



Contraceptive Equity in Action:

A Toolkit for State Implementation

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Disclaimer: The National Health Law Program (NHeLP) is providing this toolkit free of charge for the purpose of sharing information and improving understanding of contraceptive health benefits. Every effort has been made to gather up-to-date and accurate information based on existing legal sources. NHeLP will revise this toolkit periodically as needed.



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NHeLP is dedicated to ensuring appropriate implementation and monitoring for states that have adopted Contraceptive Equity laws. NHeLP developed this Toolkit to explain how Contraceptive Equity laws fit within the broader federal and state health insurance landscape. After laying out the federal legal framework for contraceptive coverage laws, the Toolkit provides a comprehensive analysis of the laws in all states that have adopted Contraceptive Equity. It then delves into specific tips and strategies for a range of stakeholders relevant to contraceptive coverage: advocates, media and communications strategists, providers, health plans, and regulators. It concludes with a series of practical tools in the Appendices, such as a model formulary, a 50-state survey detailing which states have implemented Contraceptive Equity mandates, and template violations and appeals letters.



Introduction to Equity vs. Parity: Why is Contraceptive Equity Important?

Contraceptive Equity is a policy framework under which contraceptive care is easily accessible and covered at no cost in all health programs. Why is it important? Because of the critical role that family planning plays in improving health outcomes and economic security, and because of the historically inadequate coverage of comprehensive birth control services. While many states have Contraceptive **Parity** laws, requiring coverage of contraceptives in the same manner as other prescription drugs, and the Affordable Care Act (ACA) creates federal requirements for contraceptive **coverage**, Contraceptive **Equity** remains elusive.

In addition, the current administration has taken steps to undermine the federal contraceptive coverage requirement, making state decisions regarding Medicaid and private health insurance coverage of contraception (as well as other health care services) more important than ever. States can act as a defense against ongoing federal efforts to restrict access to health care and especially reproductive care.

Contraceptive Equity laws, which started to be introduced in states in 2014, go beyond the comparable coverage in Parity laws. Contraceptive Equity laws take major steps toward equitable access by including provisions such as eliminating all co-pays, strictly limiting medical management, and requiring coverage of over-the-counter (OTC) contraception and contraception for men. Some Contraceptive Equity laws also require that plans cover an extended supply of contraception (e.g. 12 months) dispensed all at once. By enacting these laws, states are ensuring that coverage of contraceptives will survive regardless of what happens to federal requirements embedded in the ACA. These laws will be crucial to maintain and expand access to reproductive health care moving forward.

Background:

Understanding the Federal Legal Landscape

The manner in which health plans must cover contraception depends upon an amalgamation of federal and state statutes and regulations, formal and informal agency guidance, and case law. The legal frameworks for private coverage and Medicaid have also undergone significant changes with the ACA. The background information below provides an overview of the federal legal landscape before the ACA, under the ACA, and after the ACA. Note that this section, and the Toolkit generally, focuses on the federal laws governing private coverage and Medicaid because historically those are the programs subject to state Contraceptive Equity laws. Nonetheless, Contraceptive Equity as a framework is relevant to all health coverage, including Medicare, CHIP, TriCare, etc., and many of the same legal concepts may be applicable.

Before the Affordable Care Act

Private Coverage. In the late 1990's, employers routinely refused to cover contraception even when they covered other prescription drugs, leading some states to enact Contraceptive Parity laws. These laws affirm that contraceptives must be covered in the same manner as any other prescription drugs. But that means, like other prescription drugs, they can subject to cost-sharing. Additionally, in 2000, the Employment Equal Opportunity Commission ruled that employers that cover preventive prescription drugs but do not cover prescription contraceptives are engaging in sex discrimination in violation of Title VII of the Civil Rights Act of 1964, as amended by the Pregnancy Discrimination Act.¹

As of publication, thirty states and Washington, D.C. have Parity laws that require private plans to cover prescription contraception.² Additionally, Ohio and Wyoming require coverage of voluntary family planning services, although they do not specify whether prescription contraceptive coverage is mandated, and Virginia has a Contraceptive Parity law that applies to state employee plans.³ Because these are state laws, they apply to fully-insured plans regulated by the state; self-insured plans, which are governed by the federal Employee Retirement Income Security Act of 1974 (ERISA), may not be subject to state Contraceptive Parity laws.

Medicaid. Federal Medicaid law requires states to cover “family planning services and supplies” without cost-sharing.⁴ As with most other Medicaid services, states have some discretion to determine what family planning services and supplies to cover in their programs, as long the coverage is “sufficient in amount, duration, and scope to reasonably achieve its purpose.”⁵ Notably, federal Medicaid law does not explicitly require coverage of all FDA (Food and Drug Administration)-approved methods.

Over the years, state Medicaid programs have dramatically increased their use of managed care systems to deliver benefits. Almost all state Medicaid agencies contract with managed care entities, and nearly three-quarters of Medicaid enrollees receive services through some type of managed care arrangement, including managed care organizations (MCOs), prepaid health plans (PHPs), and primary care case managers (PCCMs).

Managed care has in some cases impeded access to contraceptives. Federal regulations acknowledge that Medicaid MCOs may adopt methods and procedures to safeguard against unnecessary use of services.⁶ Often referred to as “utilization management,” these methods and procedures may include requiring prior authorization for services, step therapy (requiring trial and failure of one drug or device before authorizing an alternative drug or device), and quantity limits on services or prescription drugs. Such policies can delay or prevent access to appropriate contraceptive methods and increase the risk of unintended pregnancy.

Changes under the Affordable Care Act

The ACA brought historic reforms to the private health insurance market and Medicaid, enabling millions of individuals to enroll in quality, comprehensive, and affordable insurance. The ACA added § 2713 to the Public Health Services Act, requiring most group and individual health insurance plans, sold inside and outside of the Marketplaces created by the ACA, to cover a broad array of evidence-based preventive health services without cost-sharing.⁷ The plans subject to this requirement are most commercial plans, including individual, small group, large group, and self-insured plans, as well as Medicaid Alternative Benefit Plans (ABPs).

To meet women’s unique preventive health needs, Congress directed the Department of Health and Human Services’ Health Resources and Services Administration (HRSA) to develop guidelines that identify the critical women’s health benefits that the coverage requirement must include.⁸ The HRSA guidelines require coverage of “[a]ll Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.”⁹ Importantly, plans must cover these services and supplies without cost-sharing, which means that patients should not have any out-of-pocket costs, including payment of deductibles, co-payments, co-insurance, fees, or other charges.¹⁰

Some Medicaid enrollees, and in particular the ACA's Medicaid expansion population, receive their benefits through ABPs, formerly known as Medicaid benchmarks. ABPs must cover all of the contraceptive services that most commercial insurance plans must cover under the ACA, without cost-sharing.¹¹ This means that millions of newly eligible low-income women who enroll through Medicaid expansion will receive no-cost contraceptive coverage, no matter how the state defines its family planning benefit for the rest of its Medicaid program. A growing number of states also enroll groups of Medicaid-eligible individuals other than the Medicaid expansion population into ABPs, and many states align their ABPs with Medicaid for the non-expansion population. As a result, a substantial number of Medicaid enrollees now have coverage for the full scope of contraceptive services.

Gaps after the Affordable Care Act

The ACA's contraceptive coverage requirement represents a great stride forward for women, yet it is not without challenges. The requirement itself is subject to multiple exemptions and accommodations. Additionally, the mandate is not broad enough to achieve Contraceptive Equity and gaps in coverage remain. This section describes the variety of issues that may impact equity.

Exemptions. While the ACA coverage requirement substantially changes the insurance landscape, some health plans are, by statute, not subject to the mandate. This includes self-funded student health plans and grandfathered plans (plans that have not substantially changed since March 23, 2010). Federal regulations also establish exemptions to the requirement for group health plans established or maintained by certain religious employers, which have been significantly expanded by the current Administration.¹² The original regulations narrowly define a religious employer as a church, church association, or other similar religious order.¹³ Employees and dependents of these exempt employers will not receive contraceptive coverage through their employee health plans.

In October 2017, the current Administration proposed regulations that broadened the definition of a religious employer.¹⁴ Under the proposed rules, all non-profit and closely held for-profit employers with objections to contraception based on religious or "moral" convictions, including private universities that issue student health plans, would qualify for the exemption.¹⁵ Additionally, publicly traded for-profit companies with religious objections can also be exempt.¹⁶ These new regulations have been challenged in court and the Department of Health and Human Services (HHS) is prohibited from implementing them pursuant to a nationwide injunction while the litigation proceeds.¹⁷

Additionally, in November 2018 the current Administration finalized rules that are substantively identical to the enjoined proposed rules.¹⁸ Plaintiffs to those cases amended their complaints to argue that the final rules suffer the same flaws as the

proposed rules. Again, a judge agreed to prohibit the final rules from going into effect as litigation continues.¹⁹

Accommodations. In addition to the exemption, certain organizations with religious or “moral” objections to some of all methods of contraception may qualify for an “accommodation.” The accommodation allows these entities to refuse to contract, arrange, or pay for contraception, but requires that affected women and their dependents still receive contraception without cost-sharing.²⁰ When an eligible organization requests an accommodation, the insurance issuer or third party administrator of the health plan must assume responsibility for providing contraception directly to enrollees.²¹ To take advantage of the accommodation, the entity can notify its insurer, third party administrator, or HHS.

Under the original regulations governing accommodations, only non-profit organizations with religious affiliations, including universities and hospitals, were eligible for the accommodation. This was later extended to certain “for-profit companies” with religious objections as a result of the Supreme Court decision in *Burwell v. Hobby Lobby Stores*.²² Under the new administration’s proposed and final regulations, which are currently enjoined, the accommodation would become **optional** for any entity that is eligible for the exemption. This means that women employed by organizations with religious objections, who previously received no-cost contraception directly from an insurer pursuant to the accommodation, will now be forced to pay completely out of pocket if their employers opt to forego the accommodation.

Coverage Tied to Method Categories. The ACA’s addition of § 2713 to the Public Health Services Act did not specify the extent of the contraceptive coverage requirement. Instead, HHS clarified the scope of the mandate through sub-regulatory guidance. In May 2015, HHS explained that not all contraceptives need to be covered so long as the plan covers without cost-sharing at least one form of contraception in each of the 18 FDA-approved contraceptive method categories for women.²³ Within each of the method categories, plans and issuers “may impose cost-sharing (including full cost-sharing) on some items and services,” leaving gaps and barriers for women.²⁴ Plans may choose not to cover or may charge cost-sharing for brand-name contraceptive drugs that have a generic equivalent. Plans may also use cost-sharing to “encourage use” of one of several FDA-approved hormonal intrauterine devices (IUDs).²⁵ For example, the four available progestin IUDs (Mirena, Skyla, Liletta, and Kyleena) are distinct and different, yet because of the method categorization framework, plans only have to cover one without cost sharing.

Utilization Management. Under the federal guidance, women may encounter barriers to timely access to the contraceptive of their choice because of utilization or “medical” management. Federal regulations implementing the contraceptive coverage requirement permit plans to use “reasonable medical management

techniques to determine the frequency, method, treatment or setting” for an item or service within a contraceptive method category.²⁶ Insurers routinely use utilization management techniques such as prior authorization, quantity limits, and step therapy (requiring trial and failure of one drug or device before another will be covered), to control the availability of covered benefits. Insurers use these techniques to override a provider’s clinical judgment about whether a patient should receive a particular service or treatment.²⁷ These insurer practices interfere with patient decision-making and conflict with the ACA’s intent to eliminate barriers to all FDA-approved methods of contraception.

Guidance on Related Services. Women must always be free to discontinue use of a particular method, even absent a medical reason for doing so. Additionally, medical reasons or side effects may require method discontinuation and/or device removal. Federal guidance reflects these standards of care by requiring all commercial plans and Medicaid ABPs subject to the ACA’s contraceptive coverage requirements to cover without cost-sharing “[s]ervices related to follow-up and management of side effects, counseling for continued adherence, and device removal.”²⁸ But this is not enshrined into regulation or law, meaning a new administration could easily modify this requirement. Additionally, the federal guidance requires no-cost coverage for “clinical services, including patient education and counseling, needed for provision of the contraceptive method,” but is not explicit that device insertion fees (e.g. for an IUD) must be covered without cost-sharing.²⁹

Medical Necessity Waivers. 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.³⁰ However, a particular formulation may be preferred or advisable without meeting the criteria for a medical necessity determination. For example, patients may be at risk for poor compliance with a generic formulation because they are confused by different packaging, they fear that they received the wrong pill, or they lack confidence in generics; in this situation, The American College of Obstetricians and Gynecologists (ACOG) supports patient or clinician requests for branded formulations that may require a co-pay waiver.³¹ Moreover, even though medical management techniques must be waivable in medically necessary situations through a process that is “easily accessible, transparent, and sufficiently expedient” and not “unduly burdensome” on the enrollee or provider, the process for implementing the waiver provision is not sufficiently laid out.³² As a result, providers may encourage patient use of an inappropriate contraceptive to avoid dealing with a complex insurance waiver.

Male Contraception. Federal law fails to recognize the role that men play in preventing unintended pregnancies. The ACA’s contraceptive coverage requirement does not apply to men or require coverage of male contraceptive methods such as male condoms, vasectomies, or male counseling and follow-up services. Medicaid

plans are required to cover a range of family planning services, but have no specific requirements to cover male contraception. This omission forces men to continue paying out-of-pocket if they choose to share in the responsibility for preventing an unintended pregnancy. Many insurance carriers do not cover vasectomies at all, and because the cost of a vasectomy is so high, even when the procedure is covered, the remaining co-pay may still be a significant financial barrier.³³

Prescription Requirement. Finally, the federal contraceptive coverage requirement includes all OTC contraceptive methods “as prescribed,” meaning that insurers may require enrollees to obtain a prescription for FDA-approved methods of contraception that are available OTC, specifically female or internal condoms, male condoms, the contraceptive sponge, spermicide, and some formulations of emergency contraception (EC).³⁴ Requiring women to obtain a medically unnecessary prescription imposes an additional barrier and undermines access to care.

Overview of State Contraceptive Equity Laws

State laws regulating contraceptive coverage, often referred to as Contraceptive Equity laws, can play a critical role in filling the remaining gaps from the Affordable Care Act and accompanying federal guidance, and have the potential to expand equitable access to contraceptive services for women and men. Fully-insured plans must comply with both state and federal contraceptive coverage laws, including state laws that mandate a higher level of benefits.³⁵

The latest wave enacting contraceptive coverage laws began in California in 2014, with legislation sponsored by the National Health Law Program and Essential Access Health. In the wake of enactment of that bill, the National Health Law Program created a [Model Contraceptive Equity Act](#) (Model Act) that has since been used to introduce similar legislation in 40 jurisdictions and enact versions in 14 states and Washington, D.C. as of 2019. The Model Act (found in [Appendix H](#)) prevents insurers from using medical management techniques, like cost-sharing, prior authorization, prescription requirements, gender restrictions, or quantity limitations, to erect access barriers.

The scope of Contraceptive Equity laws vary by state, but are designed to apply to both private and public health insurance programs. The provisions that apply to Medicaid are generally intended to address barriers in Medicaid managed care caused by utilization management techniques such as step therapy and prior authorization; utilization controls are less common in Medicaid fee-for-service. 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.³⁶ Advocates may consider whether application of a Contraceptive Equity law to Medicaid fee-for-service and/or the Children's Health Insurance Program (CHIP) would be beneficial in their states.

Elements of a Model Contraceptive Equity Law

Contraceptive Equity bills improve upon federal provisions to address many of the shortcomings and gaps laid bare despite enactment of the ACA. These state laws apply to most commercial plans, all plans purchased through the ACA's marketplaces, Medicaid ABPs, and Medicaid managed care plans. These Contraceptive Equity laws have three major components:

- Expanding the range of contraceptive methods and services that are covered without cost-sharing;
- Limit medical management (also known as utilization controls);
- Create gender equity in contraceptive coverage.

While different states may modify the Model Act to focus on specific components, the most comprehensive versions of Contraceptive Equity laws:

- Require coverage of all FDA-approved contraceptive drugs, devices, and products, beyond the ACA requirement of one covered contraceptive method in each of 18 categories (the laws may provide an exception for therapeutically equivalent products, so long as at least one is covered);
- Explicitly delineate coverage requirements for all related services including initial and ongoing counseling, device insertion and removal, and management of side effects;
- Strictly limit the ability of insurers to impose restrictions and delays (referred to as medical management or utilization controls);
- Prohibit prescription requirements for coverage of OTC contraceptives;
- Create equity by eliminating cost-sharing for contraception, voluntary sterilization, and contraceptive counseling for men;
- Require coverage of a year's worth of contraceptive supplies (thirteen units);
- Include narrow exemptions – self-funded plans and grandfathered plans are not subject to these laws, while health plans sponsored by nonprofit religious employers, such as churches, mosques, or synagogues, are exempt; depending on individual state law, some employers that may be able to claim an exemption from the federal requirement will nonetheless be bound by the state Contraceptive Equity law.

See [Appendix H](#) for the Model Contraceptive Equity Act language.

Preemption

Preemption is a legal doctrine that enables a higher level of government to limit, or even eliminate, the power of a lower level of government to regulate a certain issue.³⁷ Preemption stems from the U.S. Constitution's Supremacy Clause, which has been interpreted to mean that federal law governs over a conflicting state or local law.³⁸ So normally, if a state or local law prevents the application of the federal law, the state or local law would be found unconstitutional and not allowed to interfere with federal law. While preemption has the benefit of creating uniform standards, it may also hinder the innovative policy development that allows states to experiment with addressing the unique needs of their communities.³⁹

In the case of contraceptive benefit mandates, the federal requirement in the ACA sets the floor for contraceptive coverage, not the ceiling. Accordingly, if a state law requiring coverage of one or more of the preventive services required to be covered by the ACA is more generous to the individual than the federal coverage mandate (without being more restrictive in any way), then the state law likely would not be interpreted as “preventing the application” of the ACA. Because Contraceptive Equity laws provide for more generous benefits than requirements under federal guidance, they are unlikely to be preempted by federal laws.

Table 1: State-by-State Table of Contraceptive Equity Laws

This table examine state statutes and regulations for laws that align with the six main components of Contraceptive Equity laws (see list on page 14). The term “UM” refers to utilization management. When describing the scope of male methods and OTC, “Rx” denotes that a prescription is required for coverage of contraceptive drugs, devices, or both; in some cases state law may indicate coverage of an OTC product but not directly address prescription requirements in law, which is indicated on the table with “Rx reqs unclear.”

State	Application	Limited/ No UM	All Products	Male Methods	Related Services	OTC	Extended Supply
CA	Private	X	X		X		12 mos.
	Medicaid MCOs	X					12 mos.
CO	Private						3-12 mos.
CT	Private		X		X	Drugs—Rx reqs unclear	12 mos.
DE	Private				X	EC w/o Rx	12 mos.
	Medicaid MCOs				X	EC w/o Rx	12 mos.
DC	Private		X	Condoms—Rx reqs unclear	X	Rx reqs unclear	12 mos.
	Medicaid MCOs		X	Condoms—Rx reqs unclear	X	Rx reqs unclear	12 mos.
HI	Private						12 mos.
	Medicaid MCOs						12 mos.
IL	Private	X	X	Vasectomy	X	Rx reqs unclear	12 mos.
ME	Private			Condoms w/Rx			12 mos.
MD	Private	For LARCs only	X	Vasectomy, condoms w/Rx		Drugs—w/o Rx	12 mos. ¹
	Medicaid MCOs	For LARCs only					12 mos.
	CHIP	For LARCs only					12 mos.
MA	Private		X*		X	EC w/o Rx	12 mos.
	Medicaid MCOs & PCCM		X*		X	EC w/o Rx	12 mos.
NV	Private				X	Rx reqs unclear	12 mos.
	Medicaid MCOs & PCCM				X		12 mos.

¹ Effective Jan. 1, 2020.

* Coverage of drugs without a therapeutic equivalent is not required.

State	Application	Limited/ No UM	All Products	Male Methods	Related Services	OTC	Extended Supply
NH	Private			Condoms w/Rx			12 mos.
	Medicaid MCOs			Condoms w/Rx			12 mos.
NJ	Private						6 mos.
NM	Private	X ¹		Condoms w/o Rx, vasectomy, counseling ¹	X ¹	w/o Rx ¹	6 mos. ¹
	Medicaid MCOs						12 mos.
NY	Private	X ¹	X ¹		X ¹	Rx reqs unclear ¹	12 mos.
	Medicaid MCOs						12 mos. ¹
OH	Private						90 days
OR	Private	X	X	Vasectomy and condoms—Rx reqs unclear	X	Pharmacy claims for drugs—Rx reqs unclear	12 mos.
RI	Private						12 mos.
	Medicaid MCOs						12 mos.
VT	Private			Vasectomy	X		12 mos.
	Medicaid PCCM						12 mos.
VA	Private						12 mos.
WA	Private	X	X	Vasectomy and condoms w/o Rx	X	w/o Rx	12 mos.

Source: See [Appendix B](#) for a chart of the corresponding legislative, statutory, and regulatory citations.

Most Commonly Reported Coverage Issues

Despite the existence of these Contraceptive Equity laws, many of which are currently in effect, it takes time and effort for providers, health plans, and regulators to become educated about and to properly implement the expanded coverage requirements. According to patients, providers, and advocates, the most commonly reported coverage issues are:

- **Authorizations and medical necessity decisions.** Insurers may require providers to justify their choice of prescriptions and/or why the service should be considered medically necessary as a prerequisite for reimbursement. Contracts may also provide insufficient information as to which products or services require prior authorization;
- **Provider network and reimbursement.** Patients may not be able to find a qualified provider within their network to obtain comprehensive contraceptive care, especially if their managed care entity contracts primarily with religiously-affiliated providers. Despite the fact that out-of-network providers should be covered in this situation and for all Medicaid managed care enrollees under the federal “freedom of choice” protection, health plans may improperly deny coverage;
- **Benefit exclusions and limits on care.** Insurers may improperly deny certain services, such as a full year’s supply of contraceptives or removal of long-acting reversible contraception (LARC) for reasons other than medical complications. Plans may also incorrectly limit the number of family planning visits that are covered annually;
- **Ambiguous plan documents.** Managed care contracts and other plan documents frequently contain improperly limiting language, such as requiring a prescription for products that should be covered OTC, like emergency contraception, or only covering LARC insertion by a physician. The plan documents may also be inappropriately silent regarding contraceptive benefits, such as the ability to obtain an off-formulary contraceptive without cost-sharing when medically appropriate or an OTC product when prescribed, such as the internal condom;
- **Misleading formularies.** Some plans cover certain contraceptive methods and procedures (e.g., diaphragms, IUDs, and injectable contraceptives) as medical benefits, meaning they are not included in the plan’s drug formulary, or plans place certain methods on higher coverage tiers;
- **Insufficient information.** Patients may be denied care or coverage for contraceptive services, but the denial does not provide enough information for the consumer and provider to understand whether there is cause for an appeal;
- **Out-of-pocket costs.** Patients may be asked to pay cost-sharing for a drug, device, or service that should be covered at no cost to the enrollee.

