HB 1005

Department of Legislative Services

Maryland General Assembly
2016 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 1005 (Delegate Kelly, *et al.*)
Health and Government Operations Finance

Health Insurance - Contraceptive Equity Act

This bill prohibits insurers, nonprofit health service plans, and health maintenance organizations (collectively known as carriers) from applying most copayment or coinsurance requirements for a prescription contraceptive drug or device that is approved by the U.S. Food and Drug Administration (FDA). Carriers, as well as Medicaid and the Maryland Children's Health Program (MCHP), must provide coverage for a single dispensing of a six-month supply of prescription contraceptives with specified exceptions.

The bill takes effect January 1, 2018, and applies to all policies, contracts, and health benefit plans subject to the bill that are issued, delivered, or renewed in the State on or after that date.

Fiscal Summary

State Effect: Medicaid expenditures increase by $1.0 million (90% federal funds, 10% general funds) in FY 2018 to provide a six-month supply of prescription contraceptives beginning January 1, 2018. Federal matching fund revenues increase accordingly. Minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) in FY 2018 from the $125 rate and form filing fee. Review of filings can likely be handled with existing MIA resources. No impact on the State Employee and Retiree Health and Welfare Benefits Program. Future years reflect annualization and inflation.

(in dollars)	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
SF Revenue	-	$0	$0	$0	$0
FF Revenue	$930,600	$1,879,800	$1,898,600	$1,917,600	$1,936,700
GF Expenditure	$103,400	$208,900	$211,000	$213,100	$215,200
FF Expenditure	$930,600	$1,879,800	$1,898,600	$1,917,600	$1,936,700
Net Effect	($103,400)	($208,900)	($211,000)	($213,100)	($215,200)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Potential increase in expenditures for local governments that purchase fully insured health benefit plans.

Small Business Effect: Minimal. Potential increase in health insurance expenditures for small businesses.

Analysis

Bill Summary: Carriers may apply a copayment or coinsurance requirement for a contraceptive drug or device that is therapeutically equivalent to another contraceptive drug or device that is available without a copayment or coinsurance. Carriers, as well as Medicaid and MCHP, are prohibited from requiring prior authorization for certain prescription contraceptive drugs or devices. Carriers must provide coverage for off-formulary prescription contraceptives for adherence purposes, expand access to male sterilization without copayment or coinsurance requirements, and provide coverage for FDA-approved over-the-counter contraceptive drugs.

Six-month Supply of Prescription Contraceptives: Carriers, including Medicaid and MCHP, must provide coverage for a single dispensing of a six-month supply of prescription contraceptives. This requirement does not apply to the first two-month supply of prescription contraceptives dispensed under the initial prescription or any subsequent prescription for a contraceptive that is different than the last contraceptive dispensed. Carriers may provide for a smaller supply if a six-month supply would extend beyond the plan year. Whenever carriers increase the copayment for a single dispensing of a six-month supply of prescription contraceptives, the carriers must proportionately increase the dispensing fee paid to the pharmacist.

Limitations on Prior Authorization: Carriers, as well as Medicaid and MCHP, are prohibited from applying a prior authorization requirement for an intrauterine device (IUD) or implantable rod that is FDA-approved and obtained under a written prescription, unless FDA has issued a black box warning (a warning on the prescription drug or device's label designed to call attention to serious or life-threatening risks).

Applicability: Limitations on prior authorization and copayment or coinsurance requirements for contraceptive drugs and devices do not apply to a health benefit plan that is a grandfathered health plan as defined under the federal Patient Protection and Affordable Care Act (ACA).

Coverage for Contraceptive Off-formulary for Adherence: Each carrier that provides prescription drug coverage must provide a procedure for coverage for a prescription drug

or device that is not in the carrier's formulary if, in the judgment of the authorized prescriber, for a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is medically necessary for the member to adhere to the appropriate use of the prescription drug or device.

Coverage of Male Sterilization: The bill requires carriers that provide hospital, medical, or surgical benefits to groups to provide coverage for male sterilization. This mandate does not apply to a religious organization that requests an exemption. Any carriers that provide coverage for male sterilization must provide such coverage with no copayment, coinsurance, or deductible requirement.

Coverage of Over-the-counter Contraceptive Drugs: Carriers must provide coverage without a prescription for all FDA-approved contraceptive drugs available by prescription and over the counter. Carriers may not apply a copayment or coinsurance requirement for a contraceptive drug dispensed without a prescription that is greater than the copayment or coinsurance requirement for a prescription contraceptive drug. Carriers may only be required to provide point-of-sale coverage of over-the-counter contraceptive drugs at in-network pharmacies and may limit the frequency with which coverage is provided.

Current Law: Under Maryland law, there are 49 mandated health insurance benefits that certain carriers must provide to their enrollees, including coverage for prescription drugs.

Under § 15-826 of the Insurance Article, carriers must provide coverage for any FDA-approved prescription contraceptive drug or device, including coverage for the insertion or removal or any medically necessary examination associated with the use of a contraceptive drug or device. Carriers may not impose a different copayment or coinsurance for a contraceptive drug or device than is imposed for any other prescription. A religious organization may request an exclusion from this coverage if it conflicts with the religious organization's bona fide religious beliefs and practices.

Under § 15-831 of the Insurance Article, each carrier that uses a prescription drug formulary must provide coverage for an off-formulary drug or device if, in the judgment of the authorized prescriber, (1) there is no equivalent drug or device in the formulary or (2) an equivalent drug or device in the formulary has been ineffective or has caused or is likely to cause an adverse reaction or other harm.

