

Medicaid Coverage of Plan B[®] Over-the-Counter: New York State's Experience

New York significantly expanded access to emergency contraception when it agreed to cover Plan B[®] over-the-counter (OTC) through Medicaid.¹ The state agreed to pay the federal share, and waived the federal requirement that women obtain a written, fiscal order for Plan B[®] from a health practitioner. To date, few state Medicaid programs have waived the written order or prescription requirement for covering an OTC product. The Education Fund of Family Planning Advocates of New York State (FPA) sought to learn what this regulatory change has meant to low-income women and the state. Analysis of Medicaid claims data for 2007 revealed that the number of claims for Plan B[®] fell well below projections. Sixty-five percent of counties had fewer than 50 claims for Plan B[®]. Most women (89%) had only one or two courses of Plan B[®] covered by Medicaid; only 1% had claims for the six-course maximum. We estimated that between 300 and 500 unintended pregnancies were prevented.

Background

Approval of Plan B[®] by the FDA as an over-the-counter product for women 18 years of age and older in August 2006 significantly expanded access to this safe and effective method of preventing unintended pregnancy. The FDA stipulated that the product could be sold by a pharmacist without a prescription to consumers 18 years of age and older; however, younger women were still required to have a prescription. The cost of Plan B[®] is a significant barrier for low-income women, many of whom cannot afford the retail price which ranges from approximately \$35 to \$60.²

Prior to OTC approval, the cost barrier was addressed for women in the Medicaid program when New York added Plan B[®] and Preven³ to the Medicaid formulary soon after FDA approval. Once Plan B[®] went OTC, the state moved quickly to cover it. Federal Medicaid law allows states to cover over-the-counter products if they are treated as prescriptions, which requires a qualified health practitioner to provide a pharmacist with a patient- and drug-specific order in writing, by telephone or fax in advance of dispensing an OTC product.⁴ For the consumer, having to obtain a fiscal order was no easier than having to obtain a prescrip-

tion. Given that the effectiveness of Plan B[®] is greatest the sooner it is used after unprotected sexual intercourse, it was critical to find ways to avoid unnecessary delay.⁵

FPA took the lead in contacting staff of the New York State Department of Health (DOH), which administers the Medicaid program, to explore strategies to bypass the fiscal order requirement. In a letter dated January 23, 2007, the state informed pharmacists that the fiscal order would no longer be required for Plan B[®]. The letter contained billing information which facilitated quick implementation. An emergency rule, published in the *New York State Register* on February 23, 2007, and effective retroactively to February 1, provided formal notice of the change in policy. Emergency rules are only effective for 90 days, but the state continued to adopt new emergency rules throughout 2007 and 2008. A proposed final rule was published in the *New York State Register* on January 23, 2008. FPA submitted comments urging the DOH to adopt the proposed rule as final. The final rule was adopted on July 23, 2008.

Because the fiscal order is a federal requirement, New York State agreed to forgo the 90% share the federal government routinely pays for family planning services and assume 100% of the cost of Plan B[®] for eligible recipients.

The final rule imposes a cap of six courses of the drug in any twelve-month period.

New York is currently one of 16 states in which Medicaid covers Plan B[®] OTC. The other states include Arkansas, California, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Utah, Washington and Wyoming.⁶ Only four states — New York, Washington, Illinois, and Oregon — have waived the fiscal order requirement. The Medicaid program in New Mexico will soon cover Plan B[®] without a prescription for adult women.⁷ In the nine “pharmacy access” states, Medicaid covers Plan B[®] prescriptions so women of any age can easily obtain Plan B[®] at participating pharmacies.⁸

The number of courses of Plan B[®] OTC that are covered by Medicaid varies by state. Oklahoma, Oregon and Washington place no limits. New Jersey allows 12 per year, as mentioned above, New York allows six, Maryland allows one every 90 days, and Hawaii and Utah, two per year.⁹

The Study Design

This study sought to answer the following questions:

- What was the cost to the state for Plan B[®] claims in 2007?
- To what extent did claims increase as projected?
- To what extent do Plan B[®] claims to Medicaid vary by county?
- How many courses of Plan B[®] per recipient were claimed during 2007?

Data for this study were obtained through the New York State Health Department, Office of Health Insurance Programs in March 2008. The data may somewhat underestimate the total amount of claims for Plan B[®] for 2007 because pharmacists can submit claims to Medicaid after the end of the calendar year. In the tables below, the data represent accepted claims; rejected claims were excluded from the analysis.

Findings

The cost to the state for Plan B[®] Medicaid claims in 2007 was approximately \$604,918.

