

HB

25

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Alaska State Legislature

Representative Matt Claman

Session: State Capitol, Rm 118 Juneau, AK 99801 Phone: 465-4919

Interim: 1500 W. Benson Blvd., Anch, AK 99503 Phone: 269-0130

House Bill 25 Sponsor Statement

"An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services; and providing for an effective date."

Unintended pregnancies have significant and negative consequences for individual women, their families, and society as a whole. Research links births resulting from unintended or closely spaced pregnancy to adverse maternal and child health outcomes and other social and economic challenges. With Alaska's fiscal challenges, we should look for ways to reduce costs in the short-term and long-term. House Bill 25 will reduce costs associated with unintended pregnancies by making prescriptive contraceptives more easily available to Alaskan women.

In 2010, 48% of all pregnancies in Alaska were unintended. Alaska's unintended pregnancy rate in 2010 was 54 per 1,000 women aged 15-44. Of those unintended pregnancies, 60% resulted in births, 26% resulted in abortions, and the remainder resulted in miscarriages. Most unintended pregnancies are associated with significant public costs. In 2010, 64.3% of unplanned births in Alaska were publically funded, which resulted in a \$42.9 million cost to the state.

House Bill 25 seeks to reduce the costs of unintended pregnancies by making prescriptive contraceptives more easily available to Alaskan women. A research study shows that women who were dispensed a 12-month supply of oral contraceptives had 30% less odds of having an unintended pregnancy than women who received a 1- or 3-month prescription. The study concluded that health insurance programs and public health programs may avert costly unintended pregnancies by increasing dispensing limits on oral contraceptives to a 1-year supply.

House Bill 25 requires health care insurers, including Medicaid services, to dispense 12 months of prescriptive contraceptives at a time. Alaskan women often face challenges while trying to access prescription contraceptives. Women living in rural Alaska have less access to healthcare services and therefore less reliable access to prescriptive contraceptives. Fisherwomen working on a boat for two or three months at a time need longer supplies of prescription oral contraceptives. This bill looks to reduce health care costs in Alaska by preventing unintended pregnancies and providing Alaskan women greater access to family planning options.



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House Bill 25 Sectional Analysis —Version A

Section 1. Requires a health care insurer to provide coverage for prescription contraceptives and to provide reimbursement to a health care provider or dispensing entity for dispensing prescription contraceptives intended to last for a 12-month period for subsequent dispensing.

Section 2. Requires the Department of Health and Social Services to pay for prescription contraceptives intended to last for a 12-month period for subsequent dispensing for eligible recipients of medical assistance, if prescribed to and requested by the recipient, as well as pay for specified related services.

Section 3. Requires the Department of Health and Social Services to amend and submit for federal approval a state plan for medical assistance coverage consistent with Section 2 of this Act.

Section 4. Provides that Section 2 of this Act takes effect only if the provisions of Section 2 of this Act receive federal approval.

Section 5. Provides for an effective date for Section 2 of this Act.

Section 6. Except for Sec. 5 of this Act, provides for a January 1, 2018 effective date.



The Voice of Small Business®

ALASKA

January 23, 2017

The Honorable Matt Claman
Alaska State House of Representatives
State Capitol Building
Juneau, Alaska 99801-1182

RE: House Bill 25

Dear Representative Claman,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to House Bill 25. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues, not additional mandates.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased last year by 30 to 40 percent, a jaw-dropping statistic on top of double-digit increases in the past few years. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately, HB 25 mandates specified drug coverage that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

While this measure includes the state Medicaid program, it does not specifically include the state employee programs. In fairness, if the state legislature does not believe it is a benefit important enough to mandate on its own programs, how can it be fair to mandate it on small employers and individual policy purchasers.

Honorable Matt Claman
January 23, 2017
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HB 25 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs or unions providing federally regulated health plans. Thus it creates a less fair business environment for small employers.

At a minimum, HB 25 should be amended by adding the following to proposed section 21.42.227 (g)(1), "and plans provided under AS 39.30.090 or 39.30.091." This would specifically include the state employee programs.

Sincerely yours,



Dennis L. DeWitt
Alaska State Director

cc: NFIB Alaska Leadership Council
Representative Ivy Spohnholz, Chair, House Health & Social Services Committee

Alaska Dispatch News

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[Home](#) > Let's work together against unintended pregnancy in Alaska, not low-income women's access to abortion services

Matt Davis

November 17, 2015

Main Image:

[gavel](#) ^[1]

When we talk about abortion in Alaska, the discussion often morphs into a pro-choice, pro-life debate that, by virtue of being grounded in personal beliefs, is unlikely to yield an answer that satisfies both sides. If we accept this stalemate, though, we miss an important point: the surest way to prevent abortions is to reduce the number of unintended pregnancies.

The good news is almost everyone agrees that allowing women to control whether or not they become pregnant is a good thing. Despite this consensus, however, according to the Guttmacher Institute, whose mission is to advance sexual and reproductive health worldwide, around half of pregnancies in the United States are unintended ^[2]. In 2011, this translated into 18 percent of pregnancies nationwide ending in abortions. In Alaska the figure was 12 percent.

According to the Alaska Bureau of Vital Statistics ^[3], there were 1,629 abortions performed in Alaska in 2012. If we are serious about reducing that number, we will need to follow the lead of places like Colorado, where state officials say a state-run family planning initiative reduced the abortion rate ^[4] of women ages 15-19 by 42 percent and of women 20-24 by 18 percent between 2009-2013. The secret behind this incredible success? Increased access to long-acting, reversible contraceptives like intrauterine devices and implants. Fifty-one percent of women in Alaska who received abortions in 2012 were under 25 years old, so we should pay close attention to these efforts and successes.

Sadly, our public officials have sometimes resorted to blocking broader health-care access as a means of restricting abortion access. For example, in 2010 Gov. Sean Parnell vetoed the expansion of Denali KidCare ^[5] -- Alaska's version of the federal Children's Health Insurance Program that provides care to poor women and their children -- saying that, "My intention here today is to make sure we don't expand state government funding of abortions here in Alaska." That decision kept up to 1,300 children and 225 pregnant women from accessing the program.

At the beginning of November, the state of Alaska announced it will continue attempting to restrict low-income women's ability to access abortions via Medicaid funds by appealing a Superior Court ruling ^[6] in Planned Parenthood ^[7] v. Streur ^[8]. In striking down a state regulation that severely narrowed the definition of 'medical necessity' as it relates to abortion provision, the court described how the regulation came to be ^[7] in the first place: "Contrary to normal DHSS procedure, Commissioner William Streur developed the abortion regulation on his own. DHSS staff did not participate in the drafting of the regulation. The DHSS medical director played no role. No abortion providers were consulted." Of note, former Commissioner Streur is not a physician.

The American College of Obstetricians and Gynecologists states in its abortion policy statement ^[9], "Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties."

time.⁸ Family planning waiver programs, which allow states to expand eligibility for family planning services to women otherwise ineligible for Medicaid, vary widely in dispensing limits for OCPs from 1 to 17 cycles dispensed per visit.

Data from the state Medicaid waiver family planning program in California provide some insight on the effect of dispensing limits on oral contraceptive continuation. The Family PACT (Planning, Access, Care, and Treatment) Program in California provides clinical services for family planning and reproductive health at no cost to over one and a half million low-income California residents per year. Details of the program have been previously reported.⁹ Family PACT policy allows eligible public and nonprofit clinics to dispense up to 13 cycles of OCPs per visit on site. Most clients going to private providers must receive supplies at pharmacies that abide by the Medi-Cal limit of a 100-day supply. As part of an effort to control costs and reduce wastage, this study was undertaken to determine the feasibility of the 13-cycle dispensing practice at public and nonprofit clinics. Our objective was to estimate the difference, if any, in method continuation, pill wastage, service use, and program costs when different quantities of OCPs are dispensed.

MATERIALS AND METHODS

We used paid claims data on service use and OCP dispensing from the Family PACT Program. The study population consisted of the 82,319 women who were dispensed oral contraceptives through the Family PACT Program in the month of January 2003. This month was chosen to allow sufficient time for claims to be submitted and paid through the end of December 2004. Based on Family PACT data on time to submission and payment, we estimated that the claims data were 99.9% complete at the time we received them. The paid claims database is a nearly complete universe of services delivered through the Family PACT Program. There were 390 clients (0.5%) who may have received pills but whose claims were not paid.

We examined all Family PACT visits and services for the women who received OCPs in January 2003 and looked at use of services such as office visits, *Chlamydia* tests, Pap tests, and pregnancy tests for these women during 2003. We calculated direct Family PACT expenditures for these women for all visits during 2003, including all pharmacy, clinician, and laboratory claims. To estimate continuation of oral contraceptive use, we examined claims up to 24 months after January 2003. This study was approved

by the University of California San Francisco Committee on Human Research as part of the university's Family PACT Program Support and Evaluation project.

Information on client characteristics comes from the Family PACT enrollment form, reactivation of which must occur annually to maintain eligibility for services. Women were considered to be new Family PACT clients if they first enrolled in Family PACT at their January 2003 dispensing visit. Among women who are not new to Family PACT, we can distinguish between new and established OCP users based on their receipt of OCPs in 2002.

Paid claims data allowed us to construct several indicators of contraceptive continuation. We counted total months of protection dispensed to an individual in 2003 and determined whether there was pill dispensing to that same client in 2004. We were also able to determine whether a woman received a sufficient number of oral contraceptive cycles to be covered on the first of each month subsequent to January 2003. We used April 2004, 15 months after the initial dispensing, as an index date for continuation because women initially dispensed 13 cycles would need refills before that time. We distinguished sporadic use or use with gaps in protection from continuous use by examining the quantity of cycles dispensed and timing of visits to get more oral contraceptive supplies. Women were considered to be continuously protected if they received enough pill cycles to continue pill use without a break. There was a 28-day grace period in our calculations of contraceptive protection to allow for the use of a remaining cycle from a previous visit for women not new to the pill and for new users to wait one menstrual cycle before initiating pill use. We assumed that women were not using OCPs on an extended regimen where they skip the inactive pills.

To estimate wastage of oral contraceptives we looked at two distinct types of wastage. The first, *method-switching wastage*, occurs when another method of contraception was provided to the client before she could have consumed her OCPs. For example, if a woman received an injectable contraceptive 2 months after a visit in which she received three cycles of pills, one OCP cycle was considered to be wasted. Barrier methods were excluded from estimates of method-switching wastage because we could not distinguish between dual use and switching between barrier methods and oral contraceptives. The second type of wastage, *pill-oversupply wastage*, is what would occur if a woman received one brand of OCPs and switched to another brand before using the first or if she lost her



Traditionally, the state has allowed patients and physicians to determine together what may or may not constitute a medical necessity. I suspect most Alaskans would prefer the government not interfere with that relationship.

If we are truly invested in women's health, let's support it by increasing access to primary care and family planning services rather than targeting low-income women's access to abortion services. As Judge Suddock wrote, "Women voluntarily assume the risks of pregnancy in the joyful context of a wanted child. But Alaskan women denied Medicaid abortions by a restrictive standard who are unable to beg, borrow, or earn \$650 (or far more for an out-of-state second-trimester abortion) would be forced to carry to term without voluntarily assuming those risks."

I strongly urge Gov. Walker and Attorney General Richards to reconsider their appeal and to refrain from imposing their personal beliefs on low-income Alaskan women. Whether you are for or against abortion access, let's work together to reduce the need for it using evidence-based public health measures.

Matt Davis was born and raised in Anchorage and is currently attending medical school at the George Washington University School of Medicine & Health Sciences in Washington, D.C.

Correction: An earlier version of this commentary mistakenly referred to a federal initiative as the "Children's Health Insurance Plan." The correct title is "Children's Health Insurance Program."

The views expressed here are the writer's own and are not necessarily endorsed by Alaska Dispatch News, which welcomes a broad range of viewpoints. To submit a piece for consideration, email [commentary\(at\)alaskadispatch.com](mailto:commentary(at)alaskadispatch.com) [10].

Source URL: <http://www.adn.com/article/20151117/lets-work-together-against-unintended-pregnancy-alaska-not-low-income-womens-access>

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- [10] <mailto:commentary@alaskadispatch.com>

**THE FOLLOWING DOCUMENT
HAS NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL FILE**

Number of Oral Contraceptive Pill Packages Dispensed, Method Continuation, and Costs

Diana Greene Foster, PhD, Ram Parvataneni, MD, MPH, Heike Thiel de Bocanegra, PhD, MPH, Carrie Lewis, MPH, Mary Bradsberry, and Philip Darney, MD, MS

OBJECTIVE: To estimate the effect of the number of cycles of oral contraceptive pills (OCPs) dispensed per visit on method continuation, pill wastage, use of services, and health care costs.

METHODS: We used paid claims data for 82,319 women dispensed OCPs through the California Family PACT (Planning, Access, Care, and Treatment) Program in January 2003 to examine contraceptive continuation and service use.

RESULTS: Women who received 13 cycles at their first visit in January 2003 received 14.5 cycles over the course of 2003 compared with 9.0 cycles among women receiving three cycles at first visit. When client characteristics are controlled, women who received 13 cycles were 28% more likely to have OCPs on hand and twice as likely to have sufficient OCP cycles for 15 months of continuous use compared with women who received three cycles. Oral contraceptive pill wastage was higher among women initially dispensed 13 cycles (6.5% of the cycles dispensed) than among women who received three cycles (2% of cycles). Despite having one fewer clinician visit, women dispensed 13 cycles were more likely to receive Pap and *Chlamydia* tests and less likely to have a pregnancy test than women initially dispensed fewer cycles. Over the course of the year, Family PACT paid \$99 more for women who received three cycles and \$44 more for women who received only one cycle than it did for women who received 13 cycles at their first visits of 2003.

CONCLUSION: Dispensing a year's supply of OCP cycles to women is associated with higher method continuation and lower costs than dispensing fewer cycles per visit.

(*Obstet Gynecol* 2006;108:1107-14)

LEVEL OF EVIDENCE: II-2

Discontinuation and imperfect use of oral contraceptive pills (OCPs) is a leading cause of unintended pregnancy nationally. Women who use oral contraceptives experience many more pregnancies than would be expected with perfect use; 5-8% of women are estimated to have a contraceptive failure in the first year of OCP use.^{1,2} Among women presenting for abortion in 2000 and 2001 in the United States, one woman in seven was using OCPs in the month she conceived.³ Given that an estimated 11.6 million American women use oral contraceptive pills as their primary contraceptive method,⁴ improving pill use can significantly reduce the number of abortions and unintended births in the United States.

A small study by Smith and Oakley⁵ found that the third leading cause of missed pills was "no new pill pack," after "away from home" and "forgot." Although women report "running out of pills" as a common reason for erratic pill taking, the role of the number of OCP cycles dispensed on method continuation has received little research attention. Phillips et al⁶ demonstrated that, in 1996, 73% of American women obtained only a 30-day supply of OCPs per visit to the clinic or pharmacy, requiring a refill every month for continued use. Despite the potentially important role of dispensing policies on method compliance and continuation, the effect of the number of cycles dispensed on failure rates is unknown.

Most health plans limit prescriptions of all drugs filled at a community pharmacy to a 30-day supply.⁷ State Medicaid policies vary across the country, but no more than a 100-day supply is dispensed at any one

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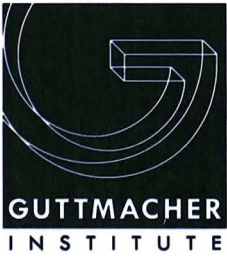
The authors thank our colleague Dr. Michael Policar for raising the issue of dispensing limits.

