SENATE . . . . . No. 2210

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

SENATE, Monday, November 13, 2017

The committee on Ways and Means, to whom was referred the House Bill relative to advancing contraceptive coverage and economic security in our state (ACCESS) (House, No. 4009) (also based on Senate, No. 2204),-- reports, recommending that the same ought to pass with an amendment striking out all after the enacting clause and inserting in place thereof the text of Senate document numbered 2210; and by inserting before the enacting clause the following emergency preamble:- "Whereas, The deferred operation of this act would tend to defeat its purpose, which is to provide forthwith contraceptive coverage and economic security in the commonwealth, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health and convenience.".

For the committee,
Karen E. Spilka

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The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

SECTION 1. Chapter 32A of the General Laws is hereby amended by adding the following section:-

Section 28. (a) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for the following services and contraceptive methods:

(i) Food and Drug Administration, FDA, approved contraceptive drugs, devices and other products; provided, however, that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs that do not have a therapeutic equivalent; and provided further, that:

(A) if the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device or product, the commission shall not be required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this section; and

(B) if there is a therapeutic equivalent of a drug, device or other product for an FDA-approved contraceptive method, the commission may provide coverage for more

than 1 drug, device or other product and may impose cost-sharing requirements as long as at least 1 drug, device or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the insurer shall provide coverage, subject to the commission's utilization management procedures, for the prescribed contraceptive drug, device or product without cost-sharing;

(ii) FDA-approved emergency contraception available over-the-counter, whether with a prescription or dispensed consistent with the requirements of section 19A of chapter 94C;

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

(iv) voluntary female sterilization procedures;

(v) patient education and counseling on contraception; and

(vi) follow-up services related to the drugs, devices, products and procedures covered under this subsection including, but not limited to, management of side effects, counseling for 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 subclauses (A) and (B) of clause (i) of subsection (a) or as otherwise required under federal law. Coverage offered under this section shall not impose unreasonable restrictions or delays in the coverage; provided, however, 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.

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

(c) Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures as prescribed by a provider for reasons other than contraceptive purposes, including, but not limited to, decreasing the risk of ovarian cancer, eliminating symptoms of menopause or providing contraception that is necessary to preserve the life or health of the enrollee or the enrollee's covered spouse or covered dependents.

(d) The commission shall ensure plan compliance with this chapter.

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

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

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

"Therapeutic equivalent", a contraceptive drug, device or product that is: (i) approved as safe and effective; (ii) pharmaceutically equivalent to another contraceptive drug, device or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity and identity; and (iii) assigned the same therapeutic equivalence code as another contraceptive drug, device or product by the FDA.

SECTION 2. Chapter 118E of the General Laws is hereby amended by inserting after section 10J the following section:-

Section 10K. (a) The division and 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 shall provide coverage for the following services and contraceptive methods:

(i) Food and Drug Administration, FDA, approved contraceptive drugs, devices and other products; provided, however, that coverage shall not be required for male condoms or FDA-approved oral contraceptives that do not have a therapeutic equivalent; and provided further, that:

(A) if the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device or product, the division shall not be required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this section;

(B) if there is a therapeutic equivalent of a drug, device or other product for an FDA-approved contraceptive method, the division may provide coverage for more than 1

drug, device or other product and may impose cost-sharing requirements as long as at least 1 drug, device or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the division shall provide coverage, subject to the division's utilization management procedures, for the prescribed contraceptive drug, device or product without cost-sharing; and

(C) 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 grievance process under section 47 of chapter 118E;

(ii) FDA-approved emergency contraception available over-the-counter, whether with a prescription or dispensed consistent with the requirements of section 19A of chapter 94C;

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

(iv) voluntary female sterilization procedures;

(v) patient education and counseling on contraception; and

(vi) follow-up services related to the drugs, devices, products and procedures covered under this subsection including, but not limited to, management of side effects, counseling for 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 subclauses (A) and (B) of clause (i) of subsection (a) or as otherwise required under federal law. Coverage provided under this section shall not impose unreasonable restrictions or delays in the coverage; provided, however, 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.

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

(c) 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 including, but not limited to, decreasing the risk of ovarian cancer, eliminating symptoms of menopause or providing contraception that is necessary to preserve the life or health of the enrollee or the enrollee's covered spouse or covered dependents.

(d) Nothing in this section shall be construed to deny or restrict the division'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.

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

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

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

"Therapeutic equivalent", a contraceptive drug, device or product that is: (i) approved as safe and effective; (ii) pharmaceutically equivalent to another contraceptive drug, device or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity and identity; and (iii)assigned the same therapeutic equivalence code as another contraceptive drug, device or product by the FDA.

