REPRODUCTIVE EQUITY NOW

Question and Answer: ACCESS Law

Q. Why is this bill necessary?

A. The Affordable Care Act is not meeting the contraception needs of people in [State]. This bill would clarify and improve on the provisions in the ACA to ensure contraceptive coverage for a greater portion of the population. Plus, the ACA and its contraceptive coverage mandate are under constant threat of federal repeal. [Insert bill name] will ensure that the contraceptive coverage mandate of the ACA would remain [State] law regardless of what happens at the federal level.

Q. How is this different from the contraceptive provision of the Affordable Care Act?

A. While the ACA mandated that contraceptives be available without cost-sharing, there are still gaps that make it difficult for many women across [State] to access the contraception that works best for them.

The key provision of [Insert bill name] is the expansion of the ACA provision from contraceptive coverage without copay to a 12-month dispensing of contraceptives without copay. This was important because: (a) proper use of contraceptives is very time sensitive, and limiting supply increases the odds of inconsistent use, either missing a dose or even skipping a month, increasing the changes for unintended pregnancy; (b) it promotes consistent use and improves access, especially for those living in rural areas with limited access to pharmacies; and (c) the CDC report recommends dispensing a year's supply of contraception, stating that "restricting the number of pill packs distributed or prescribed can result in unwanted discontinuation of the method and increased risk for pregnancy." With respect to additional coverage requirements, the language in the [State] [Insert bill name] bill is nearly identical to the federal requirement; the main difference is [Insert bill name] explicitly includes device insertion, which is implicit in the federal requirements.

The other main difference between the ACA and [Insert bill name] is that the ACA permits step therapy, where [Insert bill name] does not. Step therapy requires a patient to try and "fail" (including pregnancy or medical complications) at a method before authorizing

coverage for a more expensive method. Under [Insert bill name] , insurers may not impose restrictions or delays in coverage, including medical management techniques such as denials, step therapy, or prior authorization. This is distinct from the ACA which permits "reasonable medical management techniques" to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service. The reasons that the [Insert bill name] Coalition felt that it was so important to prohibit step therapy is that: (a) it is time-consuming for a physician and patient; (b) it creates more expense with regard to direct and indirect out-of-pocket costs; (c) it creates additional barriers that effectively deny or delay a woman's access to her preferred method of contraception, limiting her reproductive autonomy and impeding access to the most effective contraceptive methods; and (d) it may lead to lapsed or inconsistent contraceptive use and increased risk unintended pregnancy.

Q. What would this law accomplish?

A. In enacted, this legislation would accomplish the following: (1) Coverage without cost-sharing for all FDA-approved contraceptive drugs, devices, supplies, and voluntary sterilization; (2) Guaranteed approval of 12-month supply prescriptions of contraceptives without cost-sharing; (3) 100% coverage of over-the-counter contraception without copay; and (4) Prohibits use of "reasonable medical management techniques" by insurers to delay or even prevent access to contraceptives.

Notably, the law does allow insurance companies the ability to limit coverage when two or more products have the same active ingredients and safety profile that are FDA-approved.

Q. Will this raise insurance premiums?

A. No. The National Business Group on Health has estimated it costs employers, and therefore insurers, 15-17% **more not to** provide coverage for contraceptives, and recommends no cost-sharing.[1] The study took into account the cost of contraceptives to employers and insurers in comparison to both the direct medical costs of pregnancy and the indirect costs of subsequent employee absence. Furthermore, ACCESS does not require insurance companies to cover every form of contraceptive on the market, only those that are FDA Approved and do not have a therapeutic equivalent with the same ingredients and safety profile. [Insert bill name] still allows insurance companies to negotiate which contraceptives would go on their formularies, specifically for therapeutic equivalents.

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[1] Adam Sonfield, *New Federal Protections Expand Coverage Without Cost-Sharing Of Contraceptives and Other Women's Preventive Services*, 14 Guttmacher Policy Review 23 (Summer 2011), available at https://www.guttmacher.org/sites/default/files/article_files/gpr140324.pdf.

Q. Will religious employers be affected by this?

A. This bill would not force exempt religious organizations or religiously affiliated nonprofits to cover contraceptive methods and counseling.

Q. Will this result in worse overall healthcare for women as they won't have incentive to go see their doctors as frequently?

A. No. Currently, patients are not generally expected to see their physician more than once a year to receive and/or renew a prescription for a contraceptive method. Typically, prescriptions are written for 12-month supplies, although insurance companies will often only cover the cost for 1-3 months at a time. Research indicates that giving a 12-month supply of contraceptives at once decreases the risk of unintended pregnancies in comparison to 1-3 month supplies and is more cost-effective.[2]

Q. With everything going on in the world, why push for this now?

A. Basic reproductive autonomy is under constant threat: now is an ideal time to secure contraceptive equity in all states by codifying and expanding the provisions in the ACA.

Individuals who feel unhappy with their contraceptive, due to side effects or other reasons, are less likely to correctly or consistently use contraception and more likely to experience an unintended pregnancy as a result. Individuals are also more likely to choose long-acting and highly effective contraceptive methods when they recieve 100% coverage.[3] Unintended pregnancy creates significant costs for private insurers and the state, which would be reduced by [Insert bill name] . In 2010, unintended pregnancies accounted for more than $357 million in public costs, including over $138.3 million in costs to the state.[4][Customize with language specific to State]

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[2] Foster, Diana Greene, et. al, *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies*, Obstetrics and Gynecology 117 (2011): 566-572. http://www.ncbi.nlm.nih.gov/pubmed/21343759.

[3] Huber L, Hogue C, Stein A, et al. *Contraceptive use and discontinuation: findings from the contraceptive history, initiation and choice study*. Am J ObstetGynecol 2006;194: 1290-5.

[4] *State Facts About Unintended Pregnancy: Massachusetts*, Guttmacher Institute (2016), available at https://www.guttmacher.org/sites/default/files/factsheet/ma_18.pdf.