MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

By: Representative McGee To: Insurance

HOUSE BILL NO. 853

AN ACT TO REQUIRE HEALTH INSURANCE POLICIES THAT PROVIDE PREGNANCY RELATED BENEFITS TO PROVIDE COVERAGE FOR MEDICALLY NECESSARY EXPENSES OF DIAGNOSIS AND TREATMENT OF INFERTILITY; TO ESTABLISH A PILOT PROGRAM IN THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE PLAN THAT PROVIDES FOR COVERAGE FOR MEDICALLY NECESSARY EXPENSES OF TESTS AND PROCEDURES FOR THE DIAGNOSIS AND TREATMENT OF INFERTILITY; TO AMEND SECTIONS 25-15-9 AND 83-9-6, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING SECTION; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. (1) Except as otherwise provided in this section, a health insurance policy covering persons residing in Mississippi that provides pregnancy related benefits must provide, coverage to the same extent as pregnancy-related procedures are covered, coverage for medically necessary expenses of diagnosis and treatment of infertility, including, but not limited to, the following: artificial insemination; in vitro fertilization; gamete intrafallopian transfer; sperm, egg and/or inseminated egg procurement and processing; banking of sperm or inseminated eggs, to the extent such costs are not covered by the patient's insurer, if any; intra-cytoplasmic sperm injection; zygote intrafallopian

transfer; assisted hatching; and cryopreservation of eggs. Procedures under this section must conform with the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine guidelines.

(2) Coverage under this section shall be included in health insurance policies that are delivered, executed, issued, amended, adjusted, or renewed in this state, or outside this state if insuring residents of this state, on or after July 1, 2023. No insurer may terminate coverage, or refuse to deliver, execute, issue, amend, adjust or renew coverage to an individual because the individual is diagnosed with or has received treatment for infertility.

(3) Coverage of procedures for the diagnosis and treatment of infertility under this section may not exceed a lifetime benefit of Twenty-five Thousand Dollars ($25,000.00) per person.

(4) The benefits of coverage for infertility treatment shall be subject to the same deductibles, coinsurance and out-of-pocket limitations as under maternity benefit coverage.

(5) Coverage shall be provided only to married females and males, except for the coverage provided under subsection (9) of this section.

(6) Policies must provide coverage for diagnostic tests and procedures that include, but are not limited to, the following:

(a) Hysterosalpingogram;

(b) Hysteroscopy;

(c) Endometrial biopsy;

(d) Laparoscopy;

(e) Sono-hysterogram;

(f) Postcoital tests;

(g) Testis biopsy;

(h) Semen analysis;

(i) Blood tests; and

(j) Ultrasounds.

In addition to the above tests and procedures, diagnostic and exploratory procedures shall be covered, including surgical procedures to correct a medically diagnosed disease or condition of the reproductive organs, including but not limited to, endometriosis, collapsed/clogged fallopian tubes and testicular failure.

(7) Every policy that provides for prescription drug coverage shall also include drugs approved by the FDA for use in the diagnosis and treatment of infertility. Insurers shall not impose any exclusions, limitations or other restrictions on coverage of infertility drugs that are different from those imposed on any other prescription drugs, nor shall they impose deductibles, copayment, coinsurance, benefit maximums, waiting periods or any other limitations on coverage for required infertility benefits that are different from those imposed upon benefits for services not related to infertility.

(8) Nothing in this section shall be construed to limit the number of treatment cycles covered.

(9) Coverage shall include medically necessary expenses for standard fertility preservation services when a necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person. As used in this section, "iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes. Subsection (5) of this section does not apply to fertility preservation to avoid iatrogenic infertility.

(10) As used in this section, "infertility" means a disease, defined by the failure to achieve a successful pregnancy after twelve (12) months or more appropriate, timed unprotected intercourse or therapeutic donor insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after six (6) months for women over thirty-five (35) years of age.

(11) As used in this section, "health insurance policy" includes all individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, and individual and group service contracts issued by a health maintenance organization or preferred provider organization.

(12) This section does not apply to self-insured group arrangements, including the State and School Employees Health Insurance Plan, except as provided in Section 2 of this act.

(13) Coverage required under this section must be for the policyholder and the spouse of the policyholder if the spouse is a covered person under the policy.

(14) Fertilization covered under this section shall only include fertilization of the covered person's eggs with the spouse's sperm.

