

## Chapter 437

## (House Bill 1005)

AN ACT concerning

**Health Insurance – Contraceptive Equity Act**

FOR the purpose of prohibiting certain insurers, nonprofit health service plans, and health maintenance organizations from applying a copayment, coinsurance, or prior authorization requirement for certain contraceptive drugs and devices; providing that the prohibition does not apply with respect to a certain health benefit plan; ~~requiring a certain insurer, nonprofit health service plan, and health maintenance organization to post its contraceptive formulary on its Web site in a certain format, include certain information on the formulary, and provide a print copy of the formulary on request;~~ establishing an exception to the prohibition against applying a copayment or coinsurance requirement for certain contraceptive drugs or devices; requiring a certain insurer, nonprofit health service plan, and health maintenance organization to provide coverage for a single dispensing to an insured or an enrollee of a certain supply of prescription contraceptives, except for certain prescriptions, for a certain period of time subject to certain exceptions; requiring the insurer, nonprofit health service plan, and health maintenance organization to increase the dispensing fee paid to certain individuals the pharmacist under certain circumstances; requiring ~~a certain~~ the insurer, nonprofit health service plan, and health maintenance organization to provide coverage without a prescription for certain contraceptive drugs, subject to certain limitations; prohibiting the insurer, nonprofit health service plan, and health maintenance ~~organizations~~ organization from applying a copayment or coinsurance requirement for the contraceptive drugs dispensed without a prescription that exceeds a certain copayment or coinsurance requirement; requiring certain insurers, nonprofit health service plans, and health maintenance organizations to provide coverage for male sterilization; excluding a certain organization from the requirement to provide the coverage for male sterilization; prohibiting certain insurers, nonprofit health service plans, and health maintenance organizations from applying a copayment, coinsurance requirement, or deductible to coverage for male sterilization; providing that the prohibition does not apply with respect to a certain health benefit plan; altering the circumstances under which a member may receive a prescription drug or device that is not on the formulary of a certain insurer, nonprofit health service plan, or health maintenance organization; requiring the procedure under which a member may receive a prescription drug or device that is not on the formulary to provide for coverage of a contraceptive prescription drug or device that is medically necessary for ~~adherence purposes~~ the member to adhere to the appropriate use of the prescription drug or device; prohibiting the Maryland Medical Assistance Program and the Maryland Children's Health Program from applying a prior authorization requirement for certain contraceptive drugs and devices; requiring the Maryland Medical Assistance Program and the Maryland Children's Health Program to provide coverage for a single dispensing to an enrollee of a certain supply of prescription contraceptives.

subject to a certain exception; defining a certain term; providing for the application of this Act; providing for a delayed effective date; and generally relating to health insurance coverage of contraceptive drugs, devices, and procedures and contraception equity.

BY adding to

Article – Insurance

Section 15–826.1 and 15–826.2

Annotated Code of Maryland

(2011 Replacement Volume and 2015 Supplement)

BY repealing and reenacting, with amendments,

Article – Insurance

Section 15–831

Annotated Code of Maryland

(2011 Replacement Volume and 2015 Supplement)

BY adding to

Article – Health – General

Section 15–148

Annotated Code of Maryland

(2015 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,  
That the Laws of Maryland read as follows:

### Article – Insurance

#### 15–826.1.

(A) IN THIS SECTION, “AUTHORIZED PRESCRIBER” HAS THE MEANING STATED IN § 12–101 OF THE HEALTH OCCUPATIONS ARTICLE.

(B) THIS SECTION APPLIES TO:

(1) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE COVERAGE FOR CONTRACEPTIVE DRUGS AND DEVICES UNDER INDIVIDUAL, GROUP, OR BLANKET HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND

(2) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE COVERAGE FOR CONTRACEPTIVE DRUGS AND DEVICES UNDER INDIVIDUAL OR GROUP CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.

