reimbursement intelligence

Payer Survey: Current Contraception Benefit Structure and Anticipated Impact of Mandated No-Cost Access for All Members

Key Findings

- Access to contraception is a universally available benefit and is excluded only at a customer/employer's request
- Most prescription contraceptive methods are covered under the pharmacy benefit, with branded products available at Tier 2 or 3, with copays ranging from $3t to $60
- Nearly three-quarters of payers do not have a plan currently in place to address the August 1 2012 deadline in the Affordable Care Act (ACA) to begin offering all members access to prescription contraception at no cost
- Payers were divided about the potential impact of the ACA mandate, but none thought the mandate would lead to net cost savings by preventing unintended pregnancies among members

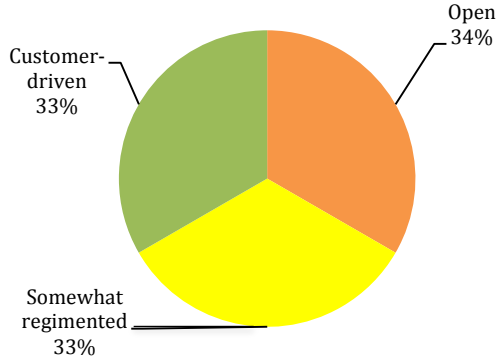
Survey Scope and Methodology

Reimbursement Intelligence conducted an on-line survey of 15 pharmacy directors representing >100 million pharmacy covered lives, fielded February 14-15, 2012. Overall, 86% of covered lives were in commercial (employer-sponsored) plans, with the balance representing free-standing pharmaceutical benefit plans (PBMs).

Approach to Contraception Benefit Design and Access

All plans offer member access to contraceptive services (Figure 1), and only a minority of employers choose to exclude coverage of contraception from the benefit plan offered to employees.

Figure 1. How would you characterize your plan's general approach toward providing access to contraceptive products and services?

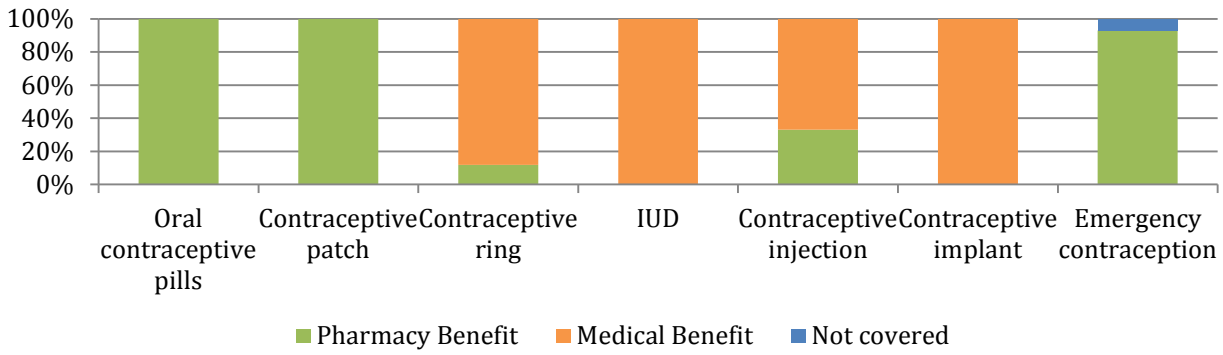


Access to contraception was defined as follows:

- **Open access** – Physicians and members can decide what's appropriate and obtain access at a nominal cost
- **Somewhat regimented** – Members must start with a low-cost or generic method, or document that such a method is medically inappropriate
- **Customer-driven** – Our customers/employers can choose whether or not to offer access to contraceptive products and services

