

California Health Benefits Review Program

Analysis of California Senate Bill (SB) 999 Contraceptives: Annual Supply

A Report to the 2015-2016 California State Legislature

March 28, 2016



Key Findings:

Analysis of California Senate Bill (SB) 999

Contraceptives: Annual Supply

Summary to the 2015-2016 California State Legislature, May 2016



AT A GLANCE

Senate Bill SB 999 would require DMHC-regulated plans or CDI-regulated policies to cover a 12-month supply of Food and Drug Administration (FDA) approved, self-administered hormonal contraceptives dispensed at one time to an enrollee, either as prescribed or at the enrollee's request.

- **Enrollees covered.** CHBRP estimates that in 2016, 25.2 million Californians have state-regulated coverage that would be subject to SB 999.
- **Impact on expenditures.** CHBRP estimates that total net annual expenditures would decrease by \$42,799,000 or 0.03% for enrollees with DMHC-regulated plans and CDI-regulated policies. Savings are attributed to prevented unintended pregnancies as a result of access to a longer supply of self-administered hormonal contraceptives and fewer office visits.
- **Essential Health Benefits.** SB 999 does not constitute a new benefit but rather, alters the terms and conditions (i.e., supply dispensed) of an existing benefit (coverage for self-administered hormonal contraceptives). SB 999 does not exceed essential health benefits (EHBs).
- **Medical effectiveness.** There is a preponderance of evidence to indicate that dispensing oral contraceptives in larger quantities leads to a reduction in unintended pregnancy and related outcomes.
- **Benefit coverage.** CHBRP estimates that coverage for an annual supply of self-administered hormonal contraceptives (including oral contraceptive pill, patch, and ring) would increase from 0% to 100% of enrollees of DMHC-regulated plans and CDI-regulated policies.
- **Utilization.** Postmandate, CHBRP estimates that the number of active self-administered hormonal contraceptive prescriptions will remain the same, but more women will receive a 12-month supply at once. Office visits are expected to decrease.
- **Public Health.** As a result of SB 999, CHBRP estimates a decrease in unintended pregnancies of 15,000 (which includes 6,000 fewer live births, 2,000 fewer miscarriages, and 7,000 fewer abortions).
- **Long-term impacts.** CHBRP projects that SB 999 would result in a decrease in the rate of unintended pregnancies and abortions over the long term, resulting in a corresponding decrease in the risk of maternal mortality, adverse child health outcomes, behavioral problems in children, and negative psychological outcomes associated with unintended pregnancies for both mothers and children. Avoiding unintended pregnancies also helps women to delay childbearing and pursue additional education, spend additional time in their careers, and have increased earning power over the long term.

BILL SUMMARY

SB 999 (introduced January 2016) would require DMHC-regulated plans or CDI-regulated policies issued, amended, renewed or delivered on or after January 1, 2017, to cover a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time to an enrollee. This includes the oral contraceptive pill, the vaginal ring, and the contraceptive patch. A 12-month supply may be dispensed either as prescribed or at the enrollee's request. Unless the prescribing provider specifies "no change to quantity" on the enrollee's prescription, the enrollee may request up to a 12-month supply from their pharmacy.

INCREMENTAL IMPACT OF SENATE BILL (SB) 999

Benefit Coverage, Utilization, and Cost

Coverage Impacts

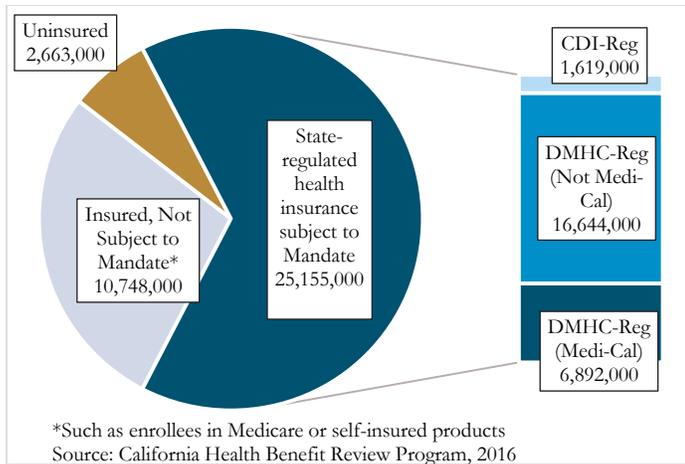
Out of the 25.2 million enrollees in DMHC-regulated plans and CDI-regulated policies subject to state mandates, all would be subject to SB 999, as the bill does not exempt any group (Figure 1). However, Medi-Cal already has a policy in place that allows enrollees to receive a 12-month supply at one time of oral contraceptives (but not the ring or patch). Premandate, 27% of enrollees have coverage that is partially compliant with this proposed bill, and 0% of enrollees have coverage that is fully compliant with SB 999.

Based on 2013 and 2014 MarketScan claims data, 744,000 California women aged 15 to 44 years subject to SB 999 (3.2% of enrollees) have active prescriptions for self-administered hormonal contraceptives. In this group:

- 67% (500,000) receive their contraceptives in a 1-month supply per refill;
- 32% (240,000) receive their contraceptives in a 3-month supply per refill;

- 0.6% (5,000) receive their contraceptives in a 12-month supply at one time.

