The ACA Contraceptive Coverage Rule

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The Affordable Care Act (ACA) requires most health insurance plans to provide coverage for a broad range of women's preventive health services without cost-sharing, including all Food and Drug Administration (FDA)-approved methods of contraception, related counseling, follow-up, side-effect management, and device insertion and removal at an in-network provider. Plans must cover at least one contraceptive method in each of 18 categories, and may impose "reasonable medical management techniques" on the coverage. However, they must provide an exceptions process to override those techniques in light of medical necessity.

What plans are subject to this requirement?

- Most non-grandfathered commercial plans, including employer sponsored plans (commercial plans that are new or have substantially changed since enactment of the ACA on March 23, 2010).
- All plans purchased through the ACA's marketplaces.
- Medicaid "Alternative Benefit Plans" (for the Medicaid expansion population).

For more information on what it means to be a grandfathered plan, see here.

What plans are not subject to this requirement?

- Self-funded student health plans.
- Grandfathered plans (plans that have not substantially changed since March 23, 2010).
    - Note: Grandfathered plans must disclose that status in materials that describe covered benefits to enrollees. Over time, we expect fewer plans to be classified as grandfathered as they make changes to their policies. Grandfathered group plans may enroll new enrollees without foregoing their grandfathered status.

What plans are exempt from this requirement?

- Health plans sponsored by a narrow category of nonprofit religious employers, as defined by the Revenue Code (houses of worship).
    - Note: These institutions are not exempt from the remainder of the women's preventive services requirements.
    - Employees and dependents **will not** receive contraceptive coverage through their employee health plans.

What plans are eligible for the "accommodation"?

Under federal rules, certain entities that provide health insurance and have religious objections to covering some or all contraceptive methods are eligible for an accommodation. To take advantage of the accommodation, the entity can fill out a form provided by HHS or notify HHS of its objection to contraception in writing.

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The employer that qualifies for the accommodation will not have to contract, arrange, or pay for contraception. The health insurance issuer or third party administrator of the plan will assume sole responsibility for providing coverage of contraceptive services directly to plan participants and beneficiaries without cost-sharing or other charges.

The entities that may be eligible for the accommodation are:

- Certain "for-profit companies," as defined by federal tax law (as a result of the Supreme Court decision in *Burwell v. Hobby Lobby Stores*).
- Non-profit organizations with religious affiliations, including universities and hospitals.

Note that the notification methods are currently under review by the Supreme Court (*Zubik v. Burwell*).

What are "reasonable medical management techniques"?

The term "medical management" is broadly understood to encompass insurer practices that aim to control costs and promote efficient delivery of care. Examples include prior authorization requirements, step therapy, or limits on visits or prescriptions that are covered.

Federal regulations do not clearly define what is and is not "reasonable" in regard to medical management techniques for contraception. HHS has said that plans can continue to impose cost sharing for services and contraceptives provided by out-of-network providers and pharmacies. But plans must cover out-of-network services without cost sharing if there is no provider in-network who can perform the service. Further, federal guidance is clear that plans may only use reasonable medical management techniques within the distinct method categories as defined by the FDA, not between categories. So, for example, a plan could encourage the use of a generic combination estrogen and progestin oral contraceptive pill over a brand name by imposing cost sharing, or a plan could cover only one progestin IUD (either Skyla, Mirena, or Liletta) without cost sharing as they all fall into one contraceptive method category.

Most importantly, if a woman's provider recommends a particular item or service based on a determination of medical necessity, the plan must defer to the provider's recommendation and cover that item or service without cost sharing even if the plan could otherwise impose reasonable medical management. For example, if a generic substitution is determined to be medically inappropriate by a woman's provider, the plan must cover the branded version at no cost to the woman. The plan must provide an exceptions process to facilitate coverage in such a situation, separate from its prior authorization process. The exceptions process must be "easily accessible, transparent, and sufficiently expedient" so that it is not "unduly burdensome on the individual or a provider." The plan or issuer must defer to the determination of the attending provider, without requiring additional medical evidence.

For more information on reasonable medical management techniques in the context of contraception, see NHeLP's analysis here.

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