(c) ~~(1)~~ ~~EXCEPT WITH RESPECT~~ THIS SUBSECTION DOES NOT APPLY TO A HEALTH BENEFIT PLAN THAT IS A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT, AN

(2) AN ENTITY SUBJECT TO THIS SECTION:

(I) EXCEPT FOR A DRUG OR DEVICE FOR WHICH THE U.S. FOOD AND DRUG ADMINISTRATION HAS ISSUED A BLACK BOX WARNING, MAY NOT APPLY A PRIOR AUTHORIZATION REQUIREMENT FOR A CONTRACEPTIVE DRUG OR DEVICE THAT IS:

1. A. AN INTRAUTERINE DEVICE; OR

B. AN IMPLANTABLE ROD;

2. APPROVED BY THE U.S. FOOD AND DRUG ADMINISTRATION; AND

3. OBTAINED UNDER A PRESCRIPTION WRITTEN BY AN AUTHORIZED PRESCRIBER; AND

~~(1)~~ (II) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, MAY NOT APPLY A COPAYMENT, COINSURANCE, OR PRIOR AUTHORIZATION COPAYMENT OR COINSURANCE REQUIREMENT FOR A CONTRACEPTIVE DRUG OR DEVICE THAT IS:

~~(1)~~ 1. APPROVED BY THE U.S. FOOD AND DRUG ADMINISTRATION; AND

~~(1)~~ 2. OBTAINED UNDER A PRESCRIPTION WRITTEN BY AN AUTHORIZED PRESCRIBER; BUT,

~~(2)~~ (3) AN ENTITY SUBJECT TO THIS SECTION MAY APPLY A COPAYMENT OR COINSURANCE REQUIREMENT FOR A CONTRACEPTIVE DRUG OR DEVICE THAT, ACCORDING TO THE U.S. FOOD AND DRUG ADMINISTRATION, IS THERAPEUTICALLY EQUIVALENT TO ANOTHER CONTRACEPTIVE DRUG OR DEVICE THAT IS AVAILABLE UNDER THE SAME POLICY OR CONTRACT WITHOUT A COPAYMENT OR COINSURANCE REQUIREMENT.

~~(D) AN ENTITY SUBJECT TO THIS SECTION SHALL:~~

~~(1) (1) POST ON ITS WEB SITE ITS CONTRACEPTIVE FORMULARY IN A CONSUMER-FRIENDLY FORMAT THAT IS ACCESSIBLE TO INDIVIDUALS SEEKING~~

~~INFORMATION ABOUT COVERAGE FOR CONTRACEPTIVE DRUGS AND DEVICES UNDER THE POLICIES OR CONTRACTS OF THE ENTITY; AND~~

~~(H) INCLUDE IN THE FORMULARY COMPLETE AND CURRENT INFORMATION ABOUT COST SHARING REQUIREMENTS FOR CONTRACEPTIVE DRUGS AND DEVICES ON AND OFF THE ENTITY'S FORMULARY; AND~~

~~(2) PROVIDE A PRINT COPY OF THE CONTRACEPTIVE FORMULARY REQUIRED UNDER ITEM (1) OF THIS SUBSECTION ON REQUEST.~~

~~(E) (D)~~ (1) EXCEPT AS PROVIDED IN ~~PARAGRAPH (2)~~ PARAGRAPHS (2) AND (3) OF THIS SUBSECTION, AN ENTITY SUBJECT TO THIS SECTION SHALL PROVIDE COVERAGE FOR A SINGLE DISPENSING TO AN INSURED OR AN ENROLLEE OF A SUPPLY OF PRESCRIPTION CONTRACEPTIVES FOR A ~~13-MONTH~~ 6-MONTH PERIOD.

(2) SUBJECT TO § 15-824 OF THIS SUBTITLE, AN ENTITY SUBJECT TO THIS SECTION MAY PROVIDE COVERAGE FOR A SUPPLY OF PRESCRIPTION CONTRACEPTIVES THAT IS FOR LESS THAN A 6-MONTH PERIOD, IF A 6-MONTH SUPPLY WOULD EXTEND BEYOND THE PLAN YEAR.

~~(2)~~ (3) PARAGRAPH (1) OF THIS SUBSECTION DOES NOT APPLY TO THE FIRST 2-MONTH SUPPLY OF PRESCRIPTION CONTRACEPTIVES DISPENSED TO AN INSURED OR AN ENROLLEE UNDER:

(I) THE INITIAL ~~FIRST~~ PRESCRIPTION FOR THE CONTRACEPTIVES; OR

(II) ANY SUBSEQUENT PRESCRIPTION FOR A CONTRACEPTIVE THAT IS DIFFERENT THAN THE LAST CONTRACEPTIVE DISPENSED TO ~~OR CHANGE IN A PRESCRIPTION FOR CONTRACEPTIVES FOR~~ THE INSURED OR THE ENROLLEE.

