

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, Addie Strumolo

Date of Bill Review: 5/5/2016 Related Bills and Key Players Planned Parenthood

Status of Bill: (check one): ☐ Upon Introduction ☐ As passed by 1st body ☒ As passed by both

Recommended Position:

☒ Support ☐ Oppose ☐ 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 specifies the contraceptive products and services that must be included in health insurance plans, and places restrictions on cost-sharing for contraceptive services. It directs the Department of Vermont Health Access (DVHA) to provide coverage for a supply of prescription contraceptives intended to last over a 12-month duration and 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:
 - Provide coverage for a supply of contraceptives intended to last over a 12-month duration, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider.
- II. Effective 10/1/2016, 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.
 - \$34,864.00 in Global Commitment funds is appropriated to DVHA in fiscal year 2017 for the purposes of increasing reimbursement rates for long-acting reversible contraceptives.

The bill additionally requires Qualified Health Plans (QHP) to allow for the enrollment of a pregnant individual, and of any individual who is eligible for coverage under the terms of the health benefit plan because of a relationship to the pregnant individual, at any time after the commencement of the pregnancy. Coverage is effective as of the first of the month following the individual's selection of a QHP.

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

LARC

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DVHA does not need legislative authority to implement the provisions of this bill. DVHA can increase reimbursement for LARC and provide a 12 month supply of contraceptives through an amendment to Vermont's Medicaid State Plan and without legislative authority.

Pregnancy SEP

Yes. If the State wants to make pregnancy a triggering event for a special enrollment period, legislation is necessary. There is no authority for the establishment of this SEP under federal law; rather, CMS has indicated that "a state may establish additional special enrollment periods to supplement those described in this section as long as they are more consumer protective than those contained in this section and otherwise comply with applicable laws and regulations."¹

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

LARC

Programmatic implications:

- Will require staff resources for the following:
 - I. Will require a State Plan Amendment (SPA) to change:
 - Drug supply from 90 days to 12 months.
 - LARC reimbursement methodology.
 - II. Will require an amendment to Medicaid administrative rule 7502.6 to change:
 - Drug supply from 90 days to 12 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:

- Increase in LARC reimbursement to value-based rate.
 - a. 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 that speaks to a value-based reimbursement, but rather one that reflects a 20% increase to the current rate of reimbursement for the LARC product (not insertion):

Estimated Net Fiscal Impact of 20% LARC Rate Increase

- \$341,051 (20% LARC rate increase)
- \$306,187 (savings from additional 5% reduction in unintended pregnancies)
- \$34,864 (gross/annualized)**

SFY 17 additional appropriation needed (assumes 10/1/16 effective date): \$26,148 (gross)

SFY 18 appropriation: \$34,864 (gross)

Fiscal Estimate for Outpatient LARC

\$341,051 gross/annualized

SFY 17 (assumes 10/1/16 effective date): \$255,788 (gross)

¹ 78 FR 42160, 42264.

Proposed rate increase for LARC product: 20%

Estimated utilization increase: 10%

Increased utilization is presumed as a result of increased promotion and awareness of LARC.

Estimated total expenditure on Outpatient LARC, with 20% rate and 10% utilization increase:

	No Change in Utilization		+ 10% Utilization	
	Annual LARC Spend (Gross)	Additional \$ Needed (Gross)	Annual LARC Spend (Gross)	Additional \$ Needed (Gross)
Current Annual Gross Spend on LARC	\$1,065,783	\$0	\$1,172,361	\$106,578
20% Rate Increase	\$1,278,940	\$213,157	\$1,406,834	\$341,051

Total Savings

\$2,681,187 gross/SFY18

\$2,681,187 in Medicaid savings assumes a 30% reduction in unintended pregnancies the promotion of LARC in both inpatient and outpatient settings.

\$2,681,187 in cost savings includes:

1. Savings already booked in BAA* (\$2,375,000 gross) for increasing post-partum inpatient DRG with an add payment to promote and capture post-partum contraceptive intervention.
 - a. This savings assumed a 25% reduction in unintended pregnancies
2. Savings associated with H.620's additional promotion of LARC in outpatient settings through a rate increase.
 - a. Assumes an additional 5% reduction in unintended pregnancies.

* It is anticipated that LARC promotion in the outpatient setting will effect savings achieved through the inpatient setting, but DVHA estimated a combined savings of \$2,681,187 between the promotion of LARC in both settings.

Assumptions that impact fiscal estimate:

1. 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.
 2. 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.
- Drug supply from 90 days to 13 months: Further analysis of this proposed change is needed.

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Disadvantages 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 12-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.

Advantage 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.

Pregnancy SEP

The programmatic impact of offering an SEP for pregnancy includes:

- Operational resources to develop business processes for enrolling a household pursuant to this qualifying event
- Operational resources to perform the enrollment including documentation of pregnancy
- IT development to add this qualifying event to the VHC portal application
- Policy resources to draft rules related to this SEP including required documentation of pregnancy; emergency rulemaking will be considered
- Outreach and education regarding the availability of the SEP

While this SEP is budget neutral, allowing customers to come into coverage when they will incur medical expenses (as opposed to during open enrollment) could adversely impact QHP premium rates. QHP issuers must file their 2017 rates in June. QHP issuers may take this additional qualifying event into consideration in this year's rate proposals. The impact could instead be felt in a later plan year after some experience with this enrollment period. Impact on the risk pool is one of the reasons that pregnancy is not a triggering event for an SEP under federal law.² At the same time, the number of potential uninsured pregnant women in Vermont who are over income for Medicaid and who do not have employer sponsored insurance is small.

Finally, DVHA believes it is important to require documentation of the pregnancy in order to qualify for this SEP. While not explicitly required under federal law, recent guidance suggests that exchanges should routinely verify eligibility for SEPs. The originally-proposed bill text, which was based on a New York statute, included a certification requirement. This requirement will need to be established in rulemaking and operationalized by VHC.

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?

² See 78 FR 42160, 42264 ("[C]urrent special enrollment periods ... appropriately account for changes in circumstances that necessitate when individuals would need to select a new or different QHP and balance these needs with considerations regarding the risk pool," in response to comment requesting establishment of additional SEP triggering events, including pregnancy.)

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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 it 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.

QHP Issuers did not oppose the pregnancy SEP, but will likely need to analyze the potential actuarial impact. Republican lawmakers asked about risk pool implications on the House floor, but no changes were made.

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

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as a critical tool for reducing unintended pregnancies.³ 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.⁴ Both ACOG and the American Academy of Pediatrics (AAP) endorse LARC for teenage women.⁵ The World Health Organization includes IUDs and implants on their list of essential medicines.⁶ 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.⁷

Advocates will support the pregnancy SEP and availability of coverage to pregnant women and their families.

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.

An appropriation to DVHA was added to increase the reimbursement rate of LARC.

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.*

AOA and DVHA previously provided language for this bill that included a medical certification requirement in order to use this SEP. Because the State's language was not used, a certification requirement should be implemented through rulemaking.

9. Gubernatorial appointments to board or commission?

No.

Secretary/Commissioner has reviewed this document:

 Date: 5-5-16

³ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/maternal-and-infant-health-initiative.pdf>

⁴ 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>

⁵ Romero L et al. Vital Signs: Trends in Use of Long-Acting Reversible 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>

⁶ <http://www.who.int/medicines/publications/essentialmedicines/en/>

⁷ <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>

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