In calendar year 2007, the total dollar amount of claims covered by state and federal dollars for Plan B[®] was \$774,904 (see Table 1). The cost to the state Medicaid program for 16,874 claims submitted for non-prescription Plan B[®] was the full \$586,031 and the state share (10%) of the Plan B[®] prescription claims was \$18,887. Thus, in all, the state covered \$604,918 in claims.¹⁰

Almost three quarters of the total Medicaid claims for Plan B[®] in 2007 were for the OTC product.

As shown in Table 1, of the 23,005 valid claims for Plan B[®] in calendar year 2007 for women 18 years of age and older, 16,874 (73%) were for Plan B[®] OTC and 6,131 (27%) were for prescriptions. There are a number of reasons why such a large percentage of women over 18 are still using a prescription. Foremost among them is that they can bypass the requirement of presenting an ID to verify their date of birth. Women 18 and over may also receive an advance prescription from their health care provider as part of an annual visit. It is also possible that pharmacists and consumers are unaware that Medicaid covers the OTC product.

Table 1. Medicaid Claims for Plan B[®] in New York, 2007

Plan B [®] product	Dollars	Number of claims ^a	Recipients ^b
Non-prescription (OTC)	\$586,031	16,874	12,112
Prescription	\$188,873	6,131	4,919
TOTAL:	\$774,904	23,005	

^a Each claim represents one course of Plan B[®].

^b Recipient counts are not unduplicated. It is possible that women obtained both OTC and prescription products in 2007.

Data Source: DOH/OHIP AFPP Data Mart

Claims for Medicaid for Plan B[®] fell below projections.

The state projected that once the fiscal order mandate was eliminated, claims would double but there was essentially no growth in claims for Plan B[®] between 2006 and 2007. There were a total of 23,402 Plan B[®] claims during the period December 1, 2005 through November 30, 2006 for recipients 18 years and older compared with 23,005 in 2007.¹¹

The number of Medicaid claims for Plan B[®] OTC is low in many counties.

As would be expected given the difference in size of each county’s Medicaid population, the number of Medicaid claims for Plan B[®] OTC varied greatly by county (see Table 2). Nonetheless, it is surprising that as many as 37 of the state’s 57 (65%) counties had submitted 50 or fewer claims for Plan B[®] OTC. Ten of these counties had 10 or fewer claims. (The actual number of women who accessed Plan B[®] was in some cases less than the number of claims since women could receive up to 6 courses of treatment per year.) Nine counties had 51-100 claims, nine counties had 101-500 claims and New York City, Erie, and Monroe counties had over 500 claims.

Table 2. Medicaid Claims and Expenditures for Plan B[®] OTC and Prescription, Women 18 and Older, by County, 2007

County	Plan B [®] OTC		Plan B [®] Rx*	
	Dollars	Claims	Dollars	Claims
Albany	\$2,848.73	84	\$92.70	3
Allegany	\$35.20	1	\$62.12	2
Broome	\$8,779.63	253	\$92.94	3
Cattaraugus	\$557.37	16	\$61.88	2
Cayuga	\$760.85	22	\$30.16	1
Chautauqua	\$1,898.78	55	\$290.06	10
Chemung	\$937.62	27	\$92.28	3
Chenango	\$1,264.79	36	\$62.12	2
Clinton	\$1,012.47	29	\$92.70	3
Columbia	\$617.38	18	\$31.06	1
Cortland	\$840.98	24	\$30.82	1
Delaware	\$894.93	26	\$92.94	3
Dutchess	\$3,075.39	88	\$279.30	9
Erie	\$17,910.01	516	\$1,803.50	61
Essex	\$139.69	4	\$0.00	0
Franklin	\$418.51	12	\$61.88	2
Fulton	\$906.79	27	\$31.06	1
Genesee	\$1,471.02	42	\$216.94	7
Greene	\$626.93	18	\$62.12	2
Hamilton	\$0.00	0	\$0.00	0
Herkimer	\$2,422.71	69	\$61.88	2
Jefferson	\$3,219.35	92	\$309.88	10
Lewis	\$70.40	2	\$0.00	0
Livingston	\$629.50	18	\$122.44	4
Madison	\$1,580.81	47	\$92.94	3
Monroe	\$30,525.86	883	\$7,916.40	259
Montgomery	\$1,331.22	38	\$123.52	4
Nassau	\$9,456.50	272	\$1,192.16	39
Niagara	\$5,914.36	170	\$340.46	11
Oneida	\$5,497.99	158	\$30.82	1
Onondaga	\$6,435.53	185	\$1,233.07	41
Ontario	\$641.74	19	\$273.24	9
Orange	\$10,419.59	299	\$459.98	15
Orleans	\$520.79	15	\$31.06	1
Oswego	\$4,458.77	129	\$429.20	14
Otsego	\$1,467.66	43	\$340.70	11
Putnam	\$139.41	4	\$0.00	0
Rensselaer	\$1,467.57	42	\$93.18	3
Rockland	\$1,389.67	40	\$295.79	10
St Lawrence	\$1,895.83	54	\$246.44	8
Saratoga	\$1,403.35	41	\$0.00	0
Schenectady	\$2,470.41	72	\$154.82	5
Schoharie	\$277.71	8	\$92.94	3
Schuyler	\$104.21	3	\$0.00	0
Seneca	\$273.94	8	\$92.28	3
Steuben	\$411.68	12	\$122.86	4
Suffolk	\$11,544.46	336	\$2,079.21	69
Sullivan	\$1,775.76	51	\$495.76	16
Tioga	\$621.65	18	\$31.06	1
Tompkins	\$492.53	14	\$122.44	4
Ulster	\$3,098.07	89	\$309.64	10
Warren	\$624.43	18	\$92.94	3
Washington	\$382.48	11	\$62.12	2
Wayne	\$696.85	20	\$580.60	19
Westchester	\$16,113.98	463	\$6,755.94	219
Wyoming	\$278.30	8	\$124.00	4
Yates	\$348.11	10	\$61.22	2
New York City	\$410,631.39	11,815	\$160,615.51	5,206
TOTAL:	\$586,031.38	16,874	\$188,873.08	4,919

