CONFIDENTIAL

AHS LEGISLATIVE BILL REVIEW FORM: 2016

Bill Number: H. 620 **Name of Bill:** An act relating to health insurance and Medicaid coverage for contraceptives
Agency/ Dept: Department of Vermont Health Access **Author of Bill Review:** Ashley Berliner, Lindsay Parker

Date of Bill Review: 3/8/2016 **Related Bills and Key Players** Planned Parenthood
Status of Bill: (check one): X Upon Introduction _____ As passed by 1st body _____As passed by both

Recommended Position:

____Support _____Oppose _X_Remain Neutral _____Support with modifications identified in #8 below

Analysis of Bill

1. **Summary of bill and issue it addresses.** *Describe what the bill is intended to accomplish and why.*

This bill proposes to specify the contraceptive products and services that must be included in health insurance plans, and places restrictions on cost-sharing for contraceptive services. It would direct the Department of Vermont Health Access (DVHA) to establish value-based payments for the insertion and removal of long-acting reversible contraceptives (LARC), comparable to those for oral contraceptives.

I. Effective 10/1/2016, the bill requires health insurance plans, as defined by 18 V.S.A. § 9402 and including Medicaid, to:

1. Cover the following:
   a. All contraceptive drugs, devices, and other products for women approved by the FDA, including products available over-the-counter or as prescribed by an enrollee's health care provider.
   b. Voluntary sterilization procedures for men and women.
   c. Patient education and counseling regarding the appropriate use of contraception.
   d. Clinical services associated with providing the aforementioned drugs, devices, products, and procedures, as well as related follow-up services, including management of side effects, counseling for continued adherence, and device insertion and removal.

2. Not impose a deductible, co-insurance, co-payment, or other cost-sharing requirement on the above covered services.

3. Not impose any restrictions or delays on the above covered services.

4. No limitations or restrictions on the above covered services based on an individual's sex assigned at birth, gender identity, or recorded sex or gender with the health insurance plan.

5. Provide coverage for a supply of contraceptives intended to last over a 13-month duration, which may be furnished or dispensed all at once or over the course of the 13 months at the discretion of the health care provider.

II. Effective 7/1/2016, the bill requires DVHA to establish and implement value-based payments to health care providers for the insertion and removal of LARC. The payments must create parity between the fees for insertion and removal of LARC and those for oral contraceptives.

2. Is there a need for this bill? *Please explain why or why not.*

DVHA does not need legislative authority to implement the provisions of this bill. Vermont Medicaid already covers and does not have cost sharing for the services included under the bill. However, an appropriation would be needed in order to finance the cost of the value-based payment rate for LARC.

Per federal law, if a medication, product or device has been FDA-approved, then DVHA is required to cover it.

In order to ensure FFP, Vermont Medicaid can only reimburse for the products that have a National Drug Code (NDC) identifying label and are produced by a manufacturer participating in Medicaid rebate program.

DVHA cannot provide for voluntary sterilization unless the Department complies with 42 CFR § 441 Subpart F. DVHA must utilize the required consent form in Subpart F of that regulation for Medicaid to pay for sterilization. DVHA has no authority to pay for sterilization outside of Medicaid.

3. What are likely to be the fiscal and programmatic implications of this bill for this Department?

Programmatic implications:

- Will require significant staff resources for the following:
  - I. Will require a State Plan Amendment (SPA) to change:
    - Drug supply from 90 days to 13 months.
    - LARC reimbursement methodology.
  - II. Will require an amendment to Medicaid administrative rule 7502.6 to change:
    - Drug supply from 90 days to 13 months.
  - III. Rate changes will subsequently require changes to the Medicaid Management Information System (MMIS). Any changes to MMIS represent new resources (staff time and funds).

Fiscal implications:

I. Increase in LARC reimbursement to value-based rate.

i. Bill language described setting a rate that is value-based, but it does not describe the methodology used to determine the new rate. DVHA is unable to provide a fiscal estimate due to lack of clarity around value-based reimbursement.

For most medical services, DVHA uses Medicare fee schedules and methodologies. However, Medicare does not pay for contraceptives, so without a defined Medicare methodology to use as a framework DVHA currently sets LARC rates

based on a review of invoices submitted by providers or inquires sent from providers to DVHA requesting higher rates, and a review of the annual appropriated budget. DVHA reviews rates for LARC on a regular basis.