(15) Nothing in this section shall apply to nongrandfathered plans in the individual and small group markets that are required to include essential health benefits under the Patient Protection and Affordable Care Act or to Medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long term care, or other limited benefit hospital insurance policies.

SECTION 2. (1) There is established a pilot program designed to help address the problem of infertility in Mississippi, by providing for coverage in the State and School Employees Health Insurance Plan (the "plan") for medically necessary expenses of tests and procedures for the diagnosis and treatment of infertility that meets the requirements of and is subject to the limitations on the coverage required for health insurance policies in Section 1 of this act.

(2) To be eligible for the pilot program, a person must have been covered by the plan for at least one (1) year, and must have

symptoms of infertility, as defined in Section 1 of this act. The pilot program shall be administered by the State and School Employees Health Insurance Management Board (the "board"), and is limited to one hundred (100) persons.

(3) Persons who meet the criteria for the pilot program shall apply to the board for benefits for medically necessary tests and procedures for the diagnosis and treatment of infertility, and those benefits shall be provided to not more than one hundred (100) applicants approved by the board on a first-come, first-served basis.

(4) The pilot program shall be conducted for a period of one (1) year, ending on July 1, 2024. After the end of the pilot program, the board shall evaluate the program and provide a report on the program to the members of the Legislature, with detailed information about the participants in the program (with the identities of those persons being confidential); the tests and procedures used by those participants; the total costs to the plan for those tests and procedures by each participant and by all participants; and any other information determined to be relevant by the board. The board shall submit its report to the Legislature not later than December 1, 2024.

SECTION 3. Section 25-15-9, Mississippi Code of 1972, is amended as follows:

25-15-9. (1) (a) The board shall design a plan of health insurance for state employees that provides benefits for

semiprivate rooms in addition to other incidental coverages that the board deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the board to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the board determines. The plan shall provide for coverage for telemedicine services as provided in Section 83-9-351. The plan shall provide for coverage of procedures for the diagnosis and treatment of infertility as provided in Section 2 of this act. The board is also authorized to accept bids for such alternate coverage and optional benefits as the board deems proper. The board is authorized to accept bids for surgical services that include assistance in locating a surgeon, setting up initial consultation, travel, a negotiated single case rate bundle and payment for orthopedic, spine, bariatric, cardiovascular and general surgeries. The surgical services may only utilize surgeons and facilities located in the State of Mississippi unless otherwise provided by the board. Any contract for alternative coverage and optional benefits shall be awarded by the board after it has carefully studied and evaluated the bids and selected the best and most cost-effective bid. The board may reject all of the bids; however, the board shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected. The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist

the board in the preparation of specifications and in the process of advertising for the bids for the plan. Those contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation that, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and that bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the

rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid. The board is authorized to promulgate rules and regulations to implement the provisions of this subsection.

The board shall develop plans for the insurance plan authorized by this section in accordance with the provisions of Section 25-15-5.

Any corporation, association, company or individual that contracts with the board for the third-party claims administration of the self-insured plan shall prepare and keep on file an explanation of benefits for each claim processed. The explanation of benefits shall contain such information relative to each processed claim that the board deems necessary, and, at a minimum, each explanation shall provide the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed to the claimant and reason codes. The information contained in the explanation of benefits shall be available for inspection upon request by the board. The board shall have access to all claims information utilized in the issuance of payments to employees and providers.

(b) There is created an advisory council to advise the board in the formulation of the State and School Employees Health Insurance Plan. The council shall be composed of the State Insurance Commissioner, or his designee, an

employee-representative of the institutions of higher learning appointed by the board of trustees thereof, an employee-representative of the Department of Transportation appointed by the director thereof, an employee-representative of the Department of Revenue appointed by the Commissioner of Revenue, an employee-representative of the Mississippi Department of Health appointed by the State Health Officer, an employee-representative of the Mississippi Department of Corrections appointed by the Commissioner of Corrections, and an employee-representative of the Department of Human Services appointed by the Executive Director of Human Services, two (2) certificated public school administrators appointed by the State Board of Education, two (2) certificated classroom teachers appointed by the State Board of Education, a noncertificated school employee appointed by the State Board of Education and a community/junior college employee appointed by the Mississippi Community College Board.

