

Kentucky Department of Insurance
Initial Cost Defrayal
Statement

After reviewing BR 2019/HB 550 as currently drafted, the Department's initial determination is that this bill contains a mandated health benefit that may result in the state being required to make payments to defray costs under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended. The provisions of the bill that may trigger the requirement are on page 4, line 27 and page 5, lines 4 & 6-10 as over-the-counter contraceptive drugs, devices, and products, along with all make barriers and male voluntary sterilization, and all follow up services are not covered under the state benchmark plan. It is also unclear if all follow-up services are covered by the current benchmark plan, especially considering the proposed mandate language states that follow-up services are "including but not limited to" the examples provided in the proposed mandate. Therefore, in accordance with KRS 304.17A-099(2), if the bill is enacted this provision will not be effective until it no longer triggers cost defrayal under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended.

Therefore, a cost defrayal analysis will be performed within the statutorily required timeframe.

Sharon P. Clark

2/13/2026

(Signature of Commissioner/Date)

Fiscal Impact Report – BR2019/HB550

Contraceptives Coverage

PREPARED FOR THE KENTUCKY DEPARTMENT OF INSURANCE

FEBRUARY 13, 2026

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Introduction

Lewis & Ellis, LLC (L&E) was engaged by the Kentucky Department of Insurance (KY DOI) to perform a fiscal impact analysis of BR2019/HB550, which would mandate the following:

- Health benefit plans provide coverage, without cost sharing, of all FDA-approved contraceptive drugs, devices, and products. This includes prescribed contraceptives, over-the-counter (OTC) contraceptives, contraceptives dispensed at a provider’s office, voluntary sterilization, patient education and counseling, and follow-up services for management of side effects, counseling on adherence, and device insertion or removal.
- The mandate also requires coverage, without cost sharing, for long-acting reversible contraception (LARC) administered during a postpartum hospital stay.
- A religious employer may request a health benefit plan without this coverage and will be required to provide written notice to covered person’s listing the contraceptives the employer refused to cover for religious reasons.

Kentucky Revised Statute (KRS) 6.948^a mandates that the sponsor of any bill proposing a health benefit mandate must request a financial impact statement from the Kentucky Department of Insurance (DOI). This statement must be completed within 30 days of the request and should include the following:

1. An assessment of the impact of the mandated health benefit on administrative expenses, premiums, and the overall cost of healthcare including any potential future cost savings.
2. Supporting documentation, including studies, written opinions, calculations, and citations that validate the findings and conclusions.
3. An estimate of any potential cost savings in the future, along with an explanation of why the bill would or would not lead to such savings, and
4. A certification confirming the accuracy of the information provided.

Additionally, KRS 6.948 mandates that the sponsor of any bill proposing a health benefit mandate must also request a federal cost defrayal impact statement from the Kentucky DOI. This statement must be completed within 30 days of the request. The federal defrayal cost impact statement shall:

1. Indicate whether a bill or amendment that contains a mandated health benefit may result in the state being required to make payments to defray costs.
2. If applicable, indicate which provision(s) of the bill or amendment may trigger the requirement to make payments to defray the costs.
3. If applicable, include an estimate of the payment amount that the state may be required to make if the bill or amendment is enacted into law.

L&E is tasked with performing the health mandate fiscal impact and federal cost defrayal impact analyses for the Kentucky insurance market, excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs. The fiscal impact analyses for these programs are

^aAs amended by 2024 House Bill 635.

performed by other entities. For this analysis, L&E reviewed literature, gathered statistics from public sources^b, and used data from the KY DOI's 2024 Insurer Annual Data report.

Administrative Expense Impact Analysis

The proposed bill is estimated to have **an immaterial (within +/- 0.05%) impact on administrative expenses** as a percent of premium, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. It is our assumption that insurers either already provide coverage for the mandated benefits or the additional administrative requirements imposed by this mandate would not significantly impact the administrative costs relative to current levels.

