AN ACT

RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Kazarian, Blazejewski, Casimiro, Alzate, and Williams

Date Introduced: March 11, 2020

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. Section 27-18-57 of the General Laws in Chapter 27-18 entitled "Accident and Sickness Insurance Policies" is hereby amended to read as follows:

27-18-57. FDA-approved prescription contraceptive drugs and devices.

(a) Every individual or group health-insurance contract, plan, or policy issued pursuant to this title that provides prescription coverage and is delivered, issued for delivery, or renewed, amended or effective in this state on or after January 1, 2021 shall provide coverage for FDA-approved contraceptive drugs and devices requiring a prescription all of the following services and contraceptive methods. Provided, that nothing in this subsection shall be deemed to mandate or require coverage for the prescription drug RU 486.

(1) All FDA-approved contraceptive drugs, devices, and other products. The following applies to this coverage:

(i) If there is a therapeutic equivalent of an FDA-approved contraceptive drug, device, or product, the contract must include either the original FDA-approved contraceptive drug device, or product or at least one of its therapeutic equivalents. “Therapeutic equivalent” shall have the same definition as that set forth by the FDA.

(ii) If the covered therapeutic equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, a group or blanket policy shall provide coverage for an alternate therapeutic equivalent version of the contraceptive drug, device, or product, based on the determination of the health care provider, without cost-sharing;
(iii) Coverage required by this section must include all over-the-counter contraceptive
drugs, devices and products approved by the FDA when prescribed by a licensed provider,
excluding male condoms;

(2) Voluntary sterilization procedures.

(3) Patient education and counseling on contraception; and

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

(b) A group or blanket policy subject to this section shall not impose a deductible,
coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant
to this section. For a qualifying high-deductible health plan for a health savings account, the carrier
shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the
minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and
withdrawals from his or her health savings account under 26 U.S.C. § 223.

(c) Except as otherwise authorized under this subsection, a group or blanket policy shall
not impose any restrictions or delays on the coverage required under this section.

(d) Benefits for an enrollee under this section shall be the same for an enrollee's covered
spouse or domestic partner and covered non-spouse dependents.

(e) Notwithstanding any other provision of this section, any insurance company may
issue to a religious employer an individual or group health-insurance contract, plan, or policy that
excludes coverage for prescription contraceptive methods that are contrary to the religious
employer's bona fide religious tenets.

(f) As used in this section, "religious employer" means an employer that is a "church or
a qualified church-controlled organization" as defined in 26 U.S.C. § 3121.

(g) This section does not apply to insurance coverage providing benefits for: (1) Hospital
confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare
supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily
injury or death by accident or both; and (9) Other limited-benefit policies.

(h) Every religious employer that invokes the exemption provided under this section
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.

(i) Beginning on the first day of each plan year after April 1, 2019, every health-
insurance issuer offering group or individual health-insurance coverage that covers prescription
contraception shall not restrict reimbursement for dispensing a covered prescription contraceptive
up to three hundred sixty-five (365) days at a time.

(j) Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, or products 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.

SECTION 2. Section 27-19-48 of the General Laws in Chapter 27-19 entitled “Nonprofit Hospital Service Corporations” is hereby amended to read as follows:


(a) Every individual or group health-insurance contract, plan, or policy issued pursuant to this title that provides prescription coverage and is delivered, issued for delivery, or renewed, amended or effective in this state on or after January 1, 2021 shall provide coverage for FDA-approved contraceptive drugs and devices requiring a prescription all of the following services and contraceptive methods. Provided, that nothing in this subsection shall be deemed to mandate or require coverage for the prescription drug RU 486.

(1) All FDA-approved contraceptive drugs, devices, and other products. The following applies to this coverage:

(i) If there is a therapeutic equivalent of an FDA-approved contraceptive drug, device, or product, the contract must include either the original FDA-approved contraceptive drug device, or product or at least one of its therapeutic equivalents. “Therapeutic equivalent” shall have the same definition as that set forth by the FDA.

(ii) If the covered therapeutic equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, a group or blanket policy shall provide coverage for an alternate therapeutic equivalent version of the contraceptive drug, device, or product, based on the determination of the health care provider, without cost-sharing;

(iii) Coverage required by this section must include all over-the-counter contraceptive drugs, devices and products approved by the FDA when prescribed by a licensed provider, excluding male condoms;

(2) Voluntary sterilization procedures.

(3) Patient education and counseling on contraception; and

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

(b) A group or blanket policy subject to this section shall not impose a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant
to this section. For a qualifying high-deductible health plan for a health savings account, the carrier shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from his or her health savings account under 26 U.S.C. § 223.

(c) Except as otherwise authorized under this subsection, a group or blanket policy shall not impose any restrictions or delays on the coverage required under this section.

(d) Benefits for an enrollee under this section shall be the same for an enrollee's covered spouse or domestic partner and covered non-spouse dependents.

(e) Notwithstanding any other provision of this section, any hospital service corporation may issue to a religious employer an individual or group health-insurance contract, plan, or policy that excludes coverage for prescription contraceptive methods that are contrary to the religious employer's bona fide religious tenets.

(f) As used in this section, "religious employer" means an employer that is a "church or a qualified church-controlled organization" as defined in 26 U.S.C. § 3121.

(g) Every religious employer that invokes the exemption provided under this section 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.

(h) Beginning on the first day of each plan year after April 1, 2019, every health-insurance issuer offering group or individual health-insurance coverage that covers prescription contraception shall not restrict reimbursement for dispensing a covered prescription contraceptive up to three hundred sixty-five (365) days at a time.

(i) Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, or products 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.