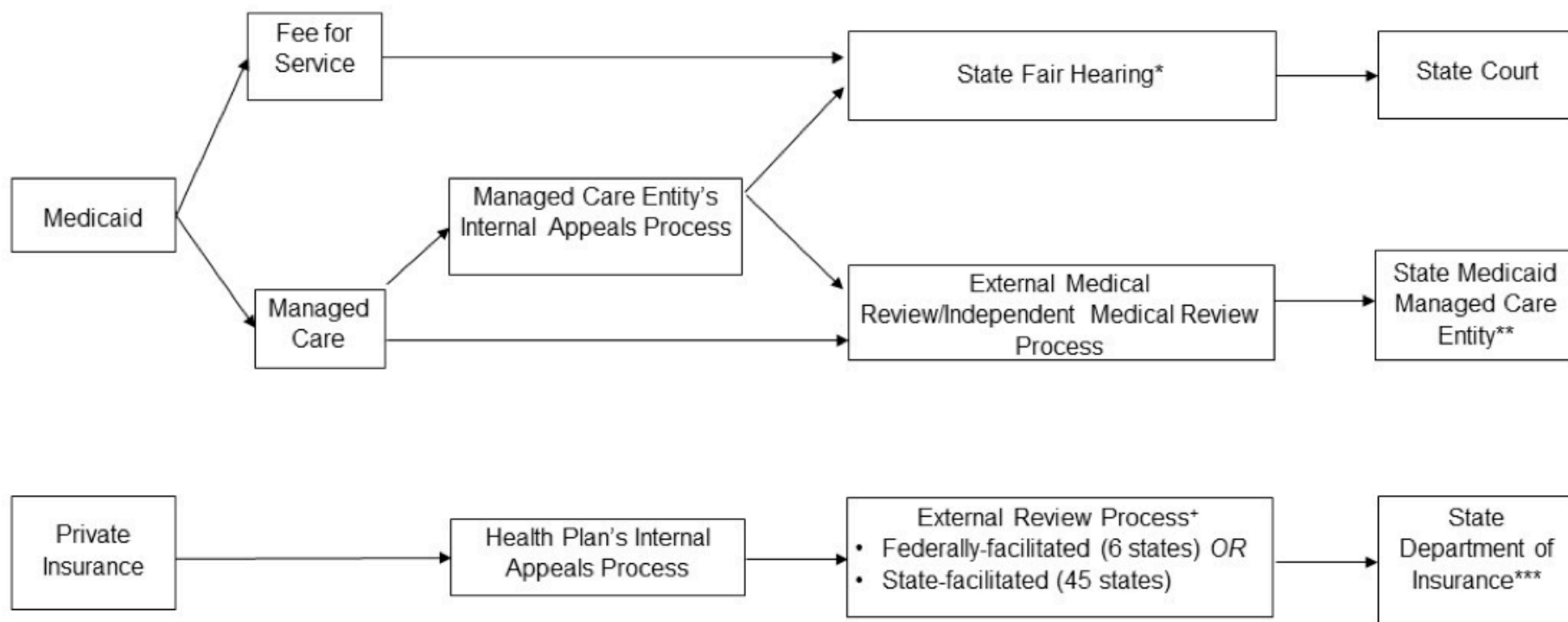
The Appeals Process

An “adverse benefit determination” includes any instance in which a request for a medical service has been made in which a member has been told “no” for all or part of the service. Different mechanisms and processes exist for using the legal system to appeal adverse benefit determinations of contraceptive supplies and services, depending on whether the client is appealing a denial from a Medicaid managed care plan, Medicaid fee for service, or a private insurance plan.

The processes for Medicaid managed care appeals are governed by federal law, as outlined in 42 C.F.R. § 438.408 and § 438.420. The processes for Medicaid fee for service are governed by 42 C.F.R. § 431.220 through § 431.246. The processes for private group and individual insurance plans subject to a state external review process are governed by 45 C.F.R. § 147.136(c), and for plans subject to a Federal external review process by 45 C.F.R. § 147.136(d). These do not apply to grandfathered health plans or self-insured plans.

This section of the Toolkit does not specifically address CHIP appeals. Many states operate CHIP as a part of their Medicaid program so the same rules would apply as for Medicaid. States that operate a separate CHIP program may have different processes; if a state’s Contraceptive Equity law applies to a separate CHIP program, NHeLP can provide additional information on the appeals process in that situation.⁴⁰

Figure 1: Appeals Flow Chart



Notes:

* State fair hearings are available pursuant to 42 C.F.R. § 438.408(f) for MMC and 42 C.F.R. § 431.220 for FFS. These are also sometimes referred to as: state hearings, fair hearings, administrative fair hearings, administrative hearings, administrative reviews, administrative appeals, appeals, or service hearings.

** Contact whichever appropriate state entity oversees Medicaid Managed Care quality of care and/or compliance of Medicaid Managed Care Entities with state and federal statutes and regulations. This may be the unit/office/branch of Medicaid Program Integrity, Medicaid Quality Assurance, Medicaid Program Oversight and Compliance, Managed Health Care, Medicaid Ombudsman and/or Inspector General. If unsure, contact the state Medicaid agency.

*** Contact the appropriate State Department of Insurance entity for your state. While most states handle these cases in their Department of Insurance, some handle them in their Department of Commerce, Regulatory Agencies, Financial Services, Financial Regulation, Business Regulation, or Office of Attorney General.

+ For more information on the State External Appeals Review Processes, see the Center for Consumer Information & Insurance Oversight's resources at https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.

Private Insurance

An insurer appeal is the process consumers use to request a review of a negative decision about their plan's benefits or insurer's coverage. Consumers can appeal all denials and any reduction, termination, or failure to provide or make payments for a contraceptive benefit, including medical necessity denials.⁴¹ If an insurer makes an "adverse benefit determination," the notice sent to the individual denying the coverage should contain sufficient description of the reason for denial, including sufficient plan provisions and the scientific or clinical judgment used, although lack of information in the denial is not uncommon.⁴²

The denial should also contain information on the appeals process.⁴³ Individuals with private health insurance, both employer/group and individual policies, usually have two levels of appeal:

- Internal appeal, where an individual asks the health plan to reconsider its negative decision; and
- External appeal/review, where an individual asks an independent organization to review the health plan's decision.⁴⁴

The external appeal decision is final and binding on both the individual and the insurer/managed care organization but may be subject to judicial review.⁴⁵

Figure 2: Private Insurer Appeals

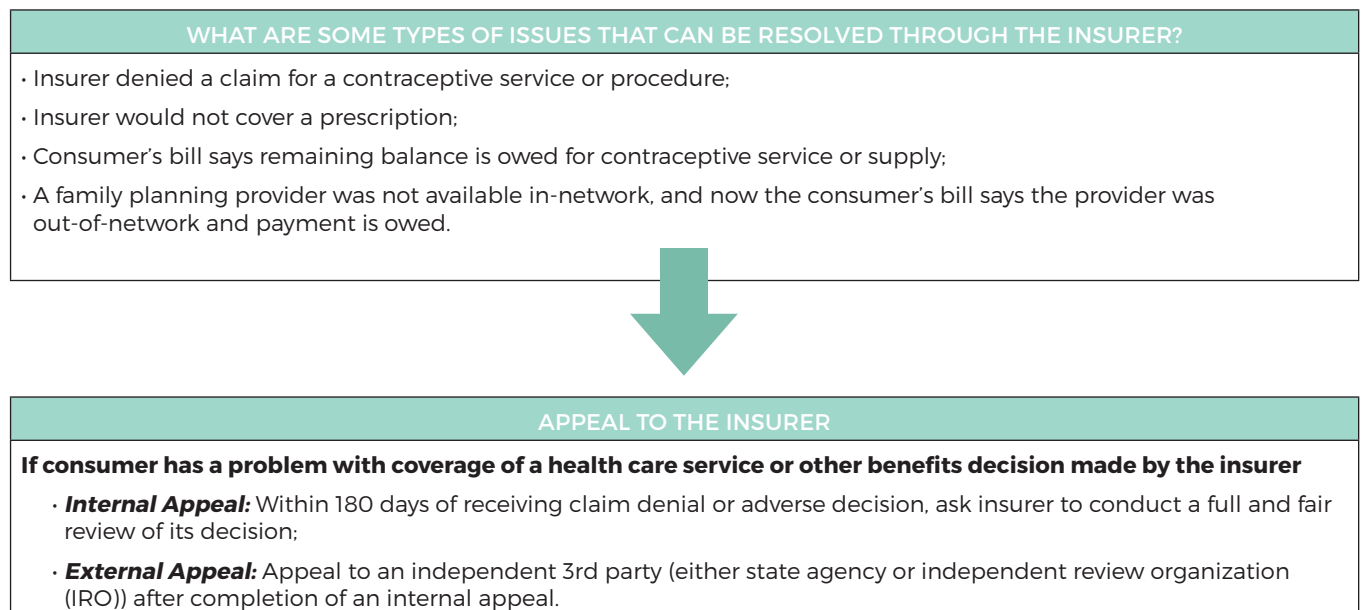


Figure adapted with permission from the Center on Budget and Policy Priorities.

If the insurer appeal decision still denies the coverage, an individual can then file an external appeal with the state Department of Insurance (DOI). DOI conducts external reviews of adverse benefit determinations, outside of the insurer appeals process, no

matter the dollar amount of a claim.⁴⁶ The office that processes the complaint will depend on which government agency is responsible for enforcing your state's Contraceptive Equity law; see [Appendix E](#) for a state-by-state chart of insurance regulators.

Figure 3: State Department of Insurance Complaints

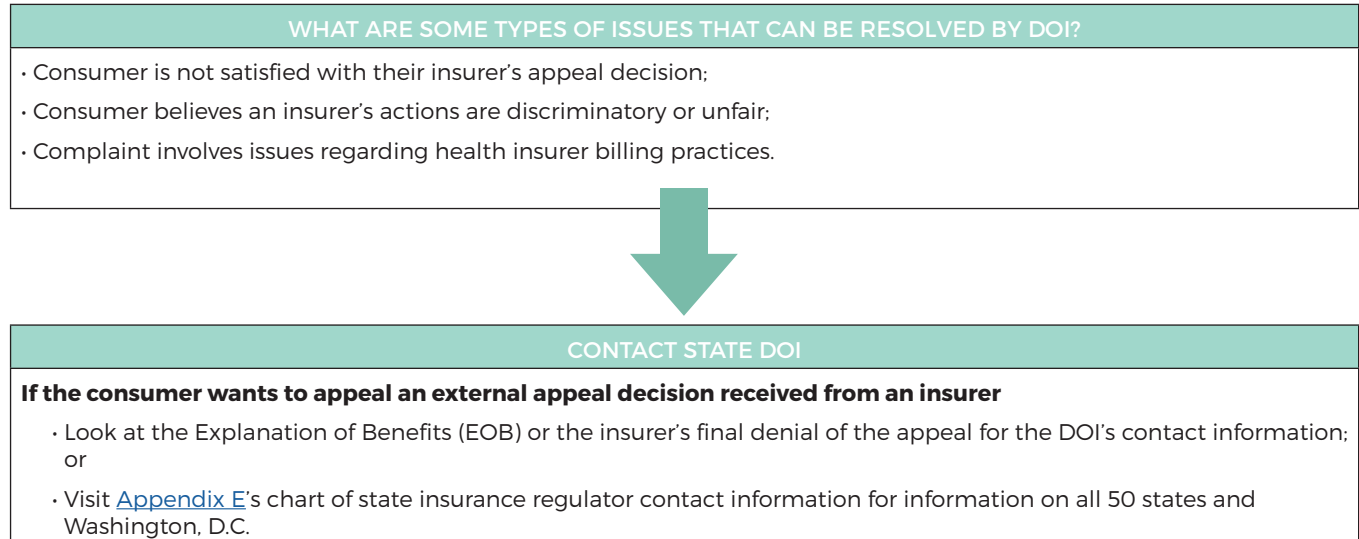


Figure adapted with permission from the Center on Budget and Policy Priorities.

Medicaid Managed Care

Background. Medicaid enrollees, including those enrolled in Medicaid managed care, have due process rights that stem from the Fourteenth Amendment of the U.S. Constitution, which prohibits governmental deprivations of “life, liberty, or property, without due process of law.”⁴⁷ The essential elements of due process in Medicaid that each managed care entity must have in place are adequate written notice of adverse benefit determinations, access to plan-level procedures to file appeals, and the opportunity to challenge an adverse benefit determination in a state fair hearing before an impartial decision maker.⁴⁸ These due process rights are part of what makes Medicaid an “entitlement” and a source of dependable insurance for the vulnerable population that needs it.⁴⁹

Managed Care Appeals. Each Medicaid managed care plan must establish and maintain an internal appeal system under which enrollees may challenge adverse benefit determinations.⁵⁰ Enrollees must receive timely and adequate notice of such a determination, at least 10 days before the date of action denying the service.⁵¹ The notice must be accessible to individuals who have disabilities or limited English proficiency.⁵² For more detailed information on what each notice must explain and how the notice must be mailed, see NHeLP’s issue brief on Medicaid Managed Care Final Regulations Grievance & Appeals Systems.⁵³

An enrollee must file an appeal within 60 calendar days from the date of the adverse benefit determination notice from the managed care entity (MCE).⁵⁴ The appeal can be filed orally or in writing (which includes online filing).⁵⁵ The MCE process must: (1) acknowledge receipt; (2) ensure that the individual who makes the decisions on the appeal was neither involved in any previous level of review or decision-making nor a subordinate of any such individual; and (3) utilize a deciding individual with “appropriate clinical expertise, as determined by the State, in treating the enrollee’s condition or disease,” if the appeal involves denial based on no medical necessity or an appeal that involves clinical issues.⁵⁶

When deciding the appeal, the deciding individual must take into account all comments, documents, records, and other information submitted by the enrollee, including information that was not submitted to or considered in the initial adverse determination.⁵⁷ The plan must also provide the enrollee with a reasonable opportunity, “in person and in writing,” to present evidence and make legal and factual arguments.⁵⁸ The MCE must provide the enrollee and his representative with the case file, including medical records and any new or additional evidence considered or generated by or at the direction of the MCE in connection with the appeal. This information must be provided free of charge and sufficiently in advance.⁵⁹

MCEs must resolve appeals as expeditiously as the enrollee’s health condition requires, within state established timeframes that may not exceed 30 calendar days from the day the health plan receives a standard appeal, unless extended; or 72 hours after the health plan receives an expedited appeal, unless extended. When appropriate, the enrollee’s appeal should explicitly document why a decision is needed sooner than the deadline.⁶⁰ An extension cannot occur at the request of the MCE unless two conditions are met: a need for additional information exists, and the state Medicaid agency establishes that the extension is in the enrollee’s interest.⁶¹

The MCE’s appeal resolution notices must be in writing.⁶² The written notice must include the results of the resolution process and the completion date.⁶³ If the MCE decides against the enrollee’s appeal request, the written notice must contain information about the right to request a state fair hearing and how to do so, including the right to continued benefits.⁶⁴ MCEs must maintain records of appeals, which the state Medicaid agency must review as part of its quality strategy.⁶⁵

Additionally, the State Medicaid Agency is required to maintain a fair hearing system that provides enrollees and potential enrollees with an opportunity to appeal the MCE’s decision and otherwise challenge benefit denials or delays.⁶⁶ An individual must file a request for a State hearing no later than 120 days after the date of the MCE’s notice of resolution.⁶⁷ In general, an enrollee must exhaust the plan-level MCE appeal and can request a state fair hearing only after receiving notice that the adverse benefit determination has been upheld.⁶⁸ However, there is an exception to exhaustion: if the MCE fails to adhere to the “notice and timing requirements”

contained in 42 C.F.R. § 438.408, the enrollee is deemed to have exhausted the in-plan MCE appeal process and can immediately request an impartial state fair hearing.⁶⁹ A claimant may request an expedited state fair hearing when the time otherwise permitted for a hearing could jeopardize the claimant's life, health, or function.⁷⁰

Once the State Medicaid Agency makes a decision regarding the claimant's hearing, it must issue a notice of decision.⁷¹ This notice should state the decision and, as applicable, the claimant's right to request judicial review and/or to file a discrimination complaint with relevant State and federal agencies.⁷² If the adjudicator reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the MCE must "authorize or provide" the services as expeditiously as the enrollee's health condition requires and no later than 72 hours from the date it receives the notice of reversal.⁷³ Notably, "the public" is entitled to access to all Agency hearing decisions, including those in managed care systems, after safeguards are made to protect confidential information.⁷⁴

What To Do If You're A(n)...

The next sections of this Toolkit will provide more specialized information for five different groups who may seek to implement or enforce a state's contraceptive equity law: advocates, media and communications strategists, providers, health plans, and state insurance regulators.

- The section for advocates provides strategies for reviewing managed care contracts, bringing violations to state regulators, and appealing specific denials of care;
- The section for media and communications strategists describes how to leverage print media relationships, social media, and press releases in order to amplify contraceptive advocacy;
- The section for providers will assist in understanding state coverage mandates, expanding billable contraceptive services, contributing to patient appeals, and getting involved in public advocacy;
- The section for health plans advises them to consider utilizing customer support hotlines, updating benefits lists and utilization management processes, evaluating quality measures, and integrating Contraceptive Equity into compliance programs;
- Finally, the section for state insurance regulators, both for Medicaid and private insurance, includes tips for issuing carrier guidance, checking contracts health plan information, investigating complaints, and sponsoring educational opportunities for relevant stakeholders.

Each of these groups has a crucial role to play in ensuring effective implementation of contraceptive equity laws and must ensure individuals can access the full scope of services outlined in federal and state law.

What To Do If You're an Advocate

Advocates serve as a key bridge between having laws on the books and ensuring implementation in practice. This section of the Toolkit will provide best practices for ensuring that advocates can successfully assist their clients in receiving the benefits of contraceptive coverage mandates.

Check the fine print. While the details of managed care programs vary greatly, they share one notable characteristic: reliance upon contracts to define the rights and responsibilities of managed care entities, purchasers (usually the state as the one purchasing the managed care entities' services for enrollees), and enrollees.⁷⁵ The contract is a promise for breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty.⁷⁶ As such, the managed care contract becomes an important legal document for enrollees and their advocates.

The failure of a contract to reflect the Contraceptive Equity statutory requirements may lead to denials of required services and, at the very least, delay services as the parties argue over who has responsibility for payment.⁷⁷ Advocates should obtain copies of managed care contracts in order to understand the terms of the agreement between the state and the plan.⁷⁸ It will also help advocates to understand whether the adverse benefit determination resulted from a failure of the health plan to follow the contract, or a failure of the contracting parties to incorporate the state Contraceptive Equity requirements into the underlying contract.

Unfortunately, some health plans refuse to release their contracts because of claims of proprietary information. However, when it comes to the state Medicaid managed care contracts, advocates are more likely to receive copies upon request. States will release their model contracts,

Request for Proposals (RFPs), or Request for Applications (RFAs) through a public records act request, and some states have begun posting the contracts on their Medicaid websites.⁷⁹ NHeLP collects contracts or RFPs from every state's managed care plan, and can assist advocates in obtaining them.

In addition to the contract, plans use a number of other documents that are instructive for advocates in determining whether contraceptive services are properly covered. These may include a Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC),

STATE PUBLIC RECORDS LAWS

The Reporters Committee for Freedom of the Press, a non-profit organization providing legal assistance to journalists, has compiled the [Open Government Guide](#) — a complete compendium of information on every state's open records and open meetings laws, including citations. This useful and easy to read guide is available without charge.

Summary Plan Description (SPD), Explanations of Benefits (EOBs), Schedule of Benefits (SOB), member handbook, provider manual, and insurance company website. In the Medicaid context, if plans are reluctant to provide these documents, advocates should request them from the state Medicaid agency.⁸⁰ If the agency does not readily provide these documents, most Medicaid managed care (MMC) data and information should be obtainable at the state level using requests for state public records or freedom of information acts.⁸¹ Advocates should familiarize themselves with their state's laws, since the legal requirements and procedures vary widely.⁸² Some states provide public record access to state residents only.⁸³ Thus, advocates seeking data and information on Medicaid managed care in other states may need to partner with advocates from that state.⁸⁴

Most commercial health plans and state Medicaid programs have adopted specific prescription drug utilization control devices that can provide a substantive reason for refusing to approve a claim. For example, many plans utilize a drug formulary.⁸⁵ Drugs not on the formulary are typically not covered, although a waiver process should be available for contraceptives that are medically necessary. The complexity of drug formulary design may lead to prescribing practices that do not always consider the best interests of patients.⁸⁶

Information on drug formularies is generally publicly available online for most health plans, though it varies from plan to plan.⁸⁷ For MMC plans, formularies must be made available on the plan's website, as well as in electronic or paper form.⁸⁸ The formulary must include which medications are covered, both generic and name brand, and what "tier" each medication is on (which determines the level of cost-sharing).⁸⁹

The National Health Law Program has developed a model Formulary Tool, available in [Appendix A](#), which describes each unique branded contraceptive and its therapeutically equivalent generics; at least one product from each line on the tool must be covered without cost-sharing under Contraceptive Equity laws that require coverage of all FDA-approved products beyond the methods framework. Advocates should compare the model Tool against the plan's specific formularies. Such a comparison can assist advocates in proactively finding violations, filing complaints and appeals, and possibly litigating.



MANAGED CARE CONTRACTS: A CONTRACEPTIVE ADVOCACY CHECKLIST

This checklist describes provisions that advocates should look for when they review managed care contracts and other plan documents. In answering these questions advocates should look for a “yes” answer, which indicates compliance with state Contraceptive Equity and federal Medicaid laws. If the contracts or other plans documents do not fulfill the checklist requirements, advocates can seek changes in a number of ways, including sending written comments and suggestions to the health plan and/or the state regulatory agency.

- ☐ Is the MCO prohibited from requiring prior authorization for contraceptive supplies and services?
- ☐ Is cost-sharing for contraceptive services and supplies proscribed?
- ☐ Are higher quantity limits for contraceptive drugs and devices allowed?
- ☐ Is reimbursement of OTC contraceptive drugs and devices without a prescription required?
- ☐ Is a simple process for obtaining prescription drugs not on the formulary delineated?
- ☐ Is the MCO required to inform members, including adolescents, of access to family planning services, in or out of network, without a referral?⁹⁰
- ☐ If reproductive health services are carved out, is the MCO required to inform enrollees which services are carved out and how and where they may obtain that care outside the plan’s network?
- ☐ Are MMC enrollees required to exhaust only one level of in-plan review before they can pursue a state fair hearing?
- ☐ Is an enrollee’s right to external medical review protected?
- ☐ [For provider contracts and guidance] Do the documents specify the International Classification of Diseases (ICD) diagnostic codes and Current Procedural Terminology (CPT) service codes related to reproductive health that are the responsibility of the MCE?

Send a letter outlining violations.⁹¹ Advocates may send violation(s) letters after they have reviewed the plan documents and identified an inconsistency between the contract, formulary, or other plan document, and the state Contraceptive Equity law. The letter should request that the health plan, appropriate regulatory agency, and/or the state Attorney

General take proactive steps to correct the violation before any clients or potential clients are substantively harmed. The letter will ideally contain specific language that the plan or the state can adopt in correcting the plan documents. If the violations involve the issuer's plan documents, best practice is to copy them on the letter. For a template violations letter, see [Appendix C](#).

Pursue an appeal. If an individual is denied coverage of a service or device covered by the Contraceptive Equity law, an advocate can help an enrollee file an appeal. Advocates must understand the different appeals processes for both private insurance and MMC so that they suggest the appropriate mechanism to resolve the client's issues. Some of these avenues have time limitations, so attention to deadlines is important. Advocates can help clients who need contraceptive coverage understand whether they have a right to an appeal, take steps to take to complete the appeal, and represent a client in an appeal or file an appeal on the client's behalf. Generally, a written appeal should include as much of the following information as possible:

- The enrollee's name, address, and telephone number;
- The provider's name and billing information;
- Description of the contraceptive service, procedure, drug, or device that was requested to be covered;
- Information supporting why it should be covered;
- EOB forms;
- References to the sections from the managed care contract, formulary, EOC, SPD, or other plan documents that apply to the enrollee's situation; and
- State statutory and/or regulatory citations from the Contraceptive Equity law to support that the services or supplies you want covered by the plan are required by state law.⁹²

Advocates may want to include their name and contact information as well. A template appeal letter is included in [Appendix D](#).