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State Facts About Unintended Pregnancy: Alaska

National Background and Context

Unintended pregnancy can have significant, negative consequences for individual women, their families and society as a whole. An extensive body of research links births resulting from unintended or closely spaced pregnancies to adverse maternal and child health outcomes and myriad social and economic challenges.[1,2] In 2011, the most recent year for which national-level data are available, 45% of all pregnancies in the United States were unintended, including three out of four teen pregnancies, and there were 45 unintended pregnancies per every 1,000 women aged 15-44, a rate significantly higher than that in many other developed countries.[3,4] If current trends continue, more than half of all women in the United States will experience an unintended pregnancy by the time they reach age 45. And economically disadvantaged women are disproportionately affected by unintended pregnancy and its consequences: In 2011, the unintended pregnancy rate among women with a family income lower than the federal poverty level, at 112 per 1,000, was more than five times the rate among women with an income greater than 200% of poverty (20 per 1,000).[3]

In any given year, two-thirds of women in the United States at risk of unintended pregnancy use contraceptives consistently throughout the year.[5] These women account for only 5% of all unintended pregnancies, while the remaining 95% of unintended pregnancies are attributable to the one-third of women who do not use contraceptives or who use them inconsistently. Public programs—notably Medicaid and the Title X national family planning program—are central to women's access to affordable contraceptive services and supplies and their ability to use contraceptives effectively. In 2014, 7.8 million women received publicly funded family planning services; these services helped women avoid 2 million unintended pregnancies, which would likely have resulted in 914,000 unplanned births and nearly 680,000 abortions (the remainder would have resulted in miscarriages).[6]

Absent publicly funded family planning services, the numbers of unintended pregnancies, unplanned births and abortions in the United States would be 68% higher—and teen pregnancies would be 73% higher—than they currently are.[6]

Unintended pregnancies are also costly to the federal and state governments, resulting in \$21.0 billion in public expenditures in 2010.[7] Yet, these costs could have been considerably higher: By helping women avoid unintended pregnancies, publicly funded family planning services saved taxpayers \$13.6 billion in 2010, or \$7.09 for every \$1 spent.[8]

Incidence and Outcomes of Unintended Pregnancy in Alaska

- In 2010, 48% of all pregnancies (8,000) in Alaska were unintended.[9]
- Alaska's unintended pregnancy rate in 2010 was 54 per 1,000 women aged 15—44. Nationally, rates among the states ranged from a low of 32 per 1,000 in New Hampshire to a high of 62 per 1,000 in Delaware.[9]

- The teen pregnancy rate in Alaska was 59 per 1,000 women aged 15—19 in 2011. The national rate was 52 per 1,000, and state rates ranged from 26 per 1,000 in New Hampshire to 72 per 1,000 in New Mexico.[10]
- In 2010, 60% of unintended pregnancies in Alaska resulted in births and 26% in abortions; the remainder resulted in miscarriages.[9]

Public Cost of Unintended Pregnancy in Alaska

- In 2010, 3,000 or 64.3% of unplanned births in Alaska were publicly funded, compared with 68% nationally.[7]
- In Alaska in 2010, the federal and state governments spent \$113.7 million on unintended pregnancies; of this, \$70.8 million (52%) was paid by the federal government and \$42.9 million was paid by the state.[7]
- The total public costs for unintended pregnancies in 2010 was \$790 per woman aged 15–44 in Alaska, compared with \$201 per woman nationally.[7]

Preventing Unintended Pregnancy in Alaska

- In 2014, 41,200 Alaska women aged 13–44 were in need of publicly funded family planning services.[6]
- Publicly supported family planning centers in Alaska served 26,070 female contraceptive clients in 2014. They met 63% of Alaska women's need for contraceptive services and supplies. Across the United States, such centers met 26% of need.[6]
- In 2010, public expenditures for family planning client services in Alaska totaled \$5.5 million; this includes \$2.1 million through Medicaid and \$1.9 million through Title X. Most states also use some of their own money (in addition to funds required to match federal grants) for family planning services. In 2010, Alaska contributed \$1.4 million. [11]
- Publicly funded family planning centers in Alaska helped avert 6,300 unintended pregnancies in 2014, which would have resulted in 3,100 unplanned births and 2,300 abortions.[6]
- By averting unintended pregnancies and other negative reproductive health outcomes, publicly funded family planning services provided by safety-net health centers in Alaska helped save the federal and state governments \$65.4 million in 2010.[8]

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Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care National and State Estimates for 2010

Adam Sonfield and Kathryn Kost

- Nationally, 51% of all U.S. births in 2010 were paid for by public insurance through Medicaid, the Children's Health Insurance Program and the Indian Health Service.
- Public insurance programs paid for 68% of the 1.5 million unplanned births that year, compared with 38% of planned births.
- Two million births were publicly funded in 2010; of those, about half—one million—were unplanned.
- A publicly funded birth in 2010 cost an average of \$12,770 in prenatal care, labor and delivery, postpartum care and 12 months of infant care; when 60 months of care are included, the cost per birth increases to \$20,716.
- Government expenditures on the births, abortions and miscarriages resulting from unintended pregnancies nationwide totaled \$21.0 billion in 2010; that amounts to 51% of the \$40.8 billion spent for all publicly funded pregnancies that year.
- To put these figures in perspective, in 2010, the federal and state governments together spent an average of \$336 on unintended pregnancies for every woman aged 15–44 in the country.
- In the absence of the current U.S. publicly funded family planning effort, the public costs of unintended pregnancies in 2010 might have been 75% higher.
- The total gross potential savings from averting all unintended pregnancies in 2010 would have been \$15.5 billion. This is less than the total public cost of all unintended pregnancies, because even if all women had been able to time their pregnancies as they wanted, some of the resulting births still would have been publicly funded. These potential savings do not account for the public investment in family planning services and other interventions that might be required to achieve them.





February 2015

Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010

Adam Sonfield and Kathryn Kost

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www.guttmacher.org

Introduction

Unintended pregnancy has long been acknowledged as an important health, social and economic problem in the United States—one that creates hardships for women and families and threatens the health and well-being of women and their infants.¹⁻⁴ Those consequences, in turn, have broad societal implications, including for the national economy and the extent of government expenditures.

Rates of unintended pregnancy are far higher among women living at or near the poverty level than among higher-income women—a disparity that grew substantially between 1994 and 2008.^{5,6} Most of these low-income women are eligible for public coverage of pregnancy-related care through Medicaid, the Children’s Health Insurance Program (CHIP) or the Indian Health Service (IHS). Thus, these programs play a central role in preserving maternal and child health, and a substantial share of the cost burden of unintended pregnancy is likely to fall on the public.

This report provides national and state-level estimates for 2010 for public expenditures on unintended pregnancy, as well as for the contribution of public insurance programs in providing essential care to pregnant women and children. It closely follows the methodology used for the Guttmacher Institute’s 2006 and 2008 estimates.^{7,8} However, because of several key changes to the methodology, public expenditure estimates for 2010 are not comparable with those for earlier years. Rates and numbers of unintended pregnancies in each state in 2010 are presented elsewhere.⁹

WHAT IS UNINTENDED PREGNANCY?

An unintended pregnancy is one that was either mistimed or unwanted. If a woman did not want to become pregnant at the time the pregnancy occurred, but did want to become pregnant at some point in the future, the pregnancy is considered mistimed; if she did not want to become pregnant then or at anytime in the future, the pregnancy is considered unwanted.

An intended pregnancy is one that was desired at the time it occurred or sooner.

When calculating unintended pregnancy rates, women who were indifferent about becoming pregnant are counted with women who had intended pregnancies, so that the unintended pregnancy rate only includes pregnancies that are unambiguously unintended.

In this report, births resulting from unintended pregnancies are referred to as unplanned and those resulting from intended pregnancies are referred to as planned.

Methodology

The analysis in this report is based on the methodology used for the Guttmacher Institute's first state-level estimates of the publicly funded costs of births from unintended pregnancy for 2006 and its follow-up for 2008.^{7,8} More details on the methodology can be found in those reports.

This report focuses on the cost of publicly funded births: those births with deliveries paid for by Medicaid, CHIP or IHS, including Medicaid and CHIP managed care plans, and Medicaid and CHIP programs operating under Section 1115 waivers (which permit states to receive federal funding for programs that do not meet federal Medicaid and CHIP requirements). For these 2010 estimates, we have included costs of prenatal care, labor and delivery, postpartum care and 60 months of care for the child. Also, we factored in the relatively small public costs of abortions and miscarriages resulting from unintended pregnancies.

To estimate the costs of publicly funded births, we obtained three underlying state-level estimates for each state: the number of unplanned births in a given year, the proportion of unplanned births with deliveries paid for by public programs and the cost to those programs for each birth. The same three underlying estimates were also obtained for planned births and births overall.

Number of Births

A related Guttmacher Institute analysis estimated 2010 unintended pregnancy rates for all 50 states and the District of Columbia.⁹ That analysis utilized birth counts from the U.S. vital statistics system; data on the intendedness of births from the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance project of the Centers for Disease Control and Prevention (CDC); data from similar state-conducted surveys; and results from multivariate linear regression analyses for several states for which data were unavailable. We obtained the estimated number of unplanned births for each state from unpublished tabulations of the data used in that analysis. Descriptions of and additional notes about those data sources can be found in that report.⁹

Births Paid for by Public Programs: Survey Data

PRAMS was the primary source for the proportion of births—all births, unplanned births and planned births—with deliveries paid for by Medicaid, CHIP and IHS. The core PRAMS questionnaire for 2010 asked how the respondent's delivery was paid for. Possible responses included Medicaid, personal income, private health insurance and up to two additional categories defined by individual states; respondents could also answer "other" and write in additional information.

PRAMS or similar data were available for 42 states. For 38 states, we obtained weighted estimates of the proportion of births paid by public funds from 2010 PRAMS data: Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

For these 38 states, we identified CHIP and IHS programs, Medicaid and CHIP managed care plans, and Medicaid and CHIP waiver programs. For some states, these payment options were included on the PRAMS questionnaire as a response option for the delivery payment question and listed either within the Medicaid payment category or as a separate category.

The IHS was included as a state-specific category in nine states in the 2010 PRAMS survey (Alaska, Minnesota, Mississippi, Nebraska, New Mexico, Oklahoma, Oregon, Washington and Wisconsin). In addition, the following state-specific programs were included in this analysis: Alabama (All Kids), Alaska (Alaska Native Health Service), Arkansas (ARKids First), Colorado (Child Health Plan Plus), Connecticut (State Administered General Assistance and Charter Oak), Florida (Medipass), Illinois (All Kids, Moms and Babies), Michigan (Medical Outpatient Maternity Services), Nebraska (Medicaid managed care), New Jersey (New Jersey FamilyCare), New Mexico (Salud!), New York (Prenatal Care Assistance Program), North Carolina (Baby Love, NC Health Choice,

Health Check, Carolina Access), Pennsylvania (adultBasic), Rhode Island (Rlte Care), Tennessee (CoverKids, Cover Tennessee and TennCare), Vermont (Dr. Dynasaur), Virginia (FAMIS) and Wisconsin (BadgerCare or BadgerCare Plus).

In addition, the payment-for-delivery question included an “other” response category, allowing respondents to write in other forms of payment. Relevant write-in responses were included for 26 states with data we were able to analyze. Those included variations and misspellings of Medicaid, CHIP and IHS; alternate program names, including generic ones (e.g., “medical assistance” or “Title XIX”) and state-specific ones (as confirmed on state Web sites); and the names of specific managed care plan issuers that specialize in Medicaid and other public insurance programs (as confirmed on state and issuer Web sites).

We also obtained tabulations from PRAMS-like surveys in four states: California (2011 Maternal and Infant Health Assessment, or MIHA), Idaho (2010 Pregnancy Risk Assessment Tracking System, or PRATS), Iowa (2010 Barriers to Prenatal Care survey) and Kentucky (2008 PRAMS pilot survey).

Births Paid for by Public Programs: Multivariate Regression

For the remaining nine jurisdictions, PRAMS or similar data were unavailable: Arizona, the District of Columbia, Indiana, Kansas, Montana, Nevada, New Hampshire, North Dakota and South Dakota. For these, we report, in Table 1, estimates from a study by Markus and colleagues (2013) on the proportion of all births paid for by Medicaid in 2010.¹⁰

That study, however, does not include estimates for unplanned births or planned births. Instead, we used a multivariate linear regression analysis to predict estimates of the proportions of unplanned and planned births paid for by public coverage (including Medicaid, CHIP or IHS).

In the model, each of the 42 states with data represented an observation. The dependent variable was the proportion of unplanned births for which the delivery was covered by public insurance. (A separate model was estimated for planned births.) Independent variables, measured at the state level, included measures of the demographic composition of women aged 15–44, overall birthrate, unplanned birthrate, proportion of all births paid for by Medicaid and income-eligibility threshold for pregnancy-related care under Medicaid and CHIP. The model’s demographic measures included the percentage of women of reproductive age in the state who were in a particular age-group (15–19, 20–24 and 25–34), race or ethnicity category (non-Hispanic white, non-Hispanic black, Hispanic, and American Indian or Alaskan Native),

poverty status category (proportion below the poverty line) and insurance category (Medicaid/CHIP and uninsured); the reference categories, which were excluded to prevent overspecification of the model, were 35 or older, non-Hispanic other, proportion at or above the poverty line and proportion with private insurance, respectively. This model was identical to the model used for the 2008 study.⁸

The R² of the final model indicated that 89% of the variation in the proportion of unplanned births that were publicly funded and 95% of the variation in the proportion of planned births that were publicly funded could be accounted for by the independent variables.

Standard errors for the nine predicted values of the proportion of unplanned births that were publicly funded ranged from 0.01 to 0.05, except for in the District of Columbia (0.10), which is somewhat unlikely to conform to a model in which all the other observations are states, as opposed to cities. Standard errors for the nine predicted values of the proportion of planned births that were publicly funded ranged from 0.01 to 0.04 (0.06 for the District of Columbia).

Cost per Publicly Funded Birth

State-level data on the average cost of a Medicaid-funded birth and 12 months of infant care in 2010 were drawn from an earlier Guttmacher Institute report.¹¹ Data on the cost of a CHIP- or IHS-funded birth were not available; for the current analysis, we assumed that it was the same as for a Medicaid-funded birth. Briefly, data on these Medicaid costs are not consistently collected for all states, but were available in applications or evaluations completed by 25 states that have sought a federal waiver to expand Medicaid eligibility specifically for family planning services (adjusted for inflation when necessary), and from another 10 states and the District of Columbia in response to a Guttmacher Institute survey.¹² For the remaining 15 states, we obtained estimates by averaging the available data and adjusting for differences among states in their Medicaid payment rates for physicians.

Additional data on the average cost of Medicaid-funded care for months 13–60 were drawn from a Guttmacher Institute analysis published in 2014, which expanded and updated our methodology for assessing the public savings related to U.S. publicly funded family planning services.¹³ That analysis relied upon 2010 state-level data from the Medicaid Statistical Information System.

For the current analysis, we separated the average cost of a Medicaid-funded birth for each state into state and federal costs, on the basis of the state’s FY 2010 federal medical assistance percentage (i.e., the proportion of medical costs under Medicaid for which states receive

reimbursement from the federal government).¹⁴

We multiplied the number of unplanned births in each state by the proportion of such births paid for by public programs to arrive at each state's number of publicly funded unplanned births. That figure was then multiplied by the average cost of a Medicaid-funded birth in the state to arrive at a total cost for the state. The same process was used for the cost of all publicly funded births in each state (including planned births, which we subsequently calculated by subtraction).

Public Costs for Miscarriages and Abortions

One change from the 2006 and 2008 iterations of this analysis is that, for 2010, we included estimates of the public costs of miscarriages and abortions to arrive at a more complete estimate of the total public costs of unintended pregnancies. Neither addition had a substantial effect on the nationwide total costs, with miscarriages accounting for 1.5% of total costs and abortions accounting for 0.3%.

We obtained unpublished numbers of total miscarriages and of miscarriages from unintended and intended pregnancies from a related Guttmacher Institute analysis of 2010 unintended pregnancy rates.⁹ Following the methodology of the Guttmacher Institute's expanded assessment of the benefits and savings from publicly funded family planning services,¹³ we assumed that the proportion of miscarriages that were publicly funded was equal to the proportion of births that were publically funded. That same report estimated that the average cost of a publicly funded miscarriage is 9.8% of the average cost of publicly funded maternity and infant care. We applied that estimate here to arrive at state-level cost estimates per miscarriage.

Public expenditures for abortions in 2010 were published in a prior Guttmacher Institute report.¹² Almost all of those costs are for the 17 states that use their own funds to pay for abortions for publicly insured women.

Potential Savings from Preventing Unintended Pregnancies

The Guttmacher Institute's expanded assessment of the benefits and savings from publicly funded family planning services also included an adjustment to account for the likelihood that some unintended pregnancies would not actually result in public savings if prevented.¹³ That is because, in some cases, a woman who is able to prevent a mistimed pregnancy, but eventually has a wanted one, may only delay rather than avoid the costs to public insurance. The expanded assessment concluded that 73.3% of unplanned publicly funded births would be cost-saving

to the government if prevented. The methodology for arriving at that adjustment factor is described in detail in the original report. (The adjustment factor is based on national data; state-level adjustments were not feasible with existing data.)

For this report, we estimated the total public costs for unintended pregnancies, alongside a second set of estimates for the potential gross savings from preventing those unintended pregnancies. To arrive at the second set of estimates, we applied the 73.3% adjustment factor to the costs of unplanned births. Note that these estimates do not account for the cost of the public investment (e.g., in family planning services) that might be required to achieve these potential savings.

National Totals

According to the National Survey of Family Growth (NSFG), there were an estimated 1.67 million unplanned births in the United States in 2008;¹⁵ by comparison, the state-specific estimates from the 2008 iteration of this study summed to 1.81 million unplanned births that year.⁸ To account for that difference, in the 2008 report, we presented both unadjusted U.S. totals (summed from the state-level data) and adjusted U.S. totals (for unplanned births, that was calculated as 92.5%—1.67 million divided by 1.81 million—of the unadjusted totals). Throughout that report, we referred exclusively to adjusted totals when discussing national estimates.

For 2010, we did not have a national estimate from the NSFG of unplanned births. (The most recent national estimate is from 2008; the next national estimate, which is expected to be published later this year, will be for 2011.) Therefore, we continued to use the 92.5% adjustment factor from the 2008 iteration of this study.

Limitations

Our estimates are subject to a number of limitations, many of which are inherent to the array of sources from which data were drawn and have been discussed previously.^{16,17} Several others are important to highlight here.

Our method of attributing costs to state and federal governments has shortcomings. There are two ways it could understate federal contributions: We did not account for enhanced federal reimbursement to states for pregnant women enrolled in CHIP, rather than Medicaid; nor did we assign costs paid for by the IHS entirely to federal expenditures (IHS does not have a state matching component). Our method could overstate federal contributions, as well. We did not reduce federal expenditures to account for the typically lower reimbursement rate to states for women covered by Medicaid only for labor and

delivery on an emergency basis (e.g., for undocumented immigrants). The number of births affected by all three of these limitations, however, was relatively small, compared with the group for whom states receive reimbursement at their standard federal medical assistance percentage.