SECTION 3. Section 27-20-43 of the General Laws in Chapter 27-20 entitled “Nonprofit Medical Service Corporations” is hereby amended to read as follows:

27-20-43. FDA-approved prescription contraceptive drugs and devices. (a) Every individual or group health-insurance contract, plan, or policy issued pursuant to this title that provides prescription coverage and is delivered, issued for delivery, or renewed, amended or effective in this state on or after January 1, 2021 shall provide coverage for FDA-approved contraceptive drugs and devices requiring a prescription all of the following services and contraceptive methods. Provided, that nothing in this subsection shall be deemed to mandate or require coverage for the prescription drug RU 486.
(1) All FDA-approved contraceptive drugs, devices, and other products. The following applies to this coverage:

   (i) If there is a therapeutic equivalent of an FDA-approved contraceptive drug, device, or product, the contract must include either the original FDA-approved contraceptive drug device, or product or at least one of its therapeutic equivalents. "Therapeutic equivalent" shall have the same definition as that set forth by the FDA.

   (ii) If the covered therapeutic equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, a group or blanket policy shall provide coverage for an alternate therapeutic equivalent version of the contraceptive drug, device, or product, based on the determination of the health care provider, without cost-sharing.

   (iii) Coverage required by this section must include all over-the-counter contraceptive drugs, devices and products approved by the FDA when prescribed by a licensed provider, excluding male condoms;

(2) Voluntary sterilization procedures.

(3) Patient education and counseling on contraception; and

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

(b) A group or blanket policy subject to this section shall not impose a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant to this section. For a qualifying high-deductible health plan for a health savings account, the carrier shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from his or her health savings account under 26 U.S.C. § 223.

(c) Except as otherwise authorized under this subsection, a group or blanket policy shall not impose any restrictions or delays on the coverage required under this section.

(d) Benefits for an enrollee under this section shall be the same for an enrollee's covered spouse or domestic partner and covered non-spouse dependents.

(e) Notwithstanding any other provision of this section, any medical service corporation may issue to a religious employer an individual or group health-insurance contract, plan, or policy that excludes coverage for prescription contraceptive methods which are contrary to the religious employer's bona fide religious tenets.

(f) As used in this section, "religious employer" means an employer that is a "church or a qualified church-controlled organization" as defined in 26 U.S.C. § 3121.
Every religious employer that invokes the exemption provided under this section 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.

Beginning on the first day of each plan year after April 1, 2019, every health-insurance issuer offering group or individual health-insurance coverage that covers prescription contraception shall not restrict reimbursement for dispensing a covered prescription contraceptive up to three hundred sixty-five (365) days at a time.

Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, or products 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.

SECTION 4. Chapter 42-12.3 of the General Laws entitled “Health Care for Children and Pregnant Women” is hereby amended by adding thereto the following section:

42-12.3-17. FDA-approved prescription contraceptive drugs and devices.

(a) Every individual or group health insurance contract, plan, or policy issued pursuant to this chapter that is delivered, issued for delivery, renewed, amended or effective in this state on or after January 1, 2021 shall provide coverage for all of the following services and contraceptive methods. Provided, that nothing in this subsection shall be deemed to mandate or require coverage for the prescription drug RU 486.

(1) All FDA-approved contraceptive drugs, devices, and other products. The following applies to this coverage:

(i) If there is a therapeutic equivalent of an FDA-approved contraceptive drug, device, or product, the contract must include either the original FDA-approved contraceptive drug device, or product or at least one of its therapeutic equivalents. “Therapeutic equivalent” shall have the same definition as that set forth by the FDA.

(ii) If the covered therapeutic equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, a group or blanket policy shall provide coverage for an alternate therapeutic equivalent version of the contraceptive drug, device, or product, based on the determination of the health care provider, without cost-sharing;

(iii) Coverage required by this section must include all over-the-counter contraceptive drugs, devices and products approved by the FDA when prescribed by a licensed provider, excluding male condoms;

(2) Voluntary sterilization procedures;

(3) Patient education and counseling on contraception; and
(4) Follow-up services related to the drugs, devices, products, and procedures covered under this section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(b) A group or blanket policy subject to this section shall not impose a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant to this section. For a qualifying high-deductible health plan for a health savings account, the carrier shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from his or her health savings account under 26 U.S.C. § 223.

(c) Except as otherwise authorized under this subsection, a group or blanket policy shall not impose any restrictions or delays on the coverage required under this section.

(d) Benefits for an enrollee under this section shall be the same for an enrollee's covered spouse or domestic partner and covered non-spouse dependents.

(e) Notwithstanding any other provision of this section, any health maintenance corporation may issue to a religious employer an individual or group health insurance contract, plan, or policy that excludes coverage for prescription contraceptive methods that are contrary to the religious employer's bona fide religious tenets.

(f) As used in this section, "religious employer" means an employer that is a "church or a qualified church-controlled organization" as defined in 26 U.S.C. § 3121.

(g) Every religious employer that invokes the exemption provided under this section 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.

(h) Beginning on the first day of each plan year after April 1, 2020, every health insurance issuer offering group or individual health insurance coverage that covers prescription contraception shall not restrict reimbursement for dispensing a covered prescription contraceptive up to three hundred sixty-five (365) days at a time.

(i) Nothing in this section shall be construed to exclude coverage for contraceptive drugs, devices, or products 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.

SECTION 5. This act shall take effect upon passage.
EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N   A C T
RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

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1 This act would require every individual or group health insurance contract effective on or after January 1, 2021, to provide coverage to the insured and the insured's spouse and dependents for all FDA-approved contraceptive drugs, devices and other products, voluntary sterilization procedures, patient education and counseling on contraception and follow-up services as well as Medicaid coverage for a twelve (12) month supply for Medicaid recipients.

2 This act would take effect upon passage.

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