During the MMC appeal, some states and health plans may improperly limit the evidence to what was before the plan when the initial adverse decision was made.⁹³ Advocates should be prepared to refute this practice to ensure that it stops.⁹⁴ In addition, the state may decide to use an external medical review. In that situation, advocates will need to ensure that the health plan and state agency personnel have been trained on the regulatory prerequisites and that the review process is held to high accountability and transparency standards so that abuses do not occur.⁹⁵



THE ADVOCATE'S APPEALS CHECKLIST⁹⁶

- ☐ Counsel enrollees to keep a record of all relevant information, including dates and names of in-plan contacts;
- ☐ Advocate for policies and managed care contract provisions that contain specific requirements for timely and adequate notices, as well as uniform notice templates that are publicly available;
- ☐ Work with states and plans to ensure that handbooks and notices inform enrollees of their rights to accessible information and the means to obtain it;
- ☐ Ensure that contracts require health plans to acknowledge receipt of all grievances and appeals (including oral requests) in writing;
- ☐ Advocate with state agencies and plans to ensure that they do not improperly limit the scope of evidence admissible or the enrollee's right to external medical review on appeal;
- ☐ Advocate for contracts, policies, and procedures to provide for prompt issuance of appeal decisions and notices, with only one level of in-plan review, and to prohibit extensions of deadlines unless all regulatory prerequisites are satisfied;
- ☐ Monitor the implementation of expedited review, as quickly as the enrollee's condition requires. It is important that written policies make it clear that if the provider indicates the need for an expedited appeal, the health plan must decide the appeal expeditiously and cannot take punitive actions against the provider.

Follow up with your state regulator. Filing individual appeals and complaints is important to get help for individual enrollees. But if you encounter more widespread violations on an ongoing basis, you should consider bringing recurring issues to the state Attorney General and/or Insurance Commissioner. These offices look to consumer and provider grievances to identify and fix systemic violations, so it is important to notify them if a health plan may be acting impermissibly.⁹⁷ In any follow up, advocates should ask the regulatory agency to provide its findings and conclusions in writing.

Enrollees are not necessarily required to exhaust the appeals process before complaining to a state regulator, but the regulatory agency will likely tell complainants to do so before it will get involved. Advocates should consider modifying the template violations letter in Appendix D as the basis for this follow up complaint, as it should contain much of the same information.

If your state regulator interprets your state law incorrectly, such as allowing utilization management before plans must cover a drug or device with no therapeutic equivalent or interpreting FDA-approved contraceptives to only include those prescribed to women, you may consider working with the bill's legislative sponsor to petition the state Attorney General or state Legislative Counsel to act. Attorneys in both offices can assist the Legislature and the Governor's administration by rendering legal opinions on issues of state constitutionality and statutory interpretation. In some situations, legislators may be able to seek confidential legal opinions from these offices.

KEY TAKEAWAYS FOR ADVOCATES:

- Check the fine print of contracts and plan documents;
- Send a letter outlining violations;
- Pursue an appeal;
- Follow up with your state regulator.

What To Do If You're a Media & Communications Strategist

Leveraging media is an important tool for educating the public about compliance and putting pressure on health plans and regulators to ensure swift resolution. The media can also work in tandem with advocacy organizations by conducting surveys, online polls, and investigative or undercover work to evaluate contraceptive access. Below are tips to keep in mind when engaging in media outreach.

Develop relationships. When you establish yourself as a credible source of information, reporters may reach out to you directly. Below are some pointers:

- Reporters often work on deadlines. If you receive an email or phone message from a reporter, respond as soon as possible;
- If a reporter contacts you about an issue you are not well-versed in, connect the reporter with someone from your organization who is or refer them to another competent partner. Be sure to get the reporter's name, email, outlet and subject matter;
- You can ask if the reporter will take a written quote via email or whether you could review your quote before the story is filed. It is not a given that a reporter will allow you to approve or review quotes. Some will, but remember you are not the reporter's editor. If you cannot provide a written quote, then practice what you want to say with others in your organization before talking to a reporter.

It is important to keep in mind that *all conversations with reporters are considered on the record unless you say otherwise*. This means anything you say can be taken by the reporter and published online, a newspaper, or broadcast over the air. Do not say anything that you do not want to be made public. If, for some reason, you want to tell a reporter something that you do not want her to use publicly, preface it by saying, "This comment is off the record."

Try not to be nervous when dealing with media. Most reporters are not out to get you, and most are not experts in reproductive health or Contraceptive Equity. Reporters, especially ones who work at small-to-medium-sized outlets, often cover many different stories, which means they find themselves trying to get information about many topics in the course of a day or week. They are usually happy with any help you can give them.

Build a media list. Researching local media outlets is a must so that you build media contact lists and create relationships with the correct contacts. Start with the largest media outlets in your area, but also remember to look for alternative media forums in your area; Pacific radio is good source for progressive talk shows. If possible, we recommend a subscription to Cision – the largest commercial database of media outlets, their staff and contact information, and the quickest and smartest way to build media lists. You may also want to research ethnic media in your area depending on the composition of your state or local area.

Social media is also a great and inexpensive way to find reporters in your area and connect with them. Many local reporters and/or their outlets will have Twitter feeds and Facebook pages. Following a reporter's Twitter feed or a news outlet's Facebook page is good way to learn what the news outlets and their reporters are covering and how they are covering those topics.

Draft a press release. Press releases are issued to announce a statement, action, work product, or event from your organization. A press release might be relevant when you file a complaint or bring a series of violations of the Contraceptive Equity law to the attention of the Attorney General, Insurance Commissioner, or Medicaid director. They are designed to prompt media to do one of two things: 1) Give media quotes and information that they can take verbatim and plug into stories; or 2) Serve as an invitation for media to contact your organization for more information. Some reporters will see the press release and think, "This group has information I need for my story," and will call for fresh or more in-depth quotes. Some reporters prefer to call, ask a few questions, and get their own quotes rather than take quotes directly from the press release, but sometimes a media outlet will republish part or all of your press release as part of an article on the topic.

Publish an opinion piece. Most newspapers are now online and include guidance on their websites for writing opinion pieces, and how to submit them. An opinion piece might be relevant if you want to help influence opinion about effectively implementing a Contraceptive Equity law or sharing stories of those affected by the lack of access to contraception. Unless you know an editorial writer or editor for a selected news outlet, it is better to follow online instructions for submitting opinion pieces. If there is no public guidance for submitting commentary to opinion sections, then call the outlet and ask to speak with the newsroom or editorial ask – ask whether outside commentary is accepted, and if so what the process is.

Get to know the types of commentary your local media outlets run, and know that local bylines are usually preferred for opinion pieces. Write about issues that reporters and laypeople are aware of or should be aware of — often editorial boards like stories of people and issues that are affecting their lives. For example, an enrollee could publish a piece describing the experience of being denied EC at the pharmacy or required to come in for multiple visits or pay device costs up-front in order to receive a LARC.

Typically, opinion pieces run between 200 and 500 words; Letters-to-the-Editor typically do not run more than 250 words. Get to know the outlets before submitting them -- there is a style that must be followed. Local outlets that have limited space to share typically prefer brevity. For sample op-eds on Contraceptive Equity, see [Appendix C](#).

Utilize social media. The benefit of using social media as a communication tool is the ability to reach audiences creatively and interactively without the high costs associated with other forms of communication. Use Facebook and Twitter to leverage existing connections with other organizations, individuals, and media outlets. You should seek to re-share or amplify the work of other organizations, using their Twitter handles and tagging groups and individuals in Facebook posts. Building your connections on social media is integral, and can help your partner organizations and your own by having a large and effective online presence.

While social media is important, you should not spend inordinate amounts of time on trying to produce an image, message, or video in order for it to go “viral.” Going viral on the Internet is akin to winning the lottery, so the pursuit of going viral will lead to large amounts of wasted time. Focus on accessible messaging and remember repetition is good. It drives your point, and your messaging can catch on with other groups and individuals, further boosting your online presence and awareness of your cause. Consider spending money to boost posts on Facebook and Twitter – essentially you spend some money to have both platforms push your messages out to audiences you can tailor.

In general, unless you are launching a coordinated large-scale campaign, you do not need to make up your own hashtags. Rather, search Twitter for hashtags that are already trending. This will allow outside groups and individuals to see your messaging and become aware of your cause. Some examples of existing reproductive health and Contraceptive Equity hashtags are: #ReproHealth #ReproRights and #HandsOffMyBC. For Twitter and Facebook, consider a tool for scheduling posts, such as [Buffer](#).

Sample tweets and Facebook posts are available in [Appendix F](#).

[Facebook Live](#) is another way to use social media for live streaming of short, accessible messages. During the efforts to repeal the Affordable Care act in summer 2016, several members of Congress used Facebook Live to share short 1-minute videos of themselves explaining why repeal of ACA must be stopped. You could invite individuals denied timely contraceptive care to share their stories or you could explain why Contraceptive Equity is so critical for reproductive health.

You may also consider using images in Tweets and Facebook posts -- they are great “eye-catchers” and are often powerful ways to convey your messaging. For guidance on image sizes for both platforms, see sproutsocial’s [“Always Up-to-Date Guide to Social Media image Sizes.”](#)

KEY TAKEAWAYS FOR MEDIA & COMMUNICATIONS STRATEGISTS:

- Develop relationships;
- Build a media list;
- Draft a press release;
- Publish an opinion piece;
- Utilize social media.

What To Do If You're a Provider

As a health care provider, Contraceptive Equity laws have the potential to significantly impact your practice in a positive way. When submitting claims, you are entitled to receive payment for a much wider array of contraceptive services, such as counseling, placement, and removal for any medically appropriate contraceptive drug, device, or product. However, navigating the insurance billing process to receive such payment can be daunting given the newness of these laws. This section of the Toolkit has compiled best practices and lessons learned to help ensure providers are able to continue offering comprehensive family planning to patients who seek it.

Confirm the scope of your state's coverage mandates. Each state's Contraceptive Equity law has its own unique combination of provisions, and it is imperative that providers understand the scope of the laws in

their jurisdiction. The data in [Table 1](#) and [Appendix B](#) are a great starting place, but not sufficient for understanding the full scope of what must be covered. For example, Contraceptive Equity laws provide for access to off-formulary contraceptives if medically indicated. This process is supposed to be easily accessible, transparent, and sufficiently expedient; however, understanding this provision ahead of time allows providers to exercise due diligence and streamline the practice.

Check the model Formulary Tool.

NHeLP has developed a model Formulary Tool, available in [Appendix A](#), which describes each unique branded

contraceptive and associated therapeutically equivalent generics; at least one product from each line on the tool must be covered without cost-sharing under Contraceptive Equity laws that require coverage of all FDA-approved products beyond the methods framework. The Formulary Tool can assist providers in prescribing products for their patients that are most likely to receive full coverage.

Apply the gold standard. ACOG has stated that, as a best practice, providers should offer contraceptive methods on the same day as requested.⁹⁸ This includes offering LARC methods at the time of delivery,

REFER PATIENTS WHO RECEIVE DENIALS OF CARE TO ASSISTANCE.

If you are a provider whose patient is improperly denied a particular contraceptive or related service, consider, with the patient's consent, referring the patient to a health advocate. If you would like assistance connecting with local advocates, please email NHeLP at nhelp@healthlaw.org with "reproductive health" in the subject line.

abortion, or miscarriage, and offering the copper IUD as emergency contraception.⁹⁹ Many Contraceptive Equity laws facilitate this practice by prohibiting insurers from requiring prior authorization, step therapy, or other utilization management that hinders immediate access to a patient's contraceptive of choice. Yet even in states with these laws, some providers may still ask patients to return for LARC methods at a separate visit; this additional barrier often results in the patient not coming back to obtain contraception at all.¹⁰⁰

Receiving appropriate reimbursement and payment for LARC services provided immediately following abortion, miscarriage, or labor and delivery can be challenging. Providers need to be aware of the elements necessary to receive payment for multiple services provided to a patient on the same day and/or during the same encounter. The most universal of these elements is using CPT modifiers to receive reimbursement for all distinct services offered during a clinical visit.¹⁰¹ Below are common examples that describe the service and procedure coding that can be used for same day LARC insertion reimbursement. Note that all CPT codes must include a corresponding diagnosis code. Providers may consider consulting third-party payers before instituting these coding practices.¹⁰²

Example 1: A provider performs an abortion and LARC insertion during the same visit.

- The provider should report the abortion CPT code, LARC insertion CPT code, and LARC Healthcare Common Procedural Coding System (HCPCS) supply code;
- The provider can also add modifier 51 or 59 (depending on the payer) to the lesser procedure, typically the LARC insertion, to indicate that an additional procedure was performed at the same time as the primary procedure.¹⁰³

Example 2: A provider performs surgery to complete a miscarriage and then immediately inserts a LARC.

- The provider should report service codes for the ultrasound, surgical abortion, and LARC insertion with modifier 51 or 59, as well as the LARC HCPCS supply code;
- If the provider spent more than half of the time face-to-face with the patient counseling on contraceptive options, the provider can also report an evaluation and management (E/M) service code (a subset of CPT codes used for office related visits) with modifier 25 to indicate that this service was significant and separate from the other reported services.¹⁰⁴

Example 3: A provider counsels a patient after a complete miscarriage and inserts a LARC during the same visit.

- The provider should report an E/M service with modifier 25, plus the LARC insertion code and the LARC HCPCS supply code.¹⁰⁵

Example 4: A provider performs labor and delivery services and then immediately inserts a LARC.

- If this occurred in a state where immediate post-partum LARC is unbundled from the global labor and delivery fee, the provider should report the global obstetric care CPT code, the LARC insertion code with modifier 51 or 59, and the LARC HCPCS supply code.¹⁰⁶
- If immediate post-partum LARC is not unbundled, providers can only bill for the global fee and the HCPCS supply code.

Many government agencies and national organizations also offer educational programs for providers that can improve your ability to obtain reimbursement efficiently. CMS has developed the National Correct Coding Initiative in Medicaid to promote correct coding methodologies for Medicaid claims.¹⁰⁷ ACOG has an entire department dedicated to developing billing, coding, and payment resources, including workshops and webinars.¹⁰⁸ Additionally, the Family Planning National Training Centers and Upstream USA have helpful and comprehensive guides to support contraceptive billing.¹⁰⁹ Several state collaboratives have created toolkits to specifically support postpartum LARC implementation.¹¹⁰ These toolkits are currently available for providers in Indiana, South Carolina, Texas, Virginia, and West Virginia.¹¹¹ Additional states have issued provider bulletins, protocols, and/or coding guidance to educate providers on LARC reimbursement.¹¹²

However, keep in mind that a one-size-fits-all focus on LARCs at the exclusion of a full discussion of other contraceptive methods does not meet the gold standard.¹¹³ LARCs are an important addition to the range of options, but they are not the only option.¹¹⁴ The medical community must ensure access to and information about the full range of current methods, and not privilege LARC over other methods.¹¹⁵ Providers should reject explicit and implicit targets or goals for total numbers of LARCs inserted, which inappropriately bias the conversation between women and clinicians and can lead to coercion.¹¹⁶ The decision to obtain a LARC should be made by each person on the basis of quality counseling that helps them identify the product and timeline that will work best for them.¹¹⁷

Check your supply. Contraceptive supplies need to be in stock in order to offer them immediately. HHS' Centers for Disease Control and Prevention and the Office of Population Affairs recommend stocking a broad range of contraceptive methods, including IUDs and implants.¹¹⁸ Nonetheless, payment policies and reimbursement structures vary by plan, which may create a financial barrier. Knowing the policies for the plans in which you participate is the first step toward ensuring a proper supply.

Reimbursement varies depending on whether the contraceptive is dispensed as a part of an inpatient or outpatient visit. In the inpatient setting, a hospital orders the contraceptive device and is responsible for stocking and supply; the provider then orders the device when needed through the hospital's pharmacy system.¹¹⁹ In the outpatient setting, contraceptives can be covered by patients' health insurance plans in two ways: as a medical benefit or a pharmacy benefit. When covered as a medical benefit, a provider buys the contraceptive directly from the manufacturer or a designated pharmacy or specialty distributor. When a patient requests that contraceptive, the provider then bills the patient's insurance carrier for the product and the associated insertion procedure. This strategy is commonly described as "buy and bill," and it requires physicians and practices to closely monitor stock and insertion rates.¹²⁰

Alternatively, a contraceptive may be covered as a pharmacy benefit, also known as "white bagging."¹²¹ In that situation, a pharmacy or specialty distributor bills the patient's insurance carrier directly for the product, and the provider is not charged for the product at any point.¹²² Instead, a provider needs only to bill the patient's insurance carrier for related procedures and services (e.g. insertion of a LARC but not the LARC itself). The downside, however, is that it can take up to seven days to receive products ordered via specialty pharmacies. Additionally, if the patient does not return for insertion within a certain time, the device generally cannot be transferred to another willing patient and instead must be shipped back to the pharmacy.¹²³ Providers should consult their managed care contracts and provider manual(s) for state-specific coverage details.

Utilize pharmacies. With the exception of formal requests for prior authorization, prescription coverage and billing decisions occur "on line" and in "real time."¹²⁴ The patient will present their clinician's prescription to the pharmacist, who then enters the relevant information in the pharmacy computer.¹²⁵ The electronic claim instantly goes to the health plan or Medicaid agency's claim processor and is then electronically processed for compliance with state or managed care prescribing rules.¹²⁶ The result is an electronic response to the pharmacist indicating whether the claim will be reimbursed and, if so, at what amount.¹²⁷ If the claim is rejected, the response will include a claim rejection code, indicating the

reason for the rejection.¹²⁸ This system puts pharmacists at the front line of patient experience with insurance coverage of prescription contraception. In addition, expanding scope of practice laws allow pharmacists to serve as contraception providers in some states. Pharmacists in 11 states are authorized to dispense contraception without a physician prescription, and patients can find a participating pharmacy near them using the tool at <https://www.birthcontrolpharmacies.com/>.

Expanded scope of practice laws have the potential to increase the number of contraception providers, but they involve a change in process, specifically billing and work flow, that is not necessarily intuitive. First, credentialing is more highly scrutinized. In the 11 states mentioned above – each state board of pharmacy determines the training required for pharmacists to participate in contraception dispensing. Next, the pharmacist must apply for a National Provider Identifier (NPI), a unique number for covered health care providers that must be used in administrative and financial transactions under the Health Insurance Portability and Accountability Act (HIPAA). Finally, when dispensing, pharmacists input their NPI number and list themselves in the prescriber field, although this practice may vary if pharmacists are dispensing contraception under a physician protocol.

This new process is a potential game-changer for women and providers; nonetheless, barriers still remain, particularly in the areas of medical billing technology and insurance contracting. As illustrated above, contraception claims go through a switch system, which communicates in real time with pharmacy benefit managers, and results in a coverage determination within seconds. But one downfall of the current system is that it can only process contraceptive products that are part of a patient's pharmacy benefit; a medical benefit on the other hand, in which plans commonly place contraceptives such as depot injections, requires medical billing technology that the majority of pharmacies do not have and cannot afford.

Finally, expanded scope of practice requires pharmacists to contract with insurance companies, and calls for insurance plans to develop innovative ways to pay pharmacists for their services. In addition to a dispensing fee, pharmacists initiating contraceptive prescriptions should be compensated for counseling time. While the cost of the birth control may be covered by insurance, in most cases, the pharmacist consultation needed to get a prescription is not. This can leave women with significant out-of-pocket costs. California, for example, enacted a law in 2016 to recognize pharmacists as providers, but the bill only applies to Medi-Cal and does not require implementation until 2021. Another issue comes

from plans restricting where patients can fill prescriptions. For example, if a plan requires patients to mail order their prescriptions from a specific out-of-state company, then the pharmacist may not be recognized as a prescriber by that mail-order company and the patients will lose out on pharmacy access. Further provider advocacy is needed to realize these recommended changes in state and plan-level policy.

Contribute to appeal efforts. As the front-line communicators with carriers on authorization and continuing care for patients, providers must be prepared to identify, report, and challenge plan requirements that appear unlawful. Especially in the case of an expedited appeal of a claim denial, the health plan will look to you as a provider to determine when a situation is “urgent” and thereby must be resolved in a limited time period. A situation rises to the level of urgent care when, in your opinion as “a physician with knowledge of the claimant’s medical condition, the standard appeal timeframe would subject a claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.”¹²⁹ If a provider indicates the need for an expedited appeal, the health plan must decide the appeal expeditiously and cannot take punitive actions against the provider.¹³⁰

Providers can also file their own complaints with the state DOI or state Medicaid agency if they experience issues regarding billing and reimbursement from a health plan. Consider modifying the template complaints in [Appendices C](#) and [D](#).

Attend public meetings. A number of states hold public meetings and community forums during the development of and contracting for their state-regulated managed care programs. Specifically for Medicaid, federal law requires states to have a Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services, help develop Medicaid policies, and give ideas about how the program should be run.¹³¹ MCAC members are appointed by the Medicaid agency director and must include physicians and providers who work with low income people.¹³²

Providers should contact their state health care agencies to find out their MCAC membership and meeting times, as well as other public meetings that may be relevant.¹³³ For example, California’s managed care agency periodically hosts a family planning stakeholder meeting.¹³⁴ In addition, state health care professional boards, such as medical, pharmacy, nursing, and midwifery boards, hold open meetings that present opportunities for providers to bring implementation and compliance issues to the attention of health plans and regulators.¹³⁵ When attending these types of

meetings, ask for a copy of the group's by-laws, meeting procedures, conflict-of-interest rules, as well as the meeting agenda and minutes.¹³⁶

KEY TAKEAWAYS FOR PROVIDERS:

- Confirm the scope of your state's coverage mandates;
- Check out the model Formulary Tool;
- Refer patients who receive denials of care to assistance;
- Apply the gold standard;
- Check your supply;
- Utilize pharmacies;
- Contribute to appeal efforts;
- Attend public meetings.

What To Do If You're a Health Plan

Contraceptive access is important for health plans, not just because they may be subject to state mandates, but also because a growing body of research suggests that the long-term economic and health benefits of increased contraceptive access far outweigh any short-term costs.¹³⁷ This section provides suggestions for policy and workflow changes that health plans can adopt to further the seamless access envisioned by Contraceptive Equity laws.

Adequately fund and staff hotlines. The majority of state Medicaid managed care programs and many private health plans operate toll-free hotlines for enrollees. In general, many hotlines have not realized their full potential for providing comprehensive information about contraceptive services. In a random hotline survey in Washington, carrier representatives frequently struggled to answer or could not correctly answer specific inquiries about women's contraceptive services and benefits.¹³⁸ Hotlines should be adequately funded, staffed, and trained. A culturally and linguistically diverse staff should be knowledgeable about the various managed care programs and capable of answering contraceptive care questions accurately and promptly. Hotline representatives should have access to interpreters for individuals with limited English proficiency. Quality control should incorporate monitoring for information on contraceptive services, and a consumer advisory board and a designated state or plan administrator should review reports generated by the hotline and verify ultimate resolution of problems.¹³⁹

Include contraceptives as both medical and pharmacy benefits. More and more, pharmacists are providing comprehensive contraceptive services, including counseling and birth control injections. However, classifying various services as either medical or pharmacy creates a barrier to patients accessing contraception at the best location for them. Patients who want the convenience of getting their regular contraceptive injection at the local pharmacy are often forced to pay around \$100 out of pocket because it is not covered as a pharmacy benefit. This could be remedied by placing all contraceptive services and products on **both** the medical and pharmacy benefit lists. This change would also support consumer transparency by creating a more accurate and comprehensive picture of contraceptive services through the public-facing formulary.

Utilize the model Formulary Tool. The National Health Law Program has developed a model Formulary Tool, available in [Appendix A](#), which describes each unique branded contraceptive and associated therapeutically equivalent generics. Plans should include at least one product from each line on the tool without cost-sharing, even if the branded product has no generic. Because plans and issuers have to cover

the full range of FDA-approved contraceptives, newly approved products must be covered promptly. Health plans should track FDA movement on newly-approved products, including reformulations, and promptly update their formularies as new products are approved.

Remove medical management barriers. Eliminating all medical management and prior authorization is the best way to improve contraceptive access. If plans do retain some medical management, they must develop an expedited exceptions process for medically inadvisable generics; this is required by statute under most Contraceptive Equity laws. While many state statutes do not dictate the specifics of this exceptions process, an ideal one would avoid a complex phone call system that requires a provider to wait on hold for long periods. We recommend adopting a quick form that providers can submit online, without the need for the submission of medical evidence and provide an email response within a designated time period or deem the request approved. At least one carrier has removed all medical management for contraceptives in its Washington Qualified Health Plan (QHP), eliminating the need for a contraceptive waiver.¹⁴⁰

Evaluate your quality measures. Contraceptive care quality measures should drive access, not incentivize providers to promote particular methods. Quality measures are important and useful, when used correctly, but should also be rooted in the recognition of the histories of reproductive oppression and abuse in vulnerable communities. Coercion is a particularly acute concern for low-income women, women of color, young women, immigrant women, LGBT people, women with disabilities and mental illness, Indigenous women, and incarcerated women. Health plans should assess whether measures are contributing to coercion of enrollees toward certain methods.

