DEPARTMENT OF ADMINISTRATION

OFFICE OF MANAGEMENT & BUDGET

State Budget Office

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State Fiscal Note for Bill Number: *2024-H 7255*

Date of State Budget Office Approval: Tuesday, March 12, 2024
Date Requested: Friday, January 19, 2024
Date Due: Monday, January 29, 2024

Impact on Expenditures		*Impact on Revenues*	
FY 2024	N/A	FY 2024	N/A
FY 2025	$579,818 - $1,324,454	FY 2025	Indeterminate
FY 2026	$781,868 - $2,345,604	FY 2026	Indeterminate
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Explanation by State Budget Office:

This bill would require every individual or group health insurance contract effective on or after January 1, 2025, to provide coverage to the insured and the insured's spouse and dependents for all FDA-approved contraceptive drugs, devices and other products, voluntary sterilization procedures, patient education and counseling on contraception and follow-up services as well as Medicaid coverage for a twelve (12) month supply for Medicaid recipients.

The bill prohibits the imposition of a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided. For qualifying high-deductible health plan for a health savings account, the bill allows the carrier to establish the plan's cost-sharing for the coverage provided at minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from their health savings account.

The bill prohibits religious employers to exclude coverage for contraceptive services or procedure for purposes other than contraception, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause.

The bill would subject plans in violation to penalties in accordance with existing statutory language as it relates to each section.

Finally, the bill establishes requirements for the Department of Business Regulation (DBR) to:

- Engage in stakeholder process prior to adoption of rule and regulations that include health care service plans, pharmacy benefit plans with consumer representatives including those representing youth, low-income people, communities of color and other interested parties. Stakeholder meetings shall be held to ensure opportunity to consider factors and processes relevant to contraceptive coverage. Stakeholder meetings shall be open to the public.
- Conduct random review of each plan and its subcontractors to ensure compliance.
- Submit an annual report to the general assembly and any other appropriate entity with findings from random compliance reviews.

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Summary of Facts and Assumptions:

Currently, individual or group health insurance plans provide coverage for FDA approved contraceptive drugs and devices requiring a prescription.

The provisions of this bill will mandate coverage to the insured and the insured's spouse and dependents, as well as Medicaid coverage for a twelve (12) month supply for Medicaid recipients for the following:

- All FDA-approved contraceptive drugs, devices and other products:
  - At least one therapeutic equivalent of an FDA-approved contraceptive drug, if one exists.
  - If therapeutic equivalent is not available or not medically tolerated or advisable to the patient, coverage for an alternate therapeutic equivalent version shall be covered.
  - Approved over the counter contraceptive drugs, devices and products shall not require a prescription to trigger coverage at in-network pharmacies.
- Voluntary sterilization procedures.
- Clinical services related to the provision or use of contraception.
- Follow-up services related to the drugs, products, and procedures covered.

Sections 1-4 of the bill solely impact Title 27: Insurance of Rhode Island General Law (RIGL). The Budget Office consulted State of Rhode Island's Office of Employee Benefits, who notes that Title 27 does not apply to the State's self-insured medical and Rx plans. Therefore, these sections will not impact the health insurance policies offered to state employees and their families and assumed to have no fiscal impact on state funds. This will impact private health insurance policies; however, this analysis solely focuses on the state funds. Though an analysis of these expenditures and corresponding impact on private insurance premiums is beyond the scope of this fiscal note, the Budget Office consulted with the Office of the Health Insurance Commissioner (OHIC) to gather additional information and context. OHIC does not believe it is possible to estimate the marginal change in premiums and premium tax because of this bill.

Section 5 of the bill impacts Medicaid coverage for which the Budget Office consulted Executive Office of Health and Human Services (EOHHS). Medicaid currently covers all FDA approved contraceptives. This includes emergency contraceptives that are currently available over the counter (OTC), such as Plan B and Ella. The FDA approved the first daily OTC contraceptive over the summer of 2024, Opill. EOHHS provided the following information summarized below to estimate fiscal impact:

- The bill directs payers to cover OTC contraceptives without a prescription. Unlike most commercial insurance, Medicaid does cover over the counter medication, if there is a prescription (e.g., a primary care physician can prescribe Advil and Medicaid will cover it). Whether more or less OTC contraceptives will be prescribed because of this bill is indeterminate at this time. OTC medications are prescribed at the discretion of the enrolled clinician and does not require other type of prior authorization for prescription. Changing the structure for certain OTC items would require complex system alterations for both MMIS and

MCOs. EOHHS would engage a MMIS system vendor to conduct a formal review and produce a project scope report to formulate all the various system changes that would be necessary to reimburse members for over-the-counter medicine without a prescription. Similarly, each health plan would need to do the same with their pharmacy benefit manager. Both EOHHS and the plans would need to set up a bifurcated system that require prescriptions for only some OTC medicine.

