Rep. Laura Fine

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AMENDMENT TO HOUSE BILL 2617

AMENDMENT NO. _____. Amend House Bill 2617, AS AMENDED, with reference to page and line numbers of House Amendment No. 1, on page 5, by replacing line 18 with the following: "changing Section 356z.4 and adding Section 356z.29 as follows:

(215 ILCS 5/356z.4)

Sec. 356z.4. Coverage for contraceptives.

(a)(1) The General Assembly hereby finds and declares all of the following:

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

(B) 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.

(C) The General Assembly intends to build on existing State and federal law to promote gender equity and women's health and to ensure greater contraceptive coverage equity and timely access to all federal Food and Drug Administration approved methods of birth control for all individuals covered by an individual or group health insurance policy in Illinois.

(D) 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.

(2) As used in this subsection (a):

"Contraceptive services" includes consultations, examinations, procedures, and medical services related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

"Medical necessity", for the purposes of this subsection (a), includes, but is not limited to, considerations such as severity of side effects, differences in permanence and reversibility of contraceptive, and ability to adhere to the appropriate use of the item or service, as determined by the attending provider.

"Therapeutic equivalent version" means drugs, devices, or products that can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling and satisfy the following

general criteria:

(i) they are approved as safe and effective;

(ii) they are pharmaceutical equivalents in that they (A) contain identical amounts of the same active drug ingredient in the same dosage form and route of administration and (B) meet compendial or other applicable standards of strength, quality, purity, and identity;

(iii) they are bioequivalent in that (A) they do not present a known or potential bioequivalence problem and they meet an acceptable in vitro standard or (B) if they do present such a known or potential problem, they are shown to meet an appropriate bioequivalence standard;

(iv) they are adequately labeled; and

(v) they are manufactured in compliance with Current Good Manufacturing Practice regulations.

(3) An individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State after the effective date of this amendatory Act of the 99th General Assembly shall provide coverage for all of the following services and contraceptive methods:

(A) All contraceptive drugs, devices, and other products approved by the United States Food and Drug Administration. This includes all over-the-counter contraceptive drugs, devices, and products approved by the United States Food and Drug Administration, excluding male condoms. The following apply:

(i) If the United States Food and Drug Administration has approved one or more therapeutic equivalent versions of a contraceptive drug, device, or product, a policy is not required to include all such therapeutic equivalent versions in its formulary, so long as at least one is included and covered without cost-sharing and in accordance with this Section.

(ii) If an individual's attending provider recommends a particular service or item approved by the United States Food and Drug Administration based on a determination of medical necessity with respect to that individual, the plan or issuer must cover that service or item without cost sharing. The plan or issuer must defer to the determination of the attending provider.

(iii) If a drug, device, or product is not covered, plans and issuers must have an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome on the individual or a provider or other individual acting as a patient's authorized representative to ensure coverage without cost sharing.

(iv) This coverage must provide for the dispensing of 12 months' worth of contraception at one time.

(B) Voluntary sterilization procedures.

(C) Contraceptive services, patient education, and

counseling on contraception.

(D) 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.

(4) Except as otherwise provided in this subsection (a), a policy subject to this subsection (a) shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided. The provisions of this paragraph do not apply to coverage of voluntary male sterilization procedures to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to the federal Internal Revenue Code, 26 U.S.C. 223.

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

(6) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any

successor provision, to defray the cost of any coverage outlined in this subsection (a), then this subsection (a) is inoperative with respect to all coverage outlined in this subsection (a) other than that authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage set forth in this subsection (a).

(b) This subsection (b) shall become operative if and only if subsection (a) becomes inoperative.

An individual or group policy of accident and health insurance amended, delivered, issued, or renewed in this State after the date this subsection (b) becomes operative that provides coverage for outpatient services and outpatient prescription drugs or devices must provide coverage for the insured and any dependent of the insured covered by the policy for all outpatient contraceptive services and all outpatient contraceptive drugs and devices approved by the Food and Drug Administration. Coverage required under this Section may not impose any deductible, coinsurance, waiting period, or other cost-sharing or limitation that is greater than that required for any outpatient service or outpatient prescription drug or device otherwise covered by the policy.

Nothing in this subsection (b) shall be construed to require an insurance company to cover services related to permanent sterilization that requires a surgical procedure.

As used in this subsection (b), "outpatient contraceptive

service" means consultations, examinations, procedures, and medical services, provided on an outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

(c) Nothing in this Section shall be construed to require an insurance company to cover services related to an abortion as the term "abortion" is defined in the Illinois Abortion Law of 1975.

(d) If a plan or issuer utilizes a network of providers, nothing in this Section shall be construed to require coverage or to prohibit the plan or issuer from imposing cost-sharing for items or services described in this Section that are provided or delivered by an out-of-network provider, unless the plan or issuer does not have in its network a provider who is able to or is willing to provide the applicable items or services.

(Source: P.A. 99-672, eff. 1-1-17.)".