The National Quality Forum (NQF) is a non-profit, non-partisan, membership-based organization that approves health quality measures and standards for care. In November 2016, NQF endorsed four contraceptive care measures:

- **Contraceptive Care: Postpartum Women (#2902)**

- *Most & Moderately Effective Methods*: measures the percentage of postpartum women provided a most or moderately effective contraceptive method within 3 and 60 days of delivery;
- *Postpartum Access to LARC*: measures the percentage of postpartum women provided a LARC within 3 and 60 days of delivery;

- **Contraceptive Care: Most & Moderately Effective Methods** (#2903): measures the percentage of at-risk women of reproductive age provided a most or moderately effective contraceptive method. Due to concerns of coercion, the intent of the measure is not to reach 100 percent compliance; it does not set a specific benchmark and should not be tied to any payment incentives;
- **Contraceptive Care: Access to LARC** (#2904): measures the percentage of at-risk women of reproductive age provided a LARC. It should not be used to encourage high rates of LARC use or in a pay-for-performance context.¹⁴¹

No single contraceptive method is right for everyone, and some concern exists that outcome-based measures may not be appropriate in the setting of a decision as complex and contextualized as the choice of a contraceptive method.¹⁴² Not only is the risk of directive counseling concerning from a reproductive autonomy perspective, but it also has the potential to be detrimental to long-term outcomes such as patient satisfaction and method continuation.¹⁴³ Women's preferences need to be paramount in the choice of a contraceptive method even if they are not consistent with the public health goal of decreasing unintended pregnancies, and a patient-centered approach to shared decision making is critical for prioritizing patient preference and preventing coercion.¹⁴⁴

Plans should be on the lookout for forthcoming contraceptive quality measures that focus on patient-reported outcomes. In 2016, the University of California at San Francisco's Person-Centered Reproductive Health Program began work on a three-year project to refine and test patient-reported outcome measures to understand patients' experiences of contraceptive counseling and inform improvements to counseling practices.¹⁴⁵ Measures such as these, that reward the quality of contraceptive care from both a patient and systems perspective while protecting women's autonomy, should be prioritized.¹⁴⁶

Publicize the appeals process. Insurers have a duty to make plan information available so that enrollees know which services are covered, and know when seeking an appeal of an adverse benefit determination is appropriate. Ongoing educational efforts should be undertaken to ensure that consumers are aware of and understand the plan- and state-level procedures at the time they enroll and at the time of a denial, reduction, or termination of services or eligibility. Member handbooks should explain all of the options.¹⁴⁷

Integrate Contraceptive Equity into your compliance program.

Compliance programs should not be a new concept. Medicaid MCOs must implement a compliance program that includes written policies and procedures, and a designated compliance officer. Compliance programs can also be beneficial for commercial and private MCOs. The purpose of a compliance program is to ensure that the health plan operates in accordance with applicable laws and regulations, including contraceptive coverage mandates.¹⁴⁸ Keeping a compliance program up-to-date can help determine issues at an early stage, and assure prompt corrective action in response to identified problems.¹⁴⁹

The three pillars of a compliance program are prevention, detection, and corrective action.¹⁵⁰ In prevention, health plans should develop written policies that provide meaningful direction to employees and contracted providers to ensure compliance with Contraceptive Equity laws. These policies should include organizational processes for dealing with compliance issues. The prevention stage also requires updating IT systems to comply with expanded coverage and decreased prior authorization for contraception. The prevention timeline may vary depending on the Contraceptive Equity law effective dates. For example, plans may need to expand the products on their formulary immediately, while they may have a longer period to make IT system changes required for approving reimbursement of a year's worth supply of contraception.

In detection, health plans should encourage compliance reporting and complaint data collection. Plans can then use reporting data to track and identify problematic trends in contraceptive reimbursement. Complaint data should be monitored, reported to the state, and utilized by the state and health plans for internal quality improvement purposes.¹⁵¹

Finally, corrective action involves investigations into the root cause of Contraceptive Equity non-compliance, and then remediation. A remediating insurer can provide immediate redress for consumer appeals, develop a systemic and thorough corrective action plan, and track corrective actions to confirm that they have been effective.

KEY TAKEAWAYS FOR HEALTH PLANS:

- Adequately fund and staff hotlines;
- Include contraceptives as both medical and pharmacy benefits;
- Utilize the model Formulary Tool;
- Remove medical management barriers;
- Evaluate your quality measures;
- Publicize the appeals process;
- Integrate Contraceptive Equity into your compliance program.

What To Do If You're a State Insurance Regulator

In every state, insurance regulators are tasked with ensuring enrollees receive efficient, effective services consistent with the law. The scope of that task may vary by regulator; for example, some states regulate all health plans, both public and private, under the same agency, while others may develop regulatory offices for each type of health plan governed by state law. The common thread among these agencies is that their enforcement efforts encourage the insurance industry to improve their practices. With that in mind, the steps outlined below highlight proactive strategies that insurance regulators can take to improve accountability for Contraceptive Equity.

Issue guidance for carrier compliance and share best practices. “All Plan Letters” (APLs) can provide clarification regarding family planning services related to contraceptive supplies, and include official policy text.¹⁵² For example, in 2016 California’s Department of Health Care Services issued an APL to all Medi-Cal managed care health plans after the state’s extended supply legislation passed.¹⁵³ The APL states that managed care plans must pay for up to thirteen cycles of contraceptives if billed by a qualified family planning provider, including a pharmacist.¹⁵⁴ It also specifies that utilization management cannot be imposed to limit the supply to less than 12 months absent clinical contraindications.¹⁵⁵ The APL is an important tool because it brings new law to the attention of plans, sets expectations for compliance, and provides a point of contact within the state regulator’s office.

Review managed care contracts. Most states require plans to submit filings with the state regulator’s office, particularly for QHPs. Consider Contraceptive Equity when reviewing and approving insurance plans, so that plans can correct violations before they are sold to the public. The National Health Law Program has developed a model Formulary Tool, available in [Appendix A](#), which describes each unique branded contraceptive and any associated therapeutically equivalent generics; at least one product from each line on the tool must be covered without cost-sharing under Contraceptive Equity laws that require coverage of all FDA-approved products beyond the methods framework, making the Tool a convenient aid for comparison against filed formularies.

Engage in market conduct review. Insurance regulators may want to conduct secret shopping or spot check calls to managed care plan’s customer service and sales representatives. Secret shopper surveys provide powerful insights into the real-life experience of enrollees and the quality of care they receive from managed care plans and providers.¹⁵⁶

TIPS FOR DESIGNING SECRET SHOPPER SURVEYS

- Develop a standard script to ask carrier representatives which contraceptive methods are covered;
- Document performance on measures such as whether the plan is covering all contraceptives without cost-sharing, and whether the coverage includes any utilization management;
- Complete the script multiple times per carrier to sample an array of representatives;
- Publish the results;
- Partner with academic institutions, local advocates, or pro bono law firms which can provide added resources to conduct secret shopper surveys and boost the profile and reach of the results.¹⁵⁷

In Washington, the Insurance Commissioner convened a meeting with advocates and plan issuers to discuss findings from an advocates' secret shopping survey.¹⁵⁸ According to the survey, no single carrier's representatives consistently said that all FDA-approved methods were covered without cost-sharing.¹⁵⁹ As a result, some carriers indicated they plan to provide training to customer services representatives.¹⁶⁰ Some carriers also agreed to revise their formularies and insurance filings with the Commissioner.¹⁶¹ In response, most health insurers in the state have clarified comprehensive contraceptive coverage options for consumers by creating informational flyers, improving information in their formularies, and adopting or simplifying their procedures for approving non-formulary contraceptives.¹⁶²

Investigate and resolve complaints. In addition to broadly publicizing the appeals process to empower individual enrollees, regulators have a duty to take action against non-compliant health care entities when they provide insufficient contraceptive coverage. After gathering consumer experience data and substantiating complaints, state regulators can:

- Require a corrective action plan from all health plans that failed to provide accurate or complete information;
- Demand information and documentation from health plans regarding their coverage and reimbursement of contraceptive drugs and devices under health insurance policies;
- Adopt sub-regulatory policy to clarify that all health plans cover the full range of FDA-approved contraceptive delivery methods at no cost-sharing and without utilization management.¹⁶³

Sponsor education and training opportunities. For Medicaid, states must ensure that MCOs have a system of training and education in place for all members of the organization. Insurance regulators should consider hosting stakeholder meetings and collecting public comments. These opportunities create a knowledge base for local advocates, providers, and health plans to greater scrutinize enrollee access to contraceptive services and providers.

KEY TAKEAWAYS FOR STATE INSURANCE REGULATORS:

- Issue guidance for carrier compliance and share best practices;
- Review managed care contracts;
- Engage in market conduct review;
- Investigate and resolve complaints;
- Sponsor education and training opportunities.

Conclusion

NHeLP developed this Toolkit, *Contraceptive Equity in Action*, to serve as a legal and policy resource for states with Contraceptive Equity laws or states considering these laws for the future. Despite the existence of state Contraceptive Equity laws, it takes time and effort for providers, health plans, and regulators to become educated about and to properly implement the expanded coverage requirements. The Toolkit is part of our continuum of contraceptive access resources, so that advocates can both enact state Contraceptive Equity laws (see [Appendix H](#)) as well as enforce them.

As states make meaningful strides toward achieving Contraceptive Equity during a time when reproductive health care is highly vulnerable at the federal level, it is more important than ever that stakeholders come together to implement their state laws. We hope that this Toolkit has proved a useful resource for doing so.

Glossary of Terms

Adverse benefit determination: The denial, reduction, suspension, termination, or delay of a service in whole or in part. It includes a denial of payment for a service; a failure to provide services in a timely manner; failure of an MCE to act within required timeframes; denial or limited authorization determinations based on requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; and a dispute involving cost-sharing, co-payments, premiums, deductibles, co-insurance, and other enrollee financial liabilities.

Affordable Care Act (ACA): The ACA is composed of two pieces of legislation – the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119 (2010)) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152, 124 Stat. 1029 (2010)).

All Plan Letter (APL): All Plan Letters provide specific guidance and information to health plans regulated by the state.

Alternative Benefit Plans (ABPs): Benefit packages offered to individuals in the new adult group authorized by the ACA, also called Medicaid Expansion. States must design these packages to cover the 10 Essential Health Benefits, but are not required to cover all other services provided to the state’s traditional Medicaid enrollees.

American College of Obstetricians and Gynecologists (ACOG): A professional organization comprised of obstetricians, gynecologists and other health care providers who specialize in women’s health. ACOG conducts research, leads advocacy efforts, and releases practice guidelines related to obstetrics and gynecology.

Appeal: A request for review of an adverse benefit determination.

Centers for Medicare & Medicaid Services (CMS): The agency within the United States Department of Health and Human Services (HHS) that is responsible for administering the Medicaid program.

Children’s Health Insurance Program (CHIP): A health insurance program that provides low-cost, comprehensive health care coverage to children from families whose incomes are too high to qualify for Medicaid, but too low to afford private

insurance. In some states, CHIP covers pregnant women as well as children. CHIP is financed jointly by federal and state governments.

Claim: Any request for benefits, including pre-service (prior authorization) and post-service (reimbursement).

Complaint: Any clear expression by an applicant or recipient, or their authorized representative, that they want the opportunity to have an adverse determination reviewed and present their case to a reviewing authority. A complaint may be brought at the plan level or at the state level.

Cost-sharing: The portion of health care expenses not covered by the insurer that the enrollee must pay. 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).

Current Procedural Terminology (CPT): Codes determined by a panel of experts at the American Medical Association that refer to the specific services that may be performed during a client's visit. CPT codes determine the reimbursement amount a provider will receive from a health plan or Medicaid agency.

Employee Retirement Income Security Act of 1974 (ERISA): A federal law that sets minimum standards for most private health plans and pension plans. These minimum standards aim to protect individuals enrolled in ERISA plans, and include requirements such as providing participants with important plan information, establishing a grievance and appeals process for participants, and giving participants the right to sue ERISA plans for benefits or breaches in fiduciary responsibilities.

Evidence of Coverage (EOC): A detailed document provided upon enrollment that describes what the plan covers and how coverage works, including cost-sharing. Some states require plans to make the EOC available to prospective enrollees upon request.

Explanation of Benefits (EOB): A statement sent by a health plan to covered individuals after utilization of insurance, explaining what medical treatments and/or services were paid for on their behalf.

Food and Drug Administration (FDA): The agency within HHS responsible for approving drugs, medical devices, and vaccines and other biologicals for sale in the U.S.

Formulary: A formulary is a list of drugs for which the plan or program will provide reimbursement when used by the enrollee for medically accepted indications.

Freedom of Choice: A provision of Medicaid (under Title XIX of the Social Security Act) that protects Medicaid enrollees' right to choose their family planning provider, as long as that provider participates in the Medicaid program. [Federal guidance](#) establishes that Medicaid programs may not exclude qualified health care providers from providing services under the program because they separately provide abortion services. This provision is also referred to as the “any willing provider” or “free choice of provider” provision.

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination. The term is also used to refer to the overall system that includes grievances and appeals handled at the MMC level and access to the State fair hearing process. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

Health insurance Marketplace: Under the ACA, some individuals have the option to purchase a qualified health plan (QHP) through a virtual health insurance Marketplace, also known as a Health Benefit Exchange. Some states have established their own Marketplaces, while others have partnered with the federal government to run a Marketplace. In states that did not set up their own state-based Marketplace or partner with the federal government, the federal government operates a federally-facilitated Marketplace (FFM) and performs all Marketplace functions in accordance with state and federal law.

Health Insurance Portability and Accountability Act (HIPAA): Federal legislation signed in 1996 that includes provisions protecting the disclosure of certain patient information. The HIPAA Privacy Rule regulates the use and disclosure of protected health information held by covered entities, including health plans and providers.

Independent review organization (IRO): Third-party organizations which provide unbiased, independent medical reviews based on medical evidence. IRO reviews aim to ensure that patients receive proper medical treatment from their clinicians and coverage from their health insurance company. Patients may request an IRO review if they receive a final decision from their insurer that the patient believes is out of compliance with state and federal laws.

International Classification of Diseases (ICD): A comprehensive list of codes, determined by the World Health Organization, that serve as the standard diagnostic tool to indicate disease, injury, symptoms, reasons for the encounter, and any factors influencing the client's health.

Long-Acting Reversible Contraception (LARC): A category of reversible contraceptive methods that includes intrauterine devices (IUDs) and the etonogestrel single-rod contraceptive implant.

Managed care entity (MCE): An entity which provides management of health care service delivery to individuals enrolled in the plan. MCEs may provide comprehensive or limited benefit packages, and may utilize risk-based or non-risk payment models as they manage the care of their enrollees. The types of federally-recognized MCEs in Medicaid include Managed Care Organizations (MCOs), Primary Care Case Management (PCCM), and Prepaid Health Plans (PHPs).

Managed care organizations (MCOs): MCOs are a type of Medicaid managed care entity which utilizes “capitated” plans, meaning that they receive a per-member-per-month payment from the state in return for providing health care services to enrollees. MCOs typically require enrollees to use a specific network of providers, and have a comprehensive risk contract with the state – they must provide inpatient hospital services and a minimum number of outpatient services.

Medicaid: A federal-state partnership public benefit program that provides health care services to millions of low-income individuals. States are not required to participate, but all states and D.C. do so. States receive significant federal funding for their programs in exchange for following the federal Medicaid statute, regulations, and other requirements.

Medicaid managed care (MMC): The system through which state Medicaid agencies contract with Managed Care Organizations (MCOs) to deliver health care services to individuals enrolled in Medicaid managed care. Medicaid MCOs are paid a capitated per member per month amount to manage and facilitate enrollees’ utilization of health care services of enrollees. Nearly three-quarters of Medicaid enrollees receive services through some type of managed care arrangement.

Medical Care Advisory Committee (MCAC): A state committee that advises the state Medicaid agency director on potential improvements to the policy surrounding, and program administration of, health and medical care services. MCACs may be comprised of a variety of appointed stakeholders, including enrollees, advocates, providers, and state officials. Each state Medicaid agency is required by federal law to have a MCAC.

Model Contraceptive Equity Act (Model Act): A piece of model legislation, written by the National Health Law Program, which aims to ensure equitable access to the full scope of contraceptive methods for both men and women in all public and private health insurance programs. The Model Act expands the range of contraceptive methods and services that are covered without cost-sharing, limits medical management (also known as utilization controls), and creates gender equity in contraceptive coverage. Since its creation, the Model Act has been used by advocates to introduce legislation in a variety of states across the country. The Model Act language can be found in [Appendix H](#) and on National Health Law Program’s [website](#).

Over-the-counter (OTC): Drugs, medical devices, and medical supplies available without a prescription. OTC contraceptive drugs include one formulation of emergency contraception (levonogestrel), spermicide, and the sponge with spermicide. OTC contraceptive devices include male and female/internal condoms.

Qualified health plan (QHP): A health insurance plan available for purchase through a health insurance Marketplace. QHPs must meet certain federal and state consumer protection requirements, including minimum scope of coverage and limits on cost-sharing.

Prepaid health plans (PHPs): PHPs are a type of Medicaid managed care entity which utilizes “capitated” plans, meaning that they receive a per-member-per-month payment from the state in return for providing health care services to enrollees. PHPs typically require enrollees to use a specific network of providers, and provide more limited services to enrollees than MCOs.

Primary care case managers (PCCMs): PCCMs are primary care providers or group practices that operate as a managed care entity and receive a per-member-per-month payment in return for locating, coordinating, and monitoring health care services. As a result, PCCMs do not have the same financial incentive as MCOs and PHPs to limit access to health care services. In addition, individuals who have PCCMs are not restricted to a specific network of specialists.

Request for Application (RFA) or Request for Proposal (RFP): Public solicitations in the competitive bidding process that describe, in detail, the requirements of the managed care entity under the managed care contract.

Schedule of Benefits (SOB): A list of the various services covered under a health plan, including the associated fees.

State Department of Insurance (DOI): The state department or agency that oversees and regulates all private insurance in the state with the aim of protecting consumers. DOIs fulfill a variety of roles, including licensing insurance companies in the state, regulating insurance policies in the state, reviewing the practices of insurance companies in the state, and helping to resolve consumer complaints.

State Department of Health (DOH): The state department or agency that oversees a variety of health programs, including public health, social services, and/or environmental protection. While some states house their state Medicaid program in their Department of Health, others may house it in another department.

State fair hearing: A complaint to the State Medicaid agency to be heard by an impartial hearing officer.

Summary of Benefits and Coverage (SBC): A short, plain-language document that the health plan must provide to potential enrollees that contains an easy-to-understand summary about a health plan's benefits and coverage.

Summary Plan Description (SPD): A document that tells ERISA-plan participants what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits becomes vested, when and in what form benefits are paid, and how to file a claim for benefits. If a plan is changed, participants must be informed, either through a revised summary plan description, or in a separate document, called a summary of material modifications.

Utilization management (UM): Sometimes called “medical” management, this set of techniques is routinely used by insurers through prior authorization, quantity limits, and step therapy (requiring trial and failure of one drug or device before another will be covered) to control the availability of covered benefits. Utilization management often conflicts with providers' clinical judgment and patient decision-making.

U.S. Department of Health & Human Services (HHS): A federal cabin-level department that aims to protect health nationwide through its programs and operating divisions, which include CMS, FDA, and HRSA.

Appendix A: Model Formulary Tool

The Model Formulary Tool below describes each unique FDA-approved contraceptive and any associated therapeutically equivalent generics. Under Contraceptive Equity laws that require coverage of all FDA-approved products beyond the methods framework (see “All Products” column in [Table 1](#)), at least one product from each line on the Tool must be covered without cost-sharing. The Tool is color-coded by contraceptive method, in alignment with the methods laid out in the FDA’s most recent [Birth Control Guide](#). It does not include sterilization methods including surgery for women and men and the sterilization implant for women (as hormonal dose, brand name, and therapeutic equivalents do not apply), but these services for women are covered under the ACA and they may be covered for men under a state Contraceptive Equity law.

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Copper IUD	n/a	n/a	n/a	n/a	Copper; Intrauterine	Paragard	n/a	contraception
IUD with Progestin	levonorgestrel	52 mg	n/a	n/a	Intrauterine	Mirena	n/a	contraception / heavy menstrual bleeding
IUD with Progestin	levonorgestrel	19.5 mg	n/a	n/a	Intrauterine	Kyleena	n/a	contraception
IUD with Progestin	levonorgestrel	13.5 mg	n/a	n/a	Intrauterine	Skyla	n/a	contraception
IUD with Progestin	levonorgestrel	52 mg	n/a	n/a	Intrauterine	Liletta	n/a	contraception
Implantable Rod	etonogestrel	68 mg	n/a	n/a	Subdermal	Nexplanon	n/a	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Shot/Injection	medoxyprogesterone	0.15 mg	n/a	n/a	Intramuscular. Vial or PFS.	Depo Provera	medoxyprogesterone acetate 150 mg/1 mL	contraception
Shot/ Injection	medoxyprogesterone	0.104 mg	n/a	n/a	Subcutaneous	Depo-SubQ Provera 104	n/a	contraception
Combined Pill	levonorgestrel	0.1 mg	ethinyl estrad-iol	20 mcg		Alesse	Aviane / Lessina / Luteria / Orsythia / Sronyx / Delyla / Vienva / Falmina / Aubra	contraception
Combined Pill	drospirenone	3 mg	ethinyl estradiol	20 mcg	Levomefolate calcium 0.451 mg (28 days)	Beyaz	Rajani	contraception / raise folate levels / acne vulgaris ≥ 14 yo / premenstrual dysphoric disorder
Combined Pill	desogestrel	0.1 mg x 7 days / 0.125 mg x 7 days / 0.15 mg x 7 days	ethinyl estradiol	25 mcg		Cyclessa	Caziant / Velivet	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Combined Pill	desogestrel	0.15 mg	ethinyl estradiol	30 mcg		Desogen	Isibloom / Julebar / Emoquette / Enskyce / Ortho-Cept / Reclipsen / Apri / Solia	contraception
Combined Pill	norethindrone	1 mg	ethinyl estradiol	20 mcg x 5 days / 30 mcg x 7 days / 35 mcg x 9 days	Ferrous fumarate 75 mg (last 7 days)	Estrostep Fe	Tri-Legest Fe / Tilia Fe / Tarina Fe	contraception
Combined Pill	norethindrone	0.4 mg	ethinyl estradiol	35 mcg	Ferrous fumarate 75 mg (last 7 days). CHEWABLE.	Femcon Fe	Wymzya Fe / Zenchent Fe / Zeosa	contraception
Combined Pill	norethindrone	0.8 mg	ethinyl estradiol	25 mcg	Ferrous fumarate 75 mg (last 4 days). CHEWABLE.	Generess Fe	Layolis FE / Kaitlib FE	contraception
Combined Pill	levonorgestrel	0.1 mg	ethinyl estradiol	20 mcg		Levlite	n/a	contraception
Combined Pill	norethindrone	1 mg	ethinyl estradiol	10 mcg x 24 days / 10 mcg x 2 days	Ferrous fumarate 75 mg (last 2 days)	Lo Loestrin Fe	Unknown Name	contraception
Combined Pill	norgestrel	0.3 mg	ethinyl estradiol	30 mcg		Lo-Ovral	Low-Ogestrel / Elinest / Cryselle	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Combined Pill	norethindrone	1.5 mg	ethinyl estradiol	30 mcg		Loestrin 1.5/30	Microgestin 1.5/30 / Gildess 1.5/30 / Junel 1.5/30 / Larin 1.5/30	contraception
Combined Pill	norethindrone	1 mg	ethinyl estradiol	20 mcg		Loestrin 1/20	Microgestin 1/20 / Gildess 1/20 / Junel 1/20 / Larin 1/20	contraception
Combined Pill	norethindrone	1 mg	ethinyl estradiol	20 mcg	Ferrous fumarate 75 mg (last 4 days)	Loestrin 24 Fe	Minastrin 24 Fe / Microgestin 24 Fe / Lomedia 24 Fe / Larin 24 Fe / Junel 24 Fe / Blisovi 24 Fe	contraception
Combined Pill	norethindrone	1.5 mg	ethinyl estradiol	30 mcg	Ferrous fumarate 75 mg (last 7 days)	Loestrin Fe 1.5/30	Microgestin Fe 1.5/30 / Gildess Fe 1.5/30 / Junel Fe 1.5/30 / Larin Fe 1.5/30	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Combined Pill	norethindrone	1 mg	ethinyl estradiol	20 mcg	Ferrous fumarate 75 mg (last 7 days)	Loestrin Fe 1/20	Microgestin Fe 1/20 / Gildess Fe 1/20 / Junel Fe 1/20 / Larin Fe 1/20 / Blisovi Fe 1/20 / Tarina Fe 1/20	contraception
Combined Pill	levonorgestrel	0.09 mg	ethinyl estradiol	20 mcg		Lybrel	Amethyst	contraception
Combined Pill	desogestrel	0.15 mg	ethinyl estradiol	20 mcg 21 days / 10 mcg last 4 days		Mircette	Kariva / Kimidess / Volnea / Violele / Pimtrea / Bekyree / Azurette	contraception
Combined Pill	norethindrone	0.5 mg	ethinyl estradiol	35 mcg		Modicon	Brevicon / Cyclofem / Necon 0.5/35 / Nortrel / Wera	contraception
Combined Pill	dienogest	2 mg (days 3-7) / 3 mg (days 8-24)	estradiol valerate	3 mg (days 1-2) / 2 mg (days 3-24) / 1 mg (days 25-26)		Natazia	n/a	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Combined Pill	levonorgestrel	0.15 mg	ethinyl estradiol	30 mcg		Nordette	Altavera / Ayuna / Kurvelo / Levora / Marlissa / Portia / Chateal	contraception
Combined Pill	norgestrel	0.5 mg	ethinyl estradiol	50 mcg		Ogestrel	n/a	contraception
Combined Pill	norethindrone	0.5 mg x 10 days / 1 mg x 11 days	ethinyl estradiol	35 mcg		Ortho Novum 10/11	Necon 10/11	contraception
Combined Pill	norgestimate	0.18 mg x 7 days / 0.215 mg x 7 days / 0.25 mg x 7 days	ethinyl estradiol	35 mcg		Ortho Tri-Cyclen	Tri-Estarylla / Tri-Mili / Tri-Linyah / Tri-Previfem / Tri-Sprintec / Trinessa	contraception / acne vulagris ≥ 15 yo
Combined Pill	norgestimate	0.18 mg x 7 days / 0.215 mg x 7 days / 0.25 mg x 7 days	ethinyl estradiol	25 mcg		Ortho Tri-Cyclen Lo	Tri Lo Sprintec / Tri Lo Estarylla / Trinessa Lo / Tri Lo Marzia	contraception
Combined Pill	norgestimate	0.25 mg	ethinyl estradiol	35 mcg		Ortho-Cyclen	Estarylla / Mili / Mono-Linyah / Previfem / Sprintec / Mononessa	contraception / acne vulagris ≥ 15 yo

