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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators Euer, DiMario, Urso, Lauria, Kallman, Valverde, Quezada, Lawson, Mack, and Sosnowski
Date Introduced: February 13, 2025

Referred To: Senate Health & Human Services

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. F.D.A. 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, 2026 shall provide coverage for ~~F.D.A. 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 shall 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 not tolerated by the patient, 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; and

(iii) A plan 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;

(2) Voluntary sterilization procedures;

(3) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; 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 their health savings account under 26 U.S.C. § 223. A health plan 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 in an amount that is less than a twelve (12) month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(c) Except as otherwise authorized under this section, 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.

~~(b)~~(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. The exclusion from coverage under this subsection 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.

~~(c)~~(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.

~~(d)~~(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.

~~(e)~~(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 healthcare services the employer refuses to cover for religious reasons.

~~(f)~~(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 that may be furnished or dispensed all at once or over the course of the twelve (12) month period at the discretion of the prescriber.

(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. A plan that violates this section is subject to penalties, in accordance with § 27-18-20. The office of the health insurance commissioner ("commissioner") may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(k) The commissioner shall monitor plan compliance in accordance with this section and shall adopt rules and regulations for the implementation of this section, including the following:

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

(2) The commissioner shall conduct random reviews of each plan and its subcontractors to ensure compliance with this section.

(3) The commissioner shall submit an annual report to the general assembly and any other appropriate entity with its findings from the random compliance reviews detailed in this section

and any other compliance or implementation efforts. This report shall be made available to the public on the commissioner's website.

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:

27-19-48. 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, 2026 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 shall 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 not tolerated by the patient, 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; and

(iii) A plan 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;

(2) Voluntary sterilization procedures;

(3) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; 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 their health savings account under 26 U.S.C. § 223. A health plan 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 in an amount that is less than a twelve (12) month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(c) Except as otherwise authorized under this section, 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.

~~(b)~~(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.

~~(c)~~(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.

~~(d)~~(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 healthcare services the employer refuses to cover for religious reasons.

~~(e)~~(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 that may be furnished or dispensed all at once or over the course of the twelve (12) month period at the discretion of the prescriber.

(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. A plan that violates this section is subject to penalties, in accordance with § 27-19-38. The commissioner may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(j) The commissioner shall monitor plan compliance in accordance with this section and shall adopt rules and regulations for the implementation of this section, including the following:

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

(2) The commissioner shall conduct random reviews of each plan and its subcontractors to ensure compliance with this section.

(3) The commissioner shall submit an annual report to the general assembly and any other appropriate entity with its findings from the random compliance reviews detailed in this section and any other compliance or implementation efforts. This report shall be made available to the public on the commissioner's website.

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, 2026 in this state 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 shall 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 not tolerated by the patient, 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; and

(iii) A plan 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;

(2) Voluntary sterilization procedures;

(3) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; 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 their health savings account under 26 U.S.C. § 223. A health plan 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 in an amount that is less than a twelve (12) month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(c) Except as otherwise authorized under this section, 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.

~~(b)~~(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 that are contrary to the religious employer’s bona fide religious tenets. The exclusion from coverage under this subsection, 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.

~~(e)~~(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.

~~(d)~~(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 healthcare services the employer refuses to cover for religious reasons.

~~(e)~~(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. that may be furnished or dispensed all at once or over the course of the twelve (12) month period at the discretion of the prescriber.

(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. A plan that violates this section is subject to penalties, in accordance with § 27-20-33. The commissioner may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(j) The commissioner shall monitor plan compliance in accordance with this section and shall adopt rules and regulations for the implementation of this section, including the following:

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

(2) The commissioner shall conduct random reviews of each plan and its subcontractors to ensure compliance with this section.

(3) The commissioner shall submit an annual report to the general assembly and any other appropriate entity with its findings from the random compliance reviews detailed in this section and any other compliance or implementation efforts. This report shall be made available to the public on the commissioner's website.

SECTION 4. Section 27-41-59 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-59. 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, 2026 shall provide coverage for ~~FDA approved contraceptive drugs and devices requiring a prescription; provided,~~ 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 shall 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 not tolerated by the patient, 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; and

(iii) A plan 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;

(2) Voluntary sterilization procedures;

(3) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; 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 their health savings account under 26 U.S.C. § 223. A health plan 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 in an amount that is less than a twelve (12) month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(c) Except as otherwise authorized under this section, 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.

~~(b)~~(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. The exclusion from coverage under this subsection 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.

~~(c)~~(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.

~~(d)~~(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 healthcare services the employer refuses to cover for religious reasons.

~~(e)~~(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 that may be furnished or dispensed all at once or over the course of the twelve (12) month period at the discretion of the prescriber.

(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. A plan that violates this section is subject to penalties, in accordance with § 27-41-21. The commissioner may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(j) The commissioner shall monitor plan compliance in accordance with this section and

shall adopt rules and regulations for the implementation of this section, including the following:

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

(2) The commissioner shall conduct random reviews of each plan and its subcontractors to ensure compliance with this section.

(3) The commissioner shall submit an annual report to the general assembly and any other appropriate entity with its findings from the random compliance reviews detailed in this section and any other compliance or implementation efforts. This report shall be made available to the public on the commissioner's website.

SECTION 5. Chapter 40-8 of the General Laws entitled "Medical Assistance" is hereby amended by adding thereto the following section:

40-8-33. F.D.A. 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, 2026 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 shall 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 not tolerated by the patient, 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; and

(iii) A plan 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;

(2) Voluntary sterilization procedures;

(3) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling; 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 their health savings account under 26 U.S.C. § 223. A health plan 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 in an amount that is less than a twelve (12) month supply, and shall not require an enrollee to make any formal request for such coverage other than a pharmacy claim.

(c) Except as otherwise authorized under this section, 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. The exclusion from coverage under this subsection 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.

(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, 2024, 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 that may be furnished or dispensed all at once or over the course of the twelve (12) month period at the discretion of the prescriber.

(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. A plan that violates this section is subject to penalties, in accordance with § 40-8-9. The executive office of health and human services may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

(j) The executive office of health and human services shall monitor plan compliance in accordance with this section and shall adopt and regulations rules for the implementation of this section, including the following:

(1) In addition to any requirements under state administrative procedures, the executive office of health and human services shall engage in a stakeholder process prior to the adoption of rules and regulations that include health care service plans, pharmacy benefit plans, consumer representatives, including those representing youth, low-income people, and communities of color, and other interested parties. The executive office of health and human services shall hold stakeholder meetings for stakeholders of different types to ensure sufficient opportunity to consider factors and processes relevant to contraceptive coverage. The executive office of health and human services shall provide notice of stakeholder meetings on the executive office of health and human services' website, and stakeholder meetings shall be open to the public.

(2) The executive office of health and human services shall conduct random reviews of each plan and its subcontractors to ensure compliance with this section.

(3) The executive office of health and human services shall submit an annual report to the general assembly and any other appropriate entity with its findings from the random compliance reviews detailed in this section and any other compliance or implementation efforts. This report shall be made available to the public on the executive office of health and human services' website.

SECTION 6. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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This act would require every individual or group health insurance contract effective on or after January 1, 2026, 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.

This act would take effect upon passage.

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