~~(3)~~ (4) WHENEVER AN ENTITY SUBJECT TO THIS SECTION INCREASES THE COPAYMENT FOR A SINGLE DISPENSING OF A SUPPLY OF PRESCRIPTION CONTRACEPTIVES FOR A ~~13-MONTH~~ 6-MONTH PERIOD, THE ENTITY SHALL ALSO INCREASE PROPORTIONATELY THE DISPENSING FEE PAID TO THE PHARMACIST ~~OR OTHER INDIVIDUAL AUTHORIZED BY LAW TO DISPENSE PRESCRIPTION CONTRACEPTIVES.~~

~~(F)~~ (E) (1) AN SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, AN ENTITY SUBJECT TO THIS SECTION:

~~(1)~~ **(I) SHALL PROVIDE COVERAGE WITHOUT A PRESCRIPTION FOR ALL CONTRACEPTIVE DRUGS APPROVED BY THE U.S. FOOD AND DRUG ADMINISTRATION AND AVAILABLE BY PRESCRIPTION AND OVER THE COUNTER; AND**

~~(2)~~ **(II) MAY NOT APPLY A COPAYMENT OR COINSURANCE REQUIREMENT FOR A CONTRACEPTIVE DRUG DISPENSED WITHOUT A PRESCRIPTION UNDER ITEM (I) OF THIS PARAGRAPH THAT EXCEEDS THE COPAYMENT OR COINSURANCE REQUIREMENT FOR THE CONTRACEPTIVE DRUG DISPENSED UNDER A PRESCRIPTION.**

**(2) AN ENTITY SUBJECT TO THIS SECTION:**

**(I) MAY ONLY BE REQUIRED TO PROVIDE POINT-OF-SALE COVERAGE UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION AT IN-NETWORK PHARMACIES; AND**

**(II) MAY LIMIT THE FREQUENCY WITH WHICH THE COVERAGE REQUIRED UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION IS PROVIDED.**

**15-826.2.**

**(A) (1) IN THIS SUBSECTION, “GROUP” MEANS A GROUP THAT IS NOT A GROUP COVERED UNDER A HEALTH INSURANCE POLICY OR CONTRACT OR UNDER A HEALTH MAINTENANCE ORGANIZATION CONTRACT ISSUED OR DELIVERED TO A SMALL EMPLOYER, AS DEFINED IN § 31-101 OF THIS ARTICLE.**

**(2) THIS SUBSECTION APPLIES TO:**

**(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO GROUPS ON AN EXPENSE-INCURRED BASIS UNDER HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND**

**(II) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE HOSPITAL, MEDICAL, OR SURGICAL BENEFITS TO GROUPS UNDER CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.**

**(3) THIS SUBSECTION DOES NOT APPLY TO AN ORGANIZATION THAT REQUESTS AND RECEIVES AN EXCLUSION FROM COVERAGE UNDER § 15-826(C) OF THIS SUBTITLE.**

**(4) AN ENTITY SUBJECT TO THIS SUBSECTION SHALL PROVIDE COVERAGE FOR MALE STERILIZATION.**

**(B) (1) THIS SUBSECTION APPLIES TO:**

**(I) INSURERS AND NONPROFIT HEALTH SERVICE PLANS THAT PROVIDE COVERAGE FOR MALE STERILIZATION UNDER INDIVIDUAL, GROUP, OR BLANKET HEALTH INSURANCE POLICIES OR CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE; AND**

**(II) HEALTH MAINTENANCE ORGANIZATIONS THAT PROVIDE COVERAGE FOR MALE STERILIZATION UNDER INDIVIDUAL OR GROUP CONTRACTS THAT ARE ISSUED OR DELIVERED IN THE STATE.**

**(2) EXCEPT WITH RESPECT TO A HEALTH BENEFIT PLAN THAT IS A GRANDFATHERED HEALTH PLAN, AS DEFINED IN § 1251 OF THE AFFORDABLE CARE ACT, AN ENTITY SUBJECT TO THIS SUBSECTION MAY NOT APPLY A COPAYMENT, COINSURANCE REQUIREMENT, OR DEDUCTIBLE TO COVERAGE FOR MALE STERILIZATION.**

15-831.