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Combined Pill	norethindrone	1 mg	ethinyl estradiol	35 mcg		Ortho-Novum 1/35	Alyacen 1/35 / Cyclafem 1/35 / Dasetta 1/35 / Norinyl 1/35 / Nortrel 1/35 / Pirmella 1/35 / Necon 1/35	contraception
Combined Pill	norethindrone	1 mg	mestranol	50 mcg		Ortho-Novum 1/50	Necon 1/50	contraception
Combined Pill	norethindrone	0.5 mg x 7 days / 0.75 mg x 7 days / 1 mg x 7 days	ethinyl estradiol	35 mcg		Ortho-Novum 7/7/7	Pirmella 7/7/7 / Alyacen 7/7/7 / Dasetta 7/7/7 / Nortrel 7/7/7 / Necon 7/7/7 / Cyclafem 7/7/7	contraception
Combined Pill	norethindrone	0.4 mg	ethinyl estradiol	35 mcg		Ovcon 35	Briellyn / Gildagia / Balziva / Philith / Vyfemla / Zenchent	contraception
Combined Pill	drospirenone	3 mg	ethinyl estradiol	30 mcg	Levomefolate calcium 0.451 mg (28 days)	Safyral	Tydemy	contraception / raise folate levels
Combined Pill	norethindrone	1 mg	ethinyl estradiol	20 mcg	Ferrous fumarate 75 mg (last 4 days). Capsules.	Taytulla	n/a	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Combined Pill	norethindrone	0.5 mg x 7 days / 1 mg x 9 days / 0.5 mg x 5 days	ethinyl estradiol	35 mcg		Tri-Norinyl	Aranelle / Leena	contraception
Combined Pill	levonorgestrel	0.05 mg (6 days) / 0.075 mg (5 days) / 0.125 mg (10 days)	ethinyl estradiol	30 mcg x 6 days / 40 mcg x 5 days / 30 mcg x 10 days		Triphasil	Levonest / Myzirla / Enpresse / Trivora	contraception
Combined Pill	drospirenone	3 mg	ethinyl estradiol	30 mcg		Yasmin	Ocella / Syeda / Yaela / Zarah / Zumandimine	contraception
Combined Pill	drospirenone	3 mg	ethinyl estradiol	20 mcg		Yaz	Gianvi / Loryna / Vestura / Nikki / Melamisa / Lo-Zumandimine	contraception / acne vulgaris ≥ 14 yo / premenstrual dysphoric disorder
Combined Pill	ethynodiol diacetate	1 mg	ethinyl estradiol	35 mcg		Zovia 1/35E	Kelnor	contraception
Combined Pill	ethynodiol diacetate	1 mg	ethinyl estradiol	50 mcg		Zovia 1/50E	Unknown Name	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Combined Pill - Extended cycle	levonorgestrel	0.15 mg	ethinyl estradiol	20 mcg x 42 days / 25 mcg x 21 days / 30 mcg x 21 days / 10 mcg x 7 days		Quartette	Fayosim	contraception
Combined Pill - Extended cycle	levonorgestrel	0.15 mg	ethinyl estradiol	30 mcg		Seasonale	Quasense / Jolessa / Introvale	contraception
Combined Pill - Extended cycle	levonorgestrel	0.15 mg	ethinyl estradiol	30 mcg x 84 days / 10 mcg x 7 days		Seasonique	Amethia / Camrese / Daysee / Ashlyna	contraception
Combined Pill - Extended cycle	levonorgestrel	0.1 mg	ethinyl estradiol	20 mcg x 84 days / 10 mcg x 7 days		Lo-Seasonique	Amethia Lo / Camrese Lo	contraception
Progestin Only Pill	norethindrone	0.35 mg	None	None		Micronor	Errin / Jencycla / Heather / Camila / Jolivette / Lyza / Nor-QD / Nor-BE / Sharobel / Norlyroc / Deblitane	contraception
Patch	norelgestromin	0.15 mg	ethinyl estradiol	35 mcg/day	Transdermal	Ortho Evra	Xulane	contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Ring	etonogestrel	11.7 mcg/day	ethinyl estradiol	2.7 mcg/day	Vaginal	NuvaRing	n/a	contraception
Ring	segesteron acetate	0.15 mg/day	ethinyl estradiol	13 mcg/day	Vaginal	Annovera Not Available Yet	n/a	contraception
Diaphragm	n/a	n/a	n/a	n/a	One Size	Caya	n/a	contraception
Diaphragm	n/a	n/a	n/a	n/a	Multiple Sizes	Omniflex	n/a	contraception
Sponge with Spermicide***	n/a	n/a	n/a	n/a	n/a	Today Sponge	n/a	contraception
Cervical Cap with Spermicide	n/a	n/a	n/a	n/a	Multiple Sizes	FemCap	n/a	contraception
Female/Internal Condom***	n/a	n/a	n/a	n/a	n/a	FC2	n/a	contraception
Male Condom***	n/a	n/a	n/a	n/a	n/a	Male Condoms (various)	Various	contraception
Spermicide Alone***	n/a	n/a	n/a	n/a	n/a	Spermicide (various)	Various	contraception
Emergency Contraception***	levonorgestrel	1.5 mg	n/a	n/a	Oral	Plan B One-Step	Next Choice One Dose, Take Action, My Way, After Pill, e-Contra EZ, Fallback Solo, Anthezia Next, Her Style, Opcon One-Step, Preventeza	emergency contraception

Appendix A: Model Formulary Tool

FDA-Approved Method	Progestin	Progestin Dose (mg)	Estrogen	Estrogen Dose (µg or mcg)	Additional Ingredients / Info	Brand Name	Therapeutic Equivalents*	FDA-Approved Indications**
Emergency Contraception	ulipristal acetate (NOT a progestin)	30 mg	n/a	n/a	Oral	ella	n/a	emergency contraception

* Some products are unavailable (no longer manufactured or distributed).

** Refer to CMS-approved compendia for approved off-label indications (available at: <https://www.cms.gov/medicare-coverage-database/indexes/medicare-coverage-documents-index.aspx?MCDIndex-Type=6&mcdtypename=Compendia&bc=AgAEAAAAAAAA&>).

*** Available by prescription OR over-the-counter.

Notes:

The Tool includes FDA-approved indications for each line of unique contraceptives; however, this is not an exhaustive list. Providers and payers should always check the [Orange Book](#) and Micromedex® DRUGDEX®, the CMS compendia for the determination of medically accepted off-label indications, for the most complete and up-to-date listing. Subject to change on a daily basis. Recommend periodic monitoring for changes (e.g., monthly) or signing up for daily email alerts from FDA.

Appendix B:

State-by State Table of Contraceptive Equity Laws

State	Equity Act Name	Year of Passage	Section Number	Statutory/Regulatory Citation
California	The Contraceptive Coverage Equity Act: Senate Bill 1053	2014	2	CAL. HEALTH & SAFETY CODE § 1367.25
	Senate Bill 999 (12 months' supply)	2016	3	HEALTH & SAFETY CODE § 1367.25
Colorado	House Bill 1186	2017	1	COLO. REV. STAT. § 10-16-104.2
Connecticut	House Bill 5210	2018	11 & 12	CONN. GEN. STAT. §§ 38a-503e, 38a-530e
Delaware	Senate Bill 151	2018	1-4	Del. Code Ann. tit. 18, §§ 3342A, 3559, tit. 29, § 5203A, tit. 31 § 526
District of Columbia	The Access to Contraceptives Amendment Act: B21-0020 (12 months' supply)	2015	2	D.C. CODE § 31-3834.01
	The Defending Access to Women's Health Care Services Amendment Act: B22-0106	2018	3	D.C. CODE §§ 31-3834.01—03
Hawaii	Senate Bill 2319	2016	2-3, 5	HAW. REV. STAT. §§ 431:10A-116.6, 432:1-604.5
Illinois	The Illinois Contraceptive Coverage Act: House Bill 5576	2016	5	215 ILL. COMP. STAT. 5/356z.4
Maine	House Paper 860 – Legislative Document 1237	2017	1-3	ME. REV. STAT. ANN. tit. 24-A, §§ 2756, 2847, 4247
Maryland	The Contraceptive Equity Act: Senate Bill 848	2016	1	MD. CODE ANN., INS. § 15-826.1—2, 15-831, HEALTH-GEN. § 15-148
	House Bills 994 and 1283, and Senate Bill 774 (12 months' supply)	2018	1	MD. CODE ANN., HEALTH-GEN. § 15-148, INS. § 15-826.1

Appendix B:

State-by State Table of Contraceptive Equity Laws

State	Equity Act Name	Year of Passage	Section Number	Statutory/Regulatory Citation
Massachusetts	The ACCESS Act: House Bill 4009	2017	1-6	MASS. GEN. LAWS ch. 32A, § 28, ch. 118E, § 10J, ch. 175, § 47W, ch. 176A, § 8W, ch. 176B, § 4W, ch. 176C, § 4O
Nevada	Senate Bill 233	2017	2, 8.5, 12, 20, 27, 33, 38, 45, 54	NEV. REV. STAT. §§ 422.27172, 639.28075, 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, 695C.1696, 695C.1715
New Hampshire	Senate Bill 421	2018	8-10	N.H. REV. STAT. ANN. §§ 415:6-w, 415:18-i, 420-A:17-c
New Jersey	Assembly Bill 2297	2017	1-10	N.J. Stat. Ann. §§ 17:48-6ee, 48A-7bb, 48E-35.29, 48F-13.2, 17B:26-2.ly, 27-46.1ee, 27A-7.12, 27A-19.15, 26:2J-4.30, 52:14-17.29j
New Mexico	N/A	2010	N/A	N.M. CODE R. § 8.324.4.18
	House Bill 89	2019	1-10	N.M. STAT. §§ 59A-22-42, 59A-46-44, 13-7, 27-2, 59A-22, 59A-23, 59A-46, 59A-47
New York	N/A	2017	N/A	N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.17(a)(36)-(37), 52.18(a)(11)-(12)
	Senate Bills 659 and 1507	2019	2-5; 1-3 (Part M)	N.Y. INS. LAW §§ 3221(l)(16), 4303(cc)(1), 3216(i)(17)(E)(v), N.Y. SOC. SERV. LAW § 365-(a)(3)(d)
Ohio	House Bill 285	2016	1	OHIO REV. CODE ANN. § 4729.40
Oregon	House Bill 3343 (12 months' supply)	2015	1	OR. REV. STAT. § 743A.066
	The Reproductive Health Equity Act: House Bill 3391	2017	2	OR. REV. STAT. § 743A.067
Rhode Island	House Bill 7625 and Senate Bill 2529	2018	1-9	R.I. GEN. LAWS §§ 27-18-57, -84, 27-19-48, -76, 27-20-43, -72, 27-41-59, -89, 40-8.4-20
Vermont	House Bill 620	2016	1	VT. STAT. ANN. tit. 8, § 4099c
Virginia	The Birth Control Access Act: House Bill 2267	2017	1	VA. CODE ANN. §§ 2.2-2818.2, 38.2-3407.5:2
Washington	House Bill 1234	2017	2	WASH. REV. CODE § 48.43.195
	The Reproductive Parity Act: Senate Bill 6219	2018	2	WASH. REV. CODE § 48.43.072

Appendix C: Template Violations Letter

NOTE: State-specific terms and optional provisions are in [brackets].

Date

Name of Regulatory Agency or Health Plan
Address

RE: NON-COMPLIANT CONTRACEPTIVE BENEFITS DESIGN IN SELECT HEALTH PLANS IN [insert state]

COMPLAINANTS

Advocate's name

Advocate's address

[Insert paragraph describing the complainant advocacy organization]

PRELIMINARY STATEMENT

This letter is filed pursuant to Section [insert number(s)] of the [insert official name of your state's Contractive Equity Act], codified at [insert citation]. Section [insert number(s)] requires health plans in [insert state] to eliminate co-pays for all FDA-approved contraceptives, and strictly limit medical management, including quantity limits, prior authorization requirements, prescription requirements for over-the-counter (OTC) contraception, and gender- or sex-based limitations. The [insert name of regulatory agency] has primary responsibility for ensuring compliance with Section [insert number(s)] through investigations and enforcement action.

[Advocacy organization] conducted an analysis of the [insert relevant plan documents] for [insert type(s) of relevant health plan(s), e.g., all Medicaid managed care health plans] operating in [insert state]. The analysis found that the plans offered by [insert name of non-compliant health plan(s)] are out of compliance with state law because [insert brief description of violations].

DISCUSSION

I. [Insert state] state law contraceptive protections

The Affordable Care Act added section 2713 to the Public Health Services Act, requiring most group and individual health insurance plans, sold inside and outside of the Marketplaces, to cover a broad array of evidence-based preventive health services without cost-sharing.¹⁶⁴ Guidelines from the Department of Health and Human Services' Health Resources and Services Administration (HRSA) require coverage of "[a]ll Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."¹⁶⁵ Importantly, plans must cover these services and supplies without cost-sharing, which means that patients should not have any out-of-pocket costs, including payment of deductibles, co-payments, co-insurance, fees, or other charges.¹⁶⁶

The ACA's contraceptive coverage requirement represents a great stride forward for women, yet, it is not without challenges. The requirement itself is subject to multiple exemptions and accommodations. Additionally, the mandate is not broad enough to achieve Contraceptive Equity and gaps in coverage remain. For this reason [insert state] enacted [insert official name of state Contraceptive Equity Act] in [insert year of passage] in order to improve upon the federal provisions. Specifically, [insert official name of state Contraceptive Equity Act]: (include all that are relevant)

- Requires coverage of all FDA-approved contraceptive drugs, devices, and products. The law provides an exception for therapeutically equivalent products, so long as at least one is covered;
- Explicitly delineates coverage requirements for all related services including initial and ongoing counseling, device insertion and removal, and management of side effects;
- Strictly limits the ability of insurers to impose restrictions and delays (referred to as medical management or utilization controls);
- Prohibits prescription requirements for coverage of OTC contraceptives;
- Creates equity by eliminating cost-sharing for contraception, voluntary sterilization, and contraceptive counseling for men;
- Requires coverage of a year's worth of contraceptive supplies (13 units);
- Includes narrow exemptions. Only health plans sponsored by nonprofit religious employers, such as churches, mosques, or synagogues, are exempt.

II. [Insert state] health plans with a non-compliant contraceptive benefit design

A. [Health plan name]

(Describe in detail the inconsistencies you have found compared with the requirements under state law. Note the specific plan documents that contain the violations.)

B. (Repeat for all non-compliant health plans)

III. Optional: How [non-compliant health plan name(s)] contraceptive benefit designs compare to other health plans sold in [insert state]

The practice of [briefly describe violation(s)] is not a market norm or necessity. Other issuers have designed their plan documents to provide comprehensive contraceptive coverage without inappropriate medical management. Below are examples of plans available in [insert state] with appropriate benefit design practices:

- [Insert compliant health plan name] [describe proper practices and/or plan document language];
- (Repeat for as many compliant plans as practical. If there is no good model language available from other plans, detail specific language that the plan or the state can adopt in correcting the plan documents.)

IV. Compliance reviews and enforcement authority

[Insert regulatory agency] has primary responsibility to monitor and enforce consumer health protections under state law. The insurer appeals process does not preclude or replace enforcement by [insert regulatory agency]. Moreover, given that contraceptive inequity is often based on longstanding and pervasive benefit design customs in the insurance industry, requiring individual denials and remedies will likely prove inadequate in detecting endemic patterns of non-compliance that threaten the reproductive health of enrollees.

[Advocacy organization] requests that [insert regulatory agency name]:

1. Review drug formularies, cost-sharing structures, prior authorization requirements, and supply limits for the contraceptive care benefits in health plans offered by [insert name(s) of non-compliant health plan(s)]; and
2. Take all necessary steps to remedy the violations in [insert name(s) of non-compliant health plan(s)], including a corrective action plan.

Barriers to and treatment interruptions for family planning care can lead to serious, adverse health consequences for people of reproductive age. [Advocacy organization] strongly urges [insert regulatory agency name] to investigate non-compliant contraceptive benefit designs in [insert state] as expeditiously as possible. We are available to offer any assistance necessary to ensure that people in [insert state] get full access the contraceptive benefits provided under [insert official name of the state Contraceptive Equity Act].

Respectfully submitted,

Advocacy organization contact person signature

Advocacy organization contact person name

Advocacy organization name

Phone number

Email

Send date



Appendix D:

Template Appeal Letter

Instructions for Sending an Appeal Letter

1. Address the Letter:

- Contact the appropriate entity, be it the state Department of Insurance, the state Medicaid agency, or another entity;
- If you were given an appeal form, check the form to identify the person to whom, and the address to which, to send the appeal.

2. Complete the Letter:

- Fill in every field in the template letter below that appears in brackets and grey background (such as [this]), with the information specific to the situation;
- Provide detail related to the patient's medical history, current condition, and recommended contraception, and if relevant an explanation of why alternative methods are inappropriate;
- If the treatment is medically necessary, explain so and request that the health plan provide you with the medical criteria it uses to make determinations;
- Attach copies of all relevant documentation, e.g., receipts and charges, for the costs incurred in obtaining contraceptive care.

3. Additional Tips for Completing an External Appeals Letter:

- The proper process for filing an external appeal/external review differs by state. While some states have their own process, others contract with a federal agency. Ensure that you use the proper process for your state.

4. Create a Record of the Letter:

- Make two copies of the letter. One copy should be retained by the client/patient, and the second copy retained by any advocate who provided assistance with the appeal.

5. After You Send the Letter:

- Continue to keep copies of any documentation that shows when a health plan has refused to properly cover contraceptive care.

Template Letter

NOTE: Case-specific terms and optional provisions are in [brackets].

[URGENT/EXPEDITED] APPEAL OF CONTRACEPTIVE BENEFITS DENIAL IN [insert name of health plan]

[Date]

Re: [Patient's Name]
Insurance ID Number: [Patient's Insurance ID #]
Date of Birth: [Patient's Date of Birth]
Claim Number: [Claim # from Patient's Explanation of Benefits or Denial Letter]
(If Patient Has Already Received the Service) Date of Service: [Date Patient Received the Services That Were Denied Payment]
Provider: [Name of Doctor and/or Hospital]

To Whom It May Concern:

I am writing to appeal [name of patient's health insurance plan]'s [insert adverse benefit determination, such as denial of coverage for a contraceptive method] for [client/patient's name]. (If urgent:) [Patient's Name]'s health situation is urgent and necessitates an expedited appeal. [Patient's provider] has prescribed [patient's name] the contraception [name of contraceptive formulation]. This recommended contraceptive is appropriate for [patient's name] because [insert specific reasons why the client's recommends this contraceptive formulation for this patient.] (If possible, include/attach studies showing this contraceptive method's appropriateness.)

This appeal is filed pursuant to Section [insert number(s)] of the [insert official name of your state's Contraceptive Equity Act], codified at [insert citation]. Section [insert number(s)] requires health plans in [insert state] to eliminate co-pays for all FDA-approved contraceptives, and strictly limit medical management, including quantity limits, prior authorization requirements, prescription requirements for over-the-counter (OTC) contraception, and gender- or sex-based limitations. [State name] enacted [official name of state Contraceptive Equity Act] in [year of legislative passage] in order to improve upon the provisions of the Affordable Care Act.

The [insert official name of state Contraceptive Equity Act] requires that [patient's name]'s insurance provide coverage of [contraceptive at issue] [explain protection, such as: without cost-sharing, without prior authorization, without a prescription, with freedom to discontinue a particular method, etc.]. However, [client/patient's name] has been asked to [insert inappropriate action required by health plan]. By [insert inappropriate adverse benefit determination, such as denying coverage for a contraceptive formulation] for [client/patient's name], [name of patient's health insurance plan] appears to be violating the [official name of state Contraceptive Equity Act].

[Explain burden placed upon the client/patient.] *(If the patient has been forced to pay out of pocket, include the following:)* [Patient name] spent [total amount] out of pocket on [name of contraceptive], despite the fact that this contraceptive should have been covered without cost-sharing. Attached to this letter, you will find copies of receipts which document these expenses. I expect that [insurance carrier] will resolve this situation by ensuring that [patient's name]'s out of pocket expenses are fully reimbursed, and changing any coverage policies that do not fully comply with the [state name] [official name of state Contraceptive Equity Act] to ensure that [name of contraceptive] is covered by [name of patient's health insurance plan] in the future.

(For internal appeal:) I respectfully request a written explanation of how [name of patient's health insurance plan] does or does not comply with the [State name] [official name of state Contraceptive Equity Act].

(For external appeal:) I respectfully request that [name of health plan]'s adverse benefit determination be overturned and required to cover [denied service]. I also request a written determination as to whether [name of health plan] is in compliance with the [State name] [official name of state Contraceptive Equity Act].

If you have any questions, you can reach me at [phone # and/or email address]. *(If filing expedited appeal:)* [Because of the urgent nature of this appeal, I am aware that you may need to contact me during non-business days for additional information. During non-business days, I can be reached at {Phone #}.]