The public expenditures for unintended pregnancies, intended pregnancies and all pregnancies estimated in this paper for 2010 are not comparable with the public expenditures estimated in earlier Guttmacher papers for 2006 and 2008. As noted above, we included costs of prenatal care, labor and delivery, postpartum care and 60 months of care for the child, and we also factored in the relatively small public costs of abortions and miscarriages resulting from unintended pregnancies. The 2006 and 2008 estimates included only 12 months of care for the child, and did not include the costs of abortions and miscarriages.

Findings

Publicly Funded Births

- Nationally, 68% of the 1.5 million unplanned births in 2010 were paid for by public insurance programs, compared with 51% of all births and 38% of planned births (Table 1).
- Two million births were publicly funded in 2010; of those, about half—1.0 million—were unplanned. (By comparison, 1.5 million out of 4.0 million total births nationwide were unplanned, 38%.)
- In eight states and the District of Columbia, at least 75% of unplanned births were paid for by public programs (Map 1). Mississippi was the state with the highest proportion (82%); the proportion in the District of Columbia was 85%. All but two of those nine jurisdictions are in the South (as categorized by the U.S. Census Bureau), a region with high levels of poverty.
- In six states, the proportion of unplanned births paid for by public programs was below 50%; North Dakota had the lowest proportion (37%). The six states with the lowest proportions follow no clear geographic pattern
- State-level patterns for public coverage of all births (Map 2) and planned births were very similar to those for unplanned births. Mississippi and the District of Columbia had the highest proportions, and other southern states followed closely. New Hampshire and North Dakota had the lowest proportions paid for by public insurance programs.

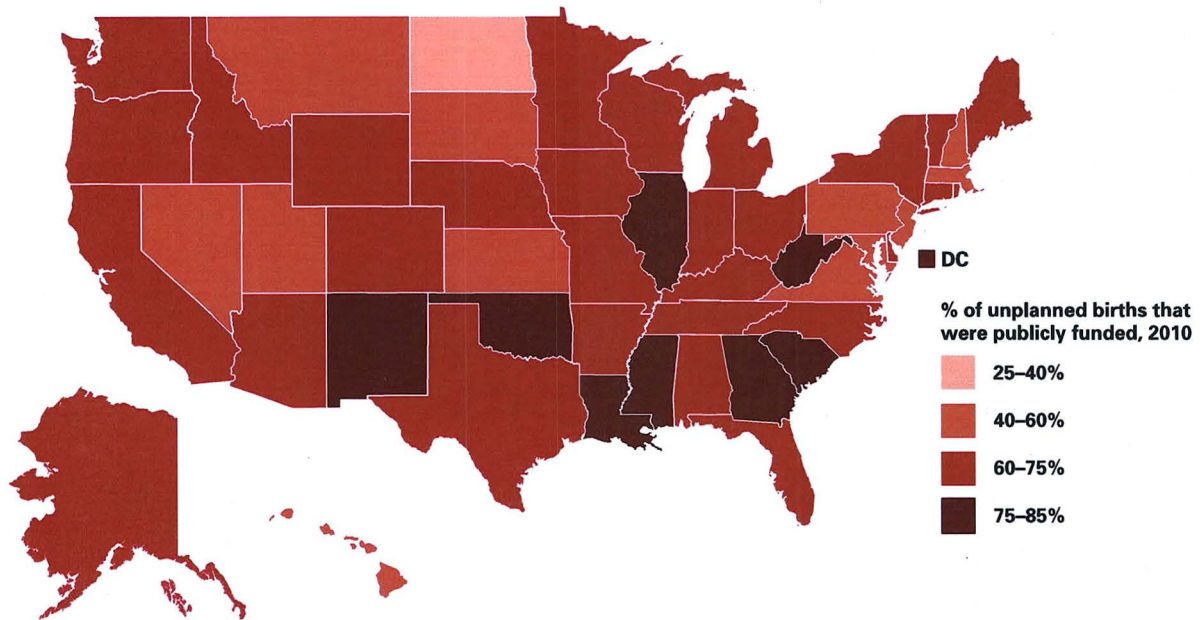
Public-Sector Costs

- On average, a publicly funded birth cost \$12,770 in prenatal care, labor and delivery, postpartum care and the first 12 months of infant care; care for months 13–60 cost, on average, another \$7,947, for a total cost per birth of \$20,716 (Table 2).
- Government expenditures on unintended pregnancies nationwide totaled \$21.0 billion in 2010; of that, \$14.6 billion were federal expenditures and \$6.4 billion were state expenditures (Table 3).
- In 19 states, public costs related to unintended pregnancies exceeded \$400 million (Map 3). Texas spent the most (\$2.9 billion), followed by California (\$1.8 billion),

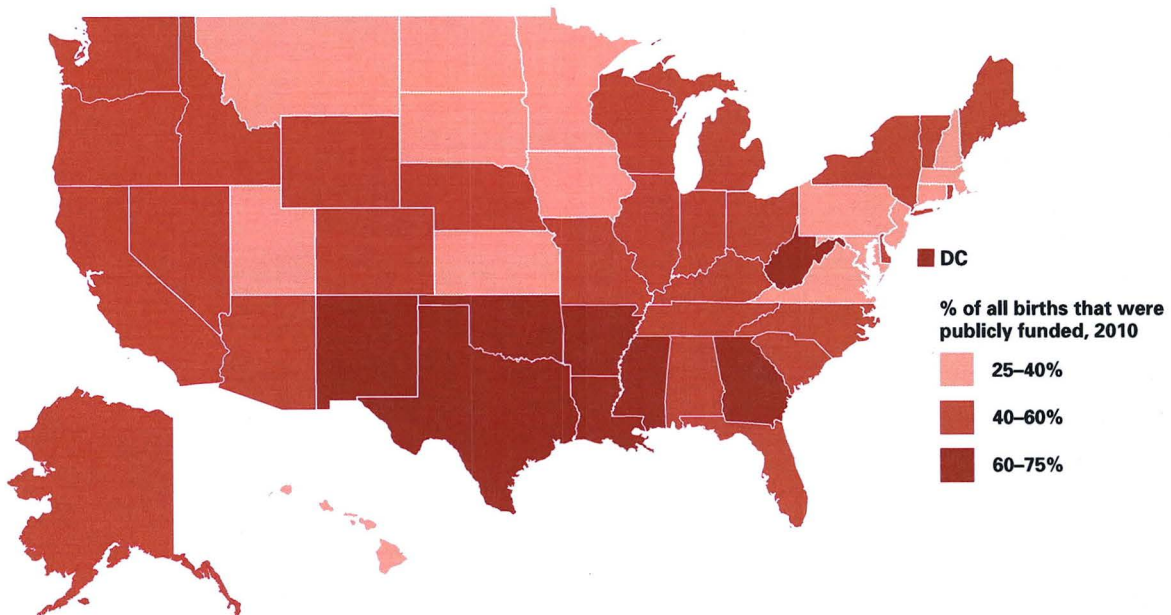
New York (\$1.5 billion) and Florida (\$1.3 billion). (Those four states are the nation's most populous.)

- To put these figures in perspective, the federal and state governments together spent an average of \$336 on unintended pregnancies for every woman aged 15–44 in the country.
- The average per woman aged 15–44 public expenditures on unintended pregnancies ranged from \$107 in New Hampshire to \$790 in Alaska; expenditures varied by state for a number of reasons, including variations in medical costs, the proportions of women who are poor and on Medicaid, the proportions of all births that are unplanned and the overall fertility rate of women in the state.
- The total potential gross savings from enabling women to avert all unintended pregnancies in 2010 would have been \$15.5 billion. This is less than the total public cost of all unintended pregnancies (74% of that total), because even if all women had been able to time their pregnancies as they wanted, some births still would have been publicly funded when they eventually occurred. In other words, improved access to and use of contraceptives would have, in some cases, only delayed the public costs, rather than avoided them entirely. (These potential savings do not account for the public investment in family planning services and other interventions that might be required to achieve them.)
- The federal and state governments spent \$19.8 billion for planned pregnancies in 2010; when added to the \$21.0 billion for unplanned pregnancies, the total for all publicly funded pregnancies was \$40.8 billion (Table 4). Thus, 51% of government expenditures on pregnancies in 2010 were spent on unplanned pregnancies.
- According to prior Guttmacher Institute research, the public investment in family planning services resulted in \$15.8 billion in gross savings in 2010 from helping women avoid unintended pregnancies and the resulting births, abortions and miscarriages.¹³ Putting that in the context of this study's findings, in the absence of the publicly funded family planning effort, the annual public costs of unintended pregnancy might be 75% higher—\$36.8 billion, instead of \$21.0 billion.

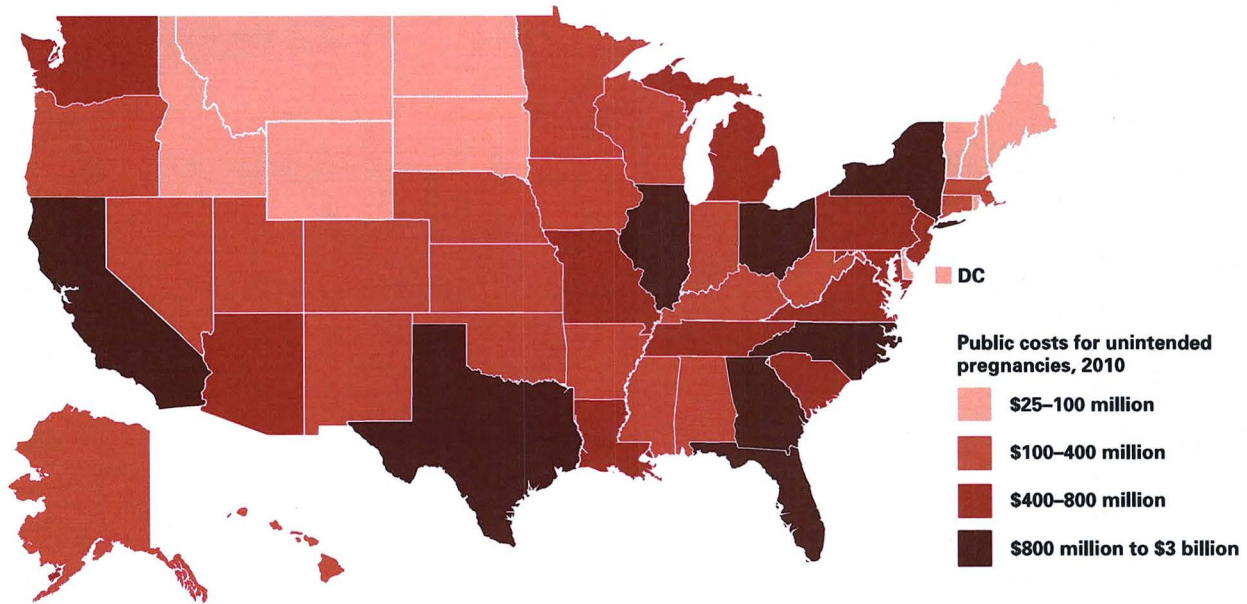
MAP 1. Medicaid and other public insurance programs paid for 68% of U.S. births resulting from unintended pregnancies in 2010, including at least 60% of births in 37 states and the District of Columbia



MAP 2. Medicaid and other public insurance programs paid for 51% of all U.S. births in 2010, including at least 40% of births in 35 states and the District of Columbia



MAP 3. Government expenditures on unintended pregnancies totaled \$21 billion in 2010, and surpassed \$400 million in 19 states



Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 27, 2017 8:25 AM
To: Lizzie Kubitz
Subject: FW: I support HB-25

From: Robert Werner [mailto:rabbitcreek@gmail.com]
Sent: Friday, February 24, 2017 9:43 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: I support HB-25

24 February 2017

Dear Representative Claman,

I am writing to express my support for HB-25, state legislation that would require insurance companies to cover one year of birth control at a time, instead of month-to-month. The legislature can ensure all women have consistent access to birth control by requiring that insurance cover one-year's supply of birth control at a time, dispensed on-site at the provider's office if available. We all deserve affordable and accessible birth control that works for us, regardless of our income or insurance carrier. Consistent access to birth control gives women the ability to control when and if they have children, giving them more career and education opportunities, healthier pregnancies, and making them less likely to depend on government programs. Today, most women have to refill their birth control every month, which is a burden for many women and leads to inconsistent birth control use.

Thank you for sponsoring the bill.

Sincerely,

Jeanne Schaaf

6961 Rabbit Creek Road

Anchorage, AK 99516

jmschaaf@gmail.com

Cc: Rep. Jennifer Johnston

Lizzie Kubitz

From: mary lee Guthrie <marylee.guthrie@gmail.com>
Sent: Sunday, February 26, 2017 5:57 PM
To: Lizzie Kubitz
Subject: HB25

Follow Up Flag: Follow up
Flag Status: Flagged

I wish to express my strong support for HB 25. As a mother, stepmother and grandmother, much of my life has been dedicated to kids.

I know access to contraceptives and related reproductive health care is part of the bedrock of healthy, happy family life. Insurance coverage for this basic medical need is reasonable.

I'm conservative and think things that matter the most about families and kids are not something that can be done by government.

But assuring ready access to birth control is something members of our Legislature can choose to do. Or not. You can obstruct access to this necessary, but not sufficient, component to growing solid Alaskan families.

I urge you to choose to vote for HB25.

Thank you.
Mary Lee Guthrie
Fairbanks

Lizzie Kubitz

From: Janice Whitton <jwflowers@gmail.com>
Sent: Friday, February 24, 2017 2:23 PM
To: Lizzie Kubitz
Subject: Birth control coverage

Dear Congresswoman Lizzie. Kubitz,

I think every woman who desires so, should be allowed birth control coverage. It is as important to a women's welfare as any other prescription drug--considering the consequences of childbirth or unwanted child birth. Thank you for your work. Janice Whitton, Fairbans AK

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 20, 2017 1:32 PM
To: Lizzie Kubitz
Subject: FW: HB 25 support

From: Laura Green [mailto:lgreen.ak@gmail.com]
Sent: Monday, February 20, 2017 12:24 PM
To: Rep. Harriet Drummond <Rep.Harriet.Drummond@akleg.gov>
Cc: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 25 support

I support HB 25 which would require insurance cover 1 year supply of birth control at a time. As a full time working woman, I found the 1 month at a time limits imposed by insurance companies for no viable medical reason to be cumbersome and I live here in Anchorage with reliable access to my own means of transportation! I can only imagine the hardship that such a silly restriction places on less fortunate women or those in more rural parts of the State.

Please support HB 25.

Thank you,
Laura Green
99503



Kachemak Bay Family Planning Clinic
3959 Ben Walters Lane
Homer, Alaska 99603
(907)235-3436



Health and Social Services Committee
State of Alaska Legislature

HB 25 Insurance Coverage of Contraceptives

I served as the Clinic Manager at Kachemak Bay Family Planning Clinic from 2003-2016 when I was hired as the Executive Director; I represent my organization when I speak today. I also serve on the Alaska Medicaid Care Advisory Committee (MCAC) and I am a Homer City Councilmember but I am not speaking on their behalf. I have two teenage children who have greatly benefitted from participating in comprehensive reproductive and sexual health curricula at Homer Middle and High Schools.

I write to provide my opinion about expanded access to cyclical birth control methods which has been formed by both my own experiences and from evidence based studies, which I will include references to.

With perfect use, hormonal birth control has a failure rate of less than 5%, but for women who lack access to transportation, move frequently, or struggle to balance work and family, monthly trips to the pharmacy make perfect use challenging. This is especially a concern in rural areas. While our clinic is in Homer we serve clients as far away as Ninilchik, Nikolaevsk, Vosnesenka and across the Bay in Seldovia and Halibut Cove. We also serve women who work or fish in remote areas for months at a time.

About one in four women say they have missed pills because they could not get the next pack in time; dispensing one-year's supply at a time reduces the odds of experiencing an unintended pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion.

Consistent use of birth control is the best way to prevent unintended pregnancy; 19% of women who inconsistently use birth control account for 43% of unintended pregnancies whereas the two-thirds of women who use birth control consistently only make up 5%. When we talk about the timing of inconsistent contraceptive use, most often the reason is given that the next cycle wasn't on hand to start on time.

Women without reliable access to transportation or living in rural areas have more barriers to dependable access to birth control, leaving them at a greater risk for unintended pregnancies.

Insurance plans that dispense one-year's supply of birth control instead of limit dispensing to one or three cycles lower their direct costs on follow-up visits and pregnancy tests, as well as long-term unintended pregnancy management.

Forty-six percent of women who unintentionally became pregnant report that they were using some form of contraceptives; providing one year of birth control at a time will increase consistent use and reduce unintended pregnancy.

Women's consistent access to birth control should not depend on her insurance carrier. By requiring that women get 12 months of birth control at a time, we can reduce barriers to contraceptives, prevent unintended pregnancy, and save money. A supply for 12 months may require up to 17 packs/cycles of a contraceptive method, depending on the instructions for use.

