A STUDY OF NEW JERSEY ASSEMBLY BILL 4503

EXPANDS REQUIREMENT FOR HEALTH INSURERS TO COVER PRESCRIPTIONS FOR CONTRACEPTIVES TO 12 MONTHS

New Jersey Mandated Health Benefits Advisory Commission

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INTRODUCTION

The New Jersey Mandated Health Benefits Advisory Commission (MHBAC) has been asked to review A-4503, which would expand the requirement for health insurers that provide coverage for prescription drugs to cover dispensing of prescription female contraceptives to 12 months from the current requirement of 6 months. The bill would apply to hospital, medical and health service corporations, commercial, individual, small employer and group health insurers, health maintenance organizations, prepaid prescription service organizations, and the State Health Benefits Program. The bill would not apply to those on Medicaid or to those who are currently uninsured.

A-4503 amends current law: P.L. 2017, c.241. It specifies that

> "The coverage provided shall include prescriptions for dispensing contraceptives for (a) a three-month period for the first dispensing of the contraceptive; and (b) a 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a 12-month period, if a 12-month period would extend beyond the term of the contract."[i]

The Mandated Health Benefits Advisory Commission Act (N.J.S.A. 17B:27D-1) tasks the Commission with providing an independent analysis of the social, medical, and financial impact of proposed legislation referred to it for review. The MHBAC prepared this report using its own resources, including staff from the New Jersey Department of Banking and Insurance. Commission members contributed their professional expertise, on a voluntary basis, in helping to shape the presentation of this report, analyzing published research, and drafting and editing its various sections.

SOCIAL IMPACT:

This section examines the social impact of extending the mandate for health insurers to cover female prescription contraception from the current 6 months to 12 months. Among the social consequences the MHBAC is asked to address under its enabling statute is *the extent to which insurance coverage for the proposed mandated health benefit already exists or, if no coverage exists, the extent to which the lack of coverage results in inadequate health care or financial hardship for the affected population of New Jersey*.

Existing coverage requirements for female contraception in New Jersey is the product of two state laws and one federal law. In 2004, New Jersey first mandated coverage for prescription female contraceptives, including any drug or device used for contraception by a female so long as it was approved by the federal Food and Drug Administration for that purpose.[ii] The law provided for exemptions for religious employers.

In 2010, the Federal Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. ("ACA"), further mandated coverage of prescription contraceptives and also provided that such coverage *must be without any cost-sharing*, with exemptions for religious organizations.[iii] The ACA does not specify the number of months in a year that must be covered (i.e., the number of refills that must be issued upon initiation of contraceptive prescriptions).

In 2017, New Jersey amended existing New Jersey law to mandate coverage for dispensing contraceptives for up to six months. So, in addressing the social impact, our finding is that coverage for female contraception under state and federal law is already mandated and coverage is without any cost sharing. The difference between existing coverage and that proposed by the bill is not a difference in coverage, but rather a difference in the duration of the permissible prescribing period: existing law requires coverage of a prescription of up to six months, while A-4503 requires coverage of a prescription of up to 12 months.

In 2016, only 8% of the New Jersey population was not covered by some form of health insurance.[iv] These were people, not eligible for employer-based plans, Medicaid/FamilyCare or Medicare, who could not afford or did not seek coverage under individual plans. Without coverage, under the individual mandate requirements of ACA, in 2016, 132,800 people paid a penalty totaling $111,600,000.[v] In 2017, this population paid an average of $675/individual adult or $2100/family in annual tax penalties.[vi]

Regardless of health care coverage, women of reproductive age, defined by the Centers for Disease Control and Prevention (CDC) as those between ages 15-44,[vii] can only fill prescriptions for birth control up to the limit specified by the prescriber. In New Jersey, as noted above, current law (P.L. 2017, c. 241) requires that initial prescriptions for contraception be covered for 3 months and that subsequent prescriptions be covered for a subsequent 6 months.[viii]

The CDC includes contraception among the ten greatest public health achievements of the 20th century.[ix] Among the benefits to women and families attributed by social scientists to contraception are:

-Reduced anxiety related to unintended pregnancy
-Control over spacing of children
-Increased likelihood that women will complete high school, undergraduate and postgraduate educational programs
-Increased ability of women to enter and remain in the workforce, and contribute to the economic strength of their families
-Reduced gender gaps in pay
-Improved relationships and longer marriages
-Improved health related to decreased morbidity and mortality associated with pregnancy, reduced rates of ovarian cancer, and reduction of menstrual disorder-related symptoms.[x]

The MHBAC enabling statute also requires an analysis of "the demand for the proposed mandated health benefit from the public and the source and extent of opposition to mandating the

health benefit." Consumer demand is difficult to evaluate. Support for the legislation seems to be driven by practice and prescribing recommendations from the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Control and Prevention. Opposition comes from the payer community, which is concerned generally about the cost impact of contraceptive supply wastage, which was also reflected in Governor Christie's conditional veto of legislation from the last session.

MEDICAL EVIDENCE

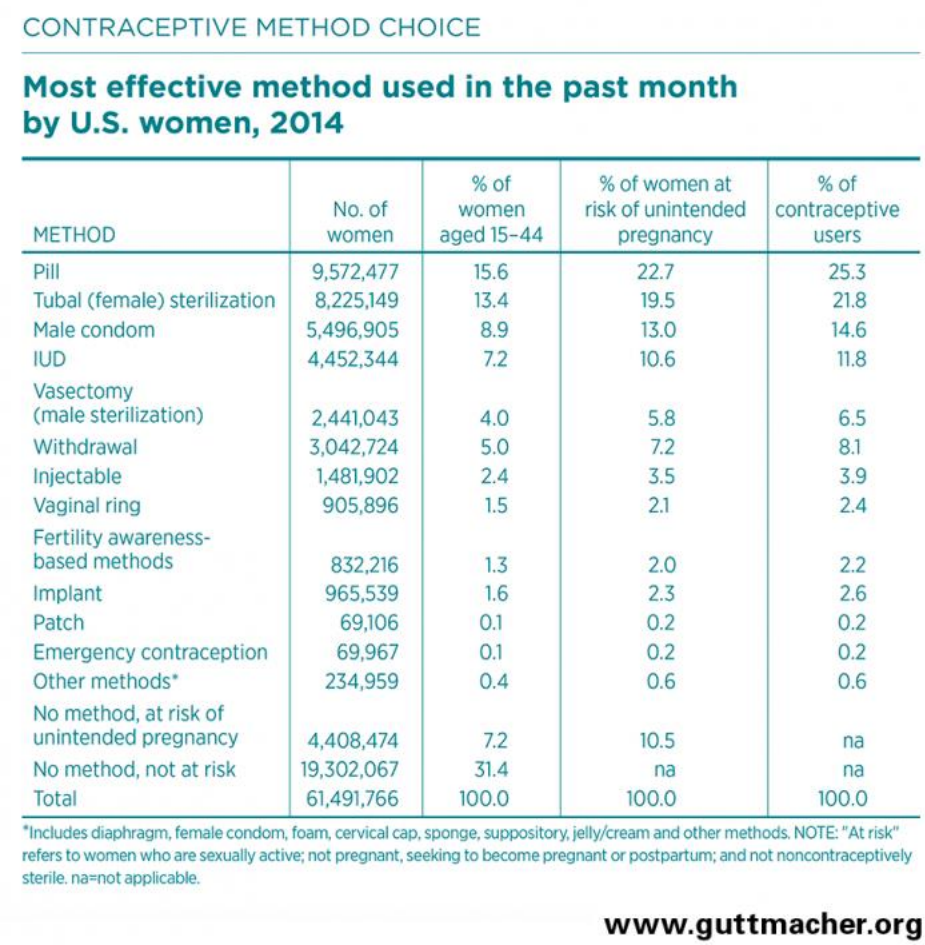
The reality is stark: Among the 61 million American women of childbearing age (15-44), 45% of them will have had an unintended pregnancy by age 45; half the number of pregnancies in the United States each year are unintended, numbering about 3 million.[xi] In New Jersey, in 2015, the highest rates of unintended pregnancy were in women under age 20 (50.7%); the next highest rates were in those age 20-24 (47.6%). Other characteristics associated with higher rates of unintended pregnancy in New Jersey were those with 12 or fewer years of education, non-Hispanic black ethnicity and being on Medicaid (46.9%), followed by those with no insurance (25.9%).[xii]

When contraception is used correctly and consistently, it is very likely to succeed in the goal of preventing unintended pregnancy.

