National
Family Planning
& Reproductive Health Association

# Affordable Care Act Contraceptive Coverage Requirement: Four Things Providers Should Know

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The Affordable Care Act (ACA) requires that almost all commercial health insurance plans cover all FDA-approved methods of contraception without copays or other cost-sharing. This requirement applies to most employer-sponsored health insurance plans, unless the plans are grandfathered[i] or if the plan is provided by certain religious institutions. The US Department of Health and Human Services (HHS) has issued guidance several times since the contraceptive coverage requirement went into effect in 2012. In May 2015, HHS released a frequently asked question (FAQ) document clarifying the contraceptive coverage requirement. Insurers must ensure that plans comply with this guidance in the first health plan year that starts on or after July 10, 2015. For many plans, including most plans purchased in a health insurance marketplace, the guidance will apply beginning on January 1, 2016.

## What methods must be covered with no cost-sharing?

Health insurance plans are required to cover all FDA-approved methods of contraception for women. The 2015 FAQ clarifies that plans must cover at least one form of contraception in each of the 18 method categories as outlined by the Food and Drug Administration[ii] with no cost-sharing. The 18 categories are as follows: 1) sterilization surgery for women; 2) surgical sterilization implant for women; 3) implantable rod; 4) copper IUD; 5) IUD with progestin; 6) shot/injection; 7) combined oral contraceptives; 8) progestin-only oral contraceptives; 9) extended or continuous use oral contraceptives; 10) contraceptive patch; 11) vaginal contraceptive ring; 12) diaphragm; 13) sponge; 14) cervical cap; 15) female condom; 16) spermicide; 17) emergency contraception [with a prescription] (Plan B/Plan B One Step/Next Choice); and 18) emergency contraception (Ella). In addition to the method itself, all associated clinical services, including patient education and counseling, needed for provision of the contraceptive method"[iii] and "services related to follow-up and management of side effects, counseling for continued adherence, and device removal"[iv] must be covered without cost-sharing.

**Are health insurance plans allowed to use "reasonable medical management" techniques for contraceptives?**

"Medical management" techniques, also known as "utilization controls" in Medicaid, are used by commercial insurers with the goal of controlling costs and promoting efficient delivery of care. Regulations issued by HHS implementing the ACA's preventive services benefit requirements, including contraceptive coverage, allowed health insurance issuers to use "reasonable medical management" techniques when "a recommendation or guidelines does not specify the frequency, method, treatment or setting for the provision of that service."[v] However, their ability to do so with contraceptives is limited. According to the 2015 FAQ, plans may only use medical management techniques *within* a contraceptive method, not between method categories. For example, plans may cover one type of IUD with progestin (e.g., Mirena) without cost-sharing while imposing cost-sharing on others (e.g., Skyla, Liletta). Conversely, a health insurance issuer may not impose cost-sharing on the patch or the vaginal contraceptive ring to encourage individuals to use oral contraceptives, which are usually lower cost, for example.

Plans may also impose cost-sharing for brand-name drugs and devices that have a generic equivalent as long as a generic equivalent is covered without cost-sharing. A plan cannot, however, say it only covers generic forms of contraception without cost-sharing, because some methods (e.g., IUDs) are only available as brand-name devices.

**What if the best method for a patient is one for which her plan imposes cost-sharing?**

If a plan uses medical management techniques within a specified contraceptive method category, it must have an "expedient exceptions process" so that the patient can access the specific birth control her health care provider determines is medically necessary. Medical necessity is defined in the 2015 FAQ to include such factors as "severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by the attending provider." The exceptions process must defer to the provider's determination.[vi]

**What should a provider do to help a patient who is having trouble accessing their method of choice without cost-sharing?**

Firstly, it is important to confirm with the patient's health insurance plan the documentation required for appropriate coverage without cost-sharing. In the instance of a plan using "reasonable medical management" techniques within a method category, contact the plan to request an exception as discussed above. If the previous two actions do not result in

appropriate coverage, or if a plan is out of compliance, contact the plan's medical director to voice concerns with barriers to accessing care. In addition, encourage the patient to contact the National Women's Law Center's CoverHer hotline (www.coverher.org, coverher@nwlc.org, or 1-866-745-5487). The hotline can help the patient navigate the process to ensure adequate coverage of the method of her choice.

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[i] According to HealthCare.gov, an insurance plan can maintain grandfathered status if the plan: 1) has not been changed in a way that will substantially cut benefits or increase costs for plan holders; 2) has notified plan holders that the plan is grandfathered; and, 3) has continuously covered at least one person since March 23, 2010.

[ii] Food and Drug Administration Office of Women's Health, "Birth Control Guide," http://www.fda.gov/downloads/ForConsumers/ByAudience/For%E2%80%A8Women/FreePublications/UCM356451.pdf

[iii] Department of Labor Employee Benefits Security Administration, "FAQs about Affordable Care Act Implementation Part XII," May 11, 2015, http://www.dol.gov/ebsa/faqs/faq-aca26.html.

[iv] Department of Labor Employee Benefits Security Administration, "FAQs about Affordable Care Act Implementation Part XXVI," February 20, 2013, http://www.dol.gov/ebsa/faqs/faqaca12.html.

[v] "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act." *Federal Register* 75:137 (July 19, 2010) pp. 41726.

[vi] Department of Labor Employee Benefits Security Administration, "FAQs about Affordable Care Act Implementation Part XII," May 11, 2015, http://www.dol.gov/ebsa/faqs/faq-aca26.html.