

# HOUSE BILL 1024

P4, C3

8lr2581  
CF SB 986

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By: **Delegates Hettleman, McIntosh, and Pendergrass**

Introduced and read first time: February 7, 2018

Assigned to: Appropriations

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## A BILL ENTITLED

1 AN ACT concerning

2 **State Employee and Retiree Health and Welfare Benefits Program –**  
3 **Contraceptive Drugs and Devices and Male Sterilization**

4 FOR the purpose of requiring the Secretary of Budget and Management to ensure that the  
5 State Employee and Retiree Health and Welfare Benefits Program complies with  
6 certain provisions of the Insurance Article relating to the coverage of contraceptive  
7 drugs and devices and male sterilization; and generally relating to the coverage of  
8 contraceptive drugs and devices and male sterilization under the State Employee  
9 and Retiree Health and Welfare Benefits Program.

10 BY repealing and reenacting, without amendments,  
11 Article – Insurance  
12 Section 15–826.1, 15–826.2, and 15–831(a) through (d)  
13 Annotated Code of Maryland  
14 (2017 Replacement Volume)

15 BY repealing and reenacting, without amendments,  
16 Article – State Personnel and Pensions  
17 Section 2–501(a) and (b)  
18 Annotated Code of Maryland  
19 (2015 Replacement Volume and 2017 Supplement)

20 BY repealing and reenacting, with amendments,  
21 Article – State Personnel and Pensions  
22 Section 2–503(a)  
23 Annotated Code of Maryland  
24 (2015 Replacement Volume and 2017 Supplement)

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

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EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.



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**Article – Insurance**

2 15–826.1.

3 (a) In this section, “authorized prescriber” has the meaning stated in § 12–101 of  
4 the Health Occupations Article.

5 (b) This section applies to:

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

9 (2) health maintenance organizations that provide coverage for  
10 contraceptive drugs and devices under individual or group contracts that are issued or  
11 delivered in the State.

12 (c) (1) This subsection does not apply to a health benefit plan that is a  
13 grandfathered health plan, as defined in § 1251 of the Affordable Care Act.

14 (2) An entity subject to this section:

15 (i) except for a drug or device for which the U.S. Food and Drug  
16 Administration has issued a black box warning, may not apply a prior authorization  
17 requirement for a contraceptive drug or device that is:

18 1. A. an intrauterine device; or

19 B. an implantable rod;

20 2. approved by the U.S. Food and Drug Administration; and

21 3. obtained under a prescription written by an authorized  
22 prescriber; and

23 (ii) except as provided in paragraph (3) of this subsection, may not  
24 apply a copayment or coinsurance requirement for a contraceptive drug or device that is:

25 1. approved by the U.S. Food and Drug Administration; and

26 2. obtained under a prescription written by an authorized  
27 prescriber.

28 (3) An entity subject to this section may apply a copayment or coinsurance  
29 requirement for a contraceptive drug or device that, according to the U.S. Food and Drug  
30 Administration, is therapeutically equivalent to another contraceptive drug or device that  
31 is available under the same policy or contract without a copayment or coinsurance

1 requirement.

2 (d) (1) Except as provided in paragraphs (2) and (3) of this subsection, an  
3 entity subject to this section shall provide coverage for a single dispensing to an insured or  
4 an enrollee of a supply of prescription contraceptives for a 6-month period.

5 (2) Subject to § 15-824 of this subtitle, an entity subject to this section may  
6 provide coverage for a supply of prescription contraceptives that is for less than a 6-month  
7 period, if a 6-month supply would extend beyond the plan year.

8 (3) Paragraph (1) of this subsection does not apply to the first 2-month  
9 supply of prescription contraceptives dispensed to an insured or an enrollee under:

10 (i) the initial prescription for the contraceptives; or

11 (ii) any subsequent prescription for a contraceptive that is different  
12 than the last contraceptive dispensed to the insured or the enrollee.

13 (4) Whenever an entity subject to this section increases the copayment for  
14 a single dispensing of a supply of prescription contraceptives for a 6-month period, the  
15 entity shall also increase proportionately the dispensing fee paid to the pharmacist.

16 (e) (1) Subject to paragraph (2) of this subsection, an entity subject to this  
17 section:

18 (i) shall provide coverage without a prescription for all  
19 contraceptive drugs approved by the U.S. Food and Drug Administration and available by  
20 prescription and over the counter; and

21 (ii) may not apply a copayment or coinsurance requirement for a  
22 contraceptive drug dispensed without a prescription under item (i) of this paragraph that  
23 exceeds the copayment or coinsurance requirement for the contraceptive drug dispensed  
24 under a prescription.

25 (2) An entity subject to this section:

26 (i) may only be required to provide point-of-sale coverage under  
27 paragraph (1)(i) of this subsection at in-network pharmacies; and

28 (ii) may limit the frequency with which the coverage required under  
29 paragraph (1)(i) of this subsection is provided.

30 15-826.2.

31 (a) (1) In this subsection, “group” means a group that is not a group covered  
32 under a health insurance policy or contract or under a health maintenance organization  
33 contract issued or delivered to a small employer, as defined in § 31-101 of this article.

1 (2) This subsection applies to:

2 (i) insurers and nonprofit health service plans that provide hospital,  
3 medical, or surgical benefits to groups on an expense-incurred basis under health  
4 insurance policies or contracts that are issued or delivered in the State; and

5 (ii) health maintenance organizations that provide hospital,  
6 medical, or surgical benefits to groups under contracts that are issued or delivered in the  
7 State.

8 (3) This subsection does not apply to an organization that requests and  
9 receives an exclusion from coverage under § 15–826(c) of this subtitle.

10 (4) An entity subject to this subsection shall provide coverage for male  
11 sterilization.

12 (b) (1) This subsection applies to:

13 (i) insurers and nonprofit health service plans that provide coverage  
14 for male sterilization under individual, group, or blanket health insurance policies or  
15 contracts that are issued or delivered in the State; and

16 (ii) health maintenance organizations that provide coverage for male  
17 sterilization under individual or group contracts that are issued or delivered in the State.

18 (2) Except with respect to a health benefit plan that is a grandfathered  
19 health plan, as defined in § 1251 of the Affordable Care Act, an entity subject to this  
20 subsection may not apply a copayment, coinsurance requirement, or deductible to coverage  
21 for male sterilization.

22 15–831.

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

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

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

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

31 (ii) “Member” includes a subscriber.

1 (b) (1) This section applies to:

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

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

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

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

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

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

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

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

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

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

26 (3) for a contraceptive prescription drug or device, the prescription drug or  
27 device that is not on the formulary is medically necessary for the member to adhere to the  
28 appropriate use of the prescription drug or device.

## 29 Article – State Personnel and Pensions

30 2–501.

31 (a) In this subtitle the following terms have the meanings indicated.

32 (b) “Program” means the State Employee and Retiree Health and Welfare

1 Benefits Program.

2 2–503.

3 (a) The Secretary shall:

4 (1) adopt regulations for the administration of the Program;

5 (2) ensure that the Program complies with:

6 (I) all federal and State laws governing employee benefit plans; AND

7 (II) §§ 15–826.1, 15–826.2, AND, AS APPLICABLE TO  
8 CONTRACEPTIVE DRUGS AND DEVICES, 15–831(A) THROUGH (D) OF THE INSURANCE  
9 ARTICLE; and

10 (3) each year, recommend to the Governor the State share of the costs of  
11 the Program.

12 SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect  
13 October 1, 2018.