> Among U.S. women at risk of unintended pregnancy, the 68% who use contraception consistently and correctly throughout the course of any given year account for only 5% of all unintended pregnancies; in contrast, the 18% who use contraception inconsistently account for 41% of unintended pregnancies, and the 14% who do not use contraceptives at all or have a gap in use of at least one month account for 54% of unintended pregnancies.[xiii]

Prescription contraception varies in efficacy relative to perfect-use or typical-use, and depending upon the nature of the contraceptive. Perfect-use is a term applied by researchers to those who use the contraceptive method consistently and correctly; typical-use applies to real-world rates of effectiveness, where users may use a method incorrectly or inconsistently. When no method of contraceptive is used, a woman's annual risk of pregnancy is 85%.[xiv] Long acting contraceptives (e.g., intrauterine devices and hormonal implants) are the most effective contraceptives: perfect-use and actual-use being virtually the same at 99%, since there is little chance for user error. While both contraceptive pills and injectables have a perfect-use rate of 99%, their typical-use rates fall to 93% (pill) and 96% (injectable). Male condoms have a perfect-use rate of 98% but a typical-use rate of 88%.[xv] (See Table 1.)

Table 1.



CONTRACEPTIVE METHOD CHOICE

Most effective method used in the past month by U.S. women, 2014

METHOD	No. of women	% of women aged 15–44	% of women at risk of unintended pregnancy	% of contraceptive users
Pill	9,572,477	15.6	22.7	25.3
Tubal (female) sterilization	8,225,149	13.4	19.5	21.8
Male condom	5,496,905	8.9	13.0	14.6
IUD	4,452,344	7.2	10.6	11.8
Vasectomy (male sterilization)	2,441,043	4.0	5.8	6.5
Withdrawal	3,042,724	5.0	7.2	8.1
Injectable	1,481,902	2.4	3.5	3.9
Vaginal ring	905,896	1.5	2.1	2.4
Fertility awareness-based methods	832,216	1.3	2.0	2.2
Implant	965,539	1.6	2.3	2.6
Patch	69,106	0.1	0.2	0.2
Emergency contraception	69,967	0.1	0.2	0.2
Other methods*	234,959	0.4	0.6	0.6
No method, at risk of unintended pregnancy	4,408,474	7.2	10.5	na
No method, not at risk	19,302,067	31.4	na	na
Total	61,491,766	100.0	100.0	100.0

*Includes diaphragm, female condom, foam, cervical cap, sponge, suppository, jelly/cream and other methods. NOTE: "At risk" refers to women who are sexually active; not pregnant, seeking to become pregnant or postpartum; and not noncontraceptively sterile. na=not applicable.

www.guttmacher.org

Many factors, both internal and external, influence a woman's ability to successfully use contraception to avoid pregnancy. Among the internal factors which have been studied are: self-esteem,[xvi] self-efficacy,[xvii] and sexual assertiveness.[xviii] The importance of these internal factors are, however, outside the scope of this report, because A-4503 is specifically focused on those external factors that have been repeatedly shown to be associated with successful contraception: access and cost.[xix, xx]

Because the efficacy of contraception depends to such an extent on the consistency of its use, organizations like the American College of Obstetricians and Gynecologists (ACOG) urge that women be provided with between 3- and 13-months of contraception at the time contraception is initiated.[xxi] Women lead busy lives and they travel. A 2016 analysis of a California bill authorizing pharmacists in that state to distribute 12-month supplies of hormonal contraceptives and requiring insurance to cover the cost found that such an expansion in provider access could reduce "unwanted gaps in use." The analysis stated, "Inconsistent supplies of birth control are problematic for many women who have unpredictable work hours, difficulty accessing transportation, or other barriers preventing them from accessing a provider, pharmacy or clinic, in a timely manner."[xxii] When contraceptive use is interrupted by an insufficient supply or lack of access to an oral, injectable, or mechanically applied method, it puts women at risk of pregnancy.

Foster and her colleagues examined over 84,000 women using oral contraceptives dispersed in 1-month, 3-month, or 12-month supplies by the California Family Planning Program. The investigators found that, "Dispensing a 1-year supply is associated with a 30% reduction in the odds of conceiving an unplanned pregnancy compared with dispensing just one or three packs…and a 46% reduction in the odds of an abortion".[xxiii] Foster and her colleagues noted that women who received the 1-year supply of oral contraceptives were significantly more likely to continue using them, compared to women who received 1-month or 3-month supplies. This, in part, was explained by the women receiving the 1-year supply of oral contraceptives being less likely to switch contraceptive methods compared to the other oral contraceptive users. The authors concluded, "Health insurance programs…may avert costly unintended pregnancies by increasing dispensing limits on oral contraceptives to a 1-year supply."[xxiv] The authors also found no discernible differences in health risks among women using oral contraceptives with 1-month, 3-month, or 12-month supplies.[xxv]

The Foster *et al.* study should be read with a couple of caveats. The data come from 2006, more than 10 years ago, when cost sharing was a consideration for women pondering the use of oral contraceptives. Such cost sharing concerns no longer apply, within the dispensing durations mandated by state law. The women in the study were grouped by the quantity of oral contraceptives they received at one time. These groupings were not random, and it is possible that the women who received a 1-year supply of oral contraceptives were more motivated to continue using the method or more motivated to avoid pregnancy than other women in the study. Finally, it is possible that the care providers staffing the sources of the 1-year supplies of oral contraceptives in the study (e.g., a Planned Parenthood clinic, a student health clinic, etc.) provided better contraceptive counseling, which had an influence on observed pregnancy rates, than the contraceptive counseling that was provided by the providers and pharmacies more likely to have provided the 1-month or 3-month supplies of oral contraceptives. Any or all of these factors could have had an influence on the results described in the study above.

The Centers for Disease Control and Prevention weighed in with specific prescribing recommendations, based on an exhaustive review of the medical literature. In its **US Selected Practice Recommendations for Contraceptive Use, 2016**, the CDC advised

- At the initial and return visits, provide or prescribe up to a 1-year supply of [oral contraceptives] (e.g., 13 28-day pill packs), depending on the woman's preferences and anticipated use.
- A woman should be able to obtain [oral contraceptives] easily in the amount and at the time she needs them.[xxvi]

OTHER STATES

To date, 17 states and the District of Columbia have passed laws expanding the dispensing of prescriptions for contraceptives to a 12-month supply, with the specific details of the prescriptions left to the discretion of the contraceptive user and her provider. (See Table 2.)

Table 2. States that Have Passed Laws Extending the Dispensing of Prescription Contraceptive Methods to a Twelve-Month Supply and Year of Enactment

State	Year
California	2016
Colorado	2017
Connecticut	2018
Delaware	2018
District of Columbia	2015
Hawaii	2016
Illinois	2016
Maine	2017
Maryland	2018
Massachusetts	2017
Nevada	2017
New Hampshire	2018
New York	2017
Oregon	2016
Rhode Island	2018
Vermont	2016
Virginia	2017
Washington	2017

Sources: https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives (May 1, 2019); https://powertodecide.org/system/files/resources/primary-download/extended-supply-contraception.pdf (August 2018)

On the other hand, in 2018 Wisconsin and Idaho voted down legislation that would have extended the dispensing of contraceptives to a 12-month supply.