The Lieutenant Governor may designate the Secretary of the Senate, the Chairman of the Senate Appropriations Committee, the Chairman of the Senate Education Committee and the Chairman of the Senate Insurance Committee, and the Speaker of the House of Representatives may designate the Clerk of the House, the Chairman of the House Appropriations Committee, the Chairman of the House Education Committee and the Chairman of the House Insurance Committee, to attend any meeting of the State and School Employees

Insurance Advisory Council. The appointing authorities may designate an alternate member from their respective houses to serve when the regular designee is unable to attend the meetings of the council. Those designees shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, the legislators shall receive per diem and expenses, which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) No change in the terms of the State and School Employees Health Insurance Plan may be made effective unless the board, or its designee, has provided notice to the State and School Employees Health Insurance Advisory Council and has called a meeting of the council at least fifteen (15) days before the effective date of the change. If the State and School Employees Health Insurance Advisory Council does not meet to advise the board on the proposed changes, the changes to the plan shall become effective at such time as the board has informed the council that the changes shall become effective.

(d) **Medical benefits for retired employees and dependents under age sixty-five (65) years and not eligible for Medicare benefits.** For employees who retire before July 1, 2005, and for employees retiring due to work-related disability under the Public Employees' Retirement System, the same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all dependents under age sixty-five (65) years who are not eligible for Medicare benefits, the level of benefits to be the same level as for all other active participants. For employees who retire on or after July 1, 2005, and not retiring due to work-related disability under the Public Employees' Retirement System, the same health insurance coverage as for all other active employees and their dependents shall be available to those retiring employees and all dependents under age sixty-five (65) years who are not eligible for Medicare benefits only if the retiring employees were participants in the State and School Employees Health Insurance Plan for four (4) years or more before their retirement, the level of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(e) **Medical benefits for retired employees and dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits.** For employees who retire before July 1,

2005, and for employees retiring due to work-related disability under the Public Employees' Retirement System, the health insurance coverage available to retired employees over age sixty-five (65) years or otherwise eligible for Medicare benefits, and all dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits, shall be the major medical coverage. For employees retiring on or after July 1, 2005, and not retiring due to work-related disability under the Public Employees' Retirement System, the health insurance coverage described in this paragraph (e) shall be available to those retiring employees only if they were participants in the State and School Employees Health Insurance Plan for four (4) years or more and are over age sixty-five (65) years or otherwise eligible for Medicare benefits, and to all dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits. Benefits shall be reduced by Medicare benefits as though the Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(f) Lifetime maximum: The lifetime maximum amount of benefits payable under the health insurance plan for each participant is Two Million Dollars ($2,000,000.00).

(2) Nonduplication of benefits — reduction of benefits by Title XIX benefits: When benefits would be payable under more than one (1) group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

No health care benefits under the state plan shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed insured, or if the insured lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an insured's diagnosis with a terminal condition. As used in this paragraph, "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which physician diagnoses as terminal.

Not later than January 1, 2016, the state health plan shall not require a higher co-payment, deductible or coinsurance amount for patient-administered anti-cancer medications, including, but

not limited to, those orally administered or self-injected, than it requires for anti-cancer medications that are injected or intravenously administered by a health care provider, regardless of the formulation or benefit category determination by the plan. For the purposes of this paragraph, the term "anti-cancer medications" has the meaning as defined in Section 83-9-24.

(3) (a) Schedule of life insurance benefits — group term: The amount of term life insurance for each active employee of a department, agency or institution of the state government shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee becomes totally and permanently disabled before age sixty-five (65) years. Employees retiring after June 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(b) Effective October 1, 1999, schedule of life insurance benefits — group term: The amount of term life insurance for each active employee of any school district, community/junior college, public library or university-based

program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver becomes totally and permanently disabled before age sixty-five (65) years. Employees of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver retiring after September 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(4) Any eligible employee who on March 1, 1971, was participating in a group life insurance program that has provisions different from those included in this article and for which the State of Mississippi was paying a part of the premium

may, at his discretion, continue to participate in that plan. The employee shall pay in full all additional costs, if any, above the minimum program established by this article. Under no circumstances shall any individual who begins employment with the state after March 1, 1971, be eligible for the provisions of this subsection.

(5) The board may offer medical savings accounts as defined in Section 71-9-3 as a plan option.

(6) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that the state contribution to the plan be the same for each employee throughout the state.

