

HOUSE No. 4009

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, November 6, 2017.

The committee on Financial Services to whom was referred the petition (accompanied by bill, House, No. 536) of Patricia A. Haddad, John W. Scibak and others relative to advancing contraceptive insurance coverage, reports recommending that the accompanying bill (House, No. 4009) ought to pass [Representative Dooley of Norfolk dissents].

For the committee,

AARON MICHLEWITZ.

HOUSE No. 4009

The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court
(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:

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

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

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

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

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

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

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

30 (4) voluntary female sterilization procedures;

31 (5) patient education and counseling on contraception; and

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

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

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

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

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

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

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

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

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

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

65 10J (a) The division and its contracted health insurers, health plans, health maintenance
66 organizations, behavioral health management firms and third-party administrators under contract
67 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
68 for all of the following services and contraceptive methods:

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

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

76 (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-
77 approved contraceptive method, the division may provide coverage for more than one drug,

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

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

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

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

96 (4) voluntary female sterilization procedures;

97 (5) patient education and counseling on contraception; and

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

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

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

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

114 (4) Nothing in this section shall be construed to deny or restrict in any way the division of
115 medical assistance's authority to ensure its contracted health insurers, health plans, health
116 maintenance organizations, behavioral health management firms and third-party administrators
117 under contract to a Medicaid managed care organization or primary care clinician plan are in
118 compliance with this chapter.

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

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

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

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

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

135 (d) An individual policy of accident and sickness insurance issued pursuant to section
136 108 that provides hospital expense and surgical expense and any group blanket policy of accident
137 and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical
138 expense insurance, delivered, issued or renewed by agreement between the insurer and the
139 policyholder, within or without the Commonwealth, (hereinafter “policy”) shall provide benefits
140 for residents of the Commonwealth and all group members having a principal place of

141 employment within the Commonwealth coverage for all of the following services and
142 contraceptive methods:

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

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

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

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

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

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

170 (4) voluntary female sterilization procedures;

171 (5) patient education and counseling on contraception; and

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

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

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

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

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

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

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

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

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

199 “Church”, a church, a convention or association of churches, or an elementary or
200 secondary school which is controlled, operated, or principally supported by a church or by a
201 convention or association of churches.

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

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

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

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

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

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

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

226 employment within the Commonwealth coverage for all of the following services and
227 contraceptive methods:

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

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

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

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

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

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

255 (4) voluntary female sterilization procedures;

256 (5) patient education and counseling on contraception; and

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

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

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

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

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

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

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

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

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

286 “Church”, a church, a convention or association of churches, or an elementary or
287 secondary school which is controlled, operated, or principally supported by a church or by a
288 convention or association of churches.

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

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

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

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

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

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

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

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

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

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

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

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

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

341 (4) voluntary female sterilization procedures;

342 (5) patient education and counseling on contraception; and

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

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

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

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

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

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

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

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

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

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

372 “Church”, a church, a convention or association of churches, or an elementary or
373 secondary school which is controlled, operated, or principally supported by a church or by a
374 convention or association of churches.

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

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

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

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

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

391 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence
392 code by the FDA.

393 SECTION 6. Chapter 176G of the General Laws, as so appearing, is hereby amended by
394 inserting after section 40(c) the following:

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

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

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

407 (ii) If there is a therapeutic equivalent of a drug, device, or other product for an FDA-
408 approved contraceptive method, a health maintenance plan may provide coverage for more than
409 one drug, device, or other product for that method and may impose cost-sharing; provided,
410 however, that if an individual's attending provider recommends a particular FDA-approved
411 contraceptive, based on a medical determination with respect to that individual, the health

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

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

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

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

426 (4) voluntary female sterilization procedures;

427 (5) patient education and counseling on contraception; and

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

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

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

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

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

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

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

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

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

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

456 “Church”, a church, a convention or association of churches, or an elementary or
457 secondary school which is controlled, operated, or principally supported by a church or by a
458 convention or association of churches.

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

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

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

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

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

475 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence
476 code by the FDA.

477 SECTION 7. Sections 1 through 6 of this act shall apply to all policies, contracts and
478 certificates of health insurance subject to chapters 32A, chapter 118E, chapter 175, chapter
479 176A, chapter 176B, and chapter 176G which are delivered, issued or renewed more than six
480 months from the effective date of this act.