- Research from California's family planning Medicaid expansion program, Family PACT, has demonstrated the impact of contraceptive coverage policies encouraging expanded dispensing practices. Specifically, researchers found that dispensing a 1-year supply of oral contraceptives was associated with a significant reduction (30%) in the odds of

conceiving an unplanned pregnancy compared with dispensing just one or three packs. *Foster DG, Hulett D, Bradsberry M, Darney P, & Policar M. Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies. Obstetrics and Gynecology, 2011: 117(3), 566-572.*

- The recently released Centers for Disease Control report, "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs" reinforces this standard. The report explicitly recommends providing or prescribing multiple cycles (ideally a full year's supply) of oral contraceptive pills, the patch, or the ring to minimize the number of times a client has to return to the service site. *Gavin L, Moskosky MS, Carter M, et al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR 2014: 63(4).*

Considerations

- It is unclear how a health benefit plan/prescription benefit program would determine whether an insured member had previously received the same contraceptive under a different program, plan, or policy. Decisions regarding how many cycles of contraceptives to prescribe are made by the insured's health care provider. If the health care provider determines that a 12-month cycle of contraceptives for a new member is warranted, the health benefit plan/prescription benefit program would have no way of determining whether this was the first dispensing of the contraceptive or a subsequent dispensing.

And, thinking about money and associated costs, you might have concerns about whether 12 month supplies would result in wastage. Anecdotal experience from my clinic is that after an initial 3 or 4 month trial period clients are confident whether or not they tolerate, like and will continue to use a method.

This anecdote is supported by analysis conducted by Rachel Linz, Epidemiologist for the Public Health Division of the Oregon Health Authority. Ms. Linz conducted a 2 year analysis of data from a program in Oregon that dispensed 12 months of contraception at a time.

Overall, she found that fewer than 2% of the clients received more than 35 cycles of the pill, patch, and/or ring within a 2-year period. The analysis used 35 units as the cut-off because for those clients taking continuous use birth control, 34 packs are needed over a 2-year period. Regardless of whether a client received one method (e.g. pill only) or multiple methods (e.g. pill, then ring) over the 2-year period, the overall percentage of clients receiving an excessive quantity was almost negligible (1.2%). This data indicates that receiving more than a 12-month supply over a 1-year period is extremely rare.

I realize that you may have already heard much of this officially researched data. I want to also share with you the unique way that working at KBFP allows me to see the benefits of providing 12 month supplies in action. KBFP is a Title X clinic, as such we are able to provide contraceptive supplies directly to clients on a sliding scale that goes as low as 100% discount. We serve some clients that have no other coverage, or are unable to use it because of confidentiality reasons. For many years now we have provided clients with up to a 12 month supply after they have established that a method works for them. We have other clients that use their insurance or Medicaid as primary coverage and revert to our sliding scale for elements that insurance doesn't cover. All Medicaid clients and some of the private insurance clients have to get their supplies from a regular pharmacy, usually in 1 or 3 month quantities. Clients that have to make repetitive trips to the pharmacy are more often the ones that discontinue use of the method or use it inconsistently.

HB 25 is important and will positively impact the health of Alaska's women, while providing a substantial saving by reducing unplanned pregnancies.

Yours,

Catriona Reynolds



The League of Women Voters

A Voice For Citizens, A Force For Change

P.O. Box 101345, Anchorage, AK 99510-1345

February 24, 2017

Dear Representative Claman and Members of the House Health & Social Services Committee:

The League of Women Voters of Alaska strongly supports HB 25, a bill related to insurance coverage for contraceptives and other services that reduce the risk of unintended pregnancies. At the national level, the League of Women Voters of the United States supports primary care for all, care that includes "prenatal and reproductive health." When women have the consistent ability to plan their pregnancies, their families benefit through greater financial well-being, healthier living conditions, healthier children, greater opportunities, and a myriad of additional benefits.

While improving the quality of life for families, the ability to avoid unintended pregnancies also reduces costs for state and federal governments. In 2010 according to the Guttmacher Institute, the State of Alaska spent nearly \$43 million on health costs related to unintended pregnancies while the federal government added another \$71 million for a total cost of \$114 million. Guttmacher reports that 48% of all pregnancies in Alaska in 2010 were unplanned and 64% of Alaska's unplanned pregnancies were publicly funded, representing the \$43 million cost.

In addition, the cost benefits of supporting women in their efforts to plan their pregnancies goes far beyond the cost of the pregnancy itself. A woman who is able to plan a pregnancy can better guarantee that her health is at optimum level prior to pregnancy, reducing the risk of a difficult pregnancy and trauma to the child. Such planning reduces the possibility of increased health problems for the child, problems which can follow the child for years and require increased health and education costs for the State. A planned pregnancy increases a woman's ability to manage her role as income provider for a family and allows that family the best opportunity to remain as financially independent as possible. Supporting affordable contraceptives prescribed on a 12-month basis will undoubtedly reduce the number of unintended pregnancies in Alaska, thereby increasing family well-being and reducing State costs.

HB 25 can assist women and families to plan pregnancies so they are ready for the added responsibility of a child. In addition, costs to the State for unintended pregnancies can be reduced. This is a win-win bill that deserves consideration by the Legislature especially as it struggles with the budget crisis. Thank you for your consideration.

Sincerely,

League of Women Voters of Alaska, Board of Directors

Pat Redmond, President; Judy Andree, Vice-President; Carol Dickason, Treasurer; Gail Knobf, Secretary; Marianne Mills, Past President; Directors Lois Pillifant, Hetty Barthel, Phyllis Tugman-Alexander, & Diane Mathisen.

The League of Women Voters is a nonpartisan political organization that encourages the informed and active participation of citizens in government and influences public policy through education and advocacy.



Increased Contraceptive Supply Linked to Fewer Unintended Pregnancies

February 22, 2011

Rates of unintended pregnancies and abortions decrease significantly when women receive a one-year supply of oral contraceptives, instead of being prescribed one- or three-month supplies, a UCSF study shows.

Researchers observed a 30 percent reduction in the odds of pregnancy and a 46 percent decrease in the odds of an abortion in women given a one-year supply of birth control pills at a clinic versus women who received the standard prescriptions for one – or three-month supplies.

The researchers speculate that a larger supply of oral contraceptive pills may allow more consistent use, since women need to make fewer visits to a clinic or pharmacy for their next supply.

“Women need to have contraceptives on hand so that their use is as automatic as using safety devices in cars,” said Diana Greene Foster, PhD, lead author and associate professor in the UCSF Department of Obstetrics, Gynecology and Reproductive Sciences. “Providing one cycle of oral contraceptives at a time is similar to asking people to visit a clinic or pharmacy to renew their seatbelts each month.”

Foster also is director of research for Advancing New Standards in Reproductive Health, part of the UCSF Bixby Center for Global Reproductive Health. Her study's findings appear online (http://journals.lww.com/greenjournal/Abstract/2011/03000/Number_of_Oral_Contraceptive_Pill_Packages.8.aspx) in the journal *Obstetrics and Gynecology*.

The researchers linked 84,401 women who received oral contraceptives in January 2006 through Family PACT (Planning, Access, Care, Treatment), a California family planning program, to Medi-Cal data showing pregnancies and births in 2006. Through Family PACT, some family planning clinics are able to dispense a one-year supply of pills on-site.

Oral contraceptive pills are the most commonly used method of reversible contraception in the United States, the team states. While highly effective when used correctly (three pregnancies per 1,000 women in the first year of use), approximately half of women regularly miss one or more pills per cycle, a practice associated with a much higher pregnancy rate (80 pregnancies per 1,000 women in the first year of use), according to the team.

The findings of this study have implications for women using oral contraceptives across the country. Most oral contraceptive users in the United States get fewer than four packs at a time; nearly half need to return every month for resupply, according to a 2010 study published in *Contraception*.

Making oral contraceptive pills more accessible may reduce the incidence of unintended pregnancy and

abortion, while saving taxpayers' dollars, the researchers state. If the 65,000 women in the analysis who received either one or three packs of pills at a time had experienced the same pregnancy and abortion rates as women who received a one-year supply, almost 1,300 publicly funded pregnancies and 300 abortions would have been averted, according to the team.

"The evidence indicates that health plans and public health programs may avoid paying for costly unintended pregnancies by increasing dispensing limits on oral contraceptives," said Foster. "Improving access to contraceptive methods reduces the need for abortion and helps women to plan their pregnancies."

Co-authors are Denis Hulett, Mary Bradsberry, Phillip Darney, MD, MSc, and Michael Policar, MD, MPH, all with the Bixby Center for Global Reproductive Health, UCSF Department of Obstetrics, Gynecology, and Reproductive Sciences, and San Francisco General Hospital.

UCSF is a leading university dedicated to promoting health worldwide through advanced biomedical research, graduate-level education in the life sciences and health professions, and excellence in patient care.

Related Links:

Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies

(http://journals.lww.com/greenjournal/Abstract/2011/03000/Number_of_Oral_Contraceptive_Pill_Packages.8.aspx)

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Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies

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Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies

Diana Greene Foster, PhD, Denis Hulett, Mary Bradsberry, Philip Darney, MD, MSc, and Michael Policar, MD, MPH

OBJECTIVE: To estimate how number of oral contraceptive pill packages dispensed relates to subsequent pregnancies and abortions.

METHODS: We linked 84,401 women who received oral contraceptives through the California family planning program in January 2006 to Medi-Cal pregnancy events and births conceived in 2006. We compared pregnancy rates for women who received a 1-year supply of oral contraceptive pills, three packs, and one pack.

RESULTS: Women who received a 1-year supply were less likely to have a pregnancy (1.2% compared with 3.3% of women getting three cycles of pills and 2.9% of women getting one cycle of pills). 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 (confidence interval [CI] 0.57–0.87) and a 46% reduction in the odds of an abortion (95% CI 0.32–0.93), controlling for age, race or ethnicity, and previous pill use.

CONCLUSION: Making oral contraceptives more accessible may reduce the incidence of unintended pregnancy and abortion. Health insurance programs and public health programs may avert costly unintended pregnancies by increasing dispensing limits on oral contraceptives to a 1-year supply.

(*Obstet Gynecol* 2011;117:566–72)

DOI: 10.1097/AOG.0b013e3182056309

LEVEL OF EVIDENCE: III

See related articles on pages 551 and 558.

From the Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology, and Reproductive Sciences, San Francisco General Hospital, University of California, San Francisco, San Francisco, California.

Corresponding author: Diana Greene Foster, PhD, 1330 Broadway, Suite 1100, Oakland, CA 94162; e-mail: greened@obgyn.ucsf.edu.

Financial Disclosure

The authors did not report any potential conflicts of interest.

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ISSN: 0029-7844/11

Oral contraceptive pills are the most commonly used reversible method of contraception in the United States.¹ Although oral contraceptive pills are highly effective when used perfectly (3 pregnancies per 1,000 users in the first year of use²), typical patterns of use, with approximately half of women regularly missing one or more pills per cycle,^{3,4} is associated with a much higher pregnancy rate (80 pregnancies per 1,000 users in the first year of use).⁵

Recent work has examined whether dispensing a greater number of oral contraceptive pill packs affects contraceptive continuation. Our previous work showed dispensing a 1-year supply at California family planning clinic visits was associated with lower health care costs and higher contraceptive continuation. In our first study, women who received a 1-year supply of pills were more likely to continue use at 15 months after the initial dispensing visit than women who received one or three packs (43% compared with 20%–22%).⁶ A study⁷ in Jamaica showed higher continuation at 1 month among women who received four cycles of pills at a visit compared with women who received one cycle of pills followed by three cycles of pills at the subsequent visit. However, women who received the larger initial quantity of packs in Jamaica did not show higher continuation at 5 months. Our objective was to estimate how the number of oral contraceptive pill packages dispensed relates to subsequent pregnancies and abortions.

MATERIALS AND METHODS

Five attributes of publicly funded reproductive health care in California permit the comparison of data from the state family planning program on specific number of oral contraceptive packs dispensed and the deliveries and abortions of pregnancies that occur in the subsequent year. First, Medi-Cal, California's Medicaid program, is in one of only 17 states that





Planned Parenthood Votes Northwest and Hawaii

Representative Claman
Alaska State Capitol
Juneau, AK 99801

Re: House Bill 25

February 15th, 2017

Dear Representative Claman,

On behalf of Planned Parenthood Votes Northwest and Hawaii, I write today to thank you for your leadership and for introducing legislation to expand birth control access in Alaska. As a health care provider that serves thousands of low-income individuals every year, we have long supported sincere efforts to expand access to birth control.

For more than 100 years, Planned Parenthood has provided birth control and other high-quality health care across the nation. In Alaska alone we serve more than 7,700 patients, which includes providing birth control to nearly 3,000 women. We believe that every woman should have full access to the birth control method that works best for her, without barriers based on cost or availability. House Bill 25 would remove such barriers and give women more career and education opportunities, encourage healthier pregnancies, and make them less likely to depend on government programs.

Providing a year's supply of birth control at a time is a solution that works for women. For many women who live in rural communities, lack reliable access to transportation, or struggle to balance work and family, a monthly trip to the pharmacy can be an insurmountable barrier to using birth control consistently. Consistent use of birth control is the best way to prevent unintended pregnancy, but one in four women say they have missed pills because they could not get the next pack in time. Getting a full year's supply at one time dramatically improves consistent use. According to a study published in *Obstetrics & Gynecology*, dispensing a full year's supply at a time reduces the odds of experience an unintended pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion. It is also cost effective for both public and private insurance plans, which lower their direct costs on follow-up visits, pregnancy tests, and long-term costs associated with unintended pregnancies.

Women's consistent access to birth control should not depend on her insurance carrier. We appreciate your leadership and hard work to expand birth control access for Alaska women and look forward to supporting your efforts.

Sincerely,

A handwritten signature in black ink that reads 'Alyson Currey'.

Alyson Currey
Legislative Liaison

Planned Parenthood Votes Northwest & Hawaii
3231 Glacier Hwy, Juneau, AK 99801
907.957.8708 | alyson.currey@ppvnh.org

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: HB 25
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB025-DHSS-HCMS-2-8-17
Title: INSURANCE COVERAGE FOR
CONTRACEPTIVES
Sponsor: CLAMAN
Requester: (H) HSS

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2018	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2018 Request	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
OPERATING EXPENDITURES	FY 2018	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits	(677.9)		(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)
Miscellaneous							
Total Operating	(677.9)	0.0	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)

Fund Source (Operating Only)

1002 Fed Rcpts (Fed)	(434.2)		(863.3)	(858.2)	(853.1)	(848.0)	(848.0)
1003 G/F Match (UGF)	(243.7)		(492.4)	(497.5)	(502.6)	(507.7)	(507.7)
Total	(677.9)	0.0	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimated SUPPLEMENTAL (FY2017) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2018) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? **Yes**
If yes, by what date are the regulations to be adopted, amended or repealed? **01/01/18**

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: <u>Margaret Brodie, Director</u>	Phone: <u>(907)334-2520</u>
Division: <u>Health Care Services</u>	Date: <u>01/19/2017 04:00 PM</u>
Approved By: <u>Shawnda O'Brien, Assistant Commissioner</u>	Date: <u>02/08/17</u>
Agency: <u>Health and Social Services</u>	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. HB025

Analysis

Administrative costs are captured in the Health Care Services Appropriation, Medical Assistance Administration Allocation in a separate fiscal note.

Benefits Costs

Oral Contraceptives: Duplication of Services

It is anticipated that there will be approximately 7,940 female Medicaid recipient oral contraceptive users annually (of which, 2,940 are through expansion). It is anticipated that approximately 10% or 794 members who are oral contraceptive users may require duplication of services (e.g., therapy changes, replacement of lost or stolen contraceptives, and diverted contraceptives). Based on an average 4-month duplication of services, and based on a \$45 per month National Average Drug Acquisition Cost average for oral contraceptives, the total duplication of services cost is estimated to be (794 members X 4 months X \$45) = \$142.9 (of which, \$52.9 is attributable to expansion)

Benefits Savings

Of the approximately 8,000 female Medicaid members who are contraceptive users, we assume that 75% or 6,000 plan to use the oral contraceptive long-term (i.e., longer than 12 months). With a standard oral contraceptive failure rate of 9% as cited by the Centers for Disease Control, 540 unintended pregnancies would result. A report by Foster et. al. (2011) projects a decrease in failure rate of approximately 30% when oral contraceptives are dispensed in 12-month quantities, which would result in an oral contraceptive failure rate of 6%. However, based on variable factors in Alaska, we have estimated a failure rate of 7%. This 7% failure rate would approximate 420 unintended pregnancies. Therefore, it is approximated that the difference between a 9% failure rate and a 7% failure rate, or 120 unintended pregnancies, may potentially be avoided through dispensing 12-month quantities of contraceptives.

Based on Medicaid claims data, the rate of complicated births is approximately 4.4%. Applying this differential, we estimate that approximately 5.28 of the avoided 120 unintended pregnancies would have been complicated births, and the remaining 114.72 would have been non-complicated. The cost factor used for a complicated birth was \$110.0; the cost factor used for a non-complicated birth was \$8.0. Therefore, benefits savings is estimated at (5.28 X \$110.0) + (114.72 X \$8.0) = \$1,498.6 (of which, \$562.0 is attributable to expansion).

\$142.9 + (\$1,498.6) = (\$1,355.6) net total annual projected savings in this component.