Premium Impact Analysis

To estimate BR2019/HB550's premium impact, L&E evaluated data from KY DOI's 2024 Insurer Annual Data report and publicly available sources. L&E used the collected information and data to estimate low-end and high-end assumptions for each variable that could impact cost or utilization. The ranges for each variable were then used to estimate the aggregate premium impact range.

While L&E selected specific assumptions to develop a range for the estimated premium impact, it is not intended to represent only the low- and high- scenarios illustrated. Each assumption range is intended to capture the various uncertainties inherent in each assumption and to provide an estimated range of resulting potential outcomes. Therefore, the final estimated aggregate premium impact range implicitly captures a wide range of scenarios and assumptions.

Each of the following sections discuss the data used to inform each assumption evaluated by L&E.

CURRENT COVERAGE FOR CONTRACEPTIVES

The Affordable Care Act (ACA) federally mandates coverage, without cost sharing, for all female FDA-approved contraceptive methods prescribed by a woman's doctor. This includes barriers, oral contraception, emergency contraception, long-acting contraception, sterilization, and patient education and counseling¹. Employer religious exemption from offering contraceptive coverage is also allowable under the ACA. Therefore, no mandate impact is estimated for the proposed mandated coverage for female contraception other than for non-prescribed (i.e., over-the-counter) female barrier and emergency contraception.

^bIncluding reports for other states who have considered or passed similar legislation.

UTILIZATION FOR CONTRACEPTIVES

Utilization data for the different types of contraceptives included in this mandate was reviewed from several sources.^{2 3 4}Based on this data, L&E selected the following range for the utilization percentages:

	Low	High
Non-Prescribed/OTC Female Barrier	0.04%	0.09%
Male Barrier	8.0%	12.0%
Non-Prescribed/OTC Emergency Contraception	0.2%	0.5%
Male Sterilization	0.1%	0.2%

In addition to the research found, based on actuarial judgment and industry experience, L&E applied a 50% utilization dampening factor to the low-end estimate for barriers and emergency contraception due to the following considerations:

1. L&E assumes that under the proposed mandate individuals may have to purchase non-prescription, OTC contraceptives at the pharmacy counter and then submit a claim for the coverage reimbursement of these products, which could dampen use of this benefit.
2. L&E assumes that this bill removes cost barriers but does not address significant barriers to contraceptive use such as patient confidentiality, attitudes and knowledge, social norms, or preferences related to the use of OTC contraceptives. For example, adolescents and young adults, the highest users of barrier contraceptives⁵ may choose not to use insurance coverage to obtain OTC contraception due to confidentiality concerns.

Conversely, for male sterilization, L&E applied a 3.0% induced utilization assumption to the high-end estimate. There is little data available regarding induced utilization^c resulting from coverage of male sterilization. However, L&E believes it is reasonable to assume that there is potential for increased utilization because of added coverage and/or decreased cost-share to the insured.

AVERAGE MONTHLY COST OF CONTRACEPTIVES

Based on the information available from publicly available research,^{2 6 7 8} L&E selected the following assumptions for the assumed average monthly cost of each contraceptive required by the mandate:

	Low	High
Female Barrier	\$8.00	\$14.00
Male Barrier	\$4.00	\$6.00
Emergency Contraception	\$3.00	\$5.00
Male Sterilization	\$83.00	\$154.00

^c An increase in demand for and utilization of health care services caused by a decrease in the level of cost-sharing that insured's are required to pay under their insurance coverage.

RESULTING PREMIUM IMPACT ESTIMATE

The following tables illustrates the range of assumptions selected by L&E and the resulting estimated premium impact range. The first four tables below show four calculations for the components of the mandate with a pricing impact. The final table aggregates these components to show the final premium impact estimate for the mandate.

