Q&A on the ACA's Contraceptive Coverage Requirement

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The Affordable Care Act (ACA) requires many health insurance plans to provide coverage for certain preventive health services, including contraception, without cost-sharing. These requirements are providing millions of individuals with new or improved access to evidence-based preventive health care without the significant barriers associated with cost-sharing. This Q&A addresses some of the most common questions surrounding the contraceptive coverage requirement.

1. Where does the contraceptive coverage requirement come from?

A. The ACA added Section 2713 to the Public Health Services Act, requiring most health insurance plans to cover a broad array of evidence-based preventive health services without cost-sharing.[1] To ensure that women's unique preventive health needs are addressed, the ACA required the Health Resources and Services Administration (HRSA) to develop guidelines that articulate the specific women's health benefits that must be covered.[2] HRSA commissioned the Institute of Medicine (IOM) to provide evidence-based recommendations, and the IOM recommended eight women's preventive health benefits, including contraceptive services and counseling. HRSA adopted the IOM's recommendations, and issued guidelines to require that they be covered without cost-sharing.[3]

2. What contraceptive drugs, devices and services do plans have to cover under this requirement?

A. Plans subject to the preventive services requirements must cover the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and contraceptive counseling, without cost-sharing. This includes oral contraceptive pills, contraceptive patches and rings, intrauterine devices (IUDs), contraceptive implants, injectables (such as Depo-Provera), and barrier methods (e.g. diaphragms). Plans must also cover, without cost sharing, FDA-approved methods that are generally

[1] The term "cost-sharing" includes copays, coinsurance, and deductibles, but does not include premiums.
[2] 42 U.S.C. § 300gg-13(a)(4) (ACA § 1001, adding § 2713 of the Public Health Services Act).
[3] The complete Guidelines for Women's Preventive Services and a link to the IOM report can be found on the HRSA website http://www.hrsa.gov/womensguidelines/.

available over-the-counter, such as contraceptive sponges, spermicides, and emergency contraception, so long as they are prescribed by a health care provider.

3. Do plans have to cover any other services related to contraceptive management?

A. Yes. In addition to all FDA-approved methods and procedures, plans must also cover services related to follow-up and management of side effects, counseling for continued adherence, and removal of devices (e.g. IUDs and implants), without cost-sharing.[4]

4. Do plans have to cover contraceptive services for men without cost-sharing?

A. No. These preventive services requirements do not include contraceptive services for men, such as vasectomies or condoms.[5] Plans may choose to cover these services without cost-sharing, but they are not required to do so.

5. What plans are subject to the contraceptive coverage requirement?

A. Individual and group (i.e. employee) health insurance plans ("plans"), including self-insured plans, must adhere to these coverage requirements unless they are "grandfathered" or qualify for a religious exception (covered below in Q6 and Q7). The requirements apply to plans sold inside and outside of the health insurance marketplaces.

6. What are grandfathered plans?

A. Grandfathered plans are plans that existed on March 23, 2010 and have not substantially changed. A plan can lose its grandfathered in a number of ways:

- significantly cutting or reducing benefits;
- raising charges associated with co-insurance, co-payments, or deductibles beyond permissible amounts;
- lowering employer contributions by more than 5 percent; or
- adding or decreasing annual limits on what the insurer will pay.[6]

If an individual enrolled in her current insurance plan on or before March 23, 2010 or enrolls in a group plan that has been in existence since March 23, 2010, she might be in a grandfathered plan. Grandfathered group plans may enroll new enrollees without foregoing their grandfathered status. For a plan to maintain grandfathered status, it

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[4] U.S. Dep'ts of Labor, Health & Human Serv., & Treasury, *Frequently Asked Questions about Affordable Care Act Implementation Part XII* Q16 (February 20, 2013), *available at* http://www.dol.gov/ebsa/faqs/faq-aca12.html#5 (hereinafter *February 2013 FAQ*).
[5] *Id.* at Q15.
[6] 45 C.F.R. 147.140(g).

must disclose that status in materials that describe covered benefits to enrollees.[7] Grandfathered plans are not subject to any of the preventive services requirements.

7. Which employers are exempt from the contraceptive coverage requirement?

A. A narrow category of nonprofit religious institutions are exempt from the contraceptive coverage requirement (these institutions are *not* exempt from the remainder of the preventive services requirements). The exemption is available to nonprofit "religious employers" that are organized under specific sections of the Internal Revenue Code as "churches, their integrated auxiliaries, and conventions or associations of churches" or "the exclusively religious activities of any religious order."[8] Women receiving health insurance coverage through an exempt "religious employer" will not receive contraceptive coverage in connection with those insurance policies.