DISCUSSION

In keeping with the ACOG recommendations, detailed above, New Jersey Legislators passed A-2297/S-659 in 2017, which became current law, P.L. 2017, c.241. When earlier versions of those bills were open to public testimony, in 2016, opponents included: The New Jersey Association of Health Plans (NJAHP), New Jersey Business and Industry Association (NJBIA), the New Jersey Association of Underwriters, and the League of American Families. Supporters included: The Medical Society of New Jersey, New Jersey League of Jewish Women, Planned Parenthood Federation, National Organization of Women, The American Civil Liberties Union, New Jersey Family Planning League and Rite Aid.

In written testimony, the New Jersey Association of Health Plans, the New Jersey Business and Industry Association, and Governor Christie's office cited concerns, should the contraceptive coverage mandate be expanded to 12 months, about potential waste, potential side effects, women's potential loss of choice, and cost. [See Appendix II, Appendix III, and Appendix IV].

It is not clear, from the A-4503 statement section of the bill, whether the language, "for…a 12-month period for any subsequent dispensing of the same contraceptive," literally means "the same," or whether it means the same-or like, contraceptive. This is important because some of the objections to the bill from insurers might be eliminated if "the same" can be interpreted broadly. Massachusetts used identical language to A-4503, but when Hawaii expanded its mandate for health insurers to cover 12 months of contraception, it used both more specific and broader language, allowing for changing the brand of contraception within the year in the face of "adverse events."[xxvii, xxviii]

Health care providers who prescribe contraceptives that require multiple refills to cover a year's supply (e.g., pills, rings, patches, injectables), recognize that women may experience side effects, particularly in the first three months of use, and can have women either return for a follow-up visit in three months, to discuss any concerns related to either side effects or issues regarding use (injectables require a 4x/year visit to a provider, in any case) or have patients follow-up by phone or email to discuss any concerns. Prescribers can reduce the potential for waste by writing prescriptions for 3 months with 4 refills (and state: may dispense up to a 12- month supply); this is a sensible and common practice among providers, already. In this way, patients can choose to get a year's supply, or not, once providers have apprised them of the benefits to efficacy and consistency (avoiding gaps in coverage, for example), of having ready access to their contraceptive method. Long-acting contraceptives (LARCS: Intrauterine devices-IUDs- and hormonal implants), once placed, last for 3-12 years, depending upon the device, which makes them the most effective methods of contraception and relieve women of the burden of repeated intervention for coverage. The CDC emphasizes the cost-savings that could be achieved by greater use of these methods; though their initial cost is high, amortized over the years of their use, they are very cost effective: Copper T: IUD: estimated at about $100/year over 12 years and the hormonal implant estimated at about $230/year over 3 years; this compares to about $50/per pack for birth control pills.[xxix, xxx, xxxi]

A 2016 assessment by the California State Health Benefits Review Program (CSHBRP) estimated that expanding the state's mandated prescription contraceptive coverage from 3 months to 12 months would result in $2 million in annual premium savings, as well as $42 million in cost savings to employers and consumers. [xxxii] These projected savings were explained by a reduction in unintended pregnancies as contraceptive users had longer periods of uninterrupted use, due to the dispensing of contraceptive supplies for longer periods. The CSHBRP calculated that the expansion of contraceptive prescriptions from 3 months to 12 months would result in an expected 15,000 fewer pregnancies and 7,000 fewer terminations of pregnancy each year.[xxxiii]

Based upon the available data, the financial impact of A-4503 is likely to result in a net cost savings to insurers, employers and consumers in New Jersey, because it will prevent unintended pregnancies and the consequent high costs associated with either carrying a pregnancy to

delivery or terminating a pregnancy. However, because New Jersey law already mandates a contraceptive prescription period of six months, the cost savings of expanding the mandated coverage period from 6 months to 12 months will be of a lesser magnitude than the substantial savings estimated in the California study cited above. That is because the California bill analysis examined the impact of expanding that state's contraceptive prescription mandate from 3 to 12 months.

Insurance carriers have raised the problem of insuring benefits for periods when consumers are no longer insured and paying premiums. For example, under this bill, a consumer may purchase coverage and pay premium in January, receive a 12-month supply of oral contraception, but then stop paying premium in February – effectively providing 11 months of coverage for oral contraceptives for only one month of premium. There is some evidence of this kind of churn, especially in the individual market, with consumers purchasing coverage for only part of the year. Enrollment statistics for the individual market published by the New Jersey Department of Banking and Insurance demonstrate that enrollment is high during the first quarter of every year and then enrollment drops significantly with each successive quarter during the year.[xxxiv]

The potential impact of this disconnect between mandated contraceptive coverage and duration of paid premium is mitigated by several factors. First, New Jersey insurers are already required to cover 6 months of contraceptive supply, so the new impact in the example above would only apply to contraceptive supplies dispensed in months seven through twelve. Second, while the data show evidence of turnover in the individual health market, there is less evidence of dropped coverage in employer-based health markets, and little evidence of dropped coverage in the state health programs. Finally, for members who drop coverage with contraceptive supplies in excess of the number of months of premium they paid, a number will join a new plan and begin paying premium while already holding a surplus contraceptive supply. As a result, there is a net effect of insurers paying for excess supplies on the one hand, and not having to pay for supplies while receiving premium on the other. The MHBAC does not have the data to assess the magnitude of this net effect of the mismatch between premium payment duration and mandated contraceptive supply coverage.

Insurance carriers have also expressed some concern of the precedential importance of this bill as it may lead to calls for other mandates for long-term prescriptions. It stands to reason, however, that each health insurance mandate bill will be evaluated on its own merits, including an assessment of the costs and savings engendered with each new prescription requirement, as well as an analysis of where those costs and benefits land.

Representatives of the New Jersey insurance carriers have also expressed a concern regarding the potential for the wastage of contraceptive supplies resulting from extending the dispensing of contraceptive supplies from the current mandate of 6 months to the proposed new mandate of 12 months. The concern for the carriers is that by expanding the contraceptive coverage mandate a greater number of contraceptive pills, already paid for by the carriers, will be wasted with the dispensing of a longer-term prescription. There is some empirical evidence to suggest this

concern is warranted. In a study of data from 2003, Foster and her colleagues (2006) found that on average women wasted 3% of the pills they received.[xxxv] Women who were dispensed three cycles of pills wasted 2% of those pills, while women who received a year's supply of oral contraceptives wasted 6.5% of those pills.[xxxvi] Pill wastage can result from contraceptive users who discontinue contraceptive use and from contraceptive users who switch methods after a longer-term prescription has been dispensed.[xxxvii]

Within the general concern about the costs of pill wastage are a number of circumstances under which contraceptive supplies or opportunities to improve the quality or lower the costs of contraception may be squandered. While the data to assess the direct cost implications of each of these points is lacking, a full evaluation of the issue of contraceptive wastage requires that these concerns be considered:

- defective contraceptive supplies could be the subject of a recall. Contraceptive users with a long-term supply might be unaware of a recall or would waste a greater quantity of supplies than contraceptive users with a shorter-term prescription dispensed;
- a generic form or less expensive form of the contraceptive could become available after a long-term supply has been dispensed;
- a long-term supply of contraceptives could be improperly stored, causing a loss in effectiveness.[xxxviii, xxxix, xl]

Detailed cost estimates of pill wastage and their impact on the total financial impact of A-4503 are provided below.