Non-Prescribed/OTC Female Barrier Claim Cost Impact Calculation		
Assumption	Low	High
Preliminary Utilization (a)	0.04%	0.09%
Utilization Dampening Factor (b)	50.0%	0.0%
Utilization Impacting Proposed Mandate (c) = (a)*(b)	0.02%	0.09%
Monthly Cost (d)	\$8.00	\$14.00
Total Claim Cost Impact PMPM (e)=(c)*(d)	\$0.00	\$0.01

Male Barrier Claim Cost Impact Calculation		
Assumption	Low	High
Preliminary Utilization (a)	8.0%	12.0%
Utilization Dampening Factor (b)	50.0%	0.0%
Utilization Impacting Proposed Mandate (c) = (a)*(b)	4.0%	12.0%
Monthly Cost (d)	\$4.00	\$6.00
Total Claim Cost Impact PMPM (e)=(c)*(d)	\$0.16	\$0.72

Non-Prescribed/OTC Emergency Contraception Claim Cost Impact Calculation		
Assumption	Low	High
Preliminary Utilization (a)	0.2%	0.5%
Utilization Dampening Factor (b)	50.0%	0.0%
Utilization Impacting Proposed Mandate (c) = (a)*(b)	0.1%	0.5%
Monthly Cost (d)	\$3.00	\$5.00
Total Claim Cost Impact PMPM (e)=(c)*(d)	\$0.00	\$0.03

Male Sterilization Claim Cost Impact Calculation		
Assumption	Low	High
Preliminary Utilization (a)	0.07%	0.16%
Induced Utilization Factor (b)	0.0%	3.0%
Utilization Impacting Proposed Mandate (c) = (a)*[1+(b)]	0.07%	0.17%
Monthly Cost (d)	\$83.00	\$154.00
Total Claim Cost Impact PMPM (e)=(c)*(d)	\$0.05	\$0.26

Claim Cost Impact Calculation		
Assumption	Low	High
Mandate Claim Cost Impact PMPM (f) ^d	\$0.22	\$1.02
Projected 2026 Total Claims Costs PMPM (g)	\$626.28	\$626.28
Mandate Claim Cost % Impact (h)=(f)/(g)	0.0%	0.2%

Premium Impact Calculation		
Assumption	Low	High
Projected 2026 KY Average Loss Ratio (i) ^e	91.1%	91.1%
Projected 2026 KY Average Premium PMPM (j)=(g)/(i)	\$687.81	\$687.81
Mandate Premium Impact PMPM (k)=(f)/(i)	\$0.24	\$1.12
Mandate Premium % Impact (l)=(k)/(j)	0.0%	0.2%
Projected 2026 KY Insured Members ^f (m)	343,644	343,644
Mandate Premium Total Annual Impact (n) = (k)*(m)*12	\$993K	\$4.6M

Total Cost of Health Care Impact Analysis

L&E defines ‘Total Cost of Health Care’ as being equal to the sum of the Allowed Cost (i.e., the amount paid by the insurer plus the amount paid by the insured) and the insurer Non-Benefit Expenses. Additionally, as required by KRS 6.948, L&E considered the impact of potential future cost savings.

POTENTIAL FOR FUTURE COST SAVINGS

L&E acknowledges that there is potential for long-term savings if unintended pregnancies and sexually transmitted infections (STIs) are replaced with contraceptive use. Several studies suggest that increasing coverage of contraceptives can be cost-effective and reduce pregnancy and abortion rates.^{9 10} However, the research available does not define the magnitude of cost savings. In addition, any cost reductions could be partially offset by induced utilization, where the increased availability of coverage results in higher-than-expected use. Based on L&E experience, actuarial judgment, and research discussed in prior sections of this report, L&E estimates the impact of potential future savings as a result of the BR2019/HB550 to be immaterial (within +/- 0.05%).

^d Calculated as the sum of (e) in each of the four preceding tables.

^e Based on 2024 Insurer Annual Data report provided by the KY DOI. Excludes KEHP and Medicaid.