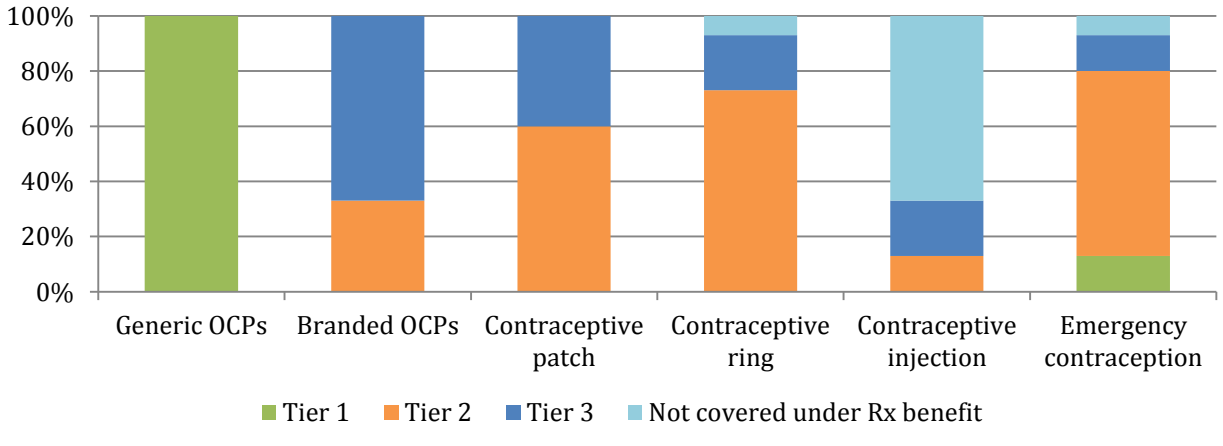
All plans cover oral contraceptive pills (OCP) and the contraceptive patch under the pharmacy benefit, and a majority (all but one plan) also cover the contraceptive ring under the pharmacy benefit (Figure 2). Emergency contraception also generally is covered under the pharmacy benefit, although one plan does not cover the so-called 'morning after' pill. IUDs and contraceptive implants are covered under the medical benefit. One-third of plans cover contraceptive injections under the pharmacy benefit, and two-thirds cover it under the medical benefit.

Figure 2. Coverage of contraception under pharmacy vs. medical benefit, by method



Payers were asked about the tier position of currently available prescription methods and average copayments for each (Figure 3). Generic OCPs are universally available under Tier 1, with an average member co-pay of $10. Brand-name OCPs are Tier 2 for one-third of respondents, and the remaining plans place these in Tier 3, with copays ranging from $35 to $60.

Figure 3. Tier placement of contraceptiion covered under the pharmacy benefit, by method



Payer Preparedness for ACA-Mandated Zero-Cost Access to Women's Preventive Health Services

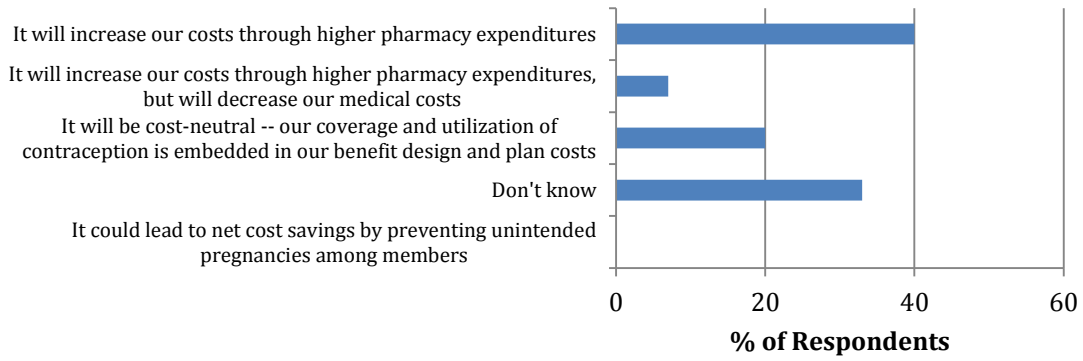
Nearly three-fourths of plans (73%) do not currently have a plan in place to meet the ACA August 1 2012 deadline, although 90% of these plans stated they would be developing an implementation plan in the next 3-6 months. Two plans stated they would develop a plan "if required". Among the payers that responded they currently have a plan in place, only one-third stated that their plan considered the possibility that the ACA mandate could include access to elective abortion services for members.

Impact of ACA Mandate on Benefit Design

Payers responding to the RI survey were split about whether the mandate for zero-cost access to contraception would change their benefit design for contraceptives, in terms of tier placement or coinsurance, with 53% saying it would change benefit design, and 47% saying it would not. Three respondents commented that the mandate could require that they cover all contraceptive methods at no cost to members, including both brands and generics.

Payers in this sample also were divided about the potential impact of the ACA mandate on their plan's per-member-per-month costs over the next 12-24 months (Figure 4). Of note, none of the respondents thought that the mandated coverage would lead to net cost savings by preventing unintended pregnancies – one of the stated objectives for inclusion of this benefit in the ACA.

Figure 4. What impact will the ACA women's preventive care requirement have on your plan's PMPM costs?



Most survey respondents stated that less than 10% of members have coverage for elective abortion, and only at the employer/customer's request.

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For more information about Reimbursement Intelligence or this survey, please contact Rhonda Greenapple, rgreenapple@reimbursementintelligence.com, 973.805.2300.