- Medicaid does not have prior authorization or other requirements that would prevent a person from getting successive birth control prescriptions filled. However, this bill would permit members to receive a full 12-month supply all at once, at the discretion of the prescriber. It is not clear how many providers would elect to offer a full 12-month prescription all at once. For those that did, there would be a potential fiscal impact associated with members getting a full 12 months of prescriptions that otherwise would not.

Table 1, attached, illustrates the FY 2025 estimated fiscal impact under different scenarios based on historical utilization and claims, and applies FY 2025 FMAP rates in calculations. The only difference between each is the percentage of scripts that are assumed to be issued for a full 12 months. The fiscal impact is based upon the average number of filled scripts per member each year now versus the assumed number of scripts if instead of getting the Rx filled monthly it was filled all at once for 12 months.

Table 1

FY 2025 Estimated fiscal impact, scenarios:

HB7255 Fiscal Impact	% to 12 mo supply	Benefits	System	All Funds	State Share (6-months of claims)	State Share (System)	FY 2025 Estimated Fiscal Impact
Low	25%	$ 2,500,000	$ 750,000	$ 3,250,000	$ 372,318	$ 187,500	$ 559,818
Medium	50%	$ 5,000,000	$ 750,000	$ 5,750,000	$ 744,636	$ 187,500	$ 932,136
High	75%	$ 7,500,000	$ 750,000	$ 8,250,000	$ 1,116,954	$ 187,500	$ 1,304,454

Observations:
-- Assumes that some share of members currently receiving less than a full year of contraceptives over the course of any given fiscal year instead receive 12 months up-front.
-- It is unclear what share of physicians would write prescriptions this way, so a low, medium, and high scenario is illustrated.
-- System changes at 75/25, but may be eligible for 90/10 if IAPD is submitted and approved. For conservatism, using standard MMIS matching rate for Maintenance & Operations costs.

EOHHS assumes in FY 2026, fiscal impact costs reflect prior year costs, less one-time system costs, trended by 5% growth. Using these assumption, a "Low" scenario would cost the State an estimated $781,868 and in a "High" scenario would cost an estimated $2,345,604.

The bill subjects non-compliant plans to penalties. Office of Revenue Analysis (ORA) is unable to assume a level of non-compliance and thus new fee revenue because it is unable to estimate that level of non-compliance.

The bill establishes requirements for Department of Business Regulation (DBR) to engage stakeholders, hold meetings and produce annual reporting requirements. DBR notes that the Office of the Health Insurance Commissioner (OHIC) would be tasked with implementing these requirements of the law. The Budget Office consulted OHIC to determine any potential costs of implementation and enforcement of the bill. OHIC estimates that it would cost approximately

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$20,000 to conduct the stakeholder process which they would rely on a consultant to perform. This cost would be a one-time expense in FY 2025 to develop rules and regulations in accordance with the bill. As authorized by R.I.G.L. §27-71, OHIC would use its examination authority to perform the compliance audits. Included in that authority is the cost of the review to be borne by the company that is subject of the examination per R.I.G.L. §27-71-15. OHIC will not be adding any additional staff resulting from the proposed annual reporting requirement as it will be performed in the normal course of business by existing staff. Therefore, the State would not incur costs to conduct compliance reviews or produce an annual report.

Enactment of this bill is assumed to be on or after January 1, 2025. Therefore, no impact is assumed for FY 2024. FY 2025 impact would represent 6 months of Medicaid claims and cost of system changes to Medicaid system, in addition to the $20,000 cost of conducting stakeholder meetings by OHIC. FY 2026 impact would represent 12 months of Medicaid claims.

Comments on Sources of Funds:

Medical claims by members of the self-insures state employee health insurance plan are financed through health insurance fund. The employer contributions to the health insurance fund are financed with all sources of funds.

Medicaid expenditures are jointly financed by general revenues and federal funds according to the prevailing Federal Medicaid Assistance Percentage (FMAP), which is 54.75 percent in SFY 2024 and 55.99 percent in FY 2025. The SFY 2024 rate is augmented by both the Families First Coronavirus Response Act (FFCRA) and the Fiscal Year 2023 Omnibus Appropriations Bill, resulting in an enhanced FMAP (eFMAP) of 55.75 in FY 2024, noting that all eFMAP opportunities have concluded as of December 2023 (FY 2024). For FY 2026, this fiscal note utilizes the FY 2025 FMAP, 55.99 percent.

Summary of Fiscal Impact:

FY 2024: No fiscal impact reported due to timing.
FY 2025: The Budget Office estimates a range of $579,818 - $1,324,454.
FY 2026: The Budget Office estimates a range of $781,868 - $2,345,604.

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Fiscal Advisor Signature: _____