Health Advocate

E-Newsletter of the National Health Law Program

Volume 42 September 2016

Key Resources

Agata Pelka, Fact Sheet: The ACA Contraceptive Coverage Rule (May, 2016)

Erin Armstrong & Agata Pelka, Medical Management and Access to Contraception (March, 2016)

National Women's Law Center, The Affordable Care Act's Birth Control Benefit (July, 2016)

Coming in October *Health Advocate*: Election Year Review

States Expand Coverage of Contraception

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A woman's reproductive health is central to her overall health. The average American woman spends approximately 30 years of her life avoiding unintended pregnancy.[1] Access to quality, comprehensive health care is critical for women to be equal, participating, and productive members of society. Additionally, the ability to time and space pregnancies improves maternal and fetal health outcomes. This month's Health Advocate provides a brief overview of the ACA's requirement to cover contraception without cost-sharing and examines how states are expanding coverage of contraception and related services through pro-active legislation.

The Problem with Cost Sharing for Contraception

Cost sharing is the portion of health care expenses not covered by the insurer that an insured must pay out-of-pocket.[2] Cost sharing includes deductibles, which are the amounts a person must pay out-of-pocket before the insurer will cover any expenses during a given benefit period, as well as copayments and coinsurance that insureds must pay out-of-pocket when they use a service or purchase a product (*e.g.*, for a doctor visit or prescription drug).[3] The imposition of cost sharing at the point of service has been justified as a means of discouraging the use of non-essential services and reducing costs.[4] The impact, however, goes beyond that intent; it is clear that cost sharing creates a barrier to accessing preventive care.[5] While copayments for preventive services have been shown to deter all individuals, and in particular low-income people, from accessing medically necessary health care services, women are most likely to defer care because of cost.[6]

Particularly with regard to contraception, high out-of-pocket cost is one of the major barriers to consistent contraceptive use by women.[7] There is a significant body of research documenting that cost sharing is a significant barrier to accessing the most effective contraceptive methods in particular. When individuals are

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[1] Guttmacher Inst., Unintended Pregnancy in the United States (2016), http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.pdf.
[2] Dahlia K. Remler & Jessica Greene, Cost-Sharing: A Blunt Instrument, 30 ANNUAL REV.PUB.HEALTH 293, 295 (2009.
[3] David Machledt & Jane Perkins, Medicaid Premiums & Cost Sharing 1 (2014), http://www.statecoverage.org/files/NHeLP_IssueBriefMedicaidCostSharing_03262014.pdf
[4] Emmett B. Keeler, Rand Corp., Effects of Cost Sharing on Use of Medical Services and Health, 8 MED. PRAC. MGMT 317, 318-19 (1992), http://www.rand.org/pubs/reprints/RP1114.html.
[5] Brief of the National Health Law Program, et al. as Amici Curiae Supporting the Government at 8-13, Zubik v. Burwell, 136 S.Ct. 444 (2015) (NOS. 14-1418, -1453, -1505, 15-35, -105, -119, & -191).
[6] *Id*.
[7] Su-Ying Liang et al., Women's Out-of-Pocket Expenditures and Dispensing Patterns for Oral Contraceptive Pills between 1996 and 2006, 83 CONTRACEPTION 491, 531 (2010).

able to access the contraceptive that works best for them, they use it more consistently, and are able to prevent unintended pregnancies at a significant rate.

The ACA Requires Coverage of Contraception without Cost Sharing

The ACA requires most health insurance plans to provide coverage for certain preventive health services, including contraception, without cost sharing. The Health Service Resources Administration (HRSA) adopted the recommendations of the Institute of Medicine to cover "all FDA-approved methods of contraception."[8] This was later defined in guidance to include at least one product in each of the 18 method categories.[9] Plans may impose "reasonable medical management techniques" to the coverage, however, they must provide an exceptions process to override those techniques in light of medical necessity.[10] Plans must also cover related counseling, follow-up, side-effect management, and device insertion and removal at an in-network provider.