SECTION 3. Section 47W of chapter 175 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following 7 subsections:

(d) An individual policy of accident and sickness insurance issued under section 108 that provides benefits for hospital expenses and surgical expenses and any group blanket policy of accident and sickness insurance issued under section 110 that provides benefits for hospital expenses and surgical expenses delivered, issued or renewed by agreement between the insurer and the policyholder, within or outside the commonwealth shall provide benefits for residents of the commonwealth and all group members having a principal place of employment in the commonwealth coverage for all of the following services and contraceptive methods:

(i) Food and Drug Administration, FDA, approved contraceptive drugs, devices and other products; provided, however, that coverage shall not be required for male condoms or

FDA-approved oral contraceptive drugs that do not have a therapeutic equivalent; and provided further, that:

(A) if the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device or product, a policy of accident and sickness insurance shall not be required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this subsection;

(B) if there is a therapeutic equivalent of a drug, device or other product for an FDA-approved contraceptive method, a policy of accident and sickness insurance may provide coverage for more than 1 drug, device or other product and may impose cost-sharing requirements as long as at least 1 drug, device or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the policy of accident and sickness insurance shall provide coverage, subject to that policy's utilization management procedures, for the prescribed contraceptive drug, device or product without cost-sharing; and

(C) 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 176O;

(ii) FDA-approved emergency contraception available over-the-counter, whether with a prescription or dispensed consistent with the requirements of section 19A of chapter 94C;

(iii) prescription contraceptives intended to last for: (A) not more than a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (B) for not more than a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled in the policy at the time the prescription 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;

(iv) voluntary female sterilization procedures;

(v) patient education and counseling on contraception; and

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

(e) (1) Coverage provided under subsection (d) shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement, except as provided for in subclauses (A) and (B) of clause (i) of subsection (d) or as otherwise required under federal law. Coveage offered under said subsection (d) shall not impose unreasonable restrictions or delays in the coverage, in accordance with the requirements of chapter 176O; provided, however, 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.

(2) Benefits for an enrollee under subsection (d) shall be the same for the enrollee’s covered spouse and covered dependents.

(f) A policy of accident and sickness insurance that is purchased by an employer that is a church or qualified church-controlled organization shall be exempt from subsection (d) at the request of the employer. An employer that invokes the exemption under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the contraceptive health care methods and services for which the employer will not provide coverage for religious reasons.

(g) Nothing in subsection (d) shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures prescribed by a provider for reasons other than contraceptive purposes, including, but not limited to, decreasing the risk of ovarian cancer, eliminating symptoms of menopause or providing contraception that is necessary to preserve the life or health of an enrollee or the enrollee's covered spouse or covered dependents.

(h) The commissioner of insurance shall ensure that plans issued under subsection (d) comply with this chapter.

(i) Nothing in subsection (d) shall be construed to require a policy of accident and sickness insurance to cover experimental or investigational treatments.

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

"Church", a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches.

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

"Qualified church-controlled organization", an organization described in section 501(c)(3) of the federal Internal Revenue Code, other than an organization that:

(i) offers goods, services or facilities for sale, other than on an incidental basis, to the general public, other than goods, services or facilities that are sold at a nominal charge that is substantially less than the cost of providing such goods, services or facilities; and (ii) normally receives more than 25 per cent of its support from: (A) governmental sources; (B) receipts from admissions, sales of merchandise, performance of services or furnishing of facilities, in activities which are not unrelated trades or businesses; or (C) both clauses (A) and (B).

"Therapeutic equivalent", a contraceptive drug, device or product that is: (i) approved as safe and effective; (ii) pharmaceutically equivalent to another contraceptive drug, device or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity and identity; and (iii) assigned the same therapeutic equivalence code as another contraceptive drug, device or product by the FDA.

SECTION 4. Section 8W of chapter 176A of the General Laws, as so appearing, is hereby amended by adding the following 7 subsections:

(d) A contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or outside the commonwealth and provides benefits for outpatient services shall provide to all individual subscribers and

members in the commonwealth and to all group members having a principal place of employment in the commonwealth coverage for all of the following services and contraceptive methods:

(i) Food and Drug Administration, FDA, approved contraceptive drugs, devices and other products; provided, however, that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs that do not have a therapeutic equivalent; and provided further, that:

(A) if the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device or product, a hospital service plan shall not be required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this subsection;

(B) if there is a therapeutic equivalent of a drug, device or other product for an FDA-approved contraceptive method, a hospital service plan may provide coverage for more than 1 drug, device or other product and may impose cost-sharing requirements as long as at least 1 drug, device or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, an individual or group hospital service plan shall provide coverage, subject to a plan's utilization management procedures, for the prescribed contraceptive drug, device or product without cost-sharing; and

(C) 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 176O;

(ii) FDA-approved emergency contraception available over-the-counter, whether with a prescription or dispensed consistent with the requirements of section 19A of chapter 94C;

(iii) prescription contraceptives intended to last for: (i) not more than a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (ii) not more than a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, 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;

(iv) voluntary female sterilization procedures;

(v) patient education and counseling on contraception; and

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

(e) (1) Coverage provided under subsection (d) shall not be subject to any deductible, coinsurance, copayment or any cost-sharing requirement except as provided for in subclauses (A) and (B) of clause (i) of subsection (d) or as otherwise required under federal law. Coverage offered under subsection (d) shall not impose any unreasonable restriction or delay in the

coverage, in accordance with the requirements of chapter 176O; provided, however, 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.

