# SENATE BILL 986

P4, C3 8lr3620
CF 8lr2581

By: **Senator Kelley**
Introduced and read first time: February 5, 2018
Assigned to: Finance

A BILL ENTITLED

AN ACT concerning

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

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

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

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

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

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

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
**[**Brackets**]** indicate matter deleted from existing law.

**Article – Insurance**

15–826.1.

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

(b) This section applies to:

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

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

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

(2) An entity subject to this section:

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

1. A. an intrauterine device; or

B. an implantable rod;

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

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

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

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

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

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

requirement.

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

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

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

(i) the initial prescription for the contraceptives; or

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

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

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

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

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

(2) An entity subject to this section:

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

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

15–826.2.

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

(2) This subsection applies to:

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

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

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

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

(b) (1) This subsection applies to:

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

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

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

15–831.

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

(2) "Authorized prescriber" has the meaning stated in § 12–101 of the Health Occupations Article.

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

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

(ii) "Member" includes a subscriber.

(b) (1) This section applies to:

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

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

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

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

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

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

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

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

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

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

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

**Article – State Personnel and Pensions**

2–501.

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

(b) "Program" means the State Employee and Retiree Health and Welfare

Benefits Program.

2–503.

(a) The Secretary shall:

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

(2) ensure that the Program complies with**:**

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

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

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

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