Figure 1. Health Insurance in CA and SB 999



Utilization Impacts

Postmandate, CHBRP estimates that the number of active self-administered hormonal contraceptive prescriptions will remain the same as prior to the mandate. It is important to note that one prescription may be used to dispense several refills. For example, a prescription valid for one year may be used to dispense four 3-month supplies throughout the year or one 12-month supply at one time. A prescription for self-administered hormonal contraceptives is typically valid for one year.

Based on evidence from the research literature, CHBRP estimates that the enrollee population that has self-administered hormonal contraceptive prescriptions would have them filled in the following distribution:

- 185,000 would choose to receive 1 month at a time;
- 275,000 would choose to receive 3 months at a time;
- 285,000 would choose to receive 12 months at one time.

Cost Impacts

CHBRP estimates that SB 999 would decrease total net annual expenditures by \$42,799,000 or 0.03% for enrollees with DMHC-regulated plans and CDI-regulated

policies (see Table 1). This estimate includes anticipated savings in 2017 from reduced unintended pregnancies (subsequent reduced delivery, miscarriage, and abortion costs), and the reduced office visits in the first year postmandate.

The mandate is expected to impact premiums in the following ways:

- Privately funded DMHC-regulated plans: range from a decrease of \$0.08 PMPM in the small-group market to a decrease of \$0.11 PMPM in the large-group market for 2017;
- CDI-regulated policies: range from a decrease of \$0.08 PMPM in the small-group market to a decrease of \$0.13 PMPM in the individual and large-group markets in 2017;
- Publicly funded DMHC-regulated plans: CalPERS HMO premiums will decrease by \$0.26 PMPM. Medi-Cal managed care plans will not have any cost impacts.

Average enrollee out-of-pocket expenses would decrease for all insured populations, with the exception of Medi-Cal beneficiaries, who would have no change. The decreases range from \$0.15 PMPM in small-group markets (both DMHC-regulated plans and CDI-regulated policies) to \$0.32 PMPM for CalPERS enrollees.

Public Health

Unintended Pregnancy

Obtaining a 12-month supply of self-administered hormonal contraceptives at one time reduces the potential for delays in refills between cycles. Consistent, continuous contraceptive use helps to prevent any extension of the usual hormone-free interval; extension of this interval results in an increased possibility of unintended pregnancy.

As a result of SB 999, CHBRP estimates that:

- Unintended pregnancies would decrease by 15,000 (which includes 6,000 fewer live births, 2,000 fewer miscarriages, and 7,000 fewer abortions).

The reduction in unintended pregnancies will also result in a reduction in negative health outcomes associated with unintended pregnancy, including delayed prenatal care, low birth weight, and preterm birth.

Risks and Harms of Increased Supply of Contraceptives Dispensed at One Time

There is no evidence to suggest that there would be any difference in health risks for women receiving a 1-month or 3-month supply versus a 12-month supply of self-administered hormonal contraceptives other than the increased risk of unintended pregnancy among the women in the 1-month and 3-month groups as described elsewhere in this report. This analysis did not find evidence to indicate any potential health risks or harms of having a larger supply of self-administered hormonal contraceptives available to a patient.

Medical Effectiveness

There is clear and convincing evidence that self-administered hormonal contraceptives are effective in preventing pregnancy. There is also clear and convincing evidence to suggest that unintended pregnancy leads to a decrease in prenatal care and breastfeeding.

However, fewer studies examine the effect of the amount of dispensed supply of self-administered hormonal contraceptives, the primary impact of SB 999. There is a preponderance of evidence from studies with moderate research designs that conclude that dispensing oral contraceptives in larger quantities leads to a reduction in unintended pregnancy and related outcomes. There was no known literature on the impact of dispensing patterns for vaginal ring and contraceptive patch.

Two studies were conducted examining data on women receiving oral contraceptive pills through the California Family PACT (Planning, Access, Care and Treatment) Program to compare pregnancy rates between women given a 12-month supply to those given a 1- or 3-month supply (Foster et al., 2011; Foster et al., 2006b).

The results indicated that women who were given a 12-month supply had reduced rates of unintended pregnancy (1.2% of women who received a 12-month supply and 3.3% of women who received a 3-month supply) (Foster et al., 2011). There was an associated 30% decrease in the odds of having an unintended pregnancy, as well as a 46% decrease in the odds of an abortion when dispensing

a 12-month supply compared to dispensing 1- or 3-month supplies (Foster et al., 2011).

Long-Term Impacts

Unintended Pregnancy and Abortion

The reductions in unintended pregnancies and resulting abortions estimated in year one postmandate are likely to persist over time. CHBRP estimates that passage of SB 999 may result in a decrease in the rate of unintended pregnancies and abortion in the long term, and thus substantial long-term cost reductions.

Maternal Mortality and Child Health Outcomes

In the long term, assuming that SB 999 increases utilization of a 12-month supply of self-administered hormonal contraceptives beyond the first year postmandate, there may be a decrease in the rate of unintended pregnancies, thereby decreasing the risk of maternal mortality. A decrease in the rate of unintended pregnancies would also decrease the risk of poor child health outcomes for children born from unintended pregnancies.

CONTEXT FOR BILL CONSIDERATION

Essential Health Benefits and the Affordable Care Act

SB 999's requirements regarding a 12-month supply of FDA-approved, self-administered hormonal contraceptives would not alter the benefit coverage requirements, only the permitted supply dispensed at one time. Therefore, SB 999 does not exceed EHBs, and would not trigger the ACA requirement that the state defray the cost of additional benefit coverage for enrollees in qualified health plans (QHPs) in Covered California.