FUND SOURCE:

The Medicaid FMAP for contraceptives is 90%

The Medicaid FMAP for pregnancy-related services is 50%

FMAP for the Medicaid expansion population changes by federal fiscal year for several years, settling at 90% for all services by calendar year 2023. Prorated by state fiscal year, the expansion FMAP rates are:

FY2018	94.5%
FY2019	93.5%
FY2020	92.5%
FY2021	91.5%
FY2022	90.5%
FY2023	90.0%

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. HB025

Analysis Continued

Applying these several FMAP rates generates the following fund source splits:

FY2018 Oral Contraceptives Costs

	Total	regular Medicaid @ 63%	expansion Medicaid @ 37%	Total
	\$142.9	\$90.0	\$52.9	
federal		\$81.0	\$50.0	\$131.0
GF match		\$9.0	\$2.9	\$11.9

FY2018 savings, unintended pregnancies avoided

	Total	regular Medicaid @ 62.5%	expansion Medicaid @ 37.5%	Total
	(\$1,498.6)	(\$936.6)	(\$562.0)	
federal		(\$468.3)	(\$531.1)	(\$999.4)
GF match		(\$468.3)	(\$30.9)	(\$499.2)

FY2018 Total

	Total	regular Medicaid	expansion Medicaid	Total
	(\$1,355.7)	(\$846.6)	(\$509.1)	
federal		(\$387.3)	(\$481.1)	(\$868.4)
GF match		(\$459.3)	(\$28.0)	(\$487.3)

Promulgation of associated regulations will take approximately six months following State Plan Amendment approval by the Centers for Medicare and Medicaid Services, with implementation effective January 1, 2018.

Since the regulations will only be in effect for six months of FY2018, cost savings have been adjusted to reflect one-half of the fiscal year. The department anticipates a net FY2018 savings of (\$434.2) federal (\$868.4 x .5 = \$434.2) and (\$243.7) GF match (\$487.3 x .5 = \$243.7). The logic of the calculations for FY2019 - 2023 is the same, except that the expansion FMAP rates are adjusted annually, as explained above.

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: HB 25
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB025-DHSS-MAA-2-8-17
Title: INSURANCE COVERAGE FOR
CONTRACEPTIVES
Sponsor: CLAMAN
Requester: (H) HSS

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Medical Assistance Administration
OMB Component Number: 242

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2018 Appropriation Requested	Included in Governor's FY2018 Request	Out-Year Cost Estimates					
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
OPERATING EXPENDITURES								
Personal Services	44.7		89.4	89.4	89.4	89.4	89.4	89.4
Travel								
Services	4.7		9.4	9.4	9.4	9.4	9.4	9.4
Commodities	8.6		2.0	2.0	2.0	2.0	2.0	2.0
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	58.0	0.0	100.8	100.8	100.8	100.8	100.8	100.8

Fund Source (Operating Only)

1002 Fed Rcpts (Fed)	29.0		50.4	50.4	50.4	50.4	50.4	50.4
1003 G/F Match (UGF)	29.0		50.4	50.4	50.4	50.4	50.4	50.4
Total	58.0	0.0	100.8	100.8	100.8	100.8	100.8	100.8

Positions

Full-time	1.0		1.0	1.0	1.0	1.0	1.0	1.0
Part-time								
Temporary								

Change in Revenues

None								
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimated SUPPLEMENTAL (FY2017) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2018) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By:	Margaret Brodie, Director	Phone:	(907)334-2520
Division:	Health Care Services	Date:	01/19/2017 04:00 PM
Approved By:	Shawnda O'Brien, Assistant Commissioner	Date:	02/09/17
Agency:	Health and Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. HB 25

Analysis

Personal Services

The Department will incur administrative costs to implement and manage a process that reviews patient eligibility in subsequent months, if the supply dispensed exceeds the months of eligibility. If a patient loses Medicaid eligibility, the cost for the months of medication where the patient no longer had Medicaid eligibility will need to shift from 90% Federal funding to 100% State GF.

Medical Assistance Administrator I, Range 16, in Anchorage:

\$ 89.4 personal services

\$ 9.4 position support services

\$ 2.0 office supplies

\$100.8 annually

\$ 7.6 computer software and equipment (one-time)

Due to the effective date of proposed changes to regulations, the services of this position will only be needed for 6 months of FY2018. Therefore, the total cost FY2018 is \$58,000 (\$100.8 / 2, plus one-time costs).

These costs are anticipated to be offset by overall benefit savings captured in the Medicaid Services appropriation, Health Care Medicaid Services Allocation, in a separate fiscal note.

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: HB 25
Fiscal Note Number: _____
() Publish Date: _____

Identifier: HB025-DCCED-DOI-02-24-17
Title: INSURANCE COVERAGE FOR
CONTRACEPTIVES
Sponsor: CLAMAN
Requester: (H) Health and Social Services

Department: Department of Commerce, Community and
Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2018	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2018 Request	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
OPERATING EXPENDITURES	FY 2018	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimated SUPPLEMENTAL (FY2017) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2018) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed? N/A

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: Lori Wing-Heier, Director Phone: (907)465-2560
Division: Division of Insurance Date: 02/24/2017 09:34 PM
Approved By: Catherine Reardon, Director Date: 02/24/17
Agency: Division of Administrative Services, DCCED

FISCAL NOTE ANALYSIS

**STATE OF ALASKA
2017 LEGISLATIVE SESSION**

BILL NO. HB 25

Analysis

HB 25 amends AS 21.42 and requires health care insurers that provide coverage for prescription contraceptives and related services to provide reimbursement for dispensing prescription contraceptives for a three-month period for the first dispensing, and a 12-month period for subsequent dispensing.

There is no anticipated fiscal impact to the Division of Insurance.

12-Month Supply of Contraceptives Backgrounder

The Affordable Care Act has established that health insurance plans must assure affordable access to contraceptive products through private insurance coverage. Plans must cover contraceptive methods and counseling for all women, as prescribed by a health care provider. 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. Yet nothing supports or requires 12-month prescription dispensing.

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 and potential life-threatening 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. 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.
- ✓ In March 2016, the New Jersey Pension and Health Benefits Review Commission recommended that legislators not enact a bill mandating coverage for dispensing a 12-month supply of contraceptives, finding that the bill may generate waste and that a plan participant could terminate coverage prior to the end of a 12-month prescription period.

90-Day Supplies of Contraceptives Provide Easy Access to Patients, While Minimizing Travel Burdens

- ✓ 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

12-Month Supply of Contraceptives Backgrounder

other location to obtain the medication. Since copays are 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.

Lizzie Kubitz

From: Dr Tomsen [REDACTED]
Sent: Monday, February 27, 2017 3:48 PM
To: Lizzie Kubitz
Subject: RE: Potential letter of support for House Bill 25

Lizzie,

Absolutely I remain in support, and would be glad to help, as I did last year via Katie Bruggeman for Sen. Berta Gardner in her effort to get women access to a years' worth of contraceptives at a time.

You may be familiar already with the CHOICE study, but if you are not I highly recommend you read up on it at <http://www.nejm.org/doi/full/10.1056/NEJMoa1400506#t=article> or in other locations (just google "CHOICE study St. Louis") – it was a brilliant study and should be mandatory reading for all those involved in making decisions about health care financing. It certainly has rocked our gynecologic world!

In addition to supporting this bill, I have often pondered a similar issue, the cost of which is borne by women disproportionately, though it is clearly a shared problem. Namely, shouldn't HPV screening, the investigation of abnormal paps and treatment of cervical dysplasia/ HPV disease, and the cost of HPV-related cancers be expenses that are paid for more equally between men and women, despite women having what amounts to "HPV's favorite organ," the cervix. Just an idea for you and Rep. Claman to ponder.

Tina Tomsen

I would like to express my support for Rep. Claman's efforts to improve women's access to contraception.

HB 25 seeks to maintain women's access and use of contraception that has proven so successful in many locations, as well as making it possible to obtain a years' worth of contraceptive pills without obstacles.

I absolutely support this bill for many reasons. Even when one excludes women for whom a pregnancy is a significant health risk, excellent reasons include:

- 1) Optimum child spacing (of 2-3 years between children) has been demonstrated to improve the health of women and their children.
- 2) Every child raised to the age of 18 costs about the same as a mortgage; in 8/2014 the average figure for a middle-income family in the U.S. was estimated by the USDA at \$245,340.

- 3) Teenage childbearing is a significant cost to the state and to the nation, not just financially but because of the increased risk of poor quality or frankly or damaging parenting by young and overwhelmed parents.
- 4) While both a man and a woman are necessary for conception, the woman disproportionately bears the responsibility for contraception and the risk of its failure.
- 5) The state stands to gain financially by supporting healthier childbearing and and improving the financial security of families through decreasing obstacles to contraception.
- 6) A woman who needs to see her practitioner only once a year to safely obtain a prescription for contraceptive pills should be able to fill that prescription when and in the amount she desires. This has long been necessary for women who will be away from their home or pharmacy (school, deployment, travel, mission trips, living remote or at remote research locations), but should not be limited to them.
- 7) If one can buy a years' worth of food, toilet paper, heating oil, or other necessities, buying a years' worth of contraceptives that are so essential to securing financial and personal health should also be possible.
- 8) The CHOICE study (<http://www.nejm.org/doi/full/10.1056/NEJMoa1400506#t=article>), states that have covered the expense of contraception, and finally the Affordable Care Act have all demonstrated that women who use LARCS (long acting reversible contraception, such as IUD's and implants) have had fewer unwanted pregnancies and abortions. Removing barriers to women obtaining oral contraceptives should similarly improve statistics for women using them, rather than risking lapses in their use of contraceptives, as is currently the case.
- 9) While the ACA made it possible for women to obtain access to LARCs they might previously not have been able to afford, it left the "loophole" open that did not require payment for removal of those devices, which in some cases was a financial obstacle when a woman needed her IUD removed and replaced, for example. This bill closes that loophole.

My only objection to this bill is that it might not go far enough – after all, expanding coverage for patients of both sexes to obtain stable long-term prescriptions that are not of an addictive or unsafe nature should be sought.

Tina Tomsen, MD

Anchorage Women's Clinic



Anchorage, AK

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 27, 2017 8:25 AM
To: Lizzie Kubitz
Subject: FW: I support HB-25

From: Robert Werner [REDACTED]
Sent: Friday, February 24, 2017 9:43 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: I support HB-25

24 February 2017

Dear Representative Claman,

I am writing to express my support for HB-25, state legislation that would require insurance companies to cover one year of birth control at a time, instead of month-to-month. The legislature can ensure all women have consistent access to birth control by requiring that insurance cover one-year's supply of birth control at a time, dispensed on-site at the provider's office if available. We all deserve affordable and accessible birth control that works for us, regardless of our income or insurance carrier. Consistent access to birth control gives women the ability to control when and if they have children, giving them more career and education opportunities, healthier pregnancies, and making them less likely to depend on government programs. Today, most women have to refill their birth control every month, which is a burden for many women and leads to inconsistent birth control use.

Thank you for sponsoring the bill.

Sincerely,

Jeanne Schaaf

[REDACTED]
Anchorage, AK 99516
[REDACTED]

Cc: Rep. Jennifer Johnston

Lizzie Kubitz

From: mary lee Guthrie [REDACTED]
Sent: Sunday, February 26, 2017 5:57 PM
To: Lizzie Kubitz
Subject: HB25

Follow Up Flag: Follow up
Flag Status: Flagged

I wish to express my strong support for HB 25. As a mother, stepmother and grandmother, much of my life has been dedicated to kids.

I know access to contraceptives and related reproductive health care is part of the bedrock of healthy, happy family life. Insurance coverage for this basic medical need is reasonable.

I'm conservative and think things that matter the most about families and kids are not something that can be done by government.

But assuring ready access to birth control is something members of our Legislature can choose to do. Or not. You can obstruct access to this necessary, but not sufficient, component to growing solid Alaskan families.

I urge you to choose to vote for HB25.

Thank you.
Mary Lee Guthrie
Fairbanks

Lizzie Kubitz

From: Janice Whitton [REDACTED]
Sent: Friday, February 24, 2017 2:23 PM
To: Lizzie Kubitz
Subject: Birth control coverage

Dear Congresswoman Lizzie. Kubitz,

I think every woman who desires so, should be allowed birth control coverage. It is as important to a women's welfare as any other prescription drug--considering the consequences of childbirth or unwanted child birth. Thank you for your work. Janice Whitton, Fairbans AK

Lizzie Kubitz

From: Rep. Matt Claman
Sent: Monday, February 20, 2017 1:32 PM
To: Lizzie Kubitz
Subject: FW: HB 25 support

From: Laura Green [REDACTED]
Sent: Monday, February 20, 2017 12:24 PM
To: Rep. Harriet Drummond <Rep.Harriet.Drummond@akleg.gov>
Cc: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 25 support

I support HB 25 which would require insurance cover 1 year supply of birth control at a time. As a full time working women, I found the 1 month at a time limits imposed by insurance companies for no viable medical reason to be cumbersome and I live here in Anchorage with reliable access to my own means of transportation! I can only imagine the hardship that such a silly restriction places on less fortunate women or those in more rural parts of the State.

Please support HB 25.

Thank you,
Laura Green
99503

From: Laura Green
Sent: Monday, February 20, 2017 12:24 PM
To: Rep. Harriet Drummond <Rep.Harriet.Drummond@akleg.gov>
Cc: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 25 support

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-----Original Message-----

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To: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: HB25

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I know access to contraceptives and related reproductive health care is part of the bedrock of healthy, happy family life. Insurance coverage for this basic medical need is reasonable.

I'm conservative and think things that matter the most about families and kids are not something that can be done by government.

But assuring ready access to birth control is something members of our Legislature can choose to do. Or not. You can obstruct access to this necessary, but not sufficient, component to growing solid Alaskan families.

I urge you to choose to vote for HB25.

Thank you.
Mary Lee Guthrie
Fairbanks

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Subject: I support HB-25

24 February 2017

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Thank you for sponsoring the bill.

Sincerely,

Jeanne Schaaf

Anchorage, AK 99516

Cc: Rep. Jennifer Johnston

-----Original Message-----

From: Mary Daniel
Sent: Tuesday, February 28, 2017 2:54 PM
To: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: HB-25

My husband and I both support HB 25 dealing with insurance coverage for contraceptives. We believe this will save on welfare programs and pre-school programs. It will reduce the number of unwanted pregnancies, which will reduce the need for abortions or adoptions. There will be fewer children that weren't really wanted and are more likely to not be taken care of properly.

Thank you for considering our opinion of this issue.

Mary Daniel
Seward, AK

From: Jeannette O
Sent: Tuesday, February 28, 2017 6:31 PM
To: househess@akleg.gov; Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: House Bill 25

Dear Representative Claman,

I just heard about the legislation you introduced to expand birth control access in Alaska. I'm writing today to say THANK YOU for your leadership.

I'm the mom of three teenagers who all know where the Planned Parenthood is in Fairbanks. They also know they can ask if they need help and that sexuality is nothing to be ashamed of. I know that all people don't have that kind of support, or access to transportation, or the money to go to the doctor, and that barriers exist for people. Even me, I'm a busy lady, which is why I'm grateful that I was able to get birth control that lasts for 5 years at a time.

Providing a year's supply of birth control at a time is, quite frankly, a genius idea. I didn't grow up in Alaska, I grew up in a suburb in Washington, but even then my birth control pills lapsed from time to time. Thank goodness I never experienced an unintended pregnancy, but I look at the chance to plan my own family as a gift, when in fact it should really be a right.

With all of the upheaval and uncertainty with healthcare and our new administration, Alaska's women deserve this peace of mind. Thank you for your leadership!

Jeannette Okinczyc

Fairbanks, Alaska
99701

From: susan bissell
Sent: Tuesday, February 28, 2017 6:32 PM
To: House Health and Social Services <lhsches@akleg.gov>
Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: In support of HB 25 - Thank you, Rep. Claman!

To the Members of the House Health and Social Services Committee:

I am writing in support of Representative Claman's leadership in expanding birth control access in Alaska through HB25/SB23. I believe that expanding birth control access is the most effective tool we have for reducing unwanted pregnancies. HB25 is particularly important for women in rural Alaska, who often cannot refill prescriptions due to transportation, cost, or embarrassment. With perfect use, hormonal birth control has a failure rate of less than 5%. This makes it an extremely effective and cost effective way to prevent unwanted pregnancy. According to a study published in Obstetrics & Gynecology, dispensing a full year's supply at a time reduces the odds of experiencing an unwanted pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion. It is also cost effective for both public and private insurance plans because it reduces the costs associated with pregnancy tests, prenatal care, and childbirth. By preventing unwanted pregnancies, HB25 also has the potential to reduce the need for government assistance.

Women must have safe, reliable access to birth control in a way that preserves their dignity and self-worth. Women should not have to argue with insurance carriers to receive birth control, or be placed in a position where birth control is not affordable or available. I appreciate your efforts to expand birth control access for women in Alaska, and I fully support you in this endeavor.

Susan Bissell
Fort Wainwright, AK

From: Sara Rikalo Cassidy
Sent: Tuesday, February 28, 2017 6:36 PM
To: House Health and Social Services <lhsches@akleg.gov>
Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: House Bill 25

To the House Health & Social Services,

I write today to express my support for HB 25/SB 53: 12 Months of Birth Control. I would also like to take the opportunity to thank Representative Claman for his leadership and for introducing legislation to expand birth control access in Alaska. Access to a one-year's supply of birth control at a time - on-site if available - would remove barriers to consistent usage and help women avoid unwanted pregnancies.