Barriers to and treatment interruptions for family planning care can lead to serious, adverse health consequences for people of reproductive age. I strongly urge [insert name of health plan or state agency] to investigate and remedy non-compliant contraceptive benefit determinations in its plan as expeditiously as possible.

Respectfully submitted,

Contact person signature
Contact person name, Title
Phone number
Email

Send date

Appendix E:

Contact for Complaints to State Insurance Regulators

Private Insurance

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link	Facebook Handle
AL	Alabama Department of Insurance	Mail, online	http://www.aldoi.gov/Consumers/FileComplaint.aspx	@AlabamaDOI	N/A	N/A
AK	Division of Insurance, Alaska Department of Commerce, Community, and Economic Development	Mail, fax, online, email	https://www.commerce.alaska.gov/web/ins/Consumers/Complaints/FileAComplaint.aspx	N/A	N/A	N/A
AZ	Arizona Insurance Department	Online	https://insurance.az.gov/consumercomplaint	@AZInsuranceDept	Facebook has a “page” that says “Arizona Department of Insurance,” but when you click on the link, it takes you to an external insurance site about the Arizona Department of Insurance.	N/A
AR	Arkansas Insurance Department	Mail, fax, online	https://www.insurance.arkansas.gov/pages/consumer-services/consumer-services/file-a-complaint/	@ARInsuranceDept	https://www.facebook.com/ArkansasInsuranceDepartment/	@ArkansasInsuranceDepartment

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link	Facebook Handle
CA	California Department of Insurance	Mail, online	http://www.insurance.ca.gov/01-consumers/101-help/	@CDInews	https://www.facebook.com/insurancecagov/	@insurancecagov
CO	Division of Insurance in the Colorado Department of Regulatory Agencies	Mail, online	https://www.colorado.gov/pacific/dora/consumer-complaint-portal	@DORAColorado	https://www.facebook.com/Dora.Colorado.gov/	@Dora.Colorado.gov
CT	Connecticut Insurance Department	Mail, online	http://www.ct.gov/cid/cwp/view.asp?q=254352	@CIDNEWS	https://www.facebook.com/CTinsurancenews	@CTinsurancenews
DE	Delaware Department of Insurance	Online	https://insurance.delaware.gov/services/filecomplaint/	@Delaware_DOI	https://www.facebook.com/DelawareInsurance	@DelawareInsurance
DC	DC Department of Insurance, Securities and Banking	Mail, fax, online, in person	https://disb.dc.gov/node/319472	@DCDISB	https://www.facebook.com/DC-Department-of-Insurance-Securities-and-Banking-87054375003/	N/A
FL	Division of Consumer Services, Florida Department of Financial Services	Email, phone, online	https://www.myfloridacfo.com/division/consumers/needourhelp.htm	@FLDFS	https://www.facebook.com/FLDFS	@FLDFS
GA	Consumer Services Division, Georgia Department of Insurance	Mail, fax, online	https://www.oci.ga.gov/ConsumerService/Home.aspx	@GA_DOI	https://www.facebook.com/georgiadoi/	@georgiadoi

Appendix E: Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link	Facebook Handle
HI	Insurance Division, Hawaii Department of Commerce and Consumer Affairs	Mail	http://cca.hawaii.gov/ins/consumers/filing_a_complaint/	@InsuranceHI	https://www.facebook.com/InsuranceHI	@InsuranceHI
ID	Consumers Affairs Section, Idaho Department of Insurance	Mail, fax, online	https://doi.idaho.gov/consumer/Complaint	@IdahoDOI	https://www.facebook.com/idahoDOI/	@idahoDOI
IL	Illinois Department of Insurance	Mail, fax, online, or by email	http://insurance.illinois.gov/Complaints/UnderstandComplaintProcess.html	@IL_Insurance	https://www.facebook.com/pages/Illinois-Department-of-Insurance/1610296122573436	N/A
IN	Indiana Department of Insurance	Mail, fax, online	https://www.in.gov/idoi/2547.htm	@INDeptInsurance	https://www.facebook.com/INDepartmentofInsurance/	@Kansas InsuranceDepartment
KY	Kentucky Department of Insurance	Mail, fax, online	http://insurance.ky.gov/static_info.aspx?static_id=1	@ppckentucky	https://www.facebook.com/KentuckyDOI/	N/A
LA	Louisiana Department of Insurance	Mail, online	https://www.lidi.la.gov/onlineservices/ConsumerComplaintForm	@LAInsuranceDept	https://www.facebook.com/lainsurancedept	@lainsurancedept
ME	Maine Bureau of Insurance	Mail, fax, online	http://www.maine.gov/pfr/insurance/complaint.html	N/A	N/A	N/A
MD	Maryland Insurance Administration	Mail, fax	http://insurance.maryland.gov/Consumer/pages/FileAComplaint.aspx	@MD_Insurance	https://www.facebook.com/MDInsuranceAdmin	@MDInsuranceAdmin
MA	Health Care Division, Massachusetts Attorney General's Office	Mail, online	https://www.mass.gov/file-an-insurance-complaint	@MassAGO	https://www.facebook.com/MassAttorneyGeneral	@MassAttorneyGeneral

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link	Facebook Handle
MI	Office of Consumer Services Michigan Department of Insurance and Financial Services	Mail, fax, email	https://www.michigan.gov/difs/0,5269,7-303-12902_12907---,00.html	@MIDIFS	https://www.facebook.com/MIDIFS/	@MIDIFS
MN	Insurance Division, Minnesota Department of Commerce	Mail, online	https://mn.gov/commerce/consumers/file-a-complaint/	@MNCommerce	https://www.facebook.com/MNCommerce/	@MNCommerce
MS	Mississippi Insurance Department	Mail, fax, online	http://www.mid.ms.gov/consumers/file-complaint.aspx	@MSInsuranceDept	https://www.facebook.com/MississippiInsuranceDepartment	@Mississippi InsuranceDepartment
MO	Missouri Department of Insurance	Mail, fax, online	https://insurance.mo.gov/consumers/complaints/index.php	@MissouriDIFP	https://www.facebook.com/MissouriDIFP	@MissouriDIFP
MT	Montana Commissioner of Securities and Insurance	Mail, fax	http://csimt.gov/insurance/complaints/	@MattRosendale	https://www.facebook.com/CommissionerMattRosendale	@Commissioner MattRosendale (Check based upon current commissioner in office.)
NE	Nebraska Department of Insurance	Mail, online	https://doi.nebraska.gov/consumer/consumer-assistance	N/A	N/A	N/A
NV	Nevada Division of Insurance	Mail, online	http://doi.nv.gov/Consumers/File-A-Complaint/	@nevadadoi	https://www.facebook.com/NevadaDivisionOfInsurance	@Nevada DivisionOfInsurance
NH	New Hampshire Insurance Department	Mail, fax, online	https://www.nh.gov/insurance/complaints/index.htm	@NHInsuranceDept	https://www.facebook.com/NHInsuranceDepartment/	@NHInsurance Department

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link	Facebook Handle
NJ	New Jersey Department of Banking and Insurance	Mail, fax, online	http://www.state.nj.us/dobi/consumer.htm#insurance	@NJDOBI	https://www.facebook.com/New-Jersey-Department-of-Banking-and-Insurance-125880464149635/	N/A
NM	New Mexico Office of Superintendent of Insurance	Online	https://www.osi.state.nm.us/ConsumerAssistance/consumercomplaint.aspx?AspxAutoDetectCookieSupport=1	N/A	https://www.facebook.com/OSINewMexico/	@OSINewMexico
NY	New York Department of Financial Services; New York Attorney General's Office	Mail, online	https://www.dfs.ny.gov/consumer/fileacomplaint.htm ; https://formsnym.ag.ny.gov/OAGOnlineSubmissionForm/faces/OAGHCHome.jsessionid=zpD-9mEMR3WfTCy0NP6C9IZHbnQIRzU7zpJGyTV!1636124734	@NYDFS @NewYorkStateAG	https://www.facebook.com/NYSDFS/ ; https://www.facebook.com/newyorkstateag/	@NYSDFS; @newyorkstateag
NC	North Carolina Department of Insurance	Mail, online	http://www.ncdoi.com/Consumer/File_a_Complaint.aspx	@NCInsuranceDept	https://www.facebook.com/NCDOI/	@NCDOI
ND	North Dakota Insurance Department	Mail	https://www.nd.gov/ndins/consumers/complaint/	@NDID	https://www.facebook.com/NDInsuranceDepartment	@NDInsurance Department
OH	Ohio Department of Insurance	Online	http://www.insurance.ohio.gov/Pages/ComplaintMain.aspx	@OHInsurance	https://www.facebook.com/OhioDepartmentofInsurance?fref=ts	@OhioDepartment ofInsurance
OK	Oklahoma Insurance Department	Mail, fax, online	https://www.ok.gov/oid/Consumers/Consumer_Assistance/File_a_Complaint.html	@oid411	https://www.facebook.com/oid411	@oid411

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link	Facebook Handle
OR	Oregon Division of Financial Regulation	Mail, fax, online	https://sbs.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=or&dswid=-9108	@OregonDCBS	https://www.facebook.com/OregonDCBS/	@OregonDCBS
PA	Pennsylvania Insurance Department	Mail, fax, online	http://www.insurance.pa.gov/Consumers/File%20a%20Complaint/Pages/default.aspx	@PAInsuranceDept	https://www.facebook.com/painsurancedepartment/	@painsurance department
RI	Rhode Island Department of Business Regulation	Online	http://www.dbr.state.ri.us/divisions/insurance/	@RIDBRInsurance	https://www.facebook.com/Rhode-Island-Department-of-Business-Regulation-405451042801225/	N/A
SC	South Carolina Department of Insurance	Mail, online	https://www.doi.sc.gov/8/Consumers	@scdoi	https://www.facebook.com/scdoi	@scdoi
SD	South Dakota Department of Labor and Regulation	Mail, online	http://dlr.sd.gov/insurance/doi_complaint.aspx	@SouthDakotaDLR	https://www.facebook.com/SouthDakotaDLR/	@SouthDakotaDLR
TN	Tennessee Department of Commerce & Insurance	Online (consumer), mail or fax (provider)	https://www.tn.gov/commerce/insurance/consumer-resources/file-a-complaint.html	@TNCommerceInsur	https://www.facebook.com/TennesseeCommerceAndInsurance	@TennesseeCommerce AndInsurance
TX	Compliance Division - Consumer Protection, Texas Department of Insurance	Mail, fax, online, email, in person	http://www.tdi.texas.gov/consumer/complfrm.html	@TexasTDI	https://www.facebook.com/TexasDepartmentofInsurance/	@TexasDepartment ofInsurance
UT	Utah Insurance Department	Online	https://insurance.utah.gov/complaint	@uidnews	N/A	N/A

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link	Facebook Handle
VT	Vermont Department of Financial Regulation	Mail, fax, online	http://www.dfr.vermont.gov/insurance/insurance-consumer/file-insurance-complaint	@VermontDFR	https://www.facebook.com/VermontDFR/	@VermontDFR
VA	Commonwealth of Virginia State Corporation Commission's Bureau of Insurance	Mail, fax, online	http://www.scc.virginia.gov/boi/complaint.aspx	@VAStateCorpComm	https://www.facebook.com/VirginiaStateCorporationCommission	
VA	Commonwealth of Virginia State Corporation Commission's Bureau of Insurance	Mail, fax, online	http://www.scc.virginia.gov/boi/complaint.aspx	@VAStateCorpComm	https://www.facebook.com/VirginiaStateCorporationCommission/	@VirginiaStateCorporationCommission
WA	Washington State Office of the Insurance Commissioner	Mail, fax, online	https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status	@WA_OIC	https://www.facebook.com/WSOIC/	@WSOIC
WV	Consumer Services Division, West Virginia Offices of the Insurance Commissioner	Mail, online	http://www.wvinsurance.gov/consumerservices/	N/A	https://www.facebook.com/wvoic	@wvoic
WI	Wisconsin Office of the Commissioner of Insurance	Mail, fax, online	https://ociaccess.oci.wi.gov/complaints/public/	@wisconsinoci	N/A	N/A
WY	Wyoming Department of Insurance	Mail, online	http://doi.wyo.gov/consumers/consumer-request-for-assistance/file-a-complaint	N/A	N/A	N/A

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Medicaid

State	Entity	Ways to Submit	Complaint Website (When possible, a specific website for complaints is listed. Otherwise, the state's general Medicaid website is listed.)	Twitter Handle	Facebook Link & Handle	Contact Information
AL	Medicaid Program Integrity Division, Alabama Medicaid Agency	Mail, phone	http://www.medicaid.alabama.gov/Contact.aspx	N/A	https://www.facebook.com/Alabama-Medicaid-Agency-141645862533621/	Mailing Address: Program Integrity Division Alabama Medicaid PO Box 5624 Montgomery, AL 36103-5624 Street/Shipping Address: 501 Dexter Avenue Montgomery, AL 36104 Medicaid's main switchboard: (334) 242-5000

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
AK	Medicaid Program Integrity, Alaska Department of Health and Social Services' Office of the Commissioner	Mail, phone, fax, email	http://dhss.alaska.gov/Commissioner/Pages/ProgramIntegrity/default.aspx	@Alaska_DHSS	https://www.facebook.com/alaska.dhss/ @alaska.dhss	Mailing Address: Department of Health and Social Services Medicaid Program Integrity 4501 Business Park Blvd., Bldg. K Anchorage, AK 99524-0249 Street Address: Alaska Department of Health and Social Services 3601 C Street #902 Anchorage, AK 99503 Phone: (907) 465-3347 Phone: (907) 269-7800 Douglas Jones Medicaid Program Integrity Manager Email: douglas.jones@alaska.gov Phone: 907.269.0361 Fax: 907.269.3460
AZ	Arizona Health Care Cost Containment System	Phone, email, online form	https://www.azahcccs.gov/ACMS/default.aspx	@AHCCCSgov	N/A	Address: 801 E Jefferson St Phoenix, AZ 85034 Phone: (602) 417-4885 Phone: (602) 417-4410 Email: CQM@azahcccs.gov

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
AR	Arkansas Division of Medical Services, Arkansas Department of Human Services	Mail, phone, fax	https://humanservices.arkansas.gov/about-dhs/dms	@ADHPIO	https://www.facebook.com/arhealthdept/ @arhealthdept	Address: Arkansas Division of Medical Services Department of Human Services Donaghey Plaza South P. O. Box 1437, Slot S401 Little Rock, AR 72203-1437 Medicaid Information Line: (800) 482-5431 Medicaid Complaint Hotline: (888) 987-1200
CA	Department of Managed Health Care (DMHC); Medi-Cal Managed Care and Mental Health Office of the Ombudsman	Mail, fax, phone, email, online form	https://www.dmhc.ca.gov/FileaComplaint/SubmittanIndependentMedicalReviewComplaintForm.aspx	@CADMHC	https://www.facebook.com/CaliforniaDMHC/ @CaliforniaDMHC	Help Center: Department of Managed Health Care 980 9th Street, Suite 500 Sacramento, CA 95814-2725 FAX: 916-255-5241 Ombudsman: Phone: 1-888-452-8609 Email: MMCDOmbudsmanOffice@dhcs.ca.gov
	Medi-Cal, California Department of Health Care Services	Mail, phone	https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx	@DHCS_CA	https://www.facebook.com/DHCS.CA/ @DHCS.CA	Member Services: 1-800-541-5555 Jennifer Kent, Director Department of Health Care Services P.O. Box 997413, MS 0000 Sacramento, CA 95899-7413 Medi-Cal Managed Care Division P.O. Box 997413, MS 4400 Sacramento, CA 95899-7413 Phone: (916) 449-5000

Appendix E: Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
CO	Ombudsman for Medicaid Managed Care	Phone, email		N/A	N/A	Phone: (303) 830-3560 (Denver Metro Area) Phone: 1-877-435-7123 (toll free) Help123@maximus.com
	Health First Colorado, Colorado Department of Health Care Policy & Financing	Mail, phone, fax, online form	https://coloradopeak.secure.force.com/HDNEW?language=EN	@CHCPCF	https://www.facebook.com/COHPCF/ @COHPCF	Colorado Department of Health Care Policy & Financing 1570 Grant Street Denver, CO 80203-1818 Phone: (303) 866-2993 Fax: (303) 866-4411
CT	Office of the Health Care Advocate	Mail, phone, fax, email	https://www.ct.gov/oha/site/default.asp	@State_of_CT_OHA	https://www.facebook.com/State-of-Connecticut-Office-of-the-Healthcare-Advocate-301102456997/	Mailing Address: Office of the Healthcare Advocate P.O. Box 1543 Hartford, CT 06144 Physical Address: 450 Capitol Avenue, 2nd floor Hartford, CT 06106 Phone: (866) 466-4446 Fax: (860) 331-2499 Email: healthcare.advocate@ct.gov
	HUSKY Health Connecticut, Connecticut Department of Social Services	Mail, phone	https://www.ct.gov/hh/site/default.asp	@HUSKYHealthCT	https://www.facebook.com/HUSKYHealthCT/ @HUSKYHealthCT	Address: 55 Farmington Avenue Hartford, CT 06105-3730 Phone: 1-877-CT-HUSKY (1-877-284-8759)

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
DE	Delaware Medicaid & Medical Assistance, Delaware Department of Health and Social Services	Mail, phone	https://www.dhss.delaware.gov/dhss/dmma/	@Delaware_DHSS	https://www.facebook.com/DelawareDHSS/ @DelawareDHSS	DHSS Herman Holloway Campus, Lewis Building 1901 N. DuPont Highway New Castle, DE 19720 Medicaid Customer Relations: (302) 571-4900, (866) 843-7212 Medicaid Health Benefits Manager: (800) 996-9969
DC	Office of Health Care Ombudsman and Bill of Rights	Mail, phone, fax, email	https://healthcareombudsman.dc.gov/	@OmbudsmanDC	https://www.facebook.com/ombudsmandc/ @ombudsmandc	One Judiciary Square 441 4th Street, NW, 900 South Washington, DC 20001 Phone: (202) 724-7491 (877) 685-6391 Fax: (202) 442-6724 (202) 535-1216 Email: healthcareombudsman@dc.gov
	DC Medicaid/Alliance, Department of Health Care Finance	Mail, phone, fax, email	https://www.dc-medicaid.com/dcwebportal/home	@DCHealthCareFin	https://www.facebook.com/DC-Department-of-Health-Care-Finance-DH-CF-142415329158066/	Address: 441 4th Street, NW, 900S Washington, DC 20001 Phone: (202) 442-5988 Fax: (202) 442-4790 TTY: 711 Email: dhcf@dc.gov

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
FL	Florida Statewide Medicaid Managed Care, Agency for Health Care Administration	Mail, email, online form	https://www.flmedicaidmanagedcare.com/home/contact https://www.flmedicaidmanagedcare.com/complaint	@AHCA_FL	https://www.facebook.com/AHCAFlorida @AHCAFlorida	Mailing address: Agency for Health Care Administration P.O. Box 5197, MS 62 Tallahassee, FL 32314 Street address: Agency for Health Care Administration 2727 Mahan Drive, MS 62 Tallahassee, FL 32308 Email: MPIComplaints@ahca.myflorida.com Telephone: 1-877-711-3662 TDD: 1-866-467-4970 Fax: 1-850-402-4678
GA	Georgia Medicaid, Georgia Department of Community Health	Mail, phone, online form	https://dch.georgia.gov/contact-dch	@GADCH	https://www.facebook.com/gadept.communityhealth/ @gadept.communityhealth	Georgia Department of Community Health 2 Peachtree Street, NW Atlanta, GA 30303 Member Services: (866) 211-0950 Customer Service/Claims Resolution: (404) 657-5468

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
HI	Medicaid Ombudsman Program	Phone, email	https://www.hilopaa.org/medicaid	N/A	N/A	O'ahu Phone: (808) 791-3467 Hawai'i Phone: (808) 333-3053 Maui & Lana'i Phone: (808) 270-1536 Moloka'i Phone: (808) 660-0063 Kaua'i Phone: (808) 240-0485 Fax: O'ahu (808) 531-3595 Email: advocate@hilopaa.org
	Med-QUEST Division, State of Hawaii Department of Human Services	Mail, phone	https://medquest.hawaii.gov/en/contact-us.html	N/A	N/A	Oahu Section 801 Dillingham Boulevard, 3rd Floor Honolulu, HI 96817-4582 East Hawaii Section 1404 Kilauea Avenue Hilo, HI 96720-4670 West Hawaii Section Lanihau Professional Center 75-5591 Palani Road, Suite 3004 Kailua-Kona, HI 96740-3633 Oahu (808) 524 – 3370 (808) 692 – 7182 Neighbor Islands 1 (800) 316 – 8005 1 (800) 603 – 1201

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
ID	Public Assistance Fraud Unit, Idaho Department of Health and Welfare	Mail, phone, email, online form	http://healthandwelfare.idaho.gov/Portals/0/Mgmt%20Services/Provider%20Fraud%20Complaint%20Form.pdf	@IDHW	https://www.facebook.com/IdahoHealthandWelfare @IdahoHealthandWelfare	Medicaid Program Integrity Unit P. O. Box 83720 Boise, ID 83720-0036 Phone: 208-334-5754 Fax: 1-208-334-2026 Email: prvfraud@dhw.idaho.gov
	Idaho Medicaid Program, Idaho Department of Health and Welfare	Mail, phone, fax, online form	https://healthandwelfare.idaho.gov/ContactUs/DirectorContact/tabid/3833/Default.aspx	@IDHW	https://www.facebook.com/IdahoHealthandWelfare @IdahoHealthandWelfare	Idaho Medicaid Program 450 W State St Boise, ID 83720 Phone: 208-334-5500 Fax: 208-334-6558
IL	Medicaid, Illinois Department of Healthcare and Family Services	Mail, phone	https://www.illinois.gov/HFS/Pages/default.aspx	N/A	https://www.facebook.com/Illinois-Department-of-Healthcare-and-Family-Services-345290005492934/	Springfield Main Office: Department of Healthcare and Family Services Prescott Bloom Building 201 South Grand Avenue, East Springfield, IL 62763 Chicago Main Office: Department of Healthcare and Family Services 401 South Clinton Chicago, IL 60607 Phone: (217) 782-1200

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
IN	Indiana Medicaid, the Family and Social Services Administration	Mail, phone, email, online form	https://www.in.gov/fssa/2404.htm	N/A	N/A	Indiana Family and Social Services Administration 402 W. Washington Street P.O. Box 7083 Indianapolis, IN 46207-7083 Office of Medicaid Policy and Planning: (317) 233-4455 Natalie Angel Director, Healthy Indiana Plan Email: Natalie.Angel@fssa.IN.gov Phone: 317-234-5547
IA	State of Iowa Office of Ombudsman	Mail, phone, email, fax	https://www.legis.iowa.gov/Ombudsman/complaints/	N/A	N/A	Office of Ombudsman Ola Babcock Miller Building 1112 East Grand Des Moines, Iowa 50319 Toll-Free: 1.888.426.6283 Phone: 515.281.3592 TTY: 515.242.5065 Fax: 515.242.6007 Email: ombudsman@legis.iowa.gov
	Medicaid, Iowa Department of Human Services	Mail, phone, fax, email, online form	https://secureapp.dhs.state.ia.us/dhs_titan_public/contactus/	N/A	N/A	Iowa Department of Human Services Hoover State Office Building 1305 E. Walnut Street Des Moines, IA 50319-0114 Iowa Medicaid Member Services (Monday to Friday from 8 a.m. to 5 p.m.) Toll-Free: 1-800-338-8366 Phone: 515-256-4606 Fax: 515-725-1351 Email: IMEMemberServices@dhs.state.ia.us