FINANCIAL IMPACT

New Jersey Health Markets and Systems Affected by A-4503

A-4503 requires that health coverage shall include prescriptions for dispensing contraceptives for a twelve-month period after an initial dispensing period of three months. This requirement is placed on the following:

- hospital/medical/health service corporation contracts,
- health maintenance organization contracts,
- individual and group health insurance policies,
- individual and small employer health benefit plans,
- State Health Benefits Program, and
- School Employees' Health Benefits Program.[xli]

As a result, New Jersey's commercial health insurance markets, comprised of the Individual Health Coverage (IHC), Small Employer Health (SEH), and mid- and large-employer insured

markets, are affected by A-4503. Approximately 1.5 million New Jersey lives are covered by insured health plans from these commercial markets.[xlii]

In addition, A-4503 impacts New Jersey's State health plans - State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP). These programs are funded by the State and provide health benefits to New Jersey's state and school employees, retirees, and their dependents. The number of lives covered by the State's health prescription drug plans is approximately 650,000 as of 2018.[xliii]

The financial impact analysis below will focus on the net costs of contraceptive supplies, pregnancy termination, and maternity care (prenatal care, delivery, and postpartum care for pregnancies carried to term). The MHBAC did not have adequate data to assess the fuller societal costs of unintended pregnancies, which includes morbidity associated with pregnancy, productivity loss to employers associated with workers who become pregnant and suffer employment disruption, and the possible interruption or the ending of educational opportunities for women who become pregnant. Such societal costs not included in this analysis would also include the health care costs associated with both well and disabled children born to women who carry pregnancies to delivery.

Financial Impact of A-4503

It is estimated that A-4503 will provide a cost savings of $1.2 to $2.7 million the first year after its passage for the affected New Jersey health markets and systems. Two offsetting factors driving this estimate are the impact of A-4503 on the rate of unintended pregnancies and the rate of contraceptive pill wastage.

By increasing the dispensing period from the current six-month period to twelve months, A-4503 reduces the potential disruptions to the contraceptive utilization regimen. The result is a reduction in the number of unintended pregnancies. A-4503 is estimated to reduce the number of unintended pregnancies by 400 to 600 in its first year after passage. The cost savings to the affected New Jersey health markets and systems is approximately $2.4 to $3.9 million.

Besides affecting the rate of unintended pregnancies, A-4503 increases the level of contraceptive pill wastage due to larger quantities of contraceptives supplied to the users. This results in an additional cost to the affected New Jersey health markets and systems. This cost is estimated to be $1.2 million in the first year after passage of A-4503.

The financial impact of these two offsetting factors from A-4503 is an estimated net savings of $1.2 to $2.7 million to the affected New Jersey health markets and systems. Although this savings estimate is modest relative to estimates from other studies[xliv], it is important to note New Jersey expanded its contraceptive dispensing period to six months in late 2017. Since A-4503 changes the dispensing period from six months to twelve months, much of the financial impact will have been realized from the initial extension of the dispensing period to six months.

The next section discusses the key assumptions underlying the cost savings estimate.

Key Assumptions

Several assumptions were used in estimating the financial impact of A-4503. The significant assumptions are the following:

- Number of females age 15 to 44 in the affected New Jersey health markets and systems,
- Percentage of the reference population currently using oral contraceptives,
- Decrease in the rate of unintended pregnancies in the reference population from the passage of A-4503,
- Cost of an unintended pregnancy, and
- Increase in the cost of pill wastage from the passage of A-4503.

These assumptions are discussed below.

Number of Females Age 15 to 44 and Percentage Using Oral Contraceptives

The number of females age 15 to 44 is estimated using health plan enrollment information from the Department of Banking and Insurance (DOBI)[xlv] and SHBP and SEHBP rate renewal reports for plan year 2019 from the Division of Pensions and Benefits.[xlvi] Age distribution information were obtained from recent rate filings submitted by a major carrier to DOBI and state pension funding reports found on the Division of Pensions and Benefits website.[xlvii] Assuming half of the health plan enrollees are female, the number of females age 15 to 44 in the affected New Jersey health markets and systems is approximately 280,000. The breakdown by market/system is on the table below.

New Jersey Market/System	Number of Females Age 15 to 44
IHC/SEH/mid to large carrier	225,000
SHBP	38,000
SEHBP	17,000
Total	280,000

In order to estimate to estimate the number of females currently using oral contraceptives, the results of a study on contraceptive use by Douglas-Hall *et al.* (2017) is employed.[xlviii] The study finds that in New Jersey 16.7% of the females use oral contraceptives. Of the 280,000 estimated number of females, approximately 47,000 are assumed to be currently using oral contraceptives.

Decrease in the Rate of Unintended Pregnancies and Cost of an Unintended Pregnancy

To estimate the decrease in the rate of unintended pregnancies from A-4503, the result from a study by Foster *et al.* (2011) is used.[xlix] The study finds that the rate of unintended pregnancy varies by the dispensing pattern of oral contraceptives. The table below shows the higher rates of unintended pregnancies associated with lower dispensing amounts of oral contraceptives.

Dispensing Pattern	Rate of Unintended Pregnancy
1 cycle (one-month supply)	2.9%
3 cycle (three-month supply)	3.3%
13 cycle (twelve-month supply)	1.2%

For the purposes of measuring the financial impact of A-4503, an estimate of the rate of unintended pregnancy associated with a 7 cycle (six-month supply) dispensing pattern is estimated. Using the rates of unintended pregnancy associated with the 3-cycle and 13-cycle supply as bounds, it is assumed that the rate of unintended pregnancy associated with a 7-cycle dispensing pattern is 2% to 2.5%.

A-4503 would increase the dispensing period from six months to twelve months, resulting in an estimated change in the unintended pregnancy rate from 2% to 2.5% (the estimate of the rate of unintended pregnancies for women dispensed 7 cycles) to 1.2% (the estimate of the rate of unintended pregnancies for women dispensed 13 cycles), a net change in the unintended pregnancy rate of 0.8% to 1.3%. Since the number of females age 15 to 44 currently using oral contraceptives in the affected New Jersey health markets and systems is approximately 47,000, the number of unintended pregnancies in this group would decrease by approximately 400 to 600.

The range of costs for an unintended pregnancy, which vary by the outcome of pregnancy (i.e., live birth, fetal loss or termination) is taken from Kost (2015)[l] and is shown in the table below. The frequency of each type of pregnancy outcome is also included in the table.

Type	Frequency	Cost
Delivery (live birth)	42%	$8,756 to $11,638
Fetal Loss	13%	$0
Termination	45%	$435 to $3,000

It is assumed that the "average" cost of an unintended pregnancy is approximately $6,000 to $6,500. This estimate is based on the weighted average cost derived from the above table using the frequency rates as weights. The average cost includes an additional $3500 for prenatal and postpartum care for pregnancies that are carried through delivery.[li] As a caveat, these cost figures come from a 2013 study and could understate the current costs of prenatal care, delivery, and postpartum care. Based on the estimate of the decrease in unintended pregnancies of 400 to

600, A-4503 is estimated to save approximately $2.4 to $3.9 million in the cost of unintended pregnancies. [*N.B.*, These estimated savings represent the range from the lower number of unintended pregnancies prevented, 400, multiplied by the lower cost of the pregnancy outcomes, $6,000, versus the higher number of unintended pregnancies prevented, 600, multiplied by the higher cost of the pregnancy outcome, $6,500.]

Increase in the Cost of Pill Wastage

To estimate the cost of contraceptive pill wastage, results from studies by Foster *et al.* (2006)[lii] and White and Westhoff (2011)[liii] are used. Foster and her colleagues (2006) estimate the rate of wastage (measured in percentage of annual cycles per year) to be the following:

Dispensing Pattern	Rate of Pill Wastage
1 cycle	2.9%
3 cycle	2.0%
13 cycle	6.5%

To estimate the rate of wastage for a 7-cycle dispensing pattern, the results from White and Westhoff (2011) showing the relationship between the rates of pill wastage for a 3-cycle and 7-cycle pattern is used. The rate of pill wastage for a 7-cycle dispensing pattern is estimated to be 3.3%.

Assuming the average cost of a 1-cycle contraceptive supply is $62[liv] and all other cycle quantities are proportionately the same cost, the cost of wastage from A-4503 increases from $27 to $52 per female, a net change of $25 per female. Since it is estimated that 47,000 females use oral contraceptives in the affected New Jersey health markets and systems, the estimated additional cost of wastage from A-4503 is approximately is approximately $1.2 million.