(7) On October 1, 1999, any school district, community/junior college district or public library may elect to remain with an existing policy or policies of group life insurance with an insurance company approved by the State and School Employees Health Insurance Management Board, in lieu of participation in the State and School Life Insurance Plan. On or after July 1, 2004, until October 1, 2004, any school district, community/junior college district or public library may elect to choose a policy or policies of group life insurance existing on October 1, 1999, with an insurance company approved by the State and School Employees Health Insurance Management Board in lieu of

participation in the State and School Life Insurance Plan. The state's contribution of up to fifty percent (50%) of the active employee's premium under the State and School Life Insurance Plan may be applied toward the cost of coverage for full-time employees participating in the approved life insurance company group plan. For purposes of this subsection (7), "life insurance company group plan" means a plan administered or sold by a private insurance company. After October 1, 1999, the board may assess charges in addition to the existing State and School Life Insurance Plan rates to such employees as a condition of enrollment in the State and School Life Insurance Plan. In order for any life insurance company group plan to be approved by the State and School Employees Health Insurance Management Board under this subsection (7), it shall meet the following criteria:

(a) The insurance company offering the group life insurance plan shall be rated "A-" or better by A.M. Best state insurance rating service and be licensed as an admitted carrier in the State of Mississippi by the Mississippi Department of Insurance.

(b) The insurance company group life insurance plan shall provide the same life insurance, accidental death and dismemberment insurance and waiver of premium benefits as provided in the State and School Life Insurance Plan.

(c) The insurance company group life insurance plan shall be fully insured, and no form of self-funding life insurance by the company shall be approved.

(d) The insurance company group life insurance plan shall have one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for active employees regardless of age and one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for all retirees regardless of age or type of retiree.

(e) The insurance company and its group life insurance plan shall comply with any administrative requirements of the State and School Employees Health Insurance Management Board. If any insurance company providing group life insurance benefits to employees under this subsection (7) fails to comply with any requirements specified in this subsection or any administrative requirements of the board, the state shall discontinue providing funding for the cost of that insurance.

SECTION 4. Section 83-9-6, Mississippi Code of 1972, is amended as follows:

83-9-6. (1) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of Mississippi. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians,

pharmacists, nurses and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and dependents enrolled in its health benefit plan; but this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services.

(2) As used in this section:

(a) "Copayment" means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service with their insurer paying the remainder of the charge. The copayment is incurred at the time the service is used. The copayment may be a fixed or variable amount.

(b) "Contract provider" means a pharmacy granted the right to provide prescription drugs and pharmacy services according to the terms of the insurer.

(c) "Health benefit plan" means any entity or program that provides reimbursement for pharmaceutical services.

(d) "Insurer" means any entity that provides or offers a health benefit plan.

(e) "Pharmacist" means a pharmacist licensed by the Mississippi State Board of Pharmacy.

(f) "Pharmacy" means a place licensed by the Mississippi State Board of Pharmacy.

(3) A health insurance plan, policy, employee benefit plan or health maintenance organization may not:

(a) Prohibit or limit any person who is a participant or beneficiary of the policy or plan from selecting a pharmacy or pharmacist of his choice who has agreed to participate in the plan according to the terms offered by the insurer;

(b) Deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services, including but not limited to prescription drugs, that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer;

(c) Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee or condition that is not equally imposed upon all beneficiaries in the same benefit category, class or copayment level under the health benefit plan when receiving services from a contract provider;

(d) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in the plan according to the terms offered by the insurer. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods;

(e) Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the

beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area;

(f) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy;

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(g) Impose upon a beneficiary any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that is more costly or more restrictive than that which would be imposed upon the beneficiary if such services were purchased from a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail order service *** * ***; or

(h) Prohibit or limit prescription drug coverage for drugs approved by the FDA for use in the diagnosis and treatment of infertility as provided in Section 1 of this bill.

(4) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent or owner, may not waive, discount, rebate or distort a copayment of any insurer, policy or plan or a beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's

acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the State Board of Pharmacy.

(5) If a health benefit plan providing reimbursement to Mississippi residents for prescription drugs restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan at least sixty (60) days before the effective date of the plan or before July 1, 1995, whichever comes first. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating

pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the state.

(6) A violation of this section creates a civil cause of action for injunctive relief in favor of any person or pharmacy aggrieved by the violation.

(7) The Commissioner of Insurance shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section.

(8) Any provision in a health benefit plan which is executed, delivered or renewed, or otherwise contracted for in this state that is contrary to this section shall, to the extent of the conflict, be void.

(9) It is a violation of this section for any insurer or any person to provide any health benefit plan providing for pharmaceutical services to residents of this state that does not conform to this section.

SECTION 5. This act shall take effect and be in force from and after July 1, 2023.