As a woman who uses birth control and has struggled with consistent access to it in the past, I believe that we all deserve affordable and accessible birth control regardless of our income or insurance carrier. Before moving to Alaska, I was a student at the University of Richmond. My international student health insurance did not cover the cost of birth control and dispensed it monthly; I needed birth control not simply for preventing unwanted pregnancies but for alleviating the symptoms of a medical condition. Once I got married, I switched to TRICARE as my insurance carrier. I was able to receive enough supply for three months at a time, and had to pick it up personally in Fairbanks, Alaska. Considering that I still had two semesters (each four months long), it was impossible for me to maintain my birth control supply until I have permanently relocated to Fairbanks.

Today, most women have to refill their birth control every month, which is a burden for many women, especially in the rural areas of Alaska. Inconsistent access to birth control affects women's ability to plan their pregnancies, which would in turn benefit their career and education opportunities, personal relationships, and health. Further, publicly funded or private insurance plans that dispense a one-year's supply of birth control instead of limiting dispensing to one or three cycles lower their direct costs on follow-up visits and pregnancy tests, as well as long-term unintended pregnancy management.

I appreciate your leadership and hard work regarding this issue, and I look forward to supporting you in your future efforts to resolve it to the benefit of all women in need of birth control.

Respectfully,

Sara Rikalo

From:

Sent: Tuesday, February 28, 2017 6:44 PM

To: House Health and Social Services <lhsches@akleg.gov>

Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>

Subject: house bill 25

To the House Health & Social Services,

I'm writing today in support of House Bill 25 and bill sponsor Rep. Claman. I want to first thank Representative Claman for introducing legislation to expand birth control access in Alaska. Taking the lead on tackling a problem that many women, like me, face here in Alaska.

I fully support this bill because i'm a hard working woman of Alaska. I work in some of the most remote locations. To take care of myself it requires skillful planning as, "trips to town" can be weather dependent, sporadic, or limited. Providing a years worth of birth control at a time removes a hurdle of summer schedule and allows me to focus on doing the best at my job. Consistent access to birth control is such a simple solution to a huge problem.

I want to thank again Rep. Claman for introducing this and give my fully support of House Bill 25.

Thank you,

- Leigh Strehlow

From: Lucas Almonte

Sent: Tuesday, February 28, 2017 6:59 PM

To: House Health and Social Services <lhsches@akleg.gov>; Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>

Subject: House Bill 25

Dear Representative Claman,

As a volunteer at Planned Parenthood, I write today to thank you for your leadership and for introducing legislation to expand birth control access in Alaska. As a volunteer at an organization that provides services to thousands of low-income individuals per year, sincere efforts

to expand birth control are greatly appreciated.

For years my spouse was afforded the opportunity to receive free health care that goes beyond birth control in itself. I believe every woman should be afforded the opportunity of having full access to birth control. House Bill 25 would remove such barriers and give women more career and education opportunities, encourage healthier pregnancies, and make them less likely to depend on government programs.

Thank you for the courage and strength to stand up for what you believe in and you will have my gratitude and support.

From: Amanda Carnes

Sent: Tuesday, February 28, 2017 8:47 PM

To: House Health and Social Services <lhsches@akleg.gov>

Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>

Subject: Support for HB 25

Dear House Health and Social Services Committee,

On behalf of Planned Parenthood Votes Northwest and Hawaii, I write today to thank you and Representative Claman for your leadership in introducing legislation to expand birth control access in Alaska. I am a Family Practice physician in Fairbanks, AK, and I have been a supporter of expanded access to contraception since becoming a volunteer for Planned Parenthood as an undergraduate premedical student.

Every day I see women who benefit from the ability to control their fertility to expand their options for education, work, and choice of partner. This allows women to achieve goals and

contribute to society in ways that may be unattainable for them otherwise. This also allows all families to decide when to start childbearing and at what interval to have their children.

I believe that expanded access to contraception with 12 month coverage up front is crucial to enabling women to have correct use of their desired contraceptive. This has been shown to reduce unintended pregnancies and reduce need for abortion, which also reduces need for public dollars to support unintended pregnancies.

Again, thank you for your support. Women across Alaska will benefit from this legislation.

Sincerely,

Amanda Carnes, MD
Family Medicine Physician
Fairbanks, AK

March 3, 2017

As a female resident of Alaska and as a proud supporter of Planned Parenthood, I'd like to thank you for introducing legislation to support affordable, convenient access to birth control to Alaskan women. In Alaska over 7,700 patients utilize Planned Parenthood and nearly 3,000 women use its services for their birth control needs. HB25/SB53 allows a year's worth of contraceptives to be dispensed at one time, removing access inefficiencies, which translates to more women reaching their educational and career goals, more women going on to have healthier pregnancies in the future, and more families becoming more self-sufficient – **at less cost to government.**

For many women, in both rural and urban areas, lack of reliable transportation, limited clinic and pharmacy hours, and struggles with work/family schedules make multiple trips to the clinic or pharmacy challenging. As a single mom/college student, and later, as a working woman, remembering to get to the clinic for a pill refill or to the pharmacy in time for a refill was yet another priority to juggle. I remember thinking how silly it seemed, in my opinion, to have to make multiple trips for a year's worth of pills. After all, they weren't an addictive medication requiring additional regulatory oversight so I didn't see why the additional trips were necessary. But the trips were required so I went. Once when my car was in the shop, I had to take the bus with my toddler in sub-zero temperatures just for a refill so I wouldn't risk going off them. I shudder to think how much harder it would have been if I didn't hadn't lived in an area with public transportation as an option.

Consistent use of birth control is the best way to prevent unintended pregnancy, yet one in four women say they've missed pills because they couldn't get their next pack in time. We need to help struggling families make family planning as easy and accessible as possible, regardless of where in the state they live.

HB25/SB53 is a "no brainer" if the goal is to reduce unplanned pregnancies and lower the abortion rate. Getting a full year's supply at one time dramatically improves consistent use. According to a study published in *Obstetrics & Gynecology*, consistent use of birth control reduces unintended pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion. It's also cost effective for both public and private insurance plans, which lower claims on follow-up visits, pregnancy tests, and long-term costs associated with unintended pregnancies.

Women's consistent access to birth control shouldn't depend on her insurance carrier. We appreciate your efforts to expand birth control access for all of Alaska's women. Thank you.

Sincerely,

Anne Green

7032 Fairweather Park Loop, Anchorage, Alaska 99518, 907-444-0703



Alaska Nurses Association
3701 E. Tudor Road, Suite 208
Anchorage, Alaska 99507
(907) 274-0827
www.aknurse.org

March 6, 2017

Representative Matt Claman
State Capitol
Juneau, Alaska 99801

Dear Representative Claman,

We are writing on behalf of the Alaska Nurses Association in strong support of HB 25: "An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services." This bill will provide for consistent contraceptive coverage for the women and families of our state.

Supporting women's and family healthcare is a long-standing priority of the Alaska Nurses Association. We believe that every woman should have full access to the birth control method that works best for her, without barriers related to cost or availability. House Bill 25 would remove such barriers and give women more career and education opportunities, encourage healthier pregnancies, and make women and families less likely to be dependent on government programs.

- With perfect use, hormonal birth control has a failure rate of less than 5%, but for people who lack access to transportation, move frequently, or struggle to balance work and family, monthly trips to the pharmacy make perfect use of contraceptives challenging.
- One in four women say they have missed contraceptive pills because they could not receive the next pack in time; dispensing a one-year supply at a time reduces the odds of experiencing an unintended pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion.
- Consistent use of birth control is the best way to help women avoid unintended pregnancies; 19% of women who inconsistently use birth control account for 43% of unintended pregnancies, whereas the two-thirds of women who use birth control consistently only make up 5%.
- Publicly-funded or private insurance plans that dispense a one-year supply of birth control (instead of limiting dispensing to one or three cycles) lower their direct costs on follow-up visits and pregnancy tests, as well as on long-term unintended pregnancy management.
- Forty-six percent of women who unintentionally became pregnant report that they were using some form of contraceptive; providing a one-year supply of birth control will increase consistent use and reduce frequency of unintended pregnancy.

Access to reliable, consistent contraceptives should not depend on your insurance carrier. By requiring insurance to allow dispensing of a one-year supply of birth control, we can remove barriers to contraceptives, help women plan their families, and avoid unintended pregnancies and save money for Alaskan families and Alaska's government.

The Alaska Nurses Association certainly appreciates your support on behalf of women and families in our state.

Sincerely,

Arlene Briscoe, RN-BC
Legislative Chair
Alaska Nurses Association

Jane Erickson, RN, CCRN
President, Board of Directors
Alaska Nurses Association

The Alaska Nurses Association strongly endorses HB 25, recognizing our shared interest in removing barriers to consistent access to contraceptives for Alaskan women and families.

The Alaska Nurses Association serves to advance and support the profession of nursing. The Alaska Nurses Association's core purpose includes working for improvement of health standards and promoting access to health care services for all Alaskans.

House Health and Social Services Committee
Alaska State Legislature
Juneau AK 99801

Feb. 28, 2017

Dear Members of the Committee:

I am writing to express my strong support for Rep. Matt Claman's bill, H.B. 25, which would require insurance companies to cover a one-year's supply of birth control at a time. This is a common-sense measure that will help women who lack access to transportation, move frequently, or struggle to balance work and family avoid unintended pregnancies. This legislation deserves broad bipartisan support because reliable access to birth control benefits everyone – and helps avoid the serious social and economic costs of unwanted pregnancies.

I hope you will support this important legislation.

Best Regards,

Alyson Pytte

[REDACTED]
[REDACTED]

Ted Madsen

From: Cat Coward [REDACTED]
Sent: Monday, February 27, 2017 2:45 PM
To: House Health and Social Services; Rep. Lance Pruitt
Subject: In support of HB 25

Dear Representative Pruitt and House Health and Services Committee,

I'm am writing in support of HB 25, legislation that would require insurance companies to cover one full year of birth control rather than simply one month or quarter.

The necessity of getting to the pharmacy once per month or quarterly, especially when one is working a full time job, has one or more children to take care of, and/or lives rurally, is challenging at best. Birth control functions only when taken consistently and properly and any help that we can give parents to ease their family planning makes sense. It also is better for our economy as it decreases the costs of unintended pregnancy. It is good news that the rate of abortions is decreasing. It is even better news that we can help decrease it even more by allowing parents, and women, the ability to purchase birth control for an entire year, thus eliminating gaps in service when they have to purchase it more often.

Thank you for your support of this bill.

Catherine Coward
[REDACTED]
[REDACTED]
[REDACTED]

March 3, 2017

As a female resident of Alaska and as a proud supporter of Planned Parenthood, I'd like to thank you for introducing legislation to support affordable, convenient access to birth control to Alaskan women. In Alaska over 7,700 patients utilize Planned Parenthood and nearly 3,000 women use its services for their birth control needs. HB25/SB53 allows a year's worth of contraceptives to be dispensed at one time, removing access inefficiencies, which translates to more women reaching their educational and career goals, more women going on to have healthier pregnancies in the future, and more families becoming more self-sufficient – at less cost to government.

For many women, in both rural and urban areas, lack of reliable transportation, limited clinic and pharmacy hours, and struggles with work/family schedules make multiple trips to the clinic or pharmacy challenging. As a single mom/college student, and later, as a working woman, remembering to get to the clinic for a pill refill or to the pharmacy in time for a refill was yet another priority to juggle. I remember thinking how silly it seemed, in my opinion, to have to make multiple trips for a year's worth of pills. After all, they weren't an addictive medication requiring additional regulatory oversight so I didn't see why the additional trips were necessary. But the trips were required so I went. Once when my car was in the shop, I had to take the bus with my toddler in sub-zero temperatures just for a refill so I wouldn't risk going off them. I shudder to think how much harder it would have been if I didn't hadn't lived in an area with public transportation as an option.

Consistent use of birth control is the best way to prevent unintended pregnancy, yet one in four women say they've missed pills because they couldn't get their next pack in time. We need to help struggling families make family planning as easy and accessible as possible, regardless of where in the state they live.

HB25/SB53 is a "no brainer" if the goal is to reduce unplanned pregnancies and lower the abortion rate. Getting a full year's supply at one time dramatically improves consistent use. According to a study published in *Obstetrics & Gynecology*, consistent use of birth control reduces unintended pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion. It's also cost effective for both public and private insurance plans, which lower claims on follow-up visits, pregnancy tests, and long-term costs associated with unintended pregnancies.

Women's consistent access to birth control shouldn't depend on her insurance carrier. We appreciate your efforts to expand birth control access for all of Alaska's women. Thank you.

Sincerely,

Anne Green



Rep. Ivy Spohnholz

From: Janel Ryan [REDACTED]
Sent: Wednesday, March 08, 2017 9:42 AM
To: Rep. Ivy Spohnholz
Subject: Oppose HB25

Dear Representative Spohnholz,

Please do not support House Bill 25. I feel strongly that I should not be forced to pay for or participate in any way with abortion. Please uphold our freedom.

Sincerely,
Janel Ryan

Rep. Ivy Spohnholz

From: David Jorgensen (jorgensen.david@alaska.gov)
Sent: Wednesday, March 01, 2017 3:28 PM
To: Rep. Ivy Spohnholz; Rep. Bryce Edgmon; Rep. Sam Kito; Rep. Geran Tarr; Rep. David Eastman; Rep. Jennifer Johnston; Rep. Colleen Sullivan-Leonard; Rep. Matt Claman; Rep. Dan Saddler
Subject: House Bills 20, 25, and 54
Categories: Follow Up

Dear Alaska House Health & Social Services Committee Member,

I STRONGLY OPPOSE Alaska House Bills 20, 25, and 54. Here's why:

HB 20: HB 20 was amended in committee to add language saying that elected officials are not required or obligated to perform marriages, but this language only serves to highlight that the "freedom to say no" is not extended to others in the state who are authorized to solemnize marriages. There is no reason to have this added language only apply to elected officials. The wording should state that "NO person authorized to solemnize marriages is under the obligation or requirement to do so." The authorization to solemnize marriages cannot be used as a reason to compel any person having such authorization to solemnize a marriage which is against their religious or personal conviction. To do so would remove that person's constitutional right to exercise their religious or conscientious beliefs.

HB 25: The bill dictates that no insurance company can include a copayment or deductible for these contraceptives – it must be covered 100 percent. The physical act of sex is a choice, in nearly ALL instances. In this regard, I consider myself PRO-CHOICE...we all have the choice to engage in sex or not. But NONE of us have the choice to avoid the consequence of ANY of our acts. Any mandated 100% coverage for any item or class of items obviously increases the cost of that item, whatever it is, to the entire pool of the insured. It is morally wrong to force anyone to pay any portion of another person's insurance if that insurance cost includes coverage for items which are against their constitutional right to exercise their religious or conscientious beliefs. If a particular item causing a religious or conscience concern, such as abortifacients, are able to be separated out of the particular item class (contraceptives in this case), and offered and billed as a separate item, ensuring only the individual insured member is paying a premium for that right to use the item, then having the item covered to 100% could be okay. However, the same principle applies to any subsidized payments by taxpayers. NO subsidies should be allowed for any insurance items that are not life-saving or needed for INVOLUNTARY existing conditions. Except for rape, sex is NEVER involuntary. Police stations, hospitals, and social service centers can keep some of the appropriate medications on hand for those very RARE instances of rape. **BOTTOM LINE:** I should never have to subsidize contraception, nor should I have to have it on my insurance plan if I don't want or need it. And my premiums should be lower due to those choices being taken into account.

HB 54: On this bill, I'll simply quote Martin Sheen: "People who are ill need real medical care and compassion. Not lethal drugs."

Please vote AGAINST these three troublesome bills. They are against the constitutionality of every American's right to exercise their religious or conscientious beliefs.

Thanks for listening to a constituent's thoughts on these important matters.

**Sincerely,
David Jorgensen**

Rep. Ivy Spohnholz

From: John and Kathy Tappel [REDACTED]
Sent: Wednesday, March 01, 2017 2:30 PM
To: Rep. Ivy Spohnholz
Subject: HB 25

Categories: Follow Up

Dear Rep Spohnholz,

I strongly oppose HB25. I do so as a pediatrician, with a pretty thorough understanding of this issue professionally.

Thanks,

JTappel, MD

Rep. Ivy Spohnholz

From: Debbie Sherfick [redacted]
Sent: Wednesday, March 01, 2017 3:30 PM
To: Rep. Ivy Spohnholz; Rep. Bryce Edgmon; Rep. Sam Kito; Rep. Jennifer Johnston; Rep. Geran Tarr; Rep. Matt Claman; Rep. David Eastman; Rep. Colleen Sullivan-Leonard; Rep. Dan Saddler
Subject: Obamacare Abortifacient Mandate – HB 25 and SB 53
Categories: Follow Up

I have no problem with people wanting an abortion. That is their choice. I don't think that this should be mandated. I don't think that taxpayers should have to pay for it either.

Please vote NO on HB25/SB53. Thank you for listening.

Debbie Sherfick
Willow, AK

Rep. Ivy Spohnholz

From: Barry Matteson [REDACTED]
Sent: Friday, March 03, 2017 12:23 PM
To: Rep. Ivy Spohnholz
Subject: HB 25

Representative Spohnholz

I am opposed to HB 25 and don't want to be forced to subsidize abortion with my health insurance premiums. We are looking forward to a new health insurance plan that will be good for all Alaskans! Thank you for your service.

