SENATE BILL 848

C3 6lr2391
CF 6lr1505

By: **Senators Kelley, Madaleno, Astle, Benson, Brochin, Conway, Currie, Feldman, Ferguson, Gladden, Guzzone, Kagan, King, Klausmeier, Lee, Manno, McFadden, Nathan–Pulliam, Pinsky, Pugh, Ramirez, Raskin, Young, and Zucker**

Introduced and read first time: February 5, 2016
Assigned to: Finance

A BILL ENTITLED

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; 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 supply of prescription contraceptives, except for certain prescriptions, for a certain period of time; requiring the insurer, nonprofit health service plan, and health maintenance organization to increase the dispensing fee to certain individuals under certain circumstances; requiring a certain insurer, nonprofit health service plan, and health maintenance organization to provide coverage without a prescription for certain contraceptive drugs; prohibiting the insurer, nonprofit health service plan, and health maintenance organizations 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

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

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; 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)

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) 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 SECTION:

(1) MAY NOT APPLY A COPAYMENT, COINSURANCE, OR PRIOR AUTHORIZATION REQUIREMENT FOR A CONTRACEPTIVE DRUG OR DEVICE THAT IS:

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

(II) OBTAINED UNDER A PRESCRIPTION WRITTEN BY AN AUTHORIZED PRESCRIBER; BUT

(2) 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) (I) 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

(II) 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) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) 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 PERIOD.

(2) PARAGRAPH (1) DOES NOT APPLY TO THE FIRST PRESCRIPTION OR CHANGE IN A PRESCRIPTION FOR CONTRACEPTIVES FOR THE INSURED OR THE ENROLLEE.

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

(F) AN ENTITY SUBJECT TO THIS SECTION:

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

(2) MAY NOT APPLY A COPAYMENT OR COINSURANCE REQUIREMENT FOR A CONTRACEPTIVE DRUG DISPENSED WITHOUT A PRESCRIPTION THAT EXCEEDS THE COPAYMENT OR COINSURANCE REQUIREMENT FOR THE CONTRACEPTIVE DRUG DISPENSED UNDER A PRESCRIPTION.

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.

(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.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to all policies, contracts, and health benefit plans 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.