CONCLUSION: Balancing Social Impact, Medical Evidence, and Financial Impact

The medical literature clearly supports the finding that women's access to longer-duration supplies of contraception is associated with longer, uninterrupted contraceptive method use and, therefore, significantly fewer unintended pregnancies and significantly fewer abortions. As noted above, New Jersey has already expanded the duration of supplies of contraception, so the impact measured herein is expanding coverage for supplies for an additional duration of six months. These outcomes are achieved without a significant increase in risks to the health of contraceptive users. The practice and prescribing recommendations of two authoritative, evidence-based entities -- the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists – strongly endorse expanding women's access to longer-term supplies of contraception – up to 12 months -- when the longer-term prescription is preferred by a woman and her provider.

Seventeen states and the District of Columbia have already passed a 12-month contraceptive mandate into law. While this is a relatively recent mandate, dating back to 2015 at the earliest, the Mandated Health Benefits Advisory Commission found no evidence that insurance carriers, businesses, or consumers in these states on balance have been harmed by this contraceptive mandate expansion. The California Health Benefits Review Program anticipated net savings in the tens of millions of dollars to employers and consumers, as a result of the expected reduction in unintended pregnancies and abortions resulting from the contraceptive supply extension mandate (*N.B.*, specifically expanding from 3-month to 12-month supplies). The beneficial social and financial impacts of the mandate expansion were expected to be substantial.

The cost analysis contained in this report also suggests that it is likely that New Jersey insurance carriers will be able to report net savings from extending the contraceptive mandate to 12 months, when good empirical evidence has been generated after several years. This is due to the expected savings resulting from the reduction in unintended pregnancies, even taking into account somewhat higher costs due to contraceptive wastage associated with the longer period of contraceptive supply.

Endnotes/References

[i] Assembly Bill A-4503, State of New Jersey, 218th Legislature. Introduced September 27, 2018, Sponsored by Assemblywoman Valerie Vainieri Huttle. (https://www.njleg.state.nj.us/2018/Bills/A5000/4503_I1.PDF).

[ii] P.L.2004, c.251. https://www.njleg.state.nj.us/2004/Bills/PL05/251_.HTM

[iii] (https://www.healthcare.gov/coverage/birth-control-benefits/).

[iv] (https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf).

[v] https://www.irs.gov/statistics/soi-tax-stats-historic-table-2

[vi] (https://money.cnn.com/2018/03/03/news/economy/obamacare-tax-penalty/index.html).

[vii] (https://www.cdc.gov/nchs/fastats/reproductive-health.htm).

[viii] (https://www.njleg.state.nj.us/2016/Bills/PL17/241_.PDF).

[ix] (http://www.berkeleywellness.com/healthy-community/health-care-policy/article/cdcs-top-10-public-health-achievements-20th-century).

[x] (https://www.gutmacher.org/report/social-and-economic-benefits-womens-ability-determine-whether-and-when-have-children).

[xi] (https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform).

[xii](https://www.nj.gov/health/fhs/maternalchild/documents/NJ%20Pregnancy%20Intention%20Topic%20Report%202012-2015.pdf).

[xiii] (https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states).

[xiv] (https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states).

[xv] (https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states).

[xvi] (https://www.ncbi.nlm.nih.gov/pubmed/759623).

[xvii] (https://www.ncbi.nlm.nih.gov/pubmed/30131220).

[xviii] Torre, C., Hughes, C., Reynolds, C. And Sherwin, L. Phase II "Assessing Sexual Assertiveness and Effective Contraceptive Behavior in Adolescent and Young Adult Women," Proceedings of the 20th National Primary Care Nurse Practitioner Symposium, July 23, 1995.

[xix] (https://www.whijournal.com/article/S1049-3867(17)30527-3/fulltext

[xx] https://www.urban.org/research/publication/access-contraception-2016-and-what-it-means-women/view/full_report).

[xxi] (https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Contraception?IsMobileSet=false; https://powertodecide.org/system/files/resources/primary-download/extended-supply-contraception.pdf).

[xxii] http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0951-1000/sb_999_cfa_20160627_103956_asm_comm.html

[xxiii] Foster, D., Hulett, D., Bradsberry, M., Darney, P., and Policar, M. "Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies," Obstetrics and Gynecology, March 2011, Vol. 117(3): 566-572. (https://journals.lww.com/greenjournal/Fulltext/2011/03000/Number_of_Oral_Contraceptive_Pill_Packages.8.aspx).

[xxiv] Ibid.

[xxv] http://analyses.chbrp.com/document/view.php?id=1207

[xxvi] **https://www.cdc.gov/reproductivehealth/contraception/mmwr/spr/combined.html**

[xxvii] https://malegislature.gov/Laws/SessionLaws/Acts/2017/Chapter120

[xxviii] https://law.justia.com/codes/hawaii/2016/title-24/chapter-431/section-431-10a-116.6

[xxix] (https://www.cdc.gov/sixeighteen/pregnancy/index.htm

[xxx] https://www.birthcontrol.com/how-much-does-birth-control-cost

[xxxi] https://money.usnews.com/money/blogs/alpha-consumer/2012/03/05/the-real-cost-of-birth-control).

[xxxii] http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0951-1000/sb_999_cfa_20160627_103956_asm_comm.html

[xxxiii] Ibid.

[xxxiv] https://www.state.nj.us/dobi/division_insurance/ihcseh/enroll/2018_4q_ihcseh_historical.pdf

[xxxv]Foster DG, Parvataneni R, Thiel de Bocanegra H, Lewis C, Bradsberry M and Darney P. Number of Oral Contraceptive Pill Packages Dispensed, Method Continuation and Costs, Obstretrics and Gynecology, 2006b; 108(5): 1107-1114. https://journals.lww.com/greenjournal/Fulltext/2006/11000/Number_of_Oral_Contraceptive_Pill_Packages.10.aspx

[xxxvi] Ibid.

[xxxvii] Gellman, K. (2019) Personal communication. Concerns with pill wastage as a result of method use discontinuation and contraceptive method switching. April 23, 2019.

[xxxviii] Kelly, S. (2019) Personal communication. Concerns with pill wastage resulting from a 12-month contraceptive supply mandate. April 1, 2019.

[xxxix] Sanders, W. (2016). Testimony of the New Jersey Association of Health Plans for the Assembly Financial Institutions and Insurance Committee. June 2, 2016.

[xl] https://www.nytimes.com/2011/08/16/health/16consumer.html

[xli] Section 36 of P.L.2007, c.103 (N.J.S.A.52:14-17.46.6) provides as follows:

> "Coverage provided under the School Employees' Health Benefits Program Act shall include coverage for all services for which coverage is mandated in the State Health Benefits Program pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.)."

[xlii] IHC and SEH enrollment information is available to the general public and is found at http://www.nj.gov/dobi/division_insurance/ihcseh/ihcsehenroll.html. IHC and SEH combined enrolled covered lives was 616,000 as of fourth quarter of 2018. Mid- to large-employer enrolled covered lives was 897,401 as of December 31, 2014.

[xliii] The estimate of covered lives is based on the number of contracts information from the rate renewal reports for SHBP and SEHBP dated September 2018 and located on website https://www.state.nj.us/treasury/pensions/rate-renewal.shtml.

[xliv] California Health Benefits Review Program – Analysis of California Senate Bill 999 Contraceptives: Annual Supply, A Report to the 2015-2016 California State Legislature, March 28, 2016.

[xlv] http://www.nj.gov/dobi/division_insurance/ihcseh/ihcsehenroll.html

[xlvi] https://www.state.nj.us/treasury/pensions/rate-renewal.shtml.