**Barry Matteson
Anchorage Alaska**



Alaska State Legislature

Representative Matt Claman

Session: State Capitol, Rm 118 Juneau, AK 99801 Phone: 465-4919

Interim: 1500 W. Benson Blvd., Anch, AK 99503 Phone: 269-0130

HB 25: Insurance Coverage for Contraceptives Summary of Changes Version A to Version J

“An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services; and providing for an effective date.”

Section 1 – Amends AS 21.42.427(d) to give health care insurers the ability to enact reasonable cost containment measures and provides a definition of cost containment. Adds a new subsection (e) which states that if the covered therapeutically equivalent version of a prescription contraceptive is not available or is considered medically inadvisable, a health care provider shall provide coverage without cost sharing for an alternative version of the prescription contraceptive.

Section 2 – Amends AS 39.30.090(a) by adding a new subsection (13) to include: “a group health insurance policy covering employees of a participating governmental unit is subject to the requirements of AS 21.42.427.”

Section 3 – Amends AS 39.30.091 to include: “a self-insured group medical plan covering active employees provided under this section is subject to the requirements of 21.42.427.”

30-LS0261J
Wallace
3/31/17

CS FOR HOUSE BILL NO. 25()
IN THE LEGISLATURE OF THE STATE OF ALASKA
THIRTIETH LEGISLATURE - FIRST SESSION

BY

Offered:

Referred:

Sponsor(s): REPRESENTATIVES CLAMAN, Spohnholz

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to insurance coverage for contraceptives and related services; relating**
2 **to medical assistance coverage for contraceptives and related services; and providing for**
3 **an effective date."**

4 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5 *** Section 1.** AS 21.42 is amended by adding a new section to read:

6 **Sec. 21.42.427. Coverage for contraceptives.** (a) A health care insurer that
7 offers, issues for delivery, delivers, or renews in the state a health care insurance plan
8 in the group or individual market shall

9 (1) provide coverage for

10 (A) prescription contraceptives;

11 (B) voluntary sterilization procedures; and

12 (C) consultations, examinations, procedures, and medical
13 services that are necessary to prescribe, dispense, insert, deliver, distribute,
14 administer, or remove the drugs, devices, and other products or services

1 provided under this paragraph;

2 (2) reimburse a health care provider or dispensing entity for dispensing
3 prescription contraceptives intended to last for a 12-month period for subsequent
4 dispensings of the same prescription contraceptive to the insured regardless of whether
5 the insured was enrolled in the health care insurance plan at the time of the first
6 dispensing.

7 (b) A health care insurer may not deny coverage or reimbursement under (a)
8 of this section because an insured changed contraceptive methods within a 12-month
9 period.

10 (c) A health care insurer may not offset the costs of compliance with (a) of
11 this section and may not require copayments or deductibles for contraceptives or
12 services covered under (a) of this section.

13 (d) A health care insurer may not restrict or delay the coverage or
14 reimbursement required under (a) of this section, including use of medical
15 management techniques, such as denials, step therapy, or prior authorization, that limit
16 an insured's choice in accessing a full range of prescription contraceptives. Nothing in
17 this subsection prevents a health care insurer from enacting reasonable cost
18 containment measures in relation to the coverage required under (a) of this section if
19 the cost containment measure does not unreasonably limit choice in access to
20 coverage. In this subsection, "cost containment" means incentivizing the use of
21 generic or lower cost medications or the use of health care providers or pharmacies
22 that offer services or prescriptions at a lower negotiated rate.

23 (e) If the covered therapeutically equivalent version of a prescription
24 contraceptive is not available or is considered medically inadvisable by the health care
25 provider of the insured, a health care insurer shall provide coverage without cost
26 sharing for an alternative therapeutically equivalent version of the prescription
27 contraceptive that is prescribed for the insured.

28 (f) A health care insurer shall provide coverage and reimbursement under (a)
29 of this section to all insureds enrolled in a health care insurance plan, including
30 enrolled spouses and dependents.

31 (g) A health care insurer that offers, issues for delivery, delivers, or renews in

1 the state a health care insurance plan in the group market to a religious employer is
2 exempt from the requirements of this section with respect to the health care insurance
3 plan of the religious employer if the religious employer opposes the coverage required
4 under this section and is an

5 (1) organization that meets the criteria set out in 26 U.S.C.
6 6033(a)(3)(A)(i) or (iii) (Internal Revenue Code of 1986), as amended; or

7 (2) eligible organization that has self-certified in the form and manner
8 specified by the United States Secretary of Labor or has provided notice to the United
9 States Secretary of Health and Human Services, under the requirements set out in 45
10 C.F.R. 147.131(b)(1) - (3).

11 (h) In this section, "prescription contraceptive" means a drug or device that
12 requires a prescription and is approved by the United States Food and Drug
13 Administration to prevent pregnancy.

14 * **Sec. 2.** AS 39.30.090(a) is amended to read:

15 (a) The Department of Administration may obtain a policy or policies of group
16 insurance covering state employees, persons entitled to coverage under AS 14.25.168,
17 14.25.480, AS 22.25.090, AS 39.35.535, 39.35.880, or former AS 39.37.145,
18 employees of other participating governmental units, or persons entitled to coverage
19 under AS 23.15.136, subject to the following conditions:

20 (1) a group insurance policy shall provide one or more of the following
21 benefits: life insurance, accidental death and dismemberment insurance, weekly
22 indemnity insurance, hospital expense insurance, surgical expense insurance, dental
23 expense insurance, audiovisual insurance, or other medical care insurance;

24 (2) each eligible employee of the state, the spouse and the unmarried
25 children chiefly dependent on the eligible employee for support, and each eligible
26 employee of another participating governmental unit shall be covered by the group
27 policy, unless exempt under regulations adopted by the commissioner of
28 administration;

29 (3) a governmental unit may participate under a group policy if

30 (A) its governing body adopts a resolution authorizing
31 participation and payment of required premiums;

1 (B) a certified copy of the resolution is filed with the
2 Department of Administration; and

3 (C) the commissioner of administration approves the
4 participation in writing;

5 (4) in procuring a policy of group health or group life insurance as
6 provided under this section or excess loss insurance as provided in AS 39.30.091, the
7 Department of Administration shall comply with the dual choice requirements of
8 AS 21.86.310, and shall obtain the insurance policy from an insurer authorized to
9 transact business in the state under AS 21.09, a hospital or medical service corporation
10 authorized to transact business in this state under AS 21.87, or a health maintenance
11 organization authorized to operate in this state under AS 21.86; an excess loss
12 insurance policy may be obtained from a life or health insurer authorized to transact
13 business in this state under AS 21.09 or from a hospital or medical service corporation
14 authorized to transact business in this state under AS 21.87;

15 (5) the Department of Administration shall make available bid
16 specifications for desired insurance benefits or for administration of benefit claims and
17 payments to (A) all insurance carriers authorized to transact business in this state
18 under AS 21.09 and all hospital or medical service corporations authorized to transact
19 business under AS 21.87 who are qualified to provide the desired benefits; and (B)
20 insurance carriers authorized to transact business in this state under AS 21.09, hospital
21 or medical service corporations authorized to transact business under AS 21.87, and
22 third-party administrators licensed to transact business in this state and qualified to
23 provide administrative services; the specifications shall be made available at least once
24 every five years; the lowest responsible bid submitted by an insurance carrier, hospital
25 or medical service corporation, or third-party administrator with adequate servicing
26 facilities shall govern selection of a carrier, hospital or medical service corporation, or
27 third-party administrator under this section or the selection of an insurance carrier or a
28 hospital or medical service corporation to provide excess loss insurance as provided in
29 AS 39.30.091;

30 (6) if the aggregate of dividends payable under the group insurance
31 policy exceeds the governmental unit's share of the premium, the excess shall be

1 applied by the governmental unit for the sole benefit of the employees;

2 (7) a person receiving benefits under AS 14.25.110, AS 22.25,
3 AS 39.35, or former AS 39.37 may continue the life insurance coverage that was in
4 effect under this section at the time of termination of employment with the state or
5 participating governmental unit;

6 (8) a person electing to have insurance under (7) of this subsection
7 shall pay the cost of this insurance;

8 (9) for each permanent part-time employee electing coverage under
9 this section, the state shall contribute one-half the state contribution rate for permanent
10 full-time state employees, and the permanent part-time employee shall contribute the
11 other one-half;

12 (10) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35,
13 or former AS 39.37 may obtain auditory, visual, and dental insurance for that person
14 and eligible dependents under this section; the level of coverage for persons over 65
15 shall be the same as that available before reaching age 65 except that the benefits
16 payable shall be supplemental to any benefits provided under the federal old age,
17 survivors, and disability insurance program; a person electing to have insurance under
18 this paragraph shall pay the cost of the insurance; the commissioner of administration
19 shall adopt regulations implementing this paragraph;

20 (11) a person receiving benefits under AS 14.25, AS 22.25, AS 39.35,
21 or former AS 39.37 may obtain long-term care insurance for that person and eligible
22 dependents under this section; a person who elects insurance under this paragraph
23 shall pay the cost of the insurance premium; the commissioner of administration shall
24 adopt regulations to implement this paragraph;

25 (12) each licensee holding a current operating agreement for a vending
26 facility under AS 23.15.010 - 23.15.210 shall be covered by the group policy that
27 applies to governmental units other than the state;

28 **(13) a group health insurance policy covering employees of a**
29 **participating governmental unit is subject to the requirements of AS 21.42.427.**

30 * Sec. 3. AS 39.30.091 is amended to read:

31 **Sec. 39.30.091. Authorization for self-insurance and excess loss insurance.**

1 Notwithstanding AS 21.86.310 or AS 39.30.090, the Department of Administration
2 may provide, by means of self-insurance, one or more of the benefits listed in
3 AS 39.30.090(a)(1) for state employees eligible for the benefits by law or under a
4 collective bargaining agreement and for persons receiving benefits under AS 14.25,
5 AS 22.25, AS 39.35, or former AS 39.37, and their dependents. The department shall
6 procure any necessary excess loss insurance under AS 39.30.090. **A self-insured**
7 **group medical plan covering active state employees provided under this section is**
8 **subject to the requirements of AS 21.42.427.**

9 * **Sec. 4.** AS 47.07.065 is amended by adding new subsections to read:

10 (b) The department shall pay for

11 (1) prescription contraceptives intended to last for a 12-month period
12 for subsequent dispensings of the same prescription contraceptive if prescribed to and
13 requested by the recipient, regardless of whether the recipient was receiving medical
14 assistance at the time of the first dispensing; and

15 (2) consultations, examinations, procedures, and medical services that
16 are necessary to

17 (A) prescribe, dispense, insert, distribute, or administer
18 prescription contraceptives; or

19 (B) remove prescription contraceptives.

20 (c) Nothing in this section requires itemized reimbursement when a service is
21 reimbursable as part of a bundled or composite rate.

22 (d) In this section, "prescription contraceptive" means a drug or device that
23 requires a prescription and is approved by the United States Food and Drug
24 Administration to prevent pregnancy.

25 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to
26 read:

27 MEDICAID STATE PLAN INSTRUCTIONS; NOTICE TO REVISOR OF
28 STATUTES. The Department of Health and Social Services shall immediately amend and
29 submit for federal approval a state plan for medical assistance coverage consistent with
30 AS 47.07.065(b) - (d), added by sec. 4 of this Act. The Department of Health and Social
31 Services shall apply to the United States Department of Health and Human Services for any

1 waivers necessary to implement AS 47.07.065(b) - (d), added by sec. 4 of this Act. The
2 commissioner of health and social services shall notify the revisor of statutes in writing if the
3 United States Department of Health and Human Services approves the provisions of
4 AS 47.07.065(b) - (d), added by sec. 4 of this Act.

5 * **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to
6 read:

7 **CONDITIONAL EFFECT.** AS 47.07.065(b) - (d), added by sec. 4 of this Act, take
8 effect only if the commissioner of health and social services notifies the revisor of statutes in
9 writing under sec. 5 of this Act, on or before January 1, 2018, that the provisions of
10 AS 47.07.065(b) - (d), added by sec. 4 of this Act, have been approved by the United States
11 Department of Health and Human Services.

12 * **Sec. 7.** If AS 47.07.065(b) - (d), added by sec. 4 of this Act, take effect, they take effect on
13 the day after the date the commissioner of health and social services makes a certification to
14 the revisor of statutes under secs. 5 and 6 of this Act.

15 * **Sec. 8.** Except as provided in sec. 7 of this Act, this Act takes effect January 1, 2018.

From: Laura Green
Sent: Monday, February 20, 2017 12:24 PM
To: Rep. Harriet Drummond <Rep.Harriet.Drummond@akleg.gov>
Cc: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: HB 25 support

I support HB 25 which would require insurance cover 1 year supply of birth control at a time. As a full time working women, I found the 1 month at a time limits imposed by insurance companies for no viable medical reason to be cumbersome and I live here in Anchorage with reliable access to my own means of transportation! I can only imagine the hardship that such a silly restriction places on less fortunate women or those in more rural parts of the State.

Please support HB 25.

Thank you,
Laura Green
99503

From: Janice Whitton
Sent: Friday, February 24, 2017 2:23 PM
To: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: Birth control coverage

Dear Congresswoman Lizzie. Kubitz,

I think every woman who desires so, should be allowed birth control coverage. It is as important to a women's welfare as any other prescription drug--considering the consequences of childbirth or unwanted child birth. Thank you for your work. Janice Whitton, Fairbans AK

-----Original Message-----

From: mary lee Guthrie
Sent: Sunday, February 26, 2017 5:57 PM
To: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: HB25

I wish to express my strong support for HB 25. As a mother, stepmother and grandmother, much of my life has been dedicated to kids.

I know access to contraceptives and related reproductive health care is part of the bedrock of healthy, happy family life. Insurance coverage for this basic medical need is reasonable.

I'm conservative and think things that matter the most about families and kids are not something that can be done by government.

But assuring ready access to birth control is something members of our Legislature can choose to do. Or not. You can obstruct access to this necessary, but not sufficient, component to growing solid Alaskan families.

I urge you to choose to vote for HB25.

Thank you.
Mary Lee Guthrie
Fairbanks

From: Robert Werner
Sent: Friday, February 24, 2017 9:43 PM
To: Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>
Subject: I support HB-25

24 February 2017

Dear Representative Claman,

I am writing to express my support for HB-25, state legislation that would require insurance companies to cover one year of birth control at a time, instead of month-to-month. The legislature can ensure all women have consistent access to birth control by requiring that insurance cover one-year's supply of birth control at a time, dispensed on-site at the provider's office if available. We all deserve affordable and accessible birth control that works for us, regardless of our income or insurance carrier. Consistent access to birth control gives women the ability to control when and if they have children, giving them more career and education opportunities, healthier pregnancies, and making them less likely to depend on government programs. Today, most women have to refill their birth control every month, which is a burden for many women and leads to inconsistent birth control use.

Thank you for sponsoring the bill.

Sincerely,

Jeanne Schaaf

Anchorage, AK 99516

Cc: Rep. Jennifer Johnston

-----Original Message-----

From: Mary Daniel
Sent: Tuesday, February 28, 2017 2:54 PM
To: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: HB-25

My husband and I both support HB 25 dealing with insurance coverage for contraceptives. We believe this will save on welfare programs and pre-school programs. It will reduce the number of unwanted pregnancies, which will reduce the need for abortions or adoptions. There will be fewer children that weren't really wanted and are more likely to not be taken care of properly.

Thank you for considering our opinion of this issue.

Mary Daniel
Seward, AK

From: Jeannette O
Sent: Tuesday, February 28, 2017 6:31 PM
To: househess@akleg.gov; Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: House Bill 25

Dear Representative Claman,

I just heard about the legislation you introduced to expand birth control access in Alaska. I'm writing today to say THANK YOU for your leadership.

I'm the mom of three teenagers who all know where the Planned Parenthood is in Fairbanks. They also know they can ask if they need help and that sexuality is nothing to be ashamed of. I know that all people don't have that kind of support, or access to transportation, or the money to go to the doctor, and that barriers exist for people. Even me, I'm a busy lady, which is why I'm grateful that I was able to get birth control that lasts for 5 years at a time.

Providing a year's supply of birth control at a time is, quite frankly, a genius idea. I didn't grow up in Alaska, I grew up in a suburb in Washington, but even then my birth control pills lapsed from time to time. Thank goodness I never experienced an unintended pregnancy, but I look at the chance to plan my own family as a gift, when in fact it should really be a right.

With all of the upheaval and uncertainty with healthcare and our new administration, Alaska's women deserve this peace of mind. Thank you for your leadership!

Jeannette Okinczyc

Fairbanks, Alaska
99701

From: susan bissell
Sent: Tuesday, February 28, 2017 6:32 PM
To: House Health and Social Services <lhsches@akleg.gov>
Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: In support of HB 25 - Thank you, Rep. Claman!

To the Members of the House Health and Social Services Committee:

I am writing in support of Representative Claman's leadership in expanding birth control access in Alaska through HB25/SB23. I believe that expanding birth control access is the most effective tool we have for reducing unwanted pregnancies. HB25 is particularly important for women in rural Alaska, who often cannot refill prescriptions due to transportation, cost, or embarrassment. With perfect use, hormonal birth control has a failure rate of less than 5%. This makes it an extremely effective and cost effective way to prevent unwanted pregnancy. According to a study published in Obstetrics & Gynecology, dispensing a full year's supply at a time reduces the odds of experiencing an unwanted pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion. It is also cost effective for both public and private insurance plans because it reduces the costs associated with pregnancy tests, prenatal care, and childbirth. By preventing unwanted pregnancies, HB25 also has the potential to reduce the need for government assistance.