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
KS	KanCare Ombudsman	Phone, email	https://www.kancare.ks.gov/kancare-ombudsman-office/contact-us	@KDADSOOfficial	https://www.facebook.com/KDADSOOfficial/ @KDADSOOfficial	Toll-Free: (855) 643-8180 Email: Kancare.ombudsman@kdads.ks.gov
	Kansas Medical Assistance Program	Mail, phone, fax	https://www.kmap-state-ks.us/	@KDHE	https://www.facebook.com/KDHEnews/ @KDHEnews	Kansas Medical Assistance Program PO Box 3571 Topeka, KS, 66601 Phone: 1-800-766-9012 Fax: 1-785-266-6112
KY	Managed Care Oversight – Contract Management Branch	Mail, phone	https://chfs.ky.gov/agencies/dms/dpqo/mco-cmb/Pages/default.aspx	N/A	N/A	Address: 275 E. Main St. 6C-C Frankfort, KY 40621 Phone: (502) 564-9444
	Department of Medicaid Services, Kentucky Cabinet for Health and Family Services	Mail, phone	https://chfs.ky.gov/agencies/dms/Pages/default.aspx	@CHFSKy	https://www.facebook.com/kychfs/ @kychfs	Mailing Address: Department of Medicaid Services 275 E. Main St. 6W-A Frankfort, KY 40621 Phone: (502) 564-4321 Member questions: (800) 635-2570

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
LA	Health Plan Management, Compliance and Program Integrity Division of Louisiana Medicaid	Email	http://ldh.la.gov/index.cfm/page/220/n/20	@LADeptHealth	https://www.facebook.com/LaDeptHealth/ @LaDeptHealth	Michael Boutte Medicaid Deputy Director - Health Plan Management, Compliance and Program Integrity Division Email: michael.boutte@la.gov
	Louisiana Medicaid, Louisiana Department of Health	Mail, phone, fax	http://ldh.la.gov/index.cfm/page/220/n/20	@LADeptHealth	https://www.facebook.com/LaDeptHealth/ @LaDeptHealth	Mailing Address: Louisiana Department of Health P. O. Box 629 Baton Rouge, LA 70821-0629 Physical Address: Louisiana Department of Health 628 N. 4th Street Baton Rouge, LA 70802 Phone: (225) 342-9500 Fax: (225) 342-5568 Medicaid Customer Service 1-888-342-6207 TTY: 1-800-220-5404 Healthy Louisiana: 1-855-229-6848 Email: MedWeb@la.gov

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
ME	Office of Maine-Care Services and Division of Audit, Maine Department of Health and Human Services	Mail, phone, fax, email	https://www.maine.gov/dhhs/oms/	@MaineDHHS	https://www.facebook.com/mainedhhs/ @mainedhhs	Office of MaineCare Services 11 State House Station, Augusta, Maine 04333-0011 Phone: (207) 287-2674 Stefanie Nadeau Director of MaineCare Services Phone: (207) 287-2674 Department of Health and Human Services, Financial Services - Audit 221 State Street Augusta, Maine Phone: (207) 287-2403 Fax: (207) 287-2601 Email: dhhs.audit@maine.gov
MD	Medicaid, Maryland Department of Health	Mail, phone	https://mmcp.health.maryland.gov/Pages/home.aspx	@MDMedicaid	https://www.facebook.com/MarylandDHMH/ @MarylandDHMH	Maryland Department of Health 201 W. Preston Street Baltimore, MD 21201-2399 Phone: (410) 767-6500 Phone: (877) 463-3464
MA	MassHealth Agency, Executive Office of Health and Human Services	Mail, phone	https://www.mass.gov/topics/masshealth	N/A	N/A	MassHealth Customer Service Center P.O. Box 121205 Boston, MA 02112-1205 Phone: (800) 841-2900

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
MI	Medicaid, Michigan Department of Health and Human Services	Mail, phone, email	http://www.michigan.gov/medicaid	@MichiganHHS	https://www.facebook.com/michiganhhs @michiganhhs	Michigan Department of Health and Human Services 333 S. Grand Ave P.O. Box 30195 Lansing, MI 48909 Beneficiary Help Line: (800) 642-3195 Email: beneficiarysupport@michigan.gov
MN	Ombudsman for Public Managed Health Care Programs	Mail, phone, fax, email	https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/contact-us/ombudsman-managed-care-contact.jsp https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	N/A	N/A	Ombudsman for Public Managed Health Care Programs P.O. Box 64249 St. Paul, MN 55164-0249 Phone: (651) 431-2660 or (800) 657-3729 Fax: (651) 431-7472 Email: dhsombudsman.smhcp@state.mn.us Managed care county advocate: https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-6666-ENG
	Medical Assistance, Minnesota Department of Human Services	Mail, phone, fax, email	https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	@MinnesotaDHS	https://www.facebook.com/MinnesotaDHS @MinnesotaDHS	Health Services and Medical Management Division and Managed Care and Payment Policy Division PO Box 64984 St. Paul, MN 55164-0984 Phone: 651-431-2203 Fax: 651-431-7420 Email: DHS.info@state.mn.us Email: dhs.healthcare-providers@state.mn.us

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
MS	Mississippi Division of Medicaid, Office of the Governor	Mail, phone, fax, online form	https://medicaid.ms.gov/wp-content/uploads/2017/04/General-Inquiry-Form.pdf	@MSMedicaid	https://www.facebook.com/msmedicaid/ @msmedicaid	Mississippi Division of Medicaid 550 High Street, Suite 1000 Jackson, MS 39201 Phone: 601-359-6050 (800) 421-2408 General Fax: (601) 359-6294 Provider Beneficiary Relations Fax: (601) 359-4185
MO	Missouri Medicaid Audit and Compliance	Mail, phone, online form	https://mmac.mo.gov/contact-us/	@DSS_Missouri	https://www.facebook.com/MOSocialServices/ @MOSocialServices	Missouri Medicaid Audit and Compliance PO Box 6500 Jefferson City, MO 65102-6500 Phone: (573) 751-3399
	MO HealthNet, Family Support Division of Missouri Department of Social Services	Mail, phone, fax	https://dss.mo.gov/mhd/	@DSS_Missouri	https://www.facebook.com/MOSocialServices/ @MOSocialServices	Missouri Department of Social Services Family Support Division P.O. Box 2320 Jefferson City, MO 65102-2320 Phone: (573) 751-3221 Fax: (573) 751-3091 MO HealthNet Division 615 Howerton Court PO Box 6500 Jefferson City, MO 65102-6500 Phone: (573) 751-3425 MO HealthNet Managed Care Enrollment Helpline: 1-800-348-6627 (TTY: 771)

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
MT	Montana Medicaid, Montana Department of Public Health and Human Services	Mail, phone, fax, email	https://dphhs.mt.gov/	@DPHHSMT	https://www.facebook.com/MTDPHHS/ @MTDPHHS	<p>Street Address: Montana Department of Public Health and Human Services 111 North Sanders Helena, MT 59601</p> <p>Mailing Address: Sheila Hogan, Director of DPHHS PO Box 4210 Helena, MT 59604-4210</p> <p>Phone: (406) 444-5622 Fax: (406) 444-1970 Email: sheilahogan@mt.gov</p> <p>Medicaid Member Help Line: 1-800-362-8312</p>
NE	Nebraska Medicaid Program, Nebraska Department of Health and Human Services	Mail, phone	http://dhhs.ne.gov/medicaid/pages/med_medindex.aspx	@NEDHHS	https://www.facebook.com/NEDHHS/ @NEDHHS	<p>Street Address: Nebraska Department of Health & Human Services 301 Centennial Mall South Lincoln, NE 68509</p> <p>Mailing Address: Nebraska Department of Health & Human Services P.O. Box 95026 Lincoln, NE 68509-5026</p> <p>Phone: (402) 471-3121</p>

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
NV	Nevada Medicaid, Division of Health Care Financing and Policy, Nevada Department of Health and Human Services	Mail, phone	http://dhcfp.nv.gov/	@DhhsNevada	https://www.facebook.com/nvhealthandhumanservices/ @nvhealthandhumanservices	Mailing Address: Nevada Medicaid Central Office 1100 East William St. Suite 102 Carson City, NV 89701 Phone: (877) 638-3472 Phone: (775) 684-3600 Nevada Medicaid Customer Service P.O. Box 30042 Reno, NV 89520-3042
NH	Quality Assurance Unit of Bureau of Improvement & Integrity, New Hampshire Department of Health and Human Services	Mail, phone, fax, online form	https://www.nh.gov/health/feedback.shtml	@NHDHSESU	https://www.facebook.com/NHDepartmentOfHealthAndHumanServices/ @NHDepartmentOfHealthAndHumanServices	Mailing Address: Quality Assurance Unit New Hampshire Department of Health & Human Services 129 Pleasant Street, Room 386 Concord, NH 03301 Quality Assurance and Improvement Fax: (603) 271-8194 Telephone (603) 271-9238 Toll Free: (800) 852-3345, ext. 9238 Fax: (603) 271-7100 Street Address: 129 Pleasant Street, Room 386 Concord, NH 03301

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
NH	New Hampshire Medicaid, New Hampshire Department of Health and Human Services	Mail, phone	https://www.dhhs.nh.gov/ombp/medicaid/	N/A	https://www.facebook.com/NHDepartmentOfHealthAndHumanServices @NHDepartmentOfHealthAndHumanServices	New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3852 Medicaid Program: (603) 271-4344 Medicaid Business & Policy: (603) 271-4344 Fax: (603) 271-8431
NJ	Medicaid Fraud Division of the Office of the State Comptroller	Mail, phone, fax, online form	https://www.state.nj.us/comptroller/divisions/medicaid/complaint.html	@NJComptroller	https://www.facebook.com/NJComptroller/ @NJComptroller	State of New Jersey Office of the State Comptroller 4th Floor Medicaid Fraud Division 20 West State Street Trenton, NJ 08625 Medicaid Fraud Division's Phone: 609-826-4700 Fax: 609-826-4801
	NJ Medicaid, Division of Medical Assistance & Health Services, State of New Jersey Department of Human Services	Mail, phone, online form	https://www.nj.gov/health/feedback.shtml	@NJDHS	https://www.facebook.com/NJDHS/ @NJDHS	Mailing Address: State of New Jersey Department of Health P. O. Box 360 Trenton, NJ 08625-0360 New Jersey Medicaid: 1-800-356-1561

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
NM	New Mexico Medicaid/Centennial Care, Medical Assistance Division of the New Mexico Human Services Department	Mail, phone, email, fax, online form	http://www.hsd.state.nm.us/submit-a-comment.aspx	@NMHSD	https://www.facebook.com/NMHSD/ @NMHSD	NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504-2348 HSD Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504-2348 Call: (505) 827-3100 Toll free: 1-888-997-2583 Fax: (505) 827-3185 Email: MADInfo.HSD@state.nm.us Email: HSD-SubmitAComment@state.nm.us Medical Assistance Division Customer Service Hot Line: (888) 997-2583
NY	Division of Managed Care and Division Quality and Evaluation	Mail, phone, email	https://www.health.ny.gov/health_care/managed_care/contact/index.htm	@HealthNYGov	https://www.facebook.com/NYSDOH/ @NYSDOH	NYSDOH Office of Health Insurance Programs Managed Care OHIP DHPCH - One Commerce Plaza, Room 1609 New York State Department of Health Albany, New York 12237-0094 Complaint help/quality of care: 1-800-206-8125 Medicaid Managed Care: 1-800-505-5678 Email: omcmail@health.state.ny.us

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
NY	Medicaid, New York State Department of Health	Mail, phone, email	https://www.health.ny.gov/health_care/medicaid/	@HealthNYGov	https://www.facebook.com/NYSDOH/ @NYSDOH	New York State Department of Health Corning Tower Empire State Plaza, Albany, NY 12237 Medicaid Consumer Helpline: 1-800-541-2831 (518) 486-9057 Email: medicaid@health.ny.gov Email: medicaid@health.state.ny.us
NC	Medicaid, NC Division of Health Benefits, North Carolina Department of Health and Human Services	Mail, phone	https://www.ncdhhs.gov/assistance/medicaid	@ncdhhs	https://www.facebook.com/ncdhhs/ @ncdhhs	Mailing Address: NC Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501 DMA Main Office Street Address: 1985 Umstead Drive Raleigh NC 27603-2001 DMA Main Office Phone: 919-855-4100 DHHS Customer Service: 1-800-662-7030

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
ND	Surveillance and Utilization Review (SUR) Section, North Dakota Department of Human Services	Mail, phone, email, fax, online form	https://apps.nd.gov/itd/recmgmt/rm/stFrm/efrms/Doc/sfn00020.pdf	N/A	N/A	<p>Mailing Address: Fraud, Waste and Abuse Administrator c/o Medical Services Division of North Dakota Department of Human Services 600 E Boulevard Ave Dept 325 Bismarck ND 58505</p> <p>Phone 1-800-755-2604 Phone: (701) 328-4024 Fax: (701) 325-1544 Email: medicaidfraud@nd.gov</p> <p>Medical Services Division: Telephone: (701) 328-7068 Toll-free: (800) 755-2604 ND Relay TTY: (800) 366-6888 or 711 Fax: (701) 328-1544 Email: dhsmed@nd.gov</p>
OH	Ohio Department of Medicaid	Mail, phone	https://www.medicaid.ohio.gov/	@OHMedicaid	N/A	<p>Ohio Department of Medicaid 50 West Town Street, Suite 400 Columbus, Ohio 43215</p> <p>Ohio Medicaid Consumer Hotline: 800-324-8680</p>
OK	Oklahoma Department of Human Services' Office of Inspector General	Mail, fax, phone, email	http://www.okdhs.org/Pages/default.aspx	@OKDHS	https://www.facebook.com/OklahomaDHS @OklahomaDHS	<p>Mailing Address: DHS Office of Inspector General P.O. Box 25352 Oklahoma City, OK, 73125</p> <p>Fax: (405) 522-4642</p> <p>Fraud hotline: (800) 784-5887</p> <p>Email: OIGFraud2@okdhs.org</p>

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
OK	SoonerCare, Oklahoma Health Care Authority	Mail, phone	http://www.okhca.org/	@oksoonercore	https://www.facebook.com/oksoonercore/ @oksoonercore	Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105 Phone: (405) 522-7300
OR	Oregon Health Plan, Oregon Health Authority, Office of Health Policy; Oregon Health Policy Board	Mail, phone, fax, email	https://www.oregon.gov/oha/hsd/ohp/pages/index.aspx	@OHAOregon	https://www.facebook.com/OregonHealthAuthority/ @OregonHealthAuthority	Oregon Health Authority 500 Summer Street, NE, E-20 Salem, OR 97301-1097 OHP Customer Service: 1-800-699-9075 OHP Client Services at 1-800-273-0557 Fax: 503-378-5628 Email: OHA.DirectorsOffice@state.or.us Oregon Health Policy Board: Phone: 503-947-2340 Toll Free: 800-375-2863 Fax: 503-947-2341 Email: HealthPolicyBoard.Info@state.or.us

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
PA	Medical Assistance, Office of Medical Assistance Programs, Pennsylvania Department of Human Services	Mail, phone, online form	https://nws.pennsylvania.egov.com/forms/dhs/feedbackform	@PAHumanServices	https://www.facebook.com/PAHumanServices/ @PAHumanServices	Mailing address: Department of Public Welfare Office of Medical Assistance Programs P.O. Box 2675 Harrisburg, PA 17105 Physical address: Pennsylvania Department of Health Health and Welfare Building 8th Floor West 625 Forster Street Harrisburg, PA 17120 Phone: 1-866-550-4355
RI	Medicaid, Executive Office of Health and Human Services (EOHHS)	Mail, phone	http://www.eohhs.ri.gov/Consumer/ConsumerInformation.aspx	@RIHumanServices	https://www.facebook.com/Rhode-Island-Department-of-Human-Services-1468332880081090/	Department of Human Services Louis Pasteur Building 57 Howard Avenue Cranston, RI 02920 RI Executive Office of Health and Human Services 3 West Road Cranston, RI 02920 HealthSource RI: 1-855-840-4774 EOHHS Phone: (401) 462-5274 Fax: (401) 462-3677 EOHHS Office of Program Integrity: (401) 462-6503

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
SC	Bureau of Compliance and Performance Review	Mail, phone	http://dss.sd.gov/contactus/	@scmedicaid	https://www.facebook.com/SCMedicaid/ @SCMedicaid	Bureau of Compliance and Performance Review P.O.Box 8206 Columbia, SC 29202-8206 Program Integrity Medicaid Fraud and Abuse Hotline: 1-888-364-3224. Division of Audits (803) 898-8881
	Healthy Connections (Medicaid), South Carolina Department of Health and Human Services	Mail, phone, email	https://www.scdhhs.gov/	@scmedicaid	https://www.facebook.com/SCMedicaid/ @SCMedicaid	SCDHHS P. O. Box 8206 Columbia, SC 29202-8206 Phone: (888) 549-0820 TTY: (888) 842-3620 Email: info@scdhhs.gov
SD	Medicaid, the Department of Social Services' Division of Economic Assistance	Mail, phone, online form	http://dss.sd.gov/contactus/	N/A	N/A	South Dakota Department of Social Services 700 Governors Drive Pierre, SD 57501 Phone: (605) 773-3165

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
TN	Office of Inspector General, Department of Finance and Administration	Mail, phone, online form	https://www.tn.gov/content/dam/tn/finance/documents/news-documents/reportproviderfraud.pdf	@TNDeptofFandA	https://www.facebook.com/financeandadministration/ @financeandadministration	Mailing address: State of Tennessee Department of Finance and Administration Office of Inspector General Post Office Box 282368 Nashville, TN 37228 Office of Inspector General's main phone: (615) 687-7200 Fraud Toll Free Hotline: 1-800-433-3982
	Division of TennCare	Mail, phone, email, online form	https://help.tn.gov/tn	@TNHumanServices	https://www.facebook.com/tennesseedepartmentofhumanservices @tennesseedepartmentofhumanservices	TennCare 310 Great Circle Rd. Nashville, TN 37243 Phone: 1-800-342-3145 TTY or TDD Phone: 1-877-779-3103 Email: Tenn.Care@tn.gov
	TennCare Advocacy Program	Phone, email, online form	http://www.tenncareadvocacy.com/index.php/contact-tenn-care-form	N/A	N/A	Call 1-800-758-1638 TTY 1-877-779-3103

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State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
TX	Health and Human Services Office of the Ombudsman (Medicaid Managed Care Ombudsman)	Phone, online form	https://hhs.texas.gov/about-hhs/your-rights/office-ombudsman/hhs-ombudsman-managed-care-help	N/A	N/A	Phone: 866-566-8989
	Medicaid, Texas Health and Human Services Commission	Mail, phone	https://hhs.texas.gov/services/health/medicaid-chip	@TexasHHSC	https://www.facebook.com/TexasHHSC/ @TexasHHSC	Mailing Address: Texas Health and Human Services (HHS) P.O. Box 13247 Austin, TX 78711-3247 Street Address: Texas Health and Human Services (HHS) Brown-Heatly Building 4900 N. Lamar Blvd. Austin, TX 78751-2316 Phone: (512) 424-6500 TTY: (512) 424-6597

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
UT	Division of Medicaid and Health Financing Constituent Services Representative, Utah Department of Health	Mail, phone, email, fax, online form	https://medicaid.utah.gov/concern-or-complaint	@UtahDepOfHealth	https://www.facebook.com/UtahDepOfHealth/ @UtahDepOfHealth	<p>Mailing Address: Utah Department of Health Division of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106</p> <p>Physical Address: Utah Department of Health Martha S. Hughes Cannon Building 288 North 1460 West Salt Lake City, UT</p> <p>For member concerns or complaints, contact the Division of Medicaid and Health Financing Constituent Services Representative: (801) 538-6417 or 1-877-291-5583 or Email medicaidmemberfeedback@utah.gov Fax: (801) 538-6805</p>
VT	Office of the Health Care Advocate (HCA)	Phone	https://vtlawhelp.org/health	N/A	N/A	Phone: 1-800-917-7787
	Medicaid, Green Mountain Care, Department of Vermont Health Access	Mail, phone, fax	https://www.greenmountaincare.org/	@DVHAVermont	N/A	<p>Green Mountain Care Health Access Member Services Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1010 Phone: 1-800-250-8427 Phone: 802 879-5900 Fax: 802 879-5651</p>

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
VA	Department of Medical Assistance Services	Mail, phone, email	http://www.dmas.virginia.gov/#/index	@VaMedicaidDir	https://www.facebook.com/coverva/ @coverva	Department of Medical Assistance Services Attn: Director's Office 600 East Broad Street Richmond, VA 23219 Phone: 804-786-7933 TDD: 800-343-0634 Recipient Helpline: 1-804-786-6145 Managed Care Helpline: 1-800-643-2273 Email: DMASinfo@dmas.virginia.gov
WA	Program Integrity Unit, Washington State Health Care Authority	Mail, phone, fax, email	https://www.hca.wa.gov/	@waDSHS	https://www.facebook.com/WaStateDSHS @WaStateDSHS	Street address: Program Integrity Cherry Street Plaza 626 8th Avenue SE Olympia, WA 98501 Mailing address: Program Integrity PO Box 45503 Olympia, WA 98504-5503 Phone: (360) 725-1750 Fax: (360) 586-0212 Email: programintegrity@hca.wa.gov

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
WA	Apple Health, Washington State Health Care Authority	Mail, phone, email	https://fortress.wa.gov/hca/plcontactus/Client_WebForm	@WA_Health_Care	https://www.facebook.com/WAHealthCareAuthority @WAHealthCareAuthority	Cherry Street Plaza 626 8th Avenue SE Olympia, WA 98501 Medical Assistance Customer Service Center (MACSC) Phone: 1-800-562-3022 Email: askmedicaid@hca.wa.gov
WV	Office of Inspector General, West Virginia Department of Health and Human Resources	Mail, phone, fax	https://dhhr.wv.gov/Pages/default.aspx	N/A	N/A	State Capitol Complex Building 6, Room 817-B Charleston, WV 25305 Phone: (304) 558-2278 Fax: (304) 558-1992
	Bureau for Medical Services, West Virginia Department of Health & Human Resources	Mail, phone, fax, email	https://dhhr.wv.gov/bms/Pages/contact.aspx	@WV_DHHR	https://www.facebook.com/wv.dhhr/ @wv.dhhr	Bureau for Medical Services West Virginia Department of Health & Human Resources 350 Capitol Street, Room 251 Charleston, WV 25301 Phone: (304) 558-1700 Susan L. Hall Director of Managed Care Phone: (304) 558-1700 Fax: (304) 558-4398 Email: Susan.L.Hall@wv.gov

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Contact for Complaints to State Insurance Regulators

State	Entity	Ways to Submit	Complaint Website	Twitter Handle	Facebook Link & Handle	Contact Information
WI	Wisconsin BadgerCare Plus or Medicaid SSI HMO Ombudsmen	Mail, phone	https://www.dhs.wisconsin.gov/publications/p1/p12002.pdf	@DHSWI	https://www.facebook.com/DHSWI/ @DHSWI	BadgerCare Plus or Medicaid SSI HMO Ombudsmen P.O. Box 6470 Madison, WI 53716-0470 Phone: (800) 760-0001
	BadgerCare Plus in the Wisconsin Department of Health Services	Mail, phone, email	https://www.dhs.wisconsin.gov/badgercareplus/index.htm	@DHSWI	https://www.facebook.com/DHSWI/ @DHSWI	Department of Health Services 1 West Wilson Street Madison, WI 53703 General phone number: 608-266-1865 TTY phone number: 711 or 800-947-3529 BadgerCare Plus Member Services: 1-800-362-3002 BadgerCare Plus Member Services: memberservices@wisconsin.gov Office of the Inspector General Phone: (608) 266-2521
WY	Medicaid, Wyoming Department of Health	Mail, phone, fax	https://health.wyo.gov/contact/	N/A	N/A	Wyoming Medicaid 6101 Yellowstone Road, Ste. 210 Cheyenne, WY 82009 Phone: (307) 777-7531 Fax: (307) 777-6964

Appendix F: Sample Social Media

Hashtags to use:

#ReproRights #ReproHealth #HandsOffMyBC

Sample Tweets:

- #ReproRights are #HumanRights. ALL individuals deserve access to contraceptive care -- w/out the red tape. Fight for #ReproHealth
- I support access to affordable contraception because my partner and I couldn't risk having a child [while working XX hours week, in graduate school, etc.]. #ReproHealth #ReproRights
- Families deserve the autonomy to have a child when they choose. I support affordable contraception for everyone! #ReproHealth #HandsOffMyBC
- Contraception is a part of basic health care, and access to #ReproHealth is under attack. #HandsOffMyBC
- Access makes all the difference. #ReproRights make sure that all individuals have access to affordable contraception of their choice!
- I shouldn't have to choose between paying [off my student loans, my car/house payment/rent, my childcare services] or paying for contraceptives. Free contraception is one of my #ReproRights #HandsOffMyBC
- Free contraception is the law. @[your state's insurance department, commissioner, politicians, etc.] where are my #ReproRights? #HandsOffMyBC

Sample Facebook Posts:

- I am looking to the [@your state's Department of Insurance page] for answers. [Your state's] Contraceptive Equity Act promises free contraception for all individuals in our state. We are not seeing that in [your state]. It is time that we enforce the law and give [your state's constituents] their #ReproRights. Fight for contraception for all!
- [Your state's constituents] are paying for their birth control, but they should not have to. Contraceptive care is one of our #ReproRights and should be free to everyone. Fight for your #ReproRights and get your #HandsOffMyBC! @[your state's insurance department, commissioner, politicians, etc.] Enforce our state's Contraceptive Equity Act and give us access to contraception in [your state]!

