MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Senator(s) Turner-Ford To: Insurance

SENATE BILL NO. 2552

AN ACT TO ENACT THE CONTRACEPTIVE EQUITY ACT OF 2024 TO PROVIDE THAT HEALTH BENEFIT PLANS SHALL COVER CERTAIN CONTRACEPTIVES, PRESCRIPTION CONTRACEPTIVE DRUGS, AND CLINICAL SERVICES; TO PROVIDE THE LEGISLATIVE INTENT OF THE ACT; TO PROHIBIT HEALTH BENEFIT PLANS FROM IMPOSING A DEDUCTIBLE, COPAYMENT OR OTHER COST-SHARING REQUIREMENT ON CONTRACEPTIVE COVERAGE; TO SET CERTAIN REQUIREMENTS AND PROHIBITIONS RELATED TO CONTRACEPTIVE COVERAGE AND HEALTH BENEFIT PLANS; TO PROVIDE THAT A RELIGIOUS EMPLOYER MAY REQUEST A HEALTH BENEFIT PLAN CONTRACT WITHOUT SUCH COVERAGE IF SUCH COVERAGE IS CONTRARY TO THE RELIGIOUS EMPLOYER'S RELIGIOUS TENETS; TO REQUIRE THE DEPARTMENT OF INSURANCE TO MONITOR HEALTH BENEFIT PLANS AND TO ADOPT RULES RELATED TO THE IMPLEMENTATION OF THIS ACT; TO SET CERTAIN DEFINITIONS RELATED THERETO; AND FOR RELATED PURPOSES.

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

SECTION 1. (1) The Legislature hereby finds and declares all of the following:

(a) Mississippi has a long history of expanding timely access to birth control to prevent unintended pregnancy.

(b) Medical management techniques such as denials, step therapy or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods.

(c) Many insurance companies do not typically cover male methods of contraception, or they require high cost-sharing despite the critical role people of all genders play in the prevention of unintended pregnancy.

(d) The COVID-19 public health emergency has further illuminated the structural inequities that disproportionately affect youth, low-income people and communities of color in accessing birth control services. A report by the Guttmacher Institute revealed that twenty-nine percent (29%) of white women, thirty-eight percent (38%) of black women, and forty-five percent (45%) of Latinas now face difficulties accessing birth control as a result of the pandemic.

(e) Sexually transmitted infections, already at record highs, have continued to increase during the COVID-19 public health emergency. Condoms are the only current contraceptive method that prevent both pregnancy and sexually transmitted infections.

(f) The federal Patient Protection and Affordable Care Act includes a contraceptive coverage guarantee as part of a broader requirement for health insurance to cover key preventive care services without out-of-pocket costs for patients.

(g) The Legislature intends to build on existing state and federal law to promote gender equity and sexual and reproductive health, and to ensure greater contraceptive coverage equity and timely access to all federal Food and Drug

Administration (FDA) identified birth control drugs, devices and products, and related services, for all individuals covered by health benefit plans in Mississippi.

(h) The Legislature intends for the relevant departments and agencies to work in concert to ensure compliance with these provisions.

(2) This act shall be known and may be cited as the "Contraceptive Equity Act of 2024."

SECTION 2. Definitions. For purposes of this act, the following definitions apply:

(a) "Grandfathered health plan" has the meaning set forth in Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations or guidance issued thereunder.

(b) "Health benefit plans" shall have the same meaning as defined in Section 83-9-6.3.

(c) "Provider" means an individual who is certified or licensed in the state and who has prescriptive authority, including medical professionals and pharmacists.

(d) "Religious employer" is an organization that is organized and operates as a nonprofit entity and is referred to in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(e) "Specialized health care service plan" is a plan that does not provide comprehensive services such as a dental-only plan or a vision-only plan.

(f) A "therapeutic equivalent" has the meaning set forth by the Food and Drug Administration.

SECTION 3. Requirements for a health care plan. (1) This act applies to every health insurance issuer and all health benefit plans, as both terms are defined in Section 83-9-6.3, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974 or health care provided pursuant to the Workers' Compensation Act.