Medicaid reimburses for the procedure of LARC insertion in the outpatient setting. The rate for the insertion of LARC by physicians is set using the Resource-Based Relative Value Scale (RBRVS), and is as follows:

LARC Insertion (CPT Code)	Non-Facility Rate	Facility Rate
Insertion of intrauterine device (IUD) (CPT 58300)	$57.97	$42.98
Insertion non-biodegradable drug delivery implant (CPT 11981)	$112.73	$66.02
Average	$85.35	$54.50

ii. Current LARC reimbursement and utilization is as follows:

LARC Products (Codes)	Current Rate for Product	SFY '15 Claims	Current Gross Spend for Product*	Estimated Gross Spend for Insertion∞	Estimated Gross Spend for Product + Insertion$^{\beta}$
Paragard (J7300)	$598.00	199	$119,002	$13,915	$132,917
Skyla (J7301)	$650.32	36	$23,412	$2,517	$25,929
Mirena (J7302, J7298); Liletta (J7297)	$679.93	766	$520,826	$53,563	$574,389
Nexaplanon (J7307)¥	$624.33	479	$299,054	$33,494	$332,548
Total		**1,480**	**$962,294**	**$103,489**	**$1,065,783**

∞ Assumes one insertion per claim.

¥ VT Medicaid reimbursement already includes cost of insertion of this device; unlike other reimbursement for other LARCs, for Nexaplanon insertion is not reimbursed separately.

* There are no dispensing fees.

$^{\beta}$ Represents average of facility and non-facility rates ($69.93 per insertion).

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iii. Estimated fiscal for increased LARC reimbursement and utilization:

The following fiscal estimate is based on DVHA's current reimbursement methodology (not proposed value-based payment), and does not factor the impact of 340b discounts:

	No Change in Utilization		+ 10% Utilization		+ 20% Utilization	
	Annual LARC Spend (Gross)	Additional $ Needed (Gross)	Annual LARC Spend (Gross)	Additional $ Needed (Gross)	Annual LARC Spend (Gross)	Additional $ Needed (Gross)
Current Spend	$1,065,783	$0	$1,172,361	$106,578	$1,278,940	$213,157
5% Rate Increase	$1,119,072	$53,289	$1,230,979	$165,196	$1,342,887	$277,104
10% Rate Increase	$1,172,361	$106,578	$1,289,597	$223,814	$1,406,834	$341,051
20% Rate Increase	$1,278,940	$213,157	$1,406,834	$341,051	$1,534,728	$468,945
40% Rate Increase	$1,492,096	$426,313	$1,641,306	$575,523	$1,790,515	$724,732
60% Rate Increase	$1,705,253	$639,470	$1,875,778	$809,995	$2,046,303	$980,520
80% Rate Increase	$1,918,409	$852,626	$2,110,250	$1,044,467	$2,302,091	$1,236,308
100% Rate Increase	$2,131,566	$1,065,783	$2,344,723	$1,278,940	$2,557,879	$1,492,096

Assumptions that impact fiscal estimate:

1. It would require legislative appropriation to increase rate.

2. A cost that would be off-set with increased utilization of LARC is the reimbursement by DVHA for a physician visit to prescribe an oral contraceptive (Medical code S4993; $20 for visit). However, this cost off-set is not reflected in the above analysis.

3. FQHCs and RHC are cost-based clinics. Hospitals receive a $200 add-on for LARC insertions performed after delivery in addition to the DRG payment. This means that an increase to LARC payment will not impact either of these provider groups.

II. Drug supply from 90 days to 13 months: Further analysis of this proposed change is needed.

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Advantage of increasing drug supply limit: May result in increased Medicaid costs and waste, as Medicaid beneficiaries often churn and many individuals would likely not be eligible for a 13-month consecutive period. Additionally, individuals often repeatedly start and discontinue oral contraceptives and/or change types.

Best practice is to reimburse for oral contraceptives for one month at first time of dispensing, and in three-month increments thereafter.

Disadvantage of increasing drug supply limit: May increase adherence to oral contraceptives and reduce unintended pregnancies. May result in savings from dispensing fees for oral contraceptives.

4. **What might be the fiscal and programmatic implications of this bill for other departments in state government, and what is likely to be their perspective on it?**

Department of Human Resources: This bill requires all health insurance plans to comply with coverage and cost sharing provisions laid out in this bill, which would have an impact on the State Health Insurance Plan administered by the Department of Human Resources.

Vermont Department of Health: VDH will support this bill, as is ensures access across payers to birth control education, services, prescriptions, and LARC in particular. Access to these services and education reduces unintended pregnancies and correlates to decreased costs as a result of fewer unintended pregnancies. Proposals in this bill are also aligned with national guidelines and best practice recommendations (ACOG, AAP, CDC) related to offering a range of contraceptive options to women.