Women must have safe, reliable access to birth control in a way that preserves their dignity and self-worth. Women should not have to argue with insurance carriers to receive birth control, or be placed in a position where birth control is not affordable or available. I appreciate your efforts to expand birth control access for women in Alaska, and I fully support you in this endeavor.

Susan Bissell
Fort Wainwright, AK

From: Sara Rikalo Cassidy
Sent: Tuesday, February 28, 2017 6:36 PM
To: House Health and Social Services <lhsches@akleg.gov>
Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: House Bill 25

To the House Health & Social Services,

I write today to express my support for HB 25/SB 53: 12 Months of Birth Control. I would also like to take the opportunity to thank Representative Claman for his leadership and for introducing legislation to expand birth control access in Alaska. Access to a one-year's supply of birth control at a time - on-site if available - would remove barriers to consistent usage and help women avoid unwanted pregnancies.

As a woman who uses birth control and has struggled with consistent access to it in the past, I believe that we all deserve affordable and accessible birth control regardless of our income or insurance carrier. Before moving to Alaska, I was a student at the University of Richmond. My international student health insurance did not cover the cost of birth control and dispensed it monthly; I needed birth control not simply for preventing unwanted pregnancies but for alleviating the symptoms of a medical condition. Once I got married, I switched to TRICARE as my insurance carrier. I was able to receive enough supply for three months at a time, and had to pick it up personally in Fairbanks, Alaska. Considering that I still had two semesters (each four months long), it was impossible for me to maintain my birth control supply until I have permanently relocated to Fairbanks.

Today, most women have to refill their birth control every month, which is a burden for many women, especially in the rural areas of Alaska. Inconsistent access to birth control affects women's ability to plan their pregnancies, which would in turn benefit their career and education opportunities, personal relationships, and health. Further, publicly funded or private insurance plans that dispense a one-year's supply of birth control instead of limiting dispensing to one or three cycles lower their direct costs on follow-up visits and pregnancy tests, as well as long-term unintended pregnancy management.

I appreciate your leadership and hard work regarding this issue, and I look forward to supporting you in your future efforts to resolve it to the benefit of all women in need of birth control.

Respectfully,

Sara Rikalo

From:

Sent: Tuesday, February 28, 2017 6:44 PM

To: House Health and Social Services <lhsches@akleg.gov>

Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>

Subject: house bill 25

To the House Health & Social Services,

I'm writing today in support of House Bill 25 and bill sponsor Rep. Claman. I want to first thank Representative Claman for introducing legislation to expand birth control access in Alaska. Taking the lead on tackling a problem that many women, like me, face here in Alaska.

I fully support this bill because i'm a hard working woman of Alaska. I work in some of the most remote locations. To take care of myself it requires skillful planning as, "trips to town" can be weather dependent, sporadic, or limited. Providing a years worth of birth control at a time removes a hurdle of summer schedule and allows me to focus on doing the best at my job. Consistent access to birth control is such a simple solution to a huge problem.

I want to thank again Rep. Claman for introducing this and give my fully support of House Bill 25.

Thank you,

- Leigh Strehlow

From: Lucas Almonte

Sent: Tuesday, February 28, 2017 6:59 PM

To: House Health and Social Services <lhsches@akleg.gov>; Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>

Subject: House Bill 25

Dear Representative Claman,

As a volunteer at Planned Parenthood, I write today to thank you for your leadership and for introducing legislation to expand birth control access in Alaska. As a volunteer at an organization that provides services to thousands of low-income individuals per year, sincere efforts

to expand birth control are greatly appreciated.

For years my spouse was afforded the opportunity to receive free health care that goes beyond birth control in itself. I believe every woman should be afforded the opportunity of having full access to birth control. House Bill 25 would remove such barriers and give women more career and education opportunities, encourage healthier pregnancies, and make them less likely to depend on government programs.

Thank you for the courage and strength to stand up for what you believe in and you will have my gratitude and support.

From: Amanda Carnes

Sent: Tuesday, February 28, 2017 8:47 PM

To: House Health and Social Services <lhsches@akleg.gov>

Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>

Subject: Support for HB 25

Dear House Health and Social Services Committee,

On behalf of Planned Parenthood Votes Northwest and Hawaii, I write today to thank you and Representative Claman for your leadership in introducing legislation to expand birth control access in Alaska. I am a Family Practice physician in Fairbanks, AK, and I have been a supporter of expanded access to contraception since becoming a volunteer for Planned Parenthood as an undergraduate premedical student.

Every day I see women who benefit from the ability to control their fertility to expand their options for education, work, and choice of partner. This allows women to achieve goals and

contribute to society in ways that may be unattainable for them otherwise. This also allows all families to decide when to start childbearing and at what interval to have their children.

I believe that expanded access to contraception with 12 month coverage up front is crucial to enabling women to have correct use of their desired contraceptive. This has been shown to reduce unintended pregnancies and reduce need for abortion, which also reduces need for public dollars to support unintended pregnancies.

Again, thank you for your support. Women across Alaska will benefit from this legislation.

Sincerely,

Amanda Carnes, MD
Family Medicine Physician
Fairbanks, AK

From: mamie Davis
Sent: Thursday, March 09, 2017 2:12 PM
To: House Health and Social Services <lhsches@akleg.gov>
Cc: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: HB 25 - Please vote YES!

Good afternoon House Health & Social Services Committee,

I first want to thank Senator Claman for sponsoring this bill! I think this is an incredibly important piece of legislation for women in Alaska. Birth control can be quite the inconvenience to a woman's life and requiring women go back to their doctor or pharmacist every three to six months only compounds the inconvenience women feel. The system we have now interrupts women's lives unnecessarily and makes taking jobs with continual travel and living in Alaska's bush communities and villages difficult become women have to think "how will I get my birth control?" It is absurd that our current system PUNISHES women for being responsible and choosing to prevent unwanted pregnancies before they happen. The law should should make it easier for women to make the responsible choice.

Also, some people have said that it may not be safe for a women to take a year's worth of birth control and that limiting birth control amounts would make sure women check back in with their doctor regularly. I 100% disagree. No law/policy should continue that forces women to pay \$200-\$400 to their doctor FOUR times a year just to "check-in" and so that they can get a new prescription. Also, believe it or not, women are far more in tune with their bodies that one might believe, especially when something goes wrong or doesn't feel right. At that point women can choose to go in to talk to their provider and perhaps change the method of birth control.

Of all places in the US, Alaska makes the most sense to provide 12mo of birth control at a time. In a state with the geographical vastness and the remoteness of 90% of the cities in Alaska, requiring women to see their provider several times a year isn't feasible for people in the bush communities. Alaska also has industries that work remotely and requiring women to go back for birth control four times a year jeopardizes women's careers in those fields and prevents women from entering those fields.

The fact that this has to be made into law to allow women greater access to a medication that gives them control over their own lives is absolutely absurd to me and just shows you how much of a patriarchal society we still live in.

Please do the right thing and vote YES!

-Mamie Davis

Fairbanks, Alaska

From: Traci Ferguson-Hayes

Sent: Monday, March 13, 2017 7:01 AM

To: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>; House Health and Social Services <lhsches@akleg.gov>

Subject: Support of HB 25

Hello,

My name is Traci Ferguson Hayes and I live in Juneau, AK in House District 34. I am writing in support of HB 53.

As a young woman of the age of 30 and as a mom of two children already, I support full access of birth control. My last pregnancy has it's complications and I was told by numerous doctors that if I was to ever get pregnant again, I or the baby would not be able to make it. Personally, it is important to me that I have access to birth control for a long period of time. If I were able to obtain birth control for an entire year, that would benefit myself and my family. It would reduce the risk of getting pregnant again and worrying about not only my life, but the life of an unborn child.

Thank you,
Traci Ferguson Hayes

--

Traci Ferguson Hayes

"No Matter What Happens, Always Keep Your Childish Innocence"

-----Original Message-----

From: Lou Gagne
Sent: Monday, March 13, 2017 10:15 AM
To: Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: SB 53

I stand in STRONG SUPPORT of SB 53. I hold Life, Family, and Health very dear. I can think of no better single avenue to prevent abortions, support loving families, and provide for healthy women than to make contraception more widely available and covered by insurance (and Medicaid) for 12-month prescriptions, as required under SB 53. Thank you for proposing the bill and holding a public hearing on it. Please pass it out of committee with resounding "Do Pass" recommendations.

Thank you.

LouAnnGagne'

Douglas, AK 99824

Sent from my iPad

-----Original Message-----

From: Kristina Miller
Sent: Tuesday, March 21, 2017 1:00 PM
To: House Health and Social Services <lhsches@akleg.gov>; Lizzie Kubitz <Lizzie.Kubitz@akleg.gov>
Subject: Support for HB 25

Dear Members of the Committee:

I am writing to express my strong support for Representative Matt Claman's House Bill 25, which would require insurance companies to cover a year supply of birth control at a time. This measure will help avoid unplanned pregnancies by giving women more control and availability of their birth control methods. It will protect those who do not have regular access to pharmacies due to the lack of resources in their town, their finances, or other barriers. Additionally, covering a full year supply of birth control will give women the ability to work, travel for work, or just travel without compromising their choice to protect against unintended pregnancies.

The health and well-being of our state depend on the health and wellbeing of its people. Alaskan women who choose to use contraceptives to prevent pregnancies they are not ready for should be supported. Alaskan women should be encouraged to exercise their right to choose what is right for their bodies and lives. Please support the health, wellbeing, and autonomy of Alaskan women by supporting H.B. 25.

Thank you, Representative Claman.

Sincerely,

Kristina Miller

-----Original Message-----

From: Pam Groves

Sent: Wednesday, April 05, 2017 10:11 AM

To: Rep. Ivy Spohnholz <Rep.Ivy.Spohnholz@akleg.gov>; Rep. Bryce Edgmon <Rep.Bryce.Edgmon@akleg.gov>; Rep. Sam Kito <Rep.Sam.Kito.III@akleg.gov>; Rep. Geran Tarr <Rep.Geran.Tarr@akleg.gov>; Rep. David Eastman <Rep.David.Eastman@akleg.gov>; Rep. Jennifer Johnston <Rep.Jennifer.Johnston@akleg.gov>; Rep. Colleen Sullivan-Leonard <Rep.Colleen.Sullivan-Leonard@akleg.gov>; Rep. Matt Claman <Rep.Matt.Claman@akleg.gov>; Rep. Dan Saddler <Rep.Dan.Saddler@akleg.gov>

Subject: HB25

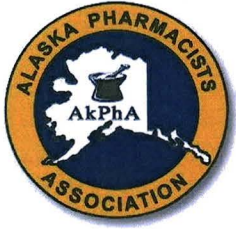
Dear HHSS Committee Members,

As a concerned Alaskan from Fairbanks, I am writing to request you all vote to pass HB 25 through committee. Access to birth control is an important right for all Alaskan women. Having insurance plans dispensing a year of birth control at a time will help women to use their birth control consistently and avoid unwanted pregnancies which have a high social cost in this state. I sincerely hope you will support this bill so that the entire House can vote on it.

Thanks you for your time.

Sincerely,

Pam Groves



Alaska Pharmacists Association

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March 2, 2017

Representative Matt Claman
Alaska State Capitol Building
Room 118
Juneau, AK 99801

Dear Representative Claman:

Thank you for introducing HB 25. The Alaska Pharmacists Association (AKPhA) appreciates your efforts and leadership on this issue. AKPhA represents over 250 pharmacists and pharmacy technicians in the State of Alaska. Our mission is to preserve, promote, and lead the profession of pharmacy in Alaska.

HB 25 strongly aligns with our mission to provide the best possible care to all of our patients, and to make needed medications, including contraceptives, readily available to these patients.

The bill will add Alaska to the 28 other states that already require insurers that cover prescription drugs to provide coverage of FDA-approved prescription contraceptive drugs and devices; and to join states such as Illinois, Oregon, Vermont and California that allow women to get 12 months of birth control pills at one time. It will be important for women to understand appropriate storage methods for their contraception and we will work to ensure that they do.

Again, we appreciate your efforts and leadership on this issue. Should there be anything that I, or the Alaska Pharmacists Association can do to help ensure passage of this legislation, please let me know.

Sincerely,

Della Cutchins, PharmD
President, Alaska Pharmacists Association
dcutchins@anthc.org

E-mail: akphrmcy@alaska.net

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ANDVSA

Alaska Network on Domestic Violence
& Sexual Assault

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Fax: (907) 279-2451

10 March 2017

The Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) is grateful to Representative Claman and his staff for putting forth House Bill 25 (Insurance Coverage for Contraceptives), for which we offer our full support.

As domestic violence and sexual assault service providers, our 24 member agencies and affiliates served 6,317 women in FY 16 alone. Domestic violence and sexual assault are both public safety and public health issues. As a consequence, we are heavily invested in reproductive health access and equity. Thinking in terms of power and control as the overall basis of domestic violence and sexual assault, we understand that victims and survivors' autonomy is fundamental in both preventing and responding to violent acts. One critical element of this autonomy is women's access to affordable and consistent reproductive health care.

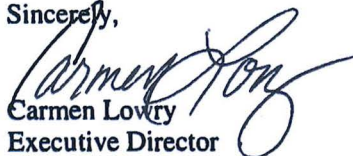
HB 25 critically enables victims and survivors' reproductive health autonomy, and greater abilities to survive and thrive. Firstly, the bill ensures that all methods of contraceptives – including long-acting reversible contraceptives (LARCs) such as intrauterine devices and implants – are covered by insurers. This is vital for women who face contraceptive coercion, in which their abusers dictate when and how contraceptives can and cannot be used as part of their exerting power and control. The expansion of choices for women to include LARCs would assist in their living as safely as possible in the short term, while they worked towards longer-term safety. Without such coverage, lack of contraceptives could lead to unintended pregnancy; which could in turn impose an even greater vulnerability on women experiencing intimate partner violence.

Further, the assurance of a 12 month prescription of contraceptives also recognizes the underlying issue of equity in enabling more, consistent contraceptive coverage for under-served populations. In particular, this legislation would break down barriers to access for women in rural areas – who, often due to a lack of access to social services and health care are especially vulnerable to domestic violence and sexual assault.

We are hopeful that our perspective helps expand your understanding that women's access to contraceptives – and, consequently, survival, health and wellness – must not depend on cost, availability, or insurance carrier. Along with many other women's health and rights organizations, we strongly urge you to support HB 25 and help provide this important support for women's autonomy: including those who are victims and survivors of domestic violence and sexual assault.

If you have any questions or need additional information, please contact me at (907) 586-3650 or clowry@andvsa.org. Thank you very much for your time and consideration.

Sincerely,



Carmen Lowry

Executive Director

Alaska Network on Domestic Violence and Sexual Assault

Member Programs

Anchorage AWAIC, STAR Barrow AWIC Bethel TWC Cordova CFRC Dillingham SAFE Fairbanks IAC Homer SPHH
Juneau AWARE Kenai LeeShore Center Ketchikan WISH Kodiak KWRCC Kotzebue MFCC Nome BSWG
Seward SeaView Community Services Sitka SAFV Unalaska USAFV Valdez AVV



APRN
ALLIANCE

16 March 2017
Representative Matt Claman
Juneau, AK 99801

Re: HB25

Dear Representative Claman,

I am writing on behalf of the Alaska Advanced Practice Registered Nurse (APRN) Alliance in strong support of SB156. The APRN Alliance is a group of nurse leaders representing nurse practitioners (CNPs), nurse-midwives (CNMs), nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs) throughout Alaska.

The APRN Alliance strongly supports this common sense bill which provides women with a full year of contraceptive coverage following an initial three month dispensing.

Sincerely,

A handwritten signature in blue ink that reads "Tracey Wiese". The signature is written in a cursive, flowing style.

Dr. Tracey Wiese, APRN, FNP-BC, PMHNP-BC
Co-chair, APRN Alliance

And

Amy Meyers, APRN, CNS
Co-chair, APRN Alliance

March 28, 2017

To: House Health & Social Services Committee Members

Re: Tanana Chiefs Conference Support of House Bill 25 (HB25)

Dear House Health & Social Services Committee Members,

Tanana Chiefs Conference (TCC) fully supports HB 25. This important piece of legislation mandates 12-month insurance coverage and uninterrupted access to contraceptive medications for women in Alaska.

The unique and extremely rural nature of much of Alaska means that there is not a pharmacy "on the corner" or "down the road" in every community. Most rural villages served by TCC are off the road system and hundreds of air miles away from the nearest pharmacy. The distance to the nearest pharmacy is compounded by high airfare costs to Fairbanks or long waits for mail deliveries by the U.S. Postal Service. By statutorily requiring insurers to cover a 12 month supply of contraceptives, patients in rural and roadless regions of our state will not have the continuous problem of running out of refills of this critically important medication.

This is of particular concern to Tanana Chiefs Conference. Alaska Native women have higher fertility rates than all other races in Alaska (almost twice as high in the 18-19 year old range) with the prevalence of unintended pregnancy following this trend. We know that access and cost are contributing factors to these statistics. HB 25 is an important step in helping all Alaskan women have affordable and dependable access to birth control.

Respectfully,
Tanana Chiefs Conference



Victor Joseph, President/Chief