

LD 1954, An Act To Ensure Access to Prescription Contraceptives

SUMMARY:

This bill requires health insurance policies to cover all contraceptive drugs, devices and products approved by the federal Food and Drug Administration without any deductible, coinsurance, copayment or other cost-sharing requirement. If the federal Food and Drug Administration has approved one or more therapeutic equivalents of a contraceptive supply, an insurer or a health maintenance organization is not required to cover all those therapeutically equivalent versions, as long as at least one is covered without any deductible, coinsurance, copayment or other cost-sharing requirement. Under current law, coverage must be provided without any deductible, coinsurance, copayment or other cost-sharing requirement for at least one contraceptive supply within each method of contraception that is identified by the federal Food and Drug Administration to prevent an unwanted pregnancy and prescribed by a health care provider.

It also requires all individual and group nonprofit hospital and medical services plan policies and contracts and all nonprofit health plan policies and contracts that provide coverage for prescription drugs or outpatient services to provide coverage for the furnishing or dispensing of prescribed contraceptive drugs, devices and products intended to last for a 12-month period, as is required of other types of health insurance policies.

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TESTIMONY: Written testimony can be found at this [link](#)

ISSUES FOR CONSIDERATION:

1. Under the federal Affordable Care Act (and codified in [State law](#)), carriers are required to provide coverage for one contraceptive product within each method of contraception with no cost sharing. LD 1954 would require coverage for all contraceptive products within a method category unless the federal Food and Drug Administration has approved one or more therapeutic equivalents of a contraceptive supply.
2. Consider impact of bill on ability to choose appropriate contraceptive without having to consider out-of-pocket cost or to have to go through carrier's process for appeals? In testimony from Planned Parenthood, it was noted that [recent FAQ](#) guidance for compliance with the existing ACA requirements described complaints made by women unable to obtain waiver of existing requirements and to receive coverage for a prescribed contraceptive supply recommended by their clinician without cost sharing. Carriers and Bureau of Insurance were asked to provide more information about appeals or complaints by Maine enrollees.
3. If the bill moves forward, consider if there is a conflict with federal law requirements for HSA-compatible plans. The Bureau of Insurance testimony notes that the Internal Revenue Service has issued guidance prohibiting plans from qualifying as HSA-compatible high-deductible health plans if they provide coverage outside the deductible for male contraceptives or any other contraceptives that are not approved by CMS as preventive services under the ACA.

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ISSUES FOR CONSIDERATION (cont'd):

4. The Bureau of Insurance testimony notes that the bill would be a mandate for coverage of any contraceptives that are not already covered by Maine law. Pursuant to [Title 24-A M.R.S.A. § 2752](#), a mandated health benefit proposal must undergo a review and evaluation by the Bureau of Insurance before the bill may be enacted. Consider whether bill requires review and evaluation? If determined to be a “mandate”, consider that the time needed for the Bureau to contract for and complete review and evaluation is at least 8 weeks. Also consider whether the bill adds an additional benefit to the State’s essential benefit package that may subject the State to the requirement for defrayal of costs or if it an expansion of an existing mandate rather than a new mandate?

FISCAL INFORMATION:

Not yet determined