[xlvii] https://www.state.nj.us/treasury/pensions/documents/financial/gasb/gasb75-state-2017.pdf

[xlviii] Douglas-Hall A., Kost K., Kavanaugh M.., "State-Level Estimates of Contraceptive Use in the United States, 2017." New York: Guttmacher Institute.
https://www.guttmacher.org/sites/default/files/report_pdf/state-level-estimates-contraceptive-use-in-us-2017.pdf

[xlix] Foster, D., Hulett, D., Bradsberry, M., Darney, P., and Policar, M. "Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies," Obstetrics and Gynecology, March 2011, Vol. 117(3): 566-572.
(https://journals.lww.com/greenjournal/Fulltext/2011/03000/Number_of_Oral_Contraceptive_Pill_Packages.8.aspx).

[l] Kost K. "Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002." New York: Guttmacher institute; 2015.
https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002

[li] Truven Health Analytics Marketscan Survey (2013), "The Cost of Having a Baby in the United States: Prepared for Childbirth Connection, Catalyst for Payment Reform and Center for Healthcare Quality and Payment Reform."
https://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf

[lii] Foster DG, Parvataneni R, Thiel de Bocanegra H, Lewis C, Bradsberry M and Darney P. Number of Oral Contraceptive Pill Packages Dispensed, Method Continuation and Costs, Obstretrics and Gynecology, 2006b; 108(5): 1107-1114. https://journals.lww.com/greenjournal/Fulltext/2006/11000/Number_of_Oral_Contraceptive_Pill_Packages.10.aspx

[liii] White KO and Westhoff C., "The Effect of Pack Supply on Oral Contraceptive Pill Continuation – A Randomized Control Study," 2011: 118(3): 615-622.

[liv] California Health Benefits Review Program – Analysis of California Senate Bill 999 Contraceptives: Annual Supply, A Report to the 2015-2016 California State Legislature, March 28, 2016, p. 29.

ASSEMBLY, No. 4503

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED SEPTEMBER 27, 2018

Sponsored by:
Assemblywoman VALERIE VAINIERI HUTTLE
District 37 (Bergen)

SYNOPSIS

Expands requirement for health insurers to cover prescriptions for contraceptives to 12 months.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning insurance coverage for prescribed contraceptives and amending P.L.2005, c.251.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.2005, c.251 (C.17:48-6ee) is amended to read as follows:

1. A hospital service corporation that provides hospital or medical expense benefits for expenses incurred in the purchase of outpatient prescription drugs under a contract shall provide coverage under every such contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** 12-month period, if a **[**six-month**]** 12-month period would extend beyond the term of the contract.

A religious employer may request, and a hospital service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to prospective subscribers and subscribers. The provisions of this section shall not be construed as authorizing a hospital service corporation to exclude coverage for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of a subscriber. For the purposes of this section, "religious employer" means an

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the contract.

This section shall apply to those contracts in which the hospital service corporation has reserved the right to change the premium.

(cf: P.L.2017, c.241, s.1)

2. Section 2 of P.L.2005, c.251 (C.17:48A-7bb) is amended to read as follows:

2. A medical service corporation that provides hospital or medical expense benefits for expenses incurred in the purchase of outpatient prescription drugs under a contract shall provide coverage under every such contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** 12-month period, if a **[**six-month**]** 12-month period would extend beyond the term of the contract.

A religious employer may request, and a medical service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to prospective subscribers and subscribers. The provisions of this section shall not be construed as authorizing a medical service corporation to exclude coverage for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives

that are necessary to preserve the life or health of a subscriber. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the contract.

This section shall apply to those contracts in which the medical service corporation has reserved the right to change the premium.

(cf: P.L.2017, c.241, s.2)

3. Section 3 of P.L.2005, c.251 (C.17:48E-35.29) is amended to read as follows:

3. A health service corporation that provides hospital or medical expense benefits for expenses incurred in the purchase of outpatient prescription drugs under a contract shall provide coverage under every such contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** 12-month period, if a **[**six-month**]** 12-month period would extend beyond the term of the contract.

A religious employer may request, and a health service corporation shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to prospective subscribers and subscribers. The provisions of this section shall not be construed as authorizing a health service corporation to exclude coverage for

prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of a subscriber. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the contract.

This section shall apply to those contracts in which the health service corporation has reserved the right to change the premium.

(cf: P.L.2017 c.241, s.3)

4. Section 4 of P.L.2005, c.251 (C.17B:27-46.1ee) is amended to read as follows:

4. A group health insurer that provides hospital or medical expense benefits for expenses incurred in the purchase of outpatient prescription drugs under a policy shall provide coverage under every such policy delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the policy was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** 12-month period, if a **[**six-month**]** 12-month period would extend beyond the term of the contract.

A religious employer may request, and an insurer shall grant, an exclusion under the policy for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to prospective insureds and insureds. The provisions of this section

shall not be construed as authorizing an insurer to exclude coverage for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of an insured. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the policy.

This section shall apply to those policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2017, c.241, s.4)

5. Section 5 of P.L.2005, c.251 (C.17B:26-2.1y) is amended to read as follows:

5. An individual health insurer that provides hospital or medical expense benefits for expenses incurred in the purchase of outpatient prescription drugs under a policy shall provide coverage under every such policy delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** <u>12-month</u> period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the policy was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** <u>12-month</u> period, if a **[**six-month**]** <u>12-month</u> period would extend beyond the term of the contract.

A religious employer may request, and an insurer shall grant, an exclusion under the policy for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to

prospective insureds and insureds. The provisions of this section shall not be construed as authorizing an insurer to exclude coverage for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of an insured. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the policy.

This section shall apply to those policies in which the insurer has reserved the right to change the premium.

(cf: P.L.2017, c.241, s.5)

6. Section 6 of P.L.2005, c.251 (C.26:2J-4.30) is amended to read as follows:

6. A certificate of authority to establish and operate a health maintenance organization in this State shall not be issued or continued on or after the effective date of this act for a health maintenance organization that provides health care services for outpatient prescription drugs under a contract, unless the health maintenance organization also provides health care services for prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** 12-month period, if a **[**six-month**]** 12-month period would extend beyond the term of the contract.

A religious employer may request, and a health maintenance organization shall grant, an exclusion under the contract for the health care services required by this section if the required health care services conflict with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains

such an exclusion shall provide written notice thereof to prospective enrollees and enrollees. The provisions of this section shall not be construed as authorizing a health maintenance organization to exclude health care services for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of an enrollee. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The health care services shall be provided to the same extent as for any other outpatient prescription drug under the contract.

The provisions of this section shall apply to those contracts for health care services by health maintenance organizations under which the right to change the schedule of charges for enrollee coverage is reserved.

(cf: P.L.2017, c.241, s.6)

7. Section 7 of P.L.2005, c.251 (C.17B:27A-7.12) is amended to read as follows:

7. An individual health benefits plan required pursuant to section 3 of P.L.1992, c.161 (C.17B:27A-4) that provides benefits for expenses incurred in the purchase of outpatient prescription drugs shall provide coverage for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the plan was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** 12-month period, if a **[**six-month**]** 12-month period would extend beyond the term of the contract.

A religious employer may request, and a carrier shall grant, an exclusion under the health benefits plan for the coverage required by this section if the required coverage conflicts with the religious

employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to prospective covered persons and covered persons. The provisions of this section shall not be construed as authorizing a carrier to exclude coverage for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the health benefits plan.

This section shall apply to all individual health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2017, c.241, s.7)

8. Section 8 of P.L.2005, c.251 (C.17B:27A-19.15) is amended to read as follows:

8. A small employer health benefits plan required pursuant to section 3 of P.L.1992, c.162 (C.17B:27A-19) that provides benefits for expenses incurred in the purchase of outpatient prescription drugs shall provide coverage for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** <u>12-month</u> period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the plan was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** <u>12-month</u> period, if a **[**six-month**]** <u>12-month</u> period would extend beyond the term of the contract.