(a) (1) In this section the following words have the meanings indicated.

(2) “Authorized prescriber” has the meaning stated in § 12-101 of the Health Occupations Article.

(3) “Formulary” means a list of prescription drugs or devices that are covered by an entity subject to this section.

(4) (i) “Member” means an individual entitled to health care benefits for prescription drugs or devices under a policy issued or delivered in the State by an entity subject to this section.

(ii) “Member” includes a subscriber.

(b) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs and devices under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs and devices under individual or group contracts that are issued or delivered in the State.

(2) An insurer, nonprofit health service plan, or health maintenance organization that provides coverage for prescription drugs and devices through a pharmacy benefit manager is subject to the requirements of this section.

(3) This section does not apply to a managed care organization as defined in § 15–101 of the Health – General Article.

(c) Each entity subject to this section that limits its coverage of prescription drugs or devices to those in a formulary shall establish and implement a procedure by which a member may receive a prescription drug or device that is not in the entity’s formulary in accordance with this section.

(d) The procedure shall provide for coverage for a prescription drug or device that is not in the formulary if, in the judgment of the authorized prescriber:

(1) there is no equivalent prescription drug or device in the entity’s formulary; [or]

(2) an equivalent prescription drug or device in the entity’s formulary:

(i) has been ineffective in treating the disease or condition of the member; or

(ii) has caused or is likely to cause an adverse reaction or other harm to the member; **OR**

**(3) FOR A CONTRACEPTIVE PRESCRIPTION DRUG OR DEVICE, THE PRESCRIPTION DRUG OR DEVICE THAT IS NOT ON THE FORMULARY IS MEDICALLY NECESSARY FOR ~~ADHERENCE PURPOSES~~ THE MEMBER TO ADHERE TO THE APPROPRIATE USE OF THE PRESCRIPTION DRUG OR DEVICE.**

(e) A decision by an entity subject to this section not to provide access to or coverage of a prescription drug or device in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed drug or device is not medically necessary, appropriate, or efficient.

### Article – Health – General

#### 15–148.

**(A) EXCEPT FOR A DRUG OR DEVICE FOR WHICH THE U.S. FOOD AND DRUG ADMINISTRATION HAS ISSUED A BLACK BOX WARNING, THE PROGRAM AND THE MARYLAND CHILDREN’S HEALTH PROGRAM MAY NOT APPLY A PRIOR AUTHORIZATION REQUIREMENT FOR A CONTRACEPTIVE DRUG OR DEVICE THAT IS:**

- (1) (I) AN INTRAUTERINE DEVICE; OR**
- (II) AN IMPLANTABLE ROD;**
- (2) APPROVED BY THE U.S. FOOD AND DRUG ADMINISTRATION; AND**
- (3) OBTAINED UNDER A PRESCRIPTION WRITTEN BY AN AUTHORIZED PRESCRIBER.**

**(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, THE PROGRAM AND THE MARYLAND CHILDREN'S HEALTH PROGRAM SHALL PROVIDE COVERAGE FOR A SINGLE DISPENSING TO AN ENROLLEE OF A SUPPLY OF PRESCRIPTION CONTRACEPTIVES FOR A 6-MONTH PERIOD.**

**(2) PARAGRAPH (1) OF THIS SUBSECTION DOES NOT APPLY TO THE FIRST 2-MONTH SUPPLY OF PRESCRIPTION CONTRACEPTIVES DISPENSED TO AN ENROLLEE UNDER:**

- (I) THE INITIAL PRESCRIPTION FOR THE CONTRACEPTIVES; OR**
- (II) ANY SUBSEQUENT PRESCRIPTION FOR A CONTRACEPTIVE THAT IS DIFFERENT THAN THE LAST CONTRACEPTIVE DISPENSED TO THE ENROLLEE.**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans subject to this Act that are issued, delivered, or renewed in the State on or after January 1, 2018.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect January 1, 2018.

**Approved by the Governor, May 10, 2016.**