECTION 7. Sections 1 through 6 of this act shall apply to all policies, contracts and certificates of health insurance subject to chapters 32A, chapter 118E, chapter 175, chapter 176A, chapter 176B, and chapter 176G which are delivered, issued or renewed more than six months from the effective date of this act.