*Dollar figures reflect the full amount of claims, i.e. the amount that will be covered by state and federal dollars.

Medicaid covered a single course of Plan B[®] for the majority of women in 2007; only one percent of women purchased six courses of Plan B[®] through the Medicaid program.

For those women who purchased Plan B[®] (with coverage by Medicaid prescription and/or OTC), the mean number of courses (or pill packets) of Plan B[®] obtained was 1.5. As shown in Table 3, 73 percent of those obtaining Plan B[®] through Medicaid got only one dose. (These data are for women of all ages and include both the prescription and non-prescription products.) One percent obtained the full six courses of treatment allowable.

Table 3. Number and Percentage of Medicaid Recipients (all ages) Who Obtained Plan B[®] in 2007 by Number of Courses of Treatment

Number of Plan B [®] courses of treatment	Number	Percent
1	12,840	73
2	2,822	16
3	1,046	6
4	446	3
5	244	1
6	217	1
TOTAL	17,615	100

Data Source: OMM/BI Query Data Warehouse

Note: Data in Tables 2 and 3 were run at a different times; number of claims and recipients differ.

It is estimated that between 300 and 500 unintended pregnancies were prevented as a result of the use of Plan B[®] OTC covered by Medicaid in 2007.

To calculate the number of pregnancies prevented, we first assumed that the probability of pregnancy after one act of unprotected intercourse was 3.1%.¹² If each claim represented one act of unprotected sex, there would have been 523 pregnancies (3.1% of 16,874). We then determined that 59%-94% of these 523 pregnancies were prevented with Plan B[®], based on the effectiveness of levonorgestrel-only EC regimens as reported in the literature and reviewed by Trussell and Raymond.¹³

Discussion

New York's patient-centered policy of providing Medicaid coverage for Plan B[®] sold over-the-counter without undue paper work removes significant financial and logistical barriers for many low-income women. More must be done by the Department of Health, health care providers, and advocates to increase consumers' awareness of this policy. The data reported here shows that almost 18,000 women ages 18 years and older obtained Plan B[®] through the Medicaid program in 2007. The Department of Health's projection that the number of Medicaid recipients using Plan B[®] would increase substantially once the fiscal order requirement was waived, proved to be unfounded. The total dollars picked up by the state which now included the federal government's share (90%) of Plan B[®] OTC was much smaller than anticipated. This finding is especially pertinent to states that provide Medicaid coverage for Plan B[®] but have not yet waived the fiscal order requirement. In addition, there were probably additional savings because health care providers did not need to write an order.

Applying conservative estimates, somewhere between 300 and 500 pregnancies were prevented. While studies have yet to demonstrate that EC causes a reduction of pregnancy and abortion rates at the population level, the research clearly indicates that when used after a specific act of unprotected sex, EC sharply reduces the chance of pregnancy. On an individual level, the ability to prevent a pregnancy after a specific act of unprotected intercourse is very significant.

There were a surprisingly large number of counties with less than 50 Medicaid claims for Plan B[®] and there did not appear to be an increase in the number of claims between 2006 and 2007. At the national level, Plan B[®] sales have increased 120% since Plan B[®] became available via the dual label.¹⁴ It is clear that more must be done to inform pharmacists and consumers about the availability of Medicaid coverage for Plan B[®] (Rx and OTC) at the local pharmacy.