As of 2015, 55.6 million women with private insurance coverage have access to new or improved coverage of evidence-based preventive health care as a result of these provisions.[11] While this requirement was a significant step forward, lack of oversight and clarity in the federal law has led to inadequate and inconsistent implementation. Reports of plans inappropriately excluding contraceptive methods or limiting coverage to generic contraceptives are less common after additional federal guidance, but some health plans continue to impose cost sharing and erect barriers such as prior authorization and charging copayments that may prevent people from getting the contraceptive they need in a timely manner – or at all.[12] Additionally consumers report difficulty in finding clear and accurate information about contraceptive coverage through their insurers.[13]

Furthermore, the federal requirement is not comprehensive. It fails to recognize the important role that men play in preventing unintended pregnancy; the ACA's coverage requirement does not extend to men or include male methods of contraception. The requirement also allows issuers to impose a prescription requirement on FDA-approved methods that are available Over-the-Counter (OTC). While women are still entitled to coverage of these methods without cost sharing, the need to see a provider and obtain a prescription is a medically unnecessary barrier that undermines the accessibility granted by OTC status. In addition, not all contraceptives are covered without cost sharing since plans can provide coverage without cost sharing for only one form of contraception in each of the FDA-approved contraceptive method categories to comply. For example, a plan has to cover only one progestin IUD (either Mirena, Skyla, or Liletta), as they all fall into the same category, even though they are distinct contraceptives. Finally, this guidance is not explicitly enshrined in regulation or law so may be changed by incoming administrations.

State Contraceptive Equity Laws

Over the last two years, states have taken the initiative and enacted legislation to codify and build on the federal contraceptive coverage requirement. These laws close gaps, improve access to a full range of contraceptive methods, and ensure that individuals have access to their choice of contraception without barriers, delays, or cost sharing.

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[8] Inst. Of Med. ("IOM"), *Clinical Preventive Services For Women: Closing The Gaps* at168 (Prepublication Ed.) (2011).
[9] U.S. Dep'ts of Labor, Health & Human Serv., & Treasury, *Frequently Asked Questions about Affordable Care Act Implementation Part XXVI* (May 11, 2015), http://www.dol.gov/ebsa/faqs/faq-aca26.html.
[10] Erin Armstrong & Agata Pelka, *Medical Management and Access to Contraception* (2016).
[11] HHS, Office of the Assistant Secretary for Planning and Evaluation, 2015. ASPE Data Point: The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans.
[12] National Women's Law Center, *The Affordable Care Act's Birth Control Benefit: Progress On Implementation and Continuing Challenges* (July 29, 2016), https://nwlc.org/resources/the-affordable-care-acts-birth-control-benefit-progress-on-implementation-and-continuing-challenges/.
[13] *Id*.

California

California's Contraceptive Coverage Equity Act was enacted in 2014. The bill (SB 1053) was introduced by Senator Holly Mitchell and cosponsored by the National Health Law Program and the California Family Health Council.[14] The law ensures that a woman in California enrolled in private health insurance and Medi-Cal (California's Medicaid program) can choose the method of birth control that is most appropriate for her and makes certain that choice is covered by her health plan.

The Contraceptive Coverage Equity Act requires private health insurance plans to cover all FDA-approved contraceptive drugs, devices, and products without cost-sharing. It builds on the FDA framework of therapeutic equivalents, ensuring that at least one of each unique contraceptive is covered by health plans. In California, a plan must cover all three progestin IUDs. It also prohibits private health insurance plans and Medi-Cal managed care plans from applying harmful medical management techniques, delays, and restrictions.[15] The law has served as a model for states throughout the country to remedy insurance practices that have undermined access to contraceptive services.

Purpose & Application to Medicaid

These contraceptive equity laws have three major components: expanding the range of contraceptive methods that are covered, prohibiting cost sharing, and limiting medical management (also known as utilization controls). The provisions that apply to Medicaid are generally intended to address barriers in Medicaid managed care caused by medical management techniques such as step therapy and prior authorization. Provisions expanding the range of contraceptive methods that must be covered generally do not apply to Medicaid because most states already have robust coverage of family planning methods. In addition, provisions prohibiting cost sharing are not extended to Medicaid since federal law explicitly prohibits cost sharing for family planning in Medicaid.[16]

Maryland

The Maryland Contraceptive Equity Act was signed by Governor Larry Hogan in May and will take effect in January 2018.[17] The law requires insurance plans regulated by the State to cover all original formulations of FDA-approved contraception with no copayments (including over-the-counter contraception and vasectomies); requires plans to provide six months dispensing for contraception; and prohibits prior authorization for contraception, including explicitly for IUDs and implantable rods. The law will apply to plans that serve about a third of state residents.[18]

Maryland became the first state to eliminate cost sharing for over-the-counter contraception, including emergency contraception, and vasectomies. By covering vasectomies without cost sharing, the law recognizes the important role that men play in preventing unintended pregnancies and ensures that men also can make their own decisions about becoming a parent. Under the law, a patient may fill up to six months of a prescription after the first two-months of an initial prescription of a new contraceptive method. The six month dispensing provision applies to Medicaid and Maryland Children's Health Program, and the bill requires a proportional

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[14] Section 1367.25 of the California Health and Safety Code. For the text of SB 1053, see http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1053.