Under § 15-824 of the Insurance Article, carriers must permit an insured or enrollee to receive up to a 90-day supply of a maintenance drug in a single dispensing of the prescription. Whenever carriers increase the copayment for a single dispensing of a prescription in a supply in excess of 30 days, the carriers must also proportionately increase the dispensing fee to the pharmacist for the prescription.

ACA requires nongrandfathered health plans to cover 10 essential health benefits (EHBs), which include prescription drugs. Under § 31-116 of the Insurance Article, EHBs must be included in the State benchmark plan and, *not withstanding any other benefits mandated by State law*, must be the benefits required in (1) all individual health benefit plans and health benefit plans offered to small employers (except for grandfathered health plans) outside the Maryland Health Benefit Exchange (MHBE) and (2) all qualified health plans offered in MHBE. Maryland's EHB package requires most health plans to cover vasectomies; however, cost sharing is permitted. Due to the contraceptive coverage requirement under ACA, Maryland's mandate applies essentially only to grandfathered plans.

Under federal guidance regarding implementation of ACA, carriers must cover, without copayments or cost sharing, at least one form of contraception in each of the 18 distinct contraceptive methods identified by FDA. Within each method, carriers may use reasonable medical management techniques and impose cost sharing on some items and services to encourage use of other specific items and services within the chosen contraceptive method. Carriers must have an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on the individual or provider.

Background: According to the U.S. Centers for Disease Control and Prevention (CDC), unintended pregnancy rates remain high in the United States; approximately 50% of all pregnancies are unintended, with higher proportions among adolescent and young women, women who are racial/ethnic minorities, and women with lower levels of education and income. CDC notes that strategies to prevent unintended pregnancy include assisting women and their partners with choosing appropriate contraceptive methods and helping women use methods correctly and consistently to prevent pregnancy.

In 2014, California enacted the Contraceptive Coverage Equity Act, which requires health insurance coverage for the full range of FDA-approved birth control methods, including at least one method in each category without cost sharing.

Based on a systematic review of the evidence, CDC found that the more combined oral contraceptive (COC) pill packs given, up to 13 cycles, the higher the continuation rate. Thus, CDC recommends that health care practitioners provide up to a one-year supply of COCs (*i.e.,* 13, 28-day pill packs). Oregon and the District of Columbia require insurers to cover a 12-month supply of COCs at a time. Similar legislation has been introduced in at least nine states.

State Fiscal Effect: According to the Department of Health and Mental Hygiene (DHMH), although prescribers currently have the discretion to write prescriptions for Medicaid and MCHP enrollees for up to a six-month supply, the majority of prescriptions

are written for a one-month or 28-day supply. DHMH further advises that about two-thirds of enrollees who lose Medicaid or MCHP coverage do not regain that coverage within six months (the remaining one-third typically regain coverage within three months and are covered retroactively).

Thus, Medicaid expenditures increase by as much as $1,033,982 (90% federal funds, 10% general funds) in fiscal 2018, which reflects the bill's January 1, 2018 effective date. This estimate reflects the cost to provide coverage for a six-month supply of prescription contraceptives in a single dispensing to those enrollees who would otherwise lose their Medicaid or MCHP benefits within the six-month period. The information and assumptions used in calculating the estimate are stated below:

- an estimated 18,628 individuals who have already received at least two months of prescription contraceptives will subsequently lose Medicaid or MCHP coverage within five months;
- 6,184 enrollees will lose coverage within one month, requiring coverage of five months of prescription contraceptives not currently covered by DHMH;
- 3,701 enrollees will lose coverage within two months, requiring coverage of four months of prescription contraceptives not currently covered by DHMH;
- 2,798 enrollees will lose coverage within three months, requiring coverage of three months of prescription contraceptives not currently covered by DHMH;
- 2,782 enrollees will lose coverage within four months, requiring coverage of two months of prescription contraceptives not currently covered by DHMH;
- 3,163 individuals will lose coverage within five months, requiring coverage of one month of prescription contraceptives not currently covered by DHMH;
- in total, coverage of 62,845 months of prescription contraceptives not currently covered by DHMH must be provided under the bill;
- the average cost of a prescription contraceptive is $32.58 per month;
- the total annual cost to cover these additional months of prescription contraceptives would be $2,047,490 if in effect in fiscal 2017;
- costs increase by 1% each year;

- the bill takes effect January 1, 2018; therefore, Medicaid costs increase by $1,033,982 to provide coverage for one-half of fiscal 2018; and

- prescription contraceptives are subject to a 90% federal matching rate, and federal matching fund revenues increase accordingly.

This estimate does not reflect any potential impact on prohibiting Medicaid and MCHP from using prior authorization for an IUD or implantable rod that is FDA-approved and obtained under a written prescription, unless FDA has issued a black box warning. The estimate also does not reflect any potential impact from a higher continuation rate of prescription contraceptive usage that may result under the bill. Medicaid expenditures may be offset by savings from a reduction in unintended pregnancies and births.

Future years reflect annualization and inflation.

Additional Information

Prior Introductions: None.

Cross File: SB 848 (Senator Kelley, *et al.*) - Finance.

Information Source(s): *U.S. Selected Practice Recommendations for Contraceptive Use, 2013,* U.S. Centers for Disease Control and Prevention; Department of Budget and Management; Department of Health and Mental Hygiene; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

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