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.

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
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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. SECTION 2. Chapter 118E of the General Laws, as so appearing, is hereby amended by 63 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.

(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.

107 (2) Benefits for an enrollee under this section shall be the same for such enrollee's108 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 experimentalor investigational treatments.

(c) For purposes of this section, the following definitions shall apply, unless the contextclearly 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.

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.

133 SECTION 3. Chapter 175 of the General Laws, as so appearing, is hereby amended by134 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

141 employment within the Commonwealth coverage for all of the following services and142 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;

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

(iii) Appeals of an adverse determination of a request for coverage of an alternative FDAapproved contraceptive drug, device, or other product without cost-sharing shall be subject to the
expedited grievance process under section 13 of chapter 1760;

(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;

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.

(f)(1) This section may not apply to a policy if such policy is purchased by an employerthat 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.

194 (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 ofaccident or sickness to cover experimental or investigational treatments.

(j) For purposes of this section, the following definitions shall apply, unless the contextclearly 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.

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--

(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 byinserting 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 andcontraceptive 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;

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

(iii) Appeals of an adverse determination of a request for coverage of an alternative FDAapproved contraceptive drug, device or other product without cost sharing shall be subject to the
expedited grievance process under section 13 of chapter 1760;

(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;

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's268 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:

(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;

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

(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 1760;

(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 12month 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;

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.

(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.

353 (2) Benefits for an enrollee under this subsection shall be the same for such enrollee's354 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.

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.

(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.

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 context371 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--

(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 391 contraceptive drugs, devices, or products must be assigned the same therapeutic equivalence392 code by the FDA.

393 SECTION 6. Chapter 176G of the General Laws, as so appearing, is hereby amended by394 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:

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 FDA408 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

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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 FDA415 approved contraceptive drug, device, or other product without cost-sharing shall be subject to the
416 expedited grievance process under section 13 of chapter 1760;

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

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 1760; 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.

438 (2) Benefits for an enrollee under this section shall be the same for such enrollee's439 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.

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 health453 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 equivalence476 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.