8. Do religiously-affiliated organizations like universities or charities that do not qualify for the exemption have to provide contraceptive coverage?

A. A broader category of nonprofit religiously-affiliated organizations that do not qualify for the exemption described above can avail themselves of an "accommodation," which allows eligible organizations to refuse to contract, arrange, or pay for contraception. However, women employees (and spouses or dependents of employees) of those organizations will nonetheless obtain coverage for contraceptive services, without cost sharing, directly from the health insurance issuer or third-party administrator that administers the eligible organization's plan.[9] An "eligible organization" for purposes of the accommodation is an organization that:

(1) opposes covering some or all contraceptive services because of a religious objection;
(2) is organized and operates as a nonprofit entity;
(3) holds itself out as religious organization; and
(4) self-certifies that it satisfies the first three criteria.[10]

Nonprofit institutions of higher education with religious objections to contraceptive coverage that meet these criteria can also qualify for the accommodation for their student health plans.[11]

At the time of this factsheet's publication, a number of pending cases are challenging the contraceptive coverage requirement based on religious objections, including two cases pending before the U.S. Supreme Court. [12]

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[7] 45 C.F.R. 147.140(a)(2).
[8] Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,870, 39,874 (July 2, 2013) (codified at 45 C.F.R. pts. 147, 156).
[9] *Id.* at 39,874.
[10] *Id.*
[11] *Id.* at 39,881.

9. What if a plan does not have any in-network providers to provide a particular required service?

A. Plans subject to these requirements must cover the required benefits without cost-sharing so long as a woman receives the services from a provider in the plan's network.[13] If a plan does not have a provider in its network who can provide a particular required preventive service, then the plan must cover the service or item without cost-sharing when provided by an out-of-network provider.[14]

10. Are plans allowed to use "medical management" to control access to these required services?[15]

A. Yes, but within limits. Medical management is broadly understood to encompass insurer practices that aim "to control costs and promote efficient delivery of care."[16] Medical management techniques generally include step therapy (requiring a patient to try one method before getting access to another), prior authorization, cost-sharing, and quantity limits. Health insurance plans are only permitted to use "*reasonable*" medical management techniques to determine the frequency, method, treatment or setting for the required preventive services to the extent not already specified in the HRSA Guidelines.[17]

The rules governing the required preventive services do not define medical management or the conditions under which it might be considered reasonable. They do, however, offer some guidance and important limitations. For example, plans may impose cost-sharing for a brand name prescription contraceptive drug when an equivalent generic version of the drug is available. However, in this instance, the rules require plans to provide a waiver process to accommodate any enrollee for whom the enrollee's provider (in consultation with the enrollee) determines the generic substitution is medically inappropriate.[18]

Particularly in the context of contraception, commonly used medical management techniques that limit the availability of methods should not be considered reasonable. Insurance-related delays in access or denials of a chosen method not only deny women control of their reproductive autonomy, they also increase risk of unintended pregnancy

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[12] NHeLP's U.S. Supreme Court amicus brief in *Sebelius v. Hobby Lobby Stores* and *Conestoga Wood Specialties v. Sebelius* is available at http://www.healthlaw.org/publications/browse-all-publications/nelp-supreme-court-amicus-brief-in-sebelius-v-hobby-lobby#.U02omfldUw1.
[13] 45 C.F.R. 147.130(a)(3).
[14] *February 2013 FAQ, supra* note 3, Q3.
[15] For more information, see NHeLP's issue brief on medical management and access to contraception, *available at* http://www.healthlaw.org/publications/browse-all-publications/medical-management-and-access-to-contraception#.U02vO_ldUw0.
[16] *February 2013 FAQ, supra* note 3, Q14.
[17] 45 CFR § 147.130(a)(4).
[18] *February 2013 FAQ, supra* note 3, Q14.

and therefore undermine the intent of the coverage requirement. As of this writing, legislation is under consideration in the California legislature to strictly limit medical management for contraception.

11. Does the contraceptive coverage requirement apply to Medicaid?

A. Medicaid coverage through "Alternative Benefit Plans" must adhere to the ACA preventive services requirements, including the contraceptive coverage requirement, as a core component of required services known as "essential health benefits." Most of the millions of low-income individuals who are newly eligible for Medicaid under the ACA's Medicaid expansion will be enrolled in Alternative Benefit Plans.

Individuals enrolled in other categories of Medicaid coverage remain entitled to family planning services and supplies without cost-sharing under longstanding federal Medicaid requirements. Additionally, many state Medicaid programs extend coverage of family planning services and supplies without cost-sharing to low-income individuals who are not otherwise eligible for Medicaid.