Thousands of low-income women in New York, including those with Medicaid, are obtaining Plan B[®] at family planning centers, including Planned Parenthood, because they can get Plan B[®] for free or at low cost. Cost is not the only advantage. Women often prefer these centers because they offer privacy and confidential care. Moreover, women know that centers regularly stock Plan B[®]. It is important to note that these centers

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provide Plan B[®] despite the fact that they often lose money on these transactions. This is because the cost of contraceptives is generally rolled into a visit rate. However, centers cannot bill for a visit if a woman comes in for Plan B[®], only. In this case, the clinic absorbs the cost of Plan B[®] when the woman cannot pay the full cost of the product. (No data are available about the number of low income women in New York who obtained Plan B[®] at a family planning clinic.)

Finally, of those women who used Medicaid to pay for Plan B[®], eighty-nine percent obtained one or two courses of Plan B[®] during 2007. It appears that few women asked for the maximum courses of treatment allowable in a year. More research is needed to understand the circumstances behind their usage, but these patterns do show that the 6-dose limit was not needed to control costs. Removing the cap would ensure that women have the ability to make decisions about what contraceptive use fits their needs. Furthermore, the data demonstrate that the fiscal impact to Medicaid to removing the cap would be minimal.

Policy Priorities

The following policy priorities are based on the research findings. The New York State Department of Health, pharmacists, advocates and health professionals are encouraged to continue their laudable efforts to increase low-income women's awareness of, and access to, emergency contraception and on-going reproductive health care.

1. Continue Medicaid coverage of Plan B® OTC without a fiscal order.
2. Inform/remind pharmacists and consumers that Medicaid will cover the prescription and nonprescription Plan B® product. Family Planning Advocates has developed a fact sheet for consumers (in English and Spanish) that describes how to access the product in pharmacies. A fact sheet for pharmacists provides questions and answers about provision of Plan B® as a dual label product including the MMIS prescriber ID. The fact sheets can be downloaded from <http://www.fpaofnys.org/resources/other/index.asp>.
3. Undertake concerted efforts to ensure that Medicaid recipients living in the counties showing low numbers of Plan B® claims are aware of Plan B® and have access to it.
4. Remove, or increase to twelve, the annual six-course cap on Medicaid coverage of Plan B®.
5. Incorporate information about Plan B® into any state initiative designed to improve birth outcomes and reduce infant mortality rates. Consumer and provider materials should provide information about Medicaid coverage of both prescription and non-prescription Plan B®. This product can play an important role in helping women prevent unintended pregnancy and the associated higher rates of poor birth outcomes.

Endnotes

1. Plan B® is a registered trademark of Duramed Pharmaceuticals, Inc.
2. Not-2-Late Website. <http://ec.princeton.edu/questions/eccost.html> (retrieved 3/21/08)
3. Preven is no longer for sale in the US.
4. According to the emergency rule published in the *NYS Register*, February 13, 2008, "a written order requires that a qualified medical practitioner provide a written, telephone or fax order for a specific drug for a specific patient." Federal regulation [42 CFR 440.120 (a)(3)] referenced in the rule, refers to a written prescription that is maintained in the records of the pharmacist or practitioner.
5. Plan B® Website. <http://www.go2planb.com/ForConsumers/Index.aspx> (retrieved 3/21/08)
6. National Health Law Program (2007). *Over the Counter or Out of Reach? A Report on Evolving State Medicaid Policies for Covering Emergency Contraception*. Also, personal communication with Dale Tinker, Executive Director, New Mexico Pharmacists Association, June 15, 2008.
7. Personal communication, Deborah Reid, Staff Attorney, National Health Law Program, 3/25/08. Personal communication with Jane Wishner, Executive Director, Southwest Women's Law Center. Personal communication with Michele Stranger Hunter, Executive Director, Naral Pro-Choice Oregon, July 8, 2008.
8. Pharmacy access states include Alaska, California, Hawaii, Maine, Massachusetts, New Hampshire, New Mexico, Washington and Vermont. In these states, under certain protocols pharmacists can prescribe EC.
9. Expanding Medicaid Coverage for EC on the State Level. (working draft) National Institute for Reproductive Health.
10. These figures exclude one prescription claim and two non-prescription claims for the year from the Office of Mental Hygiene.
11. Between 12/1/05 and 11/30/06, there were 23,402 claims for 16,934 recipients totaling \$716,841 (excluding one claim from OMH). (Data Source: DOH/OHIP AFPP Data Mart)
12. Wilcox AJ., Dunson DB, Weinberg CR, Trussell J, and Baird DD. (2001). Likelihood of conception with a single act of intercourse: providing benchmark rates for assessment of post-coital contraceptives. *Contraception*. 63:211-215.
13. Trussell J. and Raymond EG. (2008). *Emergency Contraception: A Last Chance to Prevent Unintended Pregnancy*. (Retrieved 7/7/08 from <http://ec.princeton.edu/questions/ec-review.pdf>.)
14. Andrea Porzio, Duramed, presentation delivered at the STATES Meeting hosted by the Pharmacy Access Partnership in San Francisco, May 19, 2008.

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