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

(f) A hospital service plan that is delivered, issued or renewed within or outside the commonwealth that is purchased by an employer that is a church or qualified church-controlled organization shall be exempt from subsection (d) at the request of the employer. An employer that invokes the exemption under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the contraceptive health care methods and services for which the employer will not provide coverage for religious reasons.

(g) Nothing in subsection (d) shall exclude coverage for contraceptive drugs, devices, products and procedures prescribed by a provider for a reason other than contraceptive purposes, including, but not limited to, decreasing the risk of ovarian cancer, eliminating symptoms of menopause or providing contraception that is necessary to preserve the life or health of an enrollee or the enrollee's covered spouse or covered dependents.

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

(i) Nothing in subsection (d) shall be construed to require a hospital service plan to cover experimental or investigational treatments.

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

"Church", a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches.

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

"Qualified church-controlled organization", an organization described in section 501(c)(3) of the federal Internal Revenue Code, other than an organization that: (i) offers goods, services or facilities for sale, other than on an incidental basis, to the general public, other than goods, services or facilities that are sold at a nominal charge that is substantially less than the cost of providing such goods, services or facilities; and (ii) normally receives more than 25 per cent of its support from: (A) governmental sources; (B) receipts from admissions, sales of merchandise, performance of services or furnishing of facilities in activities that are not unrelated trades or businesses; or (C) both clauses (A) and (B).

"Therapeutic equivalent", a contraceptive drug, device or product that is: (i) approved as safe and effective; (ii) pharmaceutically equivalent to another contraceptive drug, device or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity and identity; and (iii) assigned the same therapeutic equivalence code as another contraceptive drug, device or product by the FDA.

SECTION 5. Section 4W of chapter 176B of the General Laws, as so appearing, is hereby amended by adding the following 7 subsections:-

(d) A subscription certificate under an individual or group medical service agreement that is delivered, issued or renewed within or outside the commonwealth and that provides benefits for outpatient services shall provide to all individual subscribers and members in the commonwealth and to all group members having a principal place of employment in the commonwealth coverage for the following services and contraceptive methods:

(i) Food and Drug Administration, FDA, approved contraceptive drugs, devices and other products; provided, however, that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs that do not have a therapeutic equivalent; and provided further, that:

(A) if the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device or product, an individual or group hospital service plan shall not be required to include all such therapeutically equivalent version in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this subsection;

(B) if there is a therapeutic equivalent of a drug, device or other product for an FDA-approved contraceptive method, a medical service agreement may provide coverage for more than 1 drug, device or other product and may impose cost-sharing requirements as long as at least 1 drug, device or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, a medical service agreement shall provide coverage, subject to a plan's utilization management procedures, for the prescribed contraceptive drug, device or product without cost-sharing; and

(C) 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 176O;

(ii) FDA-approved emergency contraception available over-the-counter, whether with a prescription or dispensed consistent with the requirements of section 19A of chapter 94C;

(iii) prescription contraceptives intended to last: (A) for not more than a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (B) for not more than a 12-month 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;

(iv) voluntary female sterilization procedures;

(v) patient education and counseling on contraception; and

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

(e) (1) Coverage provided under subsection (d) shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement except as provided for in subclauses (A) and (B) of clause (i) of subsection (d) or otherwise as required under federal law.

Coverage offered under said subsection (d) shall not impose unreasonable restrictions or delays in the coverage, in accordance with the requirements of chapter 176O; provided, however, 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.

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

(f) A medical service agreement that is delivered, issued or renewed within or outside the commonwealth that is purchased by an employer that is a church or qualified church-controlled organization shall be exempt from subsection (d) at the request of the employer. An employer that invokes the exemption under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the contraceptive health care methods and services for which the employer will not provide coverage for religious reasons.

(g) Nothing in subsection (d) shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures prescribed by a provider for reasons other than contraceptive purposes, including, but not limited to, decreasing the risk of ovarian cancer, eliminating symptoms of menopause or providing contraception that is necessary to preserve the life or health of an enrollee or the enrollee's covered spouse or covered dependents.

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

(i) Nothing in subsection (d) shall be construed to require a medical service agreement to cover experimental or investigational treatments.