[15] Application of SB 1053 to Medi-Cal managed care plans was made easier because the bill amended the State's Knox Keene Act, which governs both commercial and Medicaid managed care plans. In other states without such a comprehensive law in place, additional provisions may be needed.

[16] 42 C.F.R. §447.56(a)(2)(ii) and 42 C.F.R. §438.108; Kaiser Family Foundation, Medicaid Coverage September 2016 of Family Planning Benefits: Results from a State Survey (Sept. 2016).

[17] For the text of SB 848, see http://mgaleg.maryland.gov/2016RS/chapters_noln/Ch_437_hb1005T.pdf.

[18] Ovetta Wiggins, *Hogan signs bill to make birth control cheaper*, Wash. Post, May 10, 2016.

increase for the dispensing fee paid to the pharmacist. Such provisions go a long way to improve usage and continuation rates of contraception. The CDC has found that the more combined oral contraceptive (COC) pill packs given to a patient, up to 13 cycles, the higher the continuation rate.[19]

Vermont

A few weeks after the Maryland bill was signed into law, Vermont codified the birth control benefit in the Affordable Care Act and extended contraceptive coverage to men by requiring insurers to cover vasectomies without copayments or other cost-sharing.[20] The law also allows patients to fill up to a year's supply of birth control at once (while reimbursing dispensing fees to providers and dispensing entities per unit), increases the Department of Vermont Health Access reimbursement rate for Long Acting Reversible Contraceptives (LARC), and allows women to enroll in a health insurance plan on the exchange immediately upon pregnancy instead of waiting for an open enrollment period or a birth. The law became effective on July 1, 2016.

Illinois

In June, Governor Bruce Rauner signed the Illinois Contraceptive Coverage Act.[21] The law requires insurance plans regulated by the State to cover all original formulations of FDA-approved contraception with no copayments (including over-the-counter contraception and vasectomies); requires plans to provide 12 months dispensing for contraception; and prohibits the use of medical management techniques that delay or prevent access to the most effective birth control options.

Comparison of Key Provisions

	ACA	California	Maryland	Vermont	Illinois
Eliminates copayments for contraception	✓ (one per FDA method)	✓ (most methods)	✓ (most methods)	✓ (one per FDA method)	✓ (most methods)
Eliminates copayment for related services (*e.g.*, counseling)	✓	✓	✓	✓	✓
Eliminates copayments for vasectomies			✓	✓	✓
Covers over-the-counter contraception			✓ (all medications, including emergency contraception)		✓ (all FDA-approved drugs, devices and other products, excluding male condoms)
Allows patients to fill multiple months of a prescription[21]			✓ (6 month supply)	✓ (12 month supply)	✓ (12 month supply)

[19] The CDC recommends that health care practitioners provide up to a one-year supply of COCs (i.e., 13, 28-day pill packs). Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm. Rep. 2016;65 (No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1.

[20] For the text of H 620, see http://legislature.vermont.gov/assets/Documents/2016/Docs/BILLS/H-0620/H-0620%20As%20Passed%20by%20Both%20House%20and%20Senate%20Official.pdf

[21] For the text of HB 5576, see http://ilga.gov/legislation/99/HB/PDF/09900HB5576lv.pdf.

Moving Forward

New York and Colorado introduced contraceptive equity bills during their last legislative sessions, and we look forward to working with them on reintroduction. We expect state interest in such bills to increase. NHeLP has developed a Model Act based on the Contraceptive Equity Bill in California to fill in the gaps left by federal guidance, limit the medical management techniques that are permissible in this context, and assist with state-level enforcement. NHeLP is available to provide technical support to state advocates who are considering a Contraceptive Coverage Equity Act in their state. If you would like more information, please contact Susan Berke Fogel at fogel@healthlaw.org, or Agata Pelka at pelka@healthlaw.org.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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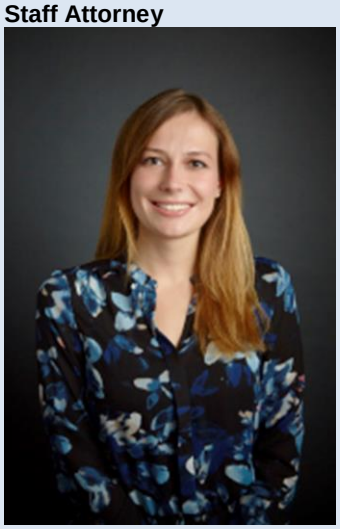

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