VDH holds that adopting a value-based payment structure that aligns reimbursement with the most effective contraceptive methods is an important strategy to consider supporting, and increasing the use of highly effective contraceptive methods, including LARC. VDH supports that reimbursing providers in a way that aligns with LARCs' value as a cost-effective health intervention will expand access to the most effective contraceptive methods, and help Vermont improve health, reduce costs, and achieve state health care goals. Increasing LARC use by removing barriers is an important strategy to improve pregnancy planning and spacing, and prevent unintended pregnancy.

AHS: Decreases in unintended pregnancies likely would have a cost-savings effect on the whole Agency of Human Services. Cost savings may result from avoidance of direct medical expenditures for Medicaid and from cost avoidance to the human services system, which disproportionately serves families resulting from unintended pregnancies.

5. **What might be the fiscal and programmatic implications of this bill for others, and what is likely to be their perspective on it?** (*for example, public, municipalities, organizations, business, regulated entities, etc)*

Providers will support this bill, as it increases the rate of reimbursement for LARC, ensures comparable coverage across payers, and reduces the administrative burden needed to collect co-payments for services or prescriptions related to coverage under this bill.

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While increasing the reimbursement rate for LARC will be favorable to all providers, providers already receive greater reimbursement for inserting LARC than for prescribing oral contraceptives. Therefore, the argument that LARC reimbursement must be increased to comparable reimbursement for prescribing oral contraceptives *plus* the monthly dispensing fees paid to pharmacies in order to promote use of LARC over oral contraceptives does not make sense. Vermont Medicaid currently reimburse medical providers for prescribing oral contraceptives; this reimbursement is separate and distinct from the reimbursement paid to pharmacists who dispensing oral contraceptives. It is erroneous logic to ask for connecting the two distinct reimbursements, one to medical providers and one to pharmacists, in order to argue for an increase in LARC reimbursement.

6. Other Stakeholders:

6.1 Who else is likely to support the proposal and why?

Advocates and beneficiaries will likely support this bill as it ensures coverage of all FDA-approved methods of birth control by all payers, and eliminates cost sharing for services and prescriptions related to birth control coverage.

Many major professional medical societies and prominent health entities endorse making LARC readily available to women of all ages. CMS and the Children's Health Insurance Program (CHIP) recognize LARC as a critical tool for reducing unintended pregnancies.[1] The American College of Obstetricians and Gynecologists (ACOG) recommends that LARC methods be available to women without unnecessary burdens or delays. ACOG advises providers to offer same-day LARC insertion whenever possible to best meet patients' needs.[2] Both ACOG and the American Academy of Pediatrics (AAP) endorse LARC for teenage women.[3] The World Health Organization includes IUDs and implants on their list of essential medicines.[4] Additionally, both the Centers for Disease Control and Prevention (CDC) and the US Department of Health and Human Services (HHS) recommend LARC as an essential component of quality family planning service provision.[5]

6.2 Who else is likely to oppose the proposal and why?

Opponents of Planned Parenthood and reproductive health access might oppose this bill.

7. Rationale for recommendation: *Justify recommendation stated above.*

Vermont Medicaid currently covers all of the services included in this bill and does not have cost sharing for these services.

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[1] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/maternal-and-infant-health-initiative.pdf

[2] ACOG Committee Opinion Number 450, Increasing Use of Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy, December 2009, Reaffirmed 2011. http://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co450.pdf?dmc=1&ts=20150509T1219029325

[3] Romero L et al. Vital Signs: Trends in Use of Long-Acting Refersible Contraception Among Teens Aged 15-19 Years Seeking Contraceptive Services – United States, 2005-2013. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Vol 64, No 13, April 2015. AND http://pediatrics.aappublications.org/content/early/2014/09/24/peds.2014-2299.full.pdf

[4] http://www.who.int/medicines/publications/essentialmedicines/en/

5 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm

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An appropriation to DVHA would be needed to increase the reimbursement rate of LARC, as required in this bill.

8. **Specific modifications that would be needed to recommend support of this bill**: *Not meant to rewrite bill, but rather, an opportunity to identify simple modifications that would change recommended position.*

DVHA recommends the following modifications to this bill:

- Language must be included that appropriates funding to DVHA for the increased reimbursement of LARC.
- Language that clarifies that Medicaid can only cover products that have National Drug Code (NDC) identifying labels and are produced by manufacturers participating in the Medicaid rebate program, in order to ensure FFP.
- Language that clarifies coverage policies must be in compliance with federal regulation.
- Language to the below provision that clarifies that any Medicaid covered service must be medically necessary.
    - "Not limitations or restrictions on above covered services based on an individual's sex assigned at birth, gender identity, or recorded sex or gender with the health insurance plan."
- Language that modifies the requirement of a 13-month drug supply to a 12-month supply.

9. **Gubernatorial appointments to board or commission?**

No.

Secretary/Commissioner has reviewed this document: _____ ***Date:*** 3-8-16

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