F I S C A L I M P A C T R E P O R T

SPONSOR Armstrong, D/Thomas **ORIGINAL DATE** 2/6/19 **LAST UPDATED** **HB** 89/aHHHC

SHORT TITLE Health Coverage for Contraception **SB**

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		See Fiscal Implications	See Fiscal Implications	See Fiscal Implications	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

See discussion

SOURCES OF INFORMATION

LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
Public School Insurance Authority (PSIA)
Human Services Department (HSD)
Department of Health (DOH)

SUMMARY

Synopsis of Amendment

The House Health and Human Service Committee amendment adds to each section of the act the exclusion of hospital-indemnity-only and limited-benefit plans from the requirement that they cover contraceptive devices and medications.

Synopsis of Original Bill

House Bill 89 requires that New Mexico health insurance policies of all types cover most contraceptive medications and devices free of cost-sharing. Each insurer would be required to have at least one product available within each Federal Drug Administration contraceptive method category; insurers could require cost-sharing for products not preferred within a category, such as brand-name medications when a generic version was available. However, step-therapy or prior authorization would not be permitted for products on an insurance provider's formulary. An appeals process would be made available for any patient denied a product deemed "medically necessary."

Provision of at least six months contraceptive coverage would be required of private plans and twelve months of Medicaid plans.

Religious entities would be exempted from the requirements of this bill: if they so chose, they could purchase health insurance that would deny coverage of contraceptive drugs and/or devices.

Section 1 of the bill applies to group health insurance coverage; Section 2 applies to the Medicaid program; Sections 3 and 5 apply to individual and group health insurance policies, health care plans, and certificates of health insurance providing prescription drug benefits.
Sections 4, 6 and 8 exclude vasectomy and male condoms from coverage under the bill in most circumstances.

Section 7 applies the same requirements to individual and group health maintenance organization contracts. Section 9 repeats the requirements for non-profit health care plans.

In all sections, insurers are prohibited from limiting or imposing cost sharing if a patient decides to change contraceptive method after having prescribed another method that has not yet been exhausted. Medical care providers would not be enjoined to provide a longer prescription than they feel indicated for a given patient.

FISCAL IMPLICATIONS

OSI notes that House Bill 89 contains language similar to that existing in the federal Affordable Care Act (ACA) of 2010, and that there would be minimal changes to the current requirements of health insurers under the bill. OSI further notes that neither the ACA nor House Bill 89 would "apply to non-doctor prescribed male condoms" or vasectomy. OSI continues that "Given the cost-effectiveness of the benefit [contraceptive provision], the actuarial value is a net positive."

Supporting this contention is a study published in the journal Contraception in 2017 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3638200/). The study analyzes cost-effectiveness of various contraceptive methods compared with no method, with lack of an effective method of contraception resulting in the consequences of an unintended pregnancy. . Among the study's findings are that "Any contraceptive method is superior to no method in terms of costs and effectiveness." The cost of providing contraceptives is more than offset by prevention of unfettered and unwanted fertility that results in unintended pregnancy.

Further, the study notes that

> Results at 5 years show that costs of unintended pregnancies reflect the majority (>90%) of the total costs for contraceptive methods that have low effectiveness rates (no method, withdrawal, fertility-awareness-based methods, and the male condom). In contrast, for highly effective methods, such as tubal ligation, vasectomy, the implant, the copper-T IUD, and the LNG-20 IUS, the method or device cost represents the majority of the costs. The copper-T IUD dominated all other methods except the LNG-20 IUS, vasectomy, tubal ligation and the implant (Table 3). However, the implant and tubal ligation cost substantially more than the copper-T IUD, with an ICER of $3,828 and $11,652 per additional percentage point of effectiveness, respectively. Vasectomy and the LNG-20 IUS had better effectiveness than the copper-T IUD but cost only marginally more, with an ICER of $164 and $1,415 per additional percentage point of effectiveness, respectively…

> Differences in method costs, the cost of an unintended pregnancy, and time horizon are important factors that affect the cost effectiveness of contraceptive methods.

OSI notes that "National studies have shown that granting expanded access to family planning to save states money. While there have yet to be comprehensive studies on the impact of the cost-sharing free contraception mandate on state budgets, current research shows that every public dollar spent on family planning results in $7.09 in savings."

SIGNIFICANT ISSUES

OSI makes the following points:

> The legislation requires insurance carriers to reimburse insureds for the cost of OTC contraception methods, such as condoms. Other states, such as Maryland and Illinois, have implemented this program without significant problems. Additionally, Tricare and IHS have required coverage for some forms of OTC contraception without prescription since 2013 without significant issue.
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> National studies have also shown that where individuals who have received a one-year supply of contraceptives were less likely to have a pregnancy (1.2 percent compared with 3.3 percent of women getting three cycles of pills and 2.9 percent of women getting one cycle of pills). Dispensing a 1-year supply is associated with a 30 percent reduction in the odds of conceiving an unplanned pregnancy compared with dispensing just one or three packs, controlling for age, race, or ethnicity, and previous pill use.
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> The language of the appeals section conforms more to processes established by state and federal regulations on exceptions to drug formularies for coverage of off-formulary drugs. Using the phrase "exception" rather than appeals might be warranted.