A religious employer may request, and a carrier shall grant, an exclusion under the health benefits plan for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious

employer that obtains such an exclusion shall provide written notice thereof to prospective covered persons and covered persons. The provisions of this section shall not be construed as authorizing a carrier to exclude coverage for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the health benefits plan.

This section shall apply to all small employer health benefits plans in which the carrier has reserved the right to change the premium.

(cf: P.L.2017, c.241, s.8)

9. Section 9 of P.L.2005, c.251 (C.17:48F-13.2) is amended to read as follows:

9. A prepaid prescription service organization that provides benefits for expenses incurred in the purchase of outpatient prescription drugs under a contract shall provide coverage under every such contract delivered, issued, executed or renewed in this State or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, for expenses incurred in the purchase of prescription female contraceptives. For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** <u>12-month</u> period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a **[**six-month**]** <u>12-month</u> period, if a **[**six-month**]** <u>12-month</u> period would extend beyond the term of the contract.

A religious employer may request, and a prepaid prescription service organization shall grant, an exclusion under the contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains such an exclusion shall provide written notice thereof to prospective enrollees and enrollees. The provisions of this section shall not be construed as authorizing a prepaid prescription service organization to exclude coverage for prescription drugs that are prescribed for reasons other than contraceptive purposes or for prescription female contraceptives that are necessary to preserve the life or health of an enrollee. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C.s.3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C.s.501(c)(3).

The benefits shall be provided to the same extent as for any other outpatient prescription drug under the contract.

This section shall apply to those prepaid prescription contracts in which the prepaid prescription service organization has reserved the right to change the premium.

(cf: P.L.2017, c.241, s.9)

10. Section 10 of P.L.2005, c.251 (C.52:14-17.29j) is amended to read as follows:

10. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides benefits for expenses incurred in the purchase of outpatient prescription drugs shall provide benefits for expenses incurred in the purchase of prescription female contraceptives.

For the purposes of this section, "prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a health care professional licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. The coverage provided shall include prescriptions for dispensing contraceptives for:

a. a three-month period for the first dispensing of the contraceptive; and

b. a **[**six-month**]** <u>12-month</u> period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under the contract was in effect at the time of the first dispensing, except that an entity subject to this section may provide

coverage for a supply of contraceptives that is for less than a ⟦six-month⟧ 12-month period, if a ⟦six-month⟧ 12-month period would extend beyond the term of the contract.
(cf: P.L.2017, c.241, s.10)

11. This act shall take effect on the 90th day next following enactment and shall apply to policies and contracts delivered, issued, executed or renewed on or after the effective date of this act.

STATEMENT

This bill amends P.L.2005, c.251, the statute requiring health insurers that provide coverage for outpatient prescription drugs to cover prescription female contraceptives, to increase the requirement for coverage of dispensing contraceptives from up to six months to up to 12 months.

Current law, pursuant to P.L.2017, c.241, requires health insurers that provide coverage for outpatient prescription drugs to cover dispensing of prescription female contraceptives for up to six months. This bill would increase that requirement to 12 months.

Under the bill, the coverage provided shall include prescriptions for dispensing contraceptives for: (1) a three-month period for the first dispensing of the contraceptive; and (2) a 12-month period for any subsequent dispensing of the same contraceptive, regardless of whether coverage under that policy or contract was in effect at the time of the first dispensing.

These amendments apply to hospital, medical, and health service corporations, commercial, individual, small employer and group health insurers, health maintenance organizations, prepaid prescription service organizations, and the State Health Benefits Program.

Testimony of the
New Jersey Association of Health Plans
For the Assembly Financial Institutions and Insurance Committee
June 2, 2016

ASSEMBLY BILL: A2297
NJAHP POSITION: OPPOSE

Chairman Coughlin and Members of the Assembly Financial Institutions and Insurance Committee:

The New Jersey Association of Health Plans ("NJAHP") is a non-profit association representing leading health care plans in the state which cover nearly seven million New Jersey residents. Our members include Aetna, AmeriGroup, AmeriHealth, Cigna, Health Republic of New Jersey, Horizon Blue Cross Blue Shield of New Jersey, Oscar, UnitedHealthcare, and WellCare. Thank you for the opportunity to comment on A2297, a bill requiring the State Health Benefits Program (but not the School Employees' Health Benefits Program) and commercial insurance carriers to provide coverage for a 3-month supply of the first dispensing of the contraceptive and a 12-month supply for subsequent dispensing. To be clear, the bill does not mandate coverage or cost-sharing requirements; rather it mandates supply amounts. Respectfully, we oppose the bill for the reasons set forth below.

Background on Contraceptive Coverage

New Jersey law has long mandated insurance coverage for expenses incurred in the purchase of prescription female contraceptives.[liv] That state-law mandate now must be read in conjunction with the federal Affordable Care Act, which mandates coverage of contraceptive methods and counseling for all women, as prescribed by a health care provider.[liv] Plans must cover the services without charging a copayment or coinsurance when they are provided by an in-network provider. Covered contraceptive methods include all Food and Drug Administration-approved contraceptive barrier methods, hormonal methods, implanted devices, emergency contraception, sterilization procedures, as well as patient education and counseling. Health plans have been complying with these requirements and covering contraceptive services as required under the ACA. Coverage is broad and coverage is without any cost-sharing. However, no existing state or federal law supports or requires 12-month prescription dispensing.

Concerns with the Bill

12-Month Supplies/Monthly Payments

- Allowing a year supply for any drug may disconnect the benefits from the actual premium payments received. The bill would allow a 12-month supply to be dispensed for someone

that pays only one month of premium. This is not a theoretical issue. A national consumer survey by McKinsey and Company on 2016 open enrollment found that 18% of consumers stopped paying their premium in 2015 and then reenrolled again in 2016, and half of these consumers returned to the same plan they stopped payment for in 2015.[liv] In the individual market in New Jersey, enrollment statistics clearly reflect the findings of this national survey. And while this bill addresses only one type of medication, the bill raises the issue of what other medications could be mandated for supplies as long as a year.

12-Month Supplies of Contraceptives Could Compromise Patient Safety and Efficacy

- As with all prescription drugs, there is an inherent risk to any long-term use of medication. Side effects and improper use of prescription drugs have a serious impact on a patient, which is why it is recommended that consumers confer regularly with their prescribing physician, pharmacist, or other health care provider. Health plans have established protocols with health professionals to help manage these outcomes, including the establishment of a 90-day limit on mail order prescriptions.
- A one-year dispensing requirement raises concerns with the overall efficacy of a medication that may not be properly stored for a year.[liv] This is why, within the private market, health plans strongly advocate that consumers who are on maintenance medications, such as contraceptives, consider the option of a 90-day supply with an auto-refill. In this way, three months of the prescription are dispensed, which helps to avoid the concerns resulting in long-term storage of medications.

12-Month Supplies of Contraceptives Could Lead to Waste, Fraud, Abuse, and Increased Costs

- It is common for patients to switch drug regimens, especially when first prescribed to a new medication. If a patient obtains a 12-month supply of contraceptives and switches dosage or medication or stops taking it after three months, then nine months of medication has been wasted. The medication may not be appropriately disposed of or destroyed, which could lead to fraud and abuse. Health plans would also be required to cover the cost of a new medication, which would lead to higher costs for all consumers.
- There still are brands on the market that do not have generic equivalents, but generics will be forthcoming. If 12 months of a brand are dispensed all at once, the State or insurer will have lost the ability to have a lower cost generic substituted that would have taken place if filled monthly or even every 90 days.

90-Day Supplies of Contraceptives Provide Easy Access to Patients

- Before the 90-day supply is exhausted, a refill can be delivered to the home of the individual, thus maintaining adherence while easing the need to travel to a pharmacy or other location to obtain the medication. Since cost-sharing is eliminated under the Affordable Care Act, this can ease the strain of access and cost of this medication while meeting the health needs of the insured.