(2) A health benefit plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, effective or delivered on or after July 1, 2024, shall provide coverage for all of the following:

(a) All FDA-approved contraceptive drugs, devices and other products, including those prescribed by the covered person's provider or as otherwise authorized under state or federal law, and all FDA-approved over-the-counter contraceptive drugs, devices and products, subject to the following:

(i) If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a prescription contraceptive drug, device or product, the health benefit plan must include either the original FDA-approved

prescription contraceptive drug, device or product or at least one of its therapeutic equivalents. If there is no therapeutic equivalent, the health benefit plan must include the original, brand name contraceptive.

(ii) If the covered contraceptive drug, device or product is not tolerated or is inappropriate for a patient as determined by the patient and the provider, the health benefit plan shall defer to the determination and judgment of the attending provider and provide coverage for the alternate prescribed contraceptive drug, device or product.

(iii) This coverage must provide for the single dispensing of contraceptives intended to last the patient for a twelve-month duration, which may be furnished or dispensed all at once or over the course of the twelve (12) months at the discretion of the prescriber. The health benefit plan shall reimburse a health care provider or dispensing entity per unit for furnishing or dispensing an extended supply of contraceptives;

(b) Voluntary sterilization procedures;

(c) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals and counseling; and

(d) Follow-up services related to the drugs, devices, products and procedures covered under this subdivision, including,

but not limited to, management of side effects, counseling for continued adherence and device removal.

(3) A health benefit plan subject to this section:

(a) Shall not impose a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided pursuant to this section, unless the health plan is offered as a qualifying high-deductible health plan for a health savings account. For such a qualifying high-deductible health plan, 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 their health savings account under Internal Revenue Service laws, regulations and guidance;

(b) Shall not require a prescription to trigger coverage of FDA approved over-the-counter contraceptive drugs, devices and products, and shall provide point-of-sale coverage for over-the-counter contraceptives at in-network pharmacies without cost-sharing or medical management restrictions; and

(c) Shall not impose utilization control or other forms of medical management limiting the supply of FDA-approved contraception that may be dispensed or furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a twelve-month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(4) Except as otherwise authorized under this section, a health benefit plan shall not impose any restrictions or delays on the coverage required under this section.

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

(6) If needed, the Division of Medicaid shall submit a State Plan Amendment in accordance with the federal Social Security Act in order to implement this section.

(7) Subsection (2) of this section shall not apply to grandfathered health plans.

SECTION 4. Religious employers. (1) A religious employer may request a health benefit plan contract without coverage for FDA-approved contraceptive methods used for contraceptive purposes that are contrary to the religious employer's religious tenets.

If so requested, a health benefit plan shall be provided without coverage for requested contraceptives. The exclusion from coverage under this provision shall not apply to contraceptive services or procedures provided for purposes other than contraception, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause.

(2) A health benefit plan that contracts with a religious employer to provide a health benefit plan that does not include coverage and benefits for FDA-approved contraceptive methods used for contraceptive purposes shall notify, in writing, upon initial

enrollment and annually thereafter upon renewal, each enrollee that FDA-approved contraceptive methods used for contraceptive purposes are not included in the enrollee's health benefit plan, and of existing programs in Mississippi.

(3) Nothing in this section shall be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within his or her scope of practice, 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.

(4) The Department of Insurance must monitor health benefit plan compliance in accordance with 83-1-101, and may adopt rules for the implementation of this section, including the following:

(a) In addition to any requirements under the Administrative Procedures Act, the department must engage in a stakeholder process prior to the adoption of rules that includes a health benefit plan, pharmacy benefit plans, consumer representatives, including those representing youth, low-income people, and communities of color, and other interested parties. The department shall hold stakeholder meetings for stakeholders of different types to ensure sufficient opportunity to consider factors and processes relevant to contraceptive coverage. The department shall provide notice of stakeholder meetings on the department's website, and stakeholder meetings shall be open to the public.

(b) The department may conduct random reviews of each health benefit plan and its subcontractors to ensure compliance with this section.

(c) The department shall submit an annual report to the Legislature and any other appropriate entity with its findings from the random compliance reviews detailed in paragraph (b) of this subsection and any other compliance or implementation efforts. This report shall be made available to the public on the department's website.

(5) A health care service plan that violates this section is subject to sanctions. The department may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status or any other source.

(6) Nothing in this section shall be construed to require a health care service plan contract to cover experimental or investigational treatments.

SECTION 5. This act shall take effect and be in force from and after July 1, 2024.