According to HSD, it "already allows up to a 12-month supply of contraceptives to be dispensed when prescribed by the Medicaid beneficiary's health care provider. This provision was implemented several years ago after determining that a 12-month supply was likely to improve patient compliance, was convenient for patients, and was cost-effective for HSD because it resulted in fewer dispensing fees being paid to pharmacies. Medicaid beneficiaries are already guaranteed freedom of choice to choose or change contraceptives in accordance with federal regulations."

DOH adds considerable information and links to studies showing the importance of contraception and long-duration contraception prescription:

> According to the Centers for Disease Control and Prevention (CDC), nearly half of all pregnancies in the U.S. 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. Unintended pregnancies increase the risk for poor maternal and infant outcomes, and in 2010 resulted in U.S. government health care expenditures of $21 billion. Approximately half of unintended pregnancies are among women who were not using contraception at the time they became pregnant… Strategies to prevent unintended pregnancy include assisting women at risk for unintended pregnancy and their partners with choosing appropriate contraceptive methods and helping them use methods correctly

and consistently to prevent pregnancy" (U.S. Selected Practice Recommendations for Contraceptive Use, 2016, retrieved on 01/03/2019 from https://www.cdc.gov/mmwr/volumes/65/rr/rr6504a1.htm).

The American Congress of Obstetricians and Gynecologists (ACOG) recommends a full year supply of contraceptives be provided to women to prevent unintended pregnancies (January 2015, Access to Contraception); "Other insurance barriers include limits on the number of contraceptive products dispensed. Data show that provision of a year's supply of contraceptives is cost effective and improves adherence and continuation rates. Insurance plan restrictions prevent 73 percent of women from receiving more than a single month's supply of contraception at a time, yet most women are unable to obtain contraceptive refills on a timely basis" (https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Contraception, retrieved on 01/03/2019). Title X (the federally funded program for voluntary family planning projects) already allows for, at a minimum, 13-month coverage for all FDA-approved contraceptive methods. All recipients of New Mexico Department of Health (NMDOH) Family Planning Program services are Title X clients who receive services regardless of ability to pay.

For Title X clients (clients who receive family planning and reproductive health services at low- or no-cost through a network of providers funded by NMDOH), 84 percent of the women who receive services receive some sort of contraceptive method. The most utilized method among female clients is the oral contraceptive (31 percent), followed by the intrauterine device (15 percent), the hormonal implant (11 percent), and the 3-month hormonal injection (10 percent). In the 44 public health offices that offer Title X services, the use of long-acting, reversible contraception is higher: the intrauterine device (17 percent) and the hormonal implant (12 percent) (2017 Family Planning Annual Report, https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf, retrieved on 01/10/2019).

From "Publicly Funded Family Planning Services in the United States," a fact sheet published in September 2016 by the Guttmacher Institute (retrieved from https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states on 01/04/2019), there are 61 million U.S. women in their childbearing years (15–44). About 43 million of them (70 percent) are at risk of unintended pregnancy; they are sexually active and do not want to become pregnant but could become pregnant if they and their partners fail to use a contraceptive method correctly and consistently. Using demographic data from the New Mexico Indicator-Based Information System (https://ibis.health.state.nm.us, retrieved on 01/04/2019), this equates to 397,976 New Mexico women in their childbearing years, with 278,583 being at risk of unintended pregnancy.

Nationally, 83 percent of Black women who are at risk of unintended pregnancy currently use a contraceptive method, compared with 91 percent of their Hispanic and white peers, and 90 percent of their Asian peers. Among women who are at risk of unintended pregnancy, 92 percent of those with incomes of 300 percent or more of the federal poverty level are currently using contraceptives, as are 89 percent of those living at 0–149 percent of the federal poverty level. Publicly funded family planning services help women to avoid pregnancies they do not want and to plan pregnancies they do want. In

2014, these services helped women across the US avoid nearly two million unintended pregnancies, which would likely have resulted in 900,000 unplanned births and nearly 700,000 abortions (Guttmacher Institute, "Publicly Funded Family Planning Services in the United States, September 2016", retrieved from https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states on 01/04/2019).

Reporting from the 2017 Family Planning Annual Report (NMDOH, Family Planning Program) shows that over 26 percent of Family Planning Program female clients are aged 19 years and younger; the most popular method in this age group is the oral contraceptive (36 percent), followed by the 3-month hormonal injection (14 percent), the hormonal implant (13 percent), emergency contraception (8 percent), and the intrauterine device (IUD) (5 percent). Over 6 percent of this age group reported they were pregnant or seeking pregnancy. Almost 25 percent of Family Planning Program clients are teens (19 years and younger). Over 77 percent of Family Planning Program clients identify as Hispanic, regardless of race. Data from the 2018 Family Planning Annual Report will be available in late February.

According to the Health Equity in New Mexico report, 12th edition, the teen birth rate for 15- to 19-year-olds is higher for American Indian/Alaska Natives, Hispanic, and Black/African American teens than for White and Asian/Pacific Islander teens. Also, the teen birth rate for 15- to 19-year-olds (regardless of race) in Border counties (counties that have geography within 60 miles of the US/Mexico border) is higher than for teens (regardless of race) in non-Border counties (https://nmhealth.org/publication/view/report/2045/, retrieved on 01/04/2019).

AMENDMENTS

PSIA suggests considering an amendment to continue to require prior authorization for surgical contraceptive measures to be certain that a given patient is not at risk from that procedure.

LAC/al/sb