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

"Church", a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches.

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

"Qualified church-controlled organization", an organization described in section 501(c)(3) of the federal Internal Revenue Code, other than an organization that: (i) offers goods, services or facilities for sale, other than on an incidental basis, to the general public, other than goods, services or facilities that are sold at a nominal charge that is substantially less than the cost of providing such goods, services or facilities; and (ii) normally receives more than 25 per cent of its support from: (A) governmental sources; (B) receipts from admissions, sales of merchandise, performance of services or furnishing of facilities in activities that are not unrelated trades or businesses; or (C) both clauses (A) and (B).

"Therapeutic equivalent", a contraceptive drug, device or product that is: (i) approved as safe and effective; (ii) pharmaceutically equivalent to another contraceptive drug, device or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of strength, quality, purity and identity; and (iii) assigned the same therapeutic equivalence code as another contraceptive drug, device or product by the FDA.

SECTION 6. Chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after section 4O(c) the following 7 subsections:

(d) An individual or group health maintenance contract that is issued, renewed or delivered within or outside 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 in the commonwealth coverage for the following services and contraceptive methods:

(i) Food and Drug Administration, FDA, approved contraceptive drugs, devices and other products; provided, however, that coverage shall not be required for male condoms or FDA-approved oral contraceptive drugs that do not have a therapeutic equivalent; provided further, that:

(A) if the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device or product, a health maintenance contract shall not be required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this subsection;

(B) if there is a therapeutic equivalent of a drug, device or other product for an FDA-approved contraceptive method, a health maintenance contract may provide coverage for more than 1 drug, device or other product for that method and may impose cost-sharing requirements as long as at least 1 drug, device or other product for that method is available without cost-sharing; provided, however, that if an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent,

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

(C) 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 176O;

(ii) FDA-approved emergency contraception available over-the-counter, whether with a prescription or dispensed consistent with the requirements of section 19A of chapter 94C;

(iii) prescription contraceptives intended to last: (A) for not more than a 3-month period for the first time the prescription contraceptive is dispensed to the covered person; and (B) for not more than a 12-month period for any subsequent dispensing of the same prescription, which may be dispensed all at once or over the course of the 12-month period, regardless of whether the covered person was enrolled in the 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;

(iv) voluntary female sterilization procedures;

(v) patient education and counseling on contraception; and

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

(e) (1) Coverage provided under subsection (d) shall not be subject to any deductible, coinsurance, copayment or any other cost-sharing requirement except as provided for in subclauses (A) and (B) of clause (i) of subsection (d) or as otherwise required under federal law. Coverage offered under said subsection (d) shall not impose unreasonable restrictions or delays in the coverage, in accordance with the requirements of chapter 176O; provided, however, 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.

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

(f) A health maintenance contract that is purchased by an employer that is a church or qualified church-controlled organization shall be exempt from subsection (d) at the request of the employer. An employer that invokes the exemption under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan and such notice shall list the contraceptive health care methods and services for which the employer will not provide coverage for religious reasons.

(g) Nothing in subsection (d) shall be construed to exclude coverage for contraceptive drugs, devices, products and procedures as prescribed by a provider for reasons other than contraceptive purposes, including, but not limited to, decreasing the risk of ovarian cancer, eliminating symptoms of menopause or providing contraception that is necessary to preserve the life or health of an enrollee or the enrollee's covered spouse or covered dependents.

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

(i) Nothing in subsection (d) shall be construed to require a health maintenance contract to cover experimental or investigational treatments.

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

"Church", a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches.

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

"Qualified church-controlled organization", an organization described in section 501(c)(3) of the federal Internal Revenue Code, other than an organization that:(i) offers goods, services or facilities for sale, other than on an incidental basis, to the general public, other than goods, services or facilities that are sold at a nominal charge that is substantially less than the cost of providing such goods, services or facilities; and(ii) normally receives more than 25 per cent of its support from: (A) governmental sources; or (B) receipts from admissions, sales of merchandise, performance of services or furnishing of facilities in activities that are not unrelated trades or businesses; or (C) both clauses (A) and (B).

"Therapeutic equivalent", a contraceptive drug, device or product that is: (i) approved as safe and effective; (ii) pharmaceutically equivalent to another contraceptive drug, device or product in that it contains an identical amount of the same active drug ingredient in the same dosage form and route of administration and meets compendial or other applicable standards of

strength, quality, purity and identity; and (iii) assigned the same therapeutic equivalence code as another contraceptive drug, device or product by the FDA.

SECTION 7. Sections 1 to 6, inclusive, shall apply to all policies, contracts and certificates of health insurance subject to chapters 32A, 118E, 175, 176A, 176B and 176G of the General Laws that are delivered, issued or renewed not less than 6 months from the effective date of this act."