^f Excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs.

RESULTING TOTAL COST OF HEALTH CARE IMPACT ESTIMATE

The table below illustrates the calculation of the estimated total cost of health care (TCoHC) impact range. Within this calculation, L&E has assumed that zero to fifteen percent of insureds are currently paying for OTC barriers, OTC emergency contraception, and male sterilization out-of-pocket (OOP).

Total Cost of Health Care (TCoHC) Calculation		
Assumption	Low	High
Percentage Paying OOP ^g (o)	15%	0%
TCoHC Impact PMPM (p) = (k) ^h [1-(o)]	\$0.20	\$1.12
Projected 2026 KY TCoHC PMPM (q)	\$828.33	\$828.33
Mandate TCoHC % Impact (r) = (p)/(q)	0.0%	0.1%
Projected 2026 KY Insured Members (m)	343,644	343,644
Mandate TCoHC Total Annual Impact (s) = (p)*(m)*12	\$844K	\$4.6M

Cost Defrayal Impact Analysis

Based on L&E’s research and actuarial judgment, L&E determined that this bill contains a mandated health benefit that may result in the state being required to make payments to defray costs under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended. The provisions of the bill that may trigger the requirement are on page 4, line 27 and page 5, lines 4 & 6-10 as over-the counter contraceptive drugs, devices, and products, along with all male barriers and male voluntary sterilization, and all follow up services are not covered under the state benchmark plan such that defrayal is required. It is also unclear if all follow-up services are covered by the current benchmark plan, especially considering the proposed mandate language states that follow-up services are “including but not limited to” the examples provided in the proposed mandate.

The estimated annual cost defrayal payment that the state may be required to make is between \$347K and \$1.6M, which is based on the portion of the mandate claims cost estimate that is attributed to the individual and small group markets.

L&E has disclosed its defrayal determination based on its earnest interpretation of federal guidance available as of the date of this report. However, determination of defrayal is ultimately under the regulatory purview of Centers for Medicare and Medicaid Services (CMS).

^g A higher percentage paying OOP results in a lower impact; therefore, the higher percentage is listed for the low end.

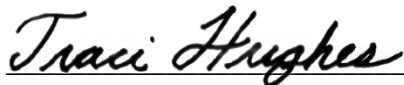
^h Premium impact is equal to the TCoHC impact, less the impact of insureds paying OOP, because the proposed mandate introduced new coverage with no cost-sharing. Therefore, allowed cost (insurer cost share plus insured cost share) is equal to paid claim cost (insurer cost share). So, where premium typically equals paid cost plus non-benefit expense, in this case it also equals allowed cost plus non-benefit expenses, which is what L&E has defined as TCoHC.

Certification of Accuracy

L&E believes the estimates are accurate based on the information disclosed in the report. To the extent that there are material inaccuracies, misrepresentations, or lack of adequate disclosure in the data, the results may be accordingly affected. Several of the assumptions made in this analysis are subject to uncertainty and it is expected that actual results could differ from the calculated estimates.



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2/13/2026

(Signature of Commissioner/Date)

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizationsⁱ, promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct^j, to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuaries are:

- Bobby Dorman, ASA, MAAA, Vice President & Consulting Actuary
- Traci Hughes, FSA, MAAA, Vice President & Principal

These actuaries are available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is February 13, 2026. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is February 13, 2026.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Kentucky Department of Insurance. The authors of this report are aware that it may be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis, LLC is financially and organizationally independent from the health insurers and providers involved in this analysis. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Kentucky Department of Insurance in assessing the financial impact of proposed legislation that includes a proposed health benefit mandate.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- L&E has reviewed the data provided by the insurers and Kentucky Department of Insurance for reasonableness, but the data has not been audited. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

ⁱ The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

^j These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- Several of the assumptions made in this analysis are subject to uncertainty and it is not unexpected that actual results could differ from the calculated estimates.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.

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