NJAHP Suggests Referral to the Mandated Health Benefits Advisory Commission

Since this bill is an insurance mandate, we respectfully request that before it moves forward it be referred to the Mandated Health Benefits Advisory Commission as required by N.J.S.A. 17B:27D-6. As noted in the legislative findings section of that law, it is "in the public interest to conduct a review of proposed mandated health benefits by an expert body to provide the Legislature with adequate and independent documentation defining the social and financial impact and medical efficacy of the proposed mandate." We believe that this bill would benefit from a thorough analysis by New Jersey's Commission.

Thank you for consideration of our comments and concerns.

Appendix III

New Jersey Business & Industry Association

NJBIA

Melanie Willoughby
Chief Government Affairs Officer

Frank Robinson
Vice President
Grassroots & Government Affairs

Mary Beaumont
Vice President
Health & Legal Affairs

Sara Bluhm
Vice President
Environment & Energy

Andrew Musick
Director
Taxation & Economic Development

Nicol Nicola
Director
Economic Research

Tyler Seville
Director
Technology & Workforce Development

Michael Wallace
Director
Employment, Labor & Federal Affairs

TO: Members of the Assembly Financial Institutions & Insurance Committee

FR: Mary Beaumont, Vice President, Health & Legal Affairs

DATE: June 2, 2016

RE: Assembly Bill 2297 (Vainieri Huttle, Spencer, Sumter)/ Senate Bill 659 (Turner)

On behalf of our 20,000 members, the New Jersey Business & Industry Association (NJBIA), respectfully OPPOSES Assembly Bill 2297 (Vainieri Huttle, Spencer, Sumter) / Senate Bill 659 (Turner). This bill requires health insurance coverage for contraceptives to include prescriptions for 12 months.

NJBIA is concerned that this measure has not been reviewed by the Mandated Health Benefits Advisory Commission prior to being heard in committee. To create an objective assessment of the impact this health insurance coverage mandate could have on the cost of purchasing healthcare benefits, the Commission is charged with providing the Legislature with independent documentation defining the social and financial impact and medical effectiveness of proposed mandated health benefits legislation.

The Association places a strong and consistent focus on the quality and affordability of health insurance in New Jersey. The cost of providing health coverage to employees is one of the most significant challenges facing employers today. It is consistently ranked the number one problem facing our members in our annual NJBIA Business Outlook Survey.

The role of the Commission is particularly important considering that employers continue to cope with rising costs for healthcare coverage. In 2015, the cost of health insurance premiums reached $6,365 for single HMO coverage and $18,096 for family coverage in the Northeast, according to the Kaiser/HRET Survey of Employer-Sponsored Health Benefits. The national average for all plans is $6,251 for single coverage and $17,545 for family coverage. In comparison to this national cost data, in 2014 the New Jersey average for employee only health coverage was $7,416 and $19,116 for family coverage, which far exceeds the national average.

With the cost of health coverage steadily climbing and coverage continually eroding, it is crucial that the impact of all coverage mandates be carefully evaluated. It is unclear what impact this mandate would have on the cost of health insurance.

For these reasons, we respectfully ask that you vote "NO" on A-2297/S-659. Thank you for your consideration of our comments.

ASSEMBLY BILL NO. 2297

To the General Assembly:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Assembly Bill No. 2297 with my recommendations for reconsideration.

This bill would require all health insurers that provide coverage for prescription drugs, as well as the State and School Health Benefits Plans, to cover twelve month prescriptions for female contraceptives.

Since the beginning of my Administration, I have strongly supported increasing access to women's health care. My administration has provided funding for vital health care services for women throughout New Jersey, most particularly Federally Qualified Health Clinics (FQHCs). We fund, now at a greater level than ever before, health care for women. I have signed legislation requiring insurance companies to cover breast exams and other testing, and I recently signed legislation expanding infertility coverage for all women in New Jersey.

While I support the bill's intention to increase access to medically-appropriate prescription drugs, including contraceptives, I am concerned that the bill would lead to unnecessary drug waste and could potentially limit patient choice

in this area. Moreover, mandating twelve full months of coverage with no patient cost-sharing, regardless of where an individual is in their policy term, affords special treatment to one particular class of drugs and will unfairly shift the cost to policy holders in the form of unnecessary premium increases.

In order to strike a more appropriate balance between the desire for increased access and the overarching concern for prescription drug waste and cost as well as patient choice, I propose that carriers be required to provide six months of coverage for contraceptives after the initial three month prescription. In addition, I recommend that a carrier may provide less than six months of coverage for a supply of prescription contraceptives if a six month supply would extend beyond the applicable plan year.

These common sense changes achieve the bill's goal of increasing access to contraceptives, but will not lead to premium increases for our citizens.

Accordingly, I herewith return Assembly Bill No. 2297 and recommend that it be amended as follows:

Page 2, Section 1, Line 27: Delete "twelve" and insert "six"

Page 2, Section 1, Line 29: After "dispensing" insert ", except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract"

Page 3, Section 2, Line 29: Delete "twelve" and insert "six"

Page 3, Section 2, Line 31: After "dispensing" insert ", except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract"

Page 4, Section 3, Line 27: Delete "twelve" and insert "six"

Page 4, Section 3, Line 29: After "dispensing" insert ", except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract"

Page 5, Section 4, Line 25: Delete "twelve" and insert "six"

Page 5, Section 4, Line 27: After "dispensing" insert ", except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract"

Page 6, Section 5, Line 21: Delete "twelve" and insert "six"

Page 6, Section 5, Line 23: After "dispensing" insert ", except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would

extend beyond the term of the contract”

Page 7, Section 6, Line 18: Delete “twelve” and insert “six”

Page 7, Section 6, Line 20: After “dispensing” insert “, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract”

Page 8, Section 7, Line 16: Delete “twelve” and insert “six”

Page 8, Section 7, Line 18: After “dispensing” insert “, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract”

Page 9, Section 8, Line 11: Delete “twelve” and insert “six”

Page 9, Section 8, Line 13: After “dispensing” insert “, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract”

Page 10, Section 9, Line 10: Delete “twelve” and insert “six”

Page 10, Section 9, Line 12: After “dispensing” insert “, except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period,

if a six month period would extend beyond the term of the contract"

Page 11, Section 10, Line 9: Delete "twelve" and insert "six"

Page 11, Section 10, Line 11: After "dispensing" insert ", except that an entity subject to this section may provide coverage for a supply of contraceptives that is for less than a six month period, if a six month period would extend beyond the term of the contract"

Respectfully,

[seal] /s/ Chris Christie

Governor

Attest:

/s/ James J. DiGiulio

Chief Counsel to the Governor

(https://www.njleg.state.nj.us/2016/Bills/A2500/2297_V1.HTM)

Appendix V

NEW JERSEY GENERAL ASSEMBLY

JOHN F. MCKEON
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COMMITTEES
MEMBER
FINANCIAL INSTITUTIONS AND INSURANCE, CHAIR
APPROPRIATIONS
ENVIRONMENT AND SOLID WASTE
INTERGOVERNMENTAL RELATIONS COMMISSION

March 15, 2019

New Jersey Mandated Health Benefits Advisory Commission
P.O. Box 325
Trenton, NJ 08625

Dear Members of the Commission:

As the Chairman of the Assembly Financial Institution and Insurance Committee, I respectfully request the Commission to review and prepare a written report of A-4503, sponsored by Assemblywoman Valerie Vainieri Huttle. The bill would expand the requirement for health insurers to cover prescriptions for contraceptives to 12 months.

If you have any questions, please do not hesitate to contact, Mark Iaconelli, Assembly Financial Institutions and Insurance Committee Aide, at 609-847-3500. Thank you for your immediate attention to this matter.

Very truly yours,

John F. McKeon
Assemblyman, 27th District

CC: Hon. Valerie Vainieri Huttle, Deputy Speaker
Mark Iaconelli, Jr., Esq., Committee Aide