Appendix G: Sample Op-Eds

From a legislator's perspective:

[Catchy title that might be specific to the legislator, such as:]
The heavy lifting is done. It's time to implement Contraceptive Equity.

[The following should be edited based upon personal experiences.]
As a representative of the people of [your state], I have worked to ensure that the people of [your state] have access to affordable contraception. That is why our legislature worked tirelessly to enact [your state's Contraceptive Equity act]. It is now the law, yet the people of our state are still facing barriers. Clinicians are unable to provide timely services. Individuals are expected to appeal to their insurance companies just to access birth control. It is time to implement and enforce this legislation; there is no excuse.

Far too many of my constituents are either going without contraception or are being put in a financial hardship due to high costs of their contraceptive care. Delaying the enforcement of [our Contraceptive Equity act] is hurting the people of our state.

I write this for [insert name if relevant],
[Share stories that resonate with you, here are a few ideas!]
A mom with 2 kids. She works 2 part-time jobs and runs the risk of losing her income if she becomes pregnant again. She knows she wants an IUD, but the doctor requires that she come back for multiple visits. With mouths to feed at home and constantly changing shift-work, she cannot make the scheduling work. She should not have to risk becoming pregnant due to administrative hoops!

A woman who needs an emergency contraceptive. When she gets to the pharmacy, it is outrageously priced. The pharmacist tells her that she needs a prescription before insurance will pay. It's called an emergency contraceptive for a reason--there is no time to visit the doctor, but paying out of pocket is not feasible.

A young professional. She has finally become financially independent, paying off her loans, signing a new lease, and making her car payments. She has a medical

condition and has to use birth control that doesn't have a generic option. It costs \$100/month, and her insurance isn't covering it. Now, she has to appeal to her insurance company, prolonging this financial burden.

I wish I could write the testimony of every individual in [my state] in order to illustrate how integrally important contraceptive care is. Instead I will say this: we wrote affordable, accessible, and hassle-free contraception into law for a reason. It is not fair to be punished for avoiding an untimely pregnancy, and the onus of arguing with insurance companies should not be on patients.

I am calling on our state's administration. To Governor ____, please contact the [Department of Insurance, Bureau of Insurance, Insurance Commissioner ____, etc.]. It is our job as lawmakers to write policies into law. It is yours to enforce them.

From a client's perspective:

[Catchy title that might be specific to the story of the client, such as:]

*Getting birth control should be hassle-free.
Why am I waiting and paying? Who is to blame?*

[Tell your personal story, or that of your daughter, friend, etc. Here is an example:]

Every month, I drive 20 minutes into town to get to the pharmacy and pick up my birth control. Between my daily commute and my work hours, I can't make it to the pharmacy before they close. I have to schedule picking up my prescriptions on my rare days off, which is risky to say the least. With the hassle of getting to my pharmacy, it's hard to pick up my prescription on time each month, which puts me at risk of getting pregnant.

I talked to my pharmacist, and she said I could get a year's worth of my birth control at once! That would save me time, money, and, needless to say, a whole lot of stress. But when she ran it through my insurance -- they denied it.

We have been promised free, easy access to contraception. Our state's [Contraceptive Equity Act] guaranteed our right to birth control without the burden. It was supposed to take away all of these hoops we have to jump through in order to get contraceptive services, but that is not happening. Why is my insurance company not following the laws of [your state]?

Who is not doing their job? I am asking an open question to our governor and legislature, to [Insurance Administrators: the Utah Insurance Department, the Washington State Insurance Commissioner, etc.], and to [my insurance provider: UnitedHealthCare, Aetna, State Medicaid, etc.]: why am I paying for birth control at the pharmacy counter [or an IUD at the gynecologist, receiving a bill for contraceptives etc.]? Why do I have to stay on hold for hours with the insurance company to get the coverage I am entitled to?

I need answers. My patience is thinning. My wallet is emptying. It is time to give the people of [my state] the contraception they have been promised.

Appendix H:

Model Contraceptive Equity Act

**NOTE: State-specific terms and optional provisions are in [brackets].*

The Contraceptive Equity Act of 2019

SECTION 1.

The Legislature hereby finds and declares all of the following:

- (a) [name of state] has a long history of expanding timely access to birth control to prevent unintended pregnancy.
- (b) The federal Patient Protection and Affordable Care Act includes a contraceptive coverage guarantee as part of a broader requirement for health insurance to cover key preventive care services without out-of-pocket costs for patients.
- (c) The Legislature intends to build on existing state and federal law to promote gender equity and sexual and reproductive health, and to ensure greater contraceptive coverage equity and timely access to all federal Food and Drug Administration approved birth control drugs, devices, and products, and related services, for all individuals covered by [health care service plan contracts] in [name of state].
- (d) Medical management techniques such as denials, step therapy, or prior authorization in public and private health care coverage can impede access to the most effective contraceptive methods.
- (e) Many insurance companies do not typically cover male methods of contraception or they require high cost-sharing despite the critical role men play in the prevention of unintended pregnancy.

SECTION 2.

- (a) Requirements for a [Health Care Service Plan].
 - (1) A [health care service plan] contract, except for a [specialized health care service plan contract], that is issued, amended, renewed, effective or delivered [on or after January 1, 2020], shall provide coverage for all of the following:

- (A) All FDA-approved contraceptive drugs, devices, and other products, including those prescribed by the covered person's provider or as otherwise authorized under state or federal law. This includes all FDA-approved over-the-counter contraceptive drugs, devices, and products. The following apply:
 - (i) If the FDA has designated a therapeutic equivalent of an FDA-approved prescription contraceptive drug, device, or product, the [health care service plan] must include either the original FDA-approved prescription contraceptive drug, device, or product or at least one of its therapeutic equivalents. If there is no therapeutic equivalent, the [health care service plan] must include the original.
 - (ii) If the covered contraceptive drug, device, or product is deemed medically inadvisable by the covered person's provider, the [health care service plan] shall defer to the determination and judgment of the attending provider and provide coverage for an alternate prescribed contraceptive drug, device, or product.
 - (iii) This coverage must provide for the single dispensing of a 13-unit supply of [prescription] contraceptives intended to last over a 12-month duration, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider. The [health care service plan] shall reimburse a health care provider or dispensing entity per unit for furnishing or dispensing an extended supply of [prescription] contraceptives.
 - (B) Voluntary sterilization procedures;
 - (C) Patient education and counseling on contraception; and
 - (D) Follow-up services related to the drugs, devices, products, and procedures covered under this section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.
- (2) A [health care service plan] subject to this section:
- (A) Shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this section, unless the health plan is offered as a qualifying high-deductible health plan for a health savings account. For such a qualifying high-deductible health plan, the carrier shall establish the plan's cost-sharing for the coverage provided pursuant to this section at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from his or her health savings account under 26 U.S.C. § 223; and
 - (B) Shall not require a prescription to trigger coverage of over-the-counter contraceptive drugs, devices, and products, approved by the federal food and drug administration.
 - (C) [This subsection does not apply to grandfathered health plans.]

- (3) Except as otherwise authorized under this section, a [health care service plan] shall not impose any restrictions or delays on the coverage required under this section.
- (4) Benefits for an enrollee under this section shall be the same for an enrollee's covered spouse [or domestic partner] and covered nonspouse dependents.
- (b) Religious Employers. A religious employer may request a [health care service plan] contract without coverage for FDA approved contraceptive methods used for contraceptive purposes that are contrary to the religious employer's religious tenets. If so requested, a [health care service plan] contract shall be provided without coverage for contraceptive methods. Every religious employer that invokes the exemption provided under this subsection shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.
- (c) Nothing in this section shall be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within his or her scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.
- (d) Nothing in this section shall be construed to deny or restrict in any way [the department's] authority to ensure compliance with [insert cite to any relevant state law] when a [health care service plan] provides coverage for contraceptive drugs, devices, and products.
- (e) Nothing in this section shall be construed to require a [health care service plan] contract to cover experimental or investigational treatments.
- (f) Definitions. For purposes of this section, the following definitions apply:
- (1) "Grandfathered health plan" has the meaning set forth in Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.
 - (2) With respect to [health care service plan] contracts issued, amended, or renewed on or after [January 1, 2019], "provider" means an individual who is certified or licensed pursuant to [insert state licensing provisions referencing any medical professional with prescriptive authority including medical professionals, pharmacists, emergency medical personnel, etc. under state law].
 - (3) Except for subsection (a)(4), ["health care service plan"] has the meaning set forth in [relevant state law] and shall include Medicaid [and CHIP] managed care plans that contract with the State [insert single state agency and relevant referencing statutes].
 - (4) A "religious employer" is an organization that is organized and operates as a nonprofit entity and is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.
 - (5) A "specialized health care service plan" is a plan that does not provide comprehensive services such as a dental-only plan or a vision-only plan.
 - (6) A "therapeutic equivalent" has the meaning set forth by the Food and Drug Administration.

Endnotes

- ¹ Kaiser Fam. Found., *State and Federal Contraceptive Coverage Requirements: Implications for Women and Employers* (2018), <http://files.kff.org/attachment/Issue-Brief-State-and-Federal-Contraceptive-Coverage-Requirements-Implications-for-Women-and-Employers> [hereinafter Kaiser Fam. Found., *State and Federal Contraceptive Coverage Requirements*]; U.S. Equal Employment Opportunity Commission, <https://www.eeoc.gov/policy/docs/decision-contraception.html> (last visited Dec. 17, 2018); 42 U.S.C. 2000e(k).
- ² Kaiser Fam. Found., *State Requirements for Insurance Coverage of Contraceptives*, <https://www.kff.org/other/state-indicator/state-requirements-for-insurance-coverage-of-contraceptives/?activeTab=map¤tTimeframe=0&selectedDistributions=state-requirements-for-prescription-contraception&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Dec. 17, 2018).
- ³ OHIO REV. CODE ANN. § 1751.01(A)(1)(h); VA. CODE ANN. § 2.2-2818(B)(5); 13 WYO. CODE R. § 7(c)(ii)(B).
- ⁴ 42 U.S.C. §§ 1396d(a)(4)(C), 1396a(a)(10); 42 C.F.R. § 447.56(a)(2)(ii) (prohibiting imposition of cost-sharing for family planning services and supplies). States do not have to cover family planning services and supplies for individuals who qualify for Medicaid due to their status as medically needy. See also 42 U.S.C. § 1396o(a)(2)(d).
- ⁵ 42 C.F.R. § 440.230(b); CMS, *State Medicaid Manual* § 4270.B.
- ⁶ 42 C.F.R. § 438.210(a)(3)(iii) (allowing plans to place limits on services for the purpose of utilization control so long as the services furnished can reasonably be expected to achieve their purpose), 438.201(b)-(d) (establishing requirements for prior authorization processes).
- ⁷ 42 U.S.C. § 300gg-13 (ACA § 1001, adding § 2713 of the Public Health Services Act).
- ⁸ *Id.* § 300gg-13(a)(4). Grandfathered plans—those that existed on March 23, 2010 and have not changed substantially—do not have to comply with the requirement until they lose their grandfathered status. See 42 U.S.C. § 18011; 45 C.F.R. §§ 147.130(d), 147.140(c). This allowance for grandfathered plans “is temporary, intended to be a means for gradually transitioning employers into mandatory coverage.” *Gilardi v. U.S. Dep’t of Health & Human Servs.*, 733 F.3d 1208, 1241 (D.C. Cir. 2013) (Edwards, J., concurring in part, dissenting in part).
- ⁹ Health Res. and Servs. Admin., *Women’s Preventive Services Guidelines*, <https://www.hrsa.gov/womens-guidelines-2016/index.html> (last visited Nov. 13, 2018) [hereinafter Health Res. and Servs. Admin., *Women’s Preventive Services Guidelines*].
- ¹⁰ 42 U.S.C. § 300gg-13(a); 45 C.F.R. § 147.130(a)(1).
- ¹¹ 42 C.F.R. § 440.347(a); 45 C.F.R. §§ 156.115(a)(4), 147.130(a)(1)(iv).

- ¹² Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,838 (Oct. 13, 2017), <https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21852.pdf> (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147) [hereinafter Moral Exemptions]; Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792 (Oct. 13, 2017), <https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21851.pdf> (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147) [hereinafter Religious Exemptions].
- ¹³ 45 C.F.R. § 147.131(a).
- ¹⁴ Religious Exemptions, *supra* note 12.
- ¹⁵ Moral Exemptions, *supra* note 12; Religious Exemptions, *supra* note 12.
- ¹⁶ Religious Exemptions, *supra* note 12.
- ¹⁷ California v. U.S. Dep’t Health & Human Servs., No.17-cv-05783-HSC, 281 F. Supp. 3d 806 (N.D. Cal. Dec. 21, 2017), <http://hr.cch.com/hrw/CaliforniavHHSNDCal12212017.pdf>; Pennsylvania v. Trump, No. 17-cv-4540, 281 F. Supp. 3d 553 (E.D. Pa. Dec. 15, 2017), <http://hr.cch.com/hrw/CommonwealthofPennsylvaniavTrumpEDPenn12152017.pdf>.
- ¹⁸ Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592 (Nov. 15, 2018), <https://www.federalregister.gov/documents/2018/11/15/2018-24514/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable>; Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536 (Nov. 15, 2018), <https://www.federalregister.gov/documents/2018/11/15/2018-24512/religious-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the>.
- ¹⁹ Pennsylvania v. Trump, No. 17-cv-4540 (E.D. Pa. Jan. 14, 2019), <https://www.aclu.org/legal-document/ed-pa-injunction-blocking-bc-rule-1-14-19>. A Ninth Circuit judge also issued a preliminary injunction but it applies only to the parties of the case (California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maryland, Minnesota, New York, North Carolina, Rhode Island, Vermont, Virginia, and Washington). California v. U.S. Dep’t Health & Human Servs., No.17-cv-05783-HSC (N.D. Cal. Jan. 13, 2019), <https://affordablecareactlitigation.files.wordpress.com/2019/01/file0.0894215591635081.pdf>.
- ²⁰ 45 C.F.R. § 147.131(b)-(c).
- ²¹ *Id.* § 147.131(c). A number of non-profit entities that currently qualify for an accommodation have claimed that the accommodation process itself violates their rights under the Constitution and the Religious Freedom Restoration Act because it requires them to facilitate a third-party’s payment for contraception. See, e.g., Geneva Coll. v. U.S. Dep’t of Health & Human Servs., Nos. 13-3536, 14-1374, 14-1376, 14-1377 slip. op. (3d Cir. Feb. 11, 2015).
- ²² 134 S. Ct. 2751 (2014).

- ²³ U.S. Dep'ts of Labor, Health & Human Servs., & Treasury, *Frequently Asked Questions about Affordable Care Act Implementation (Part XXVI)*, at 4-6 (2015), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvi.pdf> [hereinafter FAQs about ACA Implementation (Part XXVI)]. The FDA has approved the following 18 contraceptive methods for women: (1) sterilization surgery; (2) surgical sterilization implant; (3) implantable rod; (4) copper IUD; (5) IUD with progestin; (6) shot/injection; (7) combined oral contraceptives; (8) progestin only oral contraceptives; (9) extended/continuous use oral contraceptives; (10) patch; (11) vaginal contraceptive ring; (12) diaphragm with spermicide; (13) sponge with spermicide; (14) cervical cap with spermicide; (15) female condom; (16) spermicide alone; (17) Plan B./Plan B One Step/Next Choice emergency contraception; and (18) ella emergency contraception. See Food & Drug Admin., Office of Women's Health, Birth Control Guide, <https://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM517406.pdf> (last visited May 30, 2018).
- ²⁴ FAQs about ACA Implementation (Part XXVI) at 4.
- ²⁵ *Id.* See also U.S. Dep'ts of Labor, Health & Human Servs., & Treasury, *Frequently Asked Questions about Affordable Care Act Implementation (Part XII)*, at Q14 (2013), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf> [hereinafter FAQs about ACA Implementation (Part XII)].
- ²⁶ 45 C.F.R. § 147.130(a)(4).
- ²⁷ For more information about medical management, see Erin Armstrong, Nat'l Health Law Program, *Medical Management and Access to Contraception* (2013), <http://www.healthlaw.org/publications/medical-management-and-access-to-contraception#>.
- ²⁸ FAQs about ACA Implementation (Part XII), *supra* note 25.
- ²⁹ FAQs about ACA Implementation (Part XXVI), *supra* note 23.
- ³⁰ *Id.* at 4. A provider's determination that a particular contraceptive product is medically necessary "may include considerations such 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." *Id.*
- ³¹ Am. Coll. of Obs. & Gyns., *Brand Versus Generic Oral Contraceptives* (2007), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co375.pdf?dmc=1&ts=20180830T1751484333>.
- ³² FAQs about ACA Implementation (Part XXVI), *supra* note 23, at 4.
- ³³ Brian T. Nguyen et al., *Putting the Man in Contraceptive Mandate*, 89 CONTRACEPTION: INT'L REPROD. HEALTH J. 3 (2014), [https://www.contraceptionjournal.org/article/S0010-7824\(13\)00641-0/abstract](https://www.contraceptionjournal.org/article/S0010-7824(13)00641-0/abstract).
- ³⁴ *Id.*; FAQs about ACA Implementation (Part XII), *supra* note 25, at Q15-16.
- ³⁵ Kaiser Fam. Found., *State and Federal Contraceptive Coverage Requirements*, *supra* note 1.
- ³⁶ 42 C.F.R. §§ 438.108, 447.56(a)(2)(ii); Kaiser Fam. Found., *Medicaid Coverage of Family Planning Benefits: Results from a State Survey* (Sep. 2016), <http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey>.
- ³⁷ ChangeLab Solutions, *Fundamentals of Preemption* (Sept. 2013), http://changelabsolutions.org/sites/default/files/Fundamentals_Preemption_FS_FINAL_20130911.pdf.

- ³⁸ *Id.*
- ³⁹ Johns Hopkins Bloomberg School of Public Health, Preemption, <https://www.jhsph.edu/research/centers-and-institutes/center-for-law-and-the-publics-health/research/preemption.html> (last visited Nov. 13, 2018).
- ⁴⁰ See Georgetown University Center for Children and Families, *Children's Health Insurance Program* (Jan. 2017), <https://ccf.georgetown.edu/wp-content/uploads/2017/08/Slide1.jpg>.
- ⁴¹ CMS, CCIO, *Internal Claims and Appeals and the External Review Process Overview* (Apr. 2018), <https://marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf> [hereinafter CCIO Claims, Appeals, and External Review Overview].
- ⁴² *Id.*
- ⁴³ *Id.*
- ⁴⁴ 42 U.S.C. § 300gg-19; 45 C.F.R. § 147.136.
- ⁴⁵ Center on Budget and Policy Priorities, *Marketplace Appeals Process* (Feb. 2018), http://www.healthreformbeyondthebasics.org/wp-content/uploads/2018/02/Webinar-OE5-2018-02-28_NHeLP_Marketplace-Appeals-Process.pdf.
- ⁴⁶ CCIO Claims, Appeals, and External Review Overview, *supra* note 41.
- ⁴⁷ *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970). See also 42 U.S.C. § 1396a(a)(3) (providing for a hearing for individuals whose claims for medical assistance under the plan are denied or not acted upon with reasonable promptness).
- ⁴⁸ *Goldberg*, 397 U.S. at 267; 42 U.S.C. § 1396u-2(a)(1)(A)(i), (b)(4); 42 C.F.R. §§ 431.210–431.240, 438.400–438.424; Jane Perkins, Nat'l Health Law Prog., *Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems* (May 2016), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2016/05/2016_05_2016_Issue_Brief_2_MMC_Regs_Grievance_Appeals.pdf [hereinafter NHeLP MMC Final Rule].
- ⁴⁹ Wayne Turner et al., Nat'l Health Law Prog., *A Guide to Oversight, Transparency, and Accountability in Medicaid Managed Care* (March 2015), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2015/03/2015_03_17_NHeLP_ManagedCareAccountabilityGuide-1.pdf [hereinafter NHeLP Guide to Accountability].
- ⁵⁰ Disability Rights Educ. & Def. Fund, *Advocates' Guide to Accessibility in Medicaid Managed Care Grievances and Appeals* (June 2018), <https://dredf.org/wp-content/uploads/2018/07/Advocates-Guide-to-Accessibility-in-Medicaid-Managed-Care-Appeals.pdf> [hereinafter DREDF Advocates' Guide]; 42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. § 438.400(a)(3).
- ⁵¹ 42 C.F.R. § 438.404; Medicaid & CHIP Payment & Access Comm'n, *Federal Requirements and State Options: Appeals* (July 2018), <https://www.macpac.gov/wp-content/uploads/2018/07/Federal-Requirements-and-State-Options-Appeals.pdf>.
- ⁵² 42 C.F.R. § 438.404.
- ⁵³ NHeLP MMC Final Rule, *supra* note 48.
- ⁵⁴ *Id.*; 42 C.F.R. § 438.402.
- ⁵⁵ 42 C.F.R. § 438.402; NHeLP MMC Final Rule, *supra* note 48.
- ⁵⁶ 42 C.F.R. § 438.406(b)(2).
- ⁵⁷ *Id.* § 438.406; NHeLP MMC Final Rule, *supra* note 48.

- ⁵⁸ 42 C.F.R. § 438.402(b)(4).
- ⁵⁹ *Id.* § 438.402(b)(5).
- ⁶⁰ NHeLP MMC Final Rule, *supra* note 48.
- ⁶¹ *Id.*
- ⁶² 81 Fed. Reg. 27,636 (May 6, 2016) (“We remind managed care plans that any necessary translation or alternative formats must be completed in a manner that does not impede the enrollee’s ability, or reduce the enrollee’s time, to request continuation of benefits....”).
- ⁶³ 42 C.F.R. § 438.408; NHeLP MMC Final Rule, *supra* note 48.
- ⁶⁴ 42 C.F.R. at § 438.408(e).
- ⁶⁵ *Id.* § 438.416.
- ⁶⁶ DREDF Advocates’ Guide, *supra* note 50; 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.220, 438.408(f)(1). State Fair Hearings are available when an individual’s claim for assistance is denied or not acted upon promptly. 42 U.S.C. § 1396a(a)(3). Other grievances, e.g., complaints about quality of care or interpersonal relationships with providers, do not trigger fair hearing rights. *Id.*
- ⁶⁷ 42 C.F.R. §§ 431.221(d), 438.408(f)(2).
- ⁶⁸ *Id.* § 438.402; NHeLP MMC Final Rule, *supra* note 48.
- ⁶⁹ 42 C.F.R. § 438.402(c)(1)(i)(A) (called deemed exhaustion in the final rule).
- ⁷⁰ *Id.* § 431.224(a) (2017).
- ⁷¹ *Id.* § 431.245.
- ⁷² *Id.* §§ 431.244(d)–(e), 431.245; DREDF Advocates’ Guide, *supra* note 50.
- ⁷³ 42 C.F.R. § 438.424; NHeLP MMC Final Rule, *supra* note 48.
- ⁷⁴ 42 C.F.R. § 431.244(g).
- ⁷⁵ Jane Perkins, Nat’l Health Law Prog., *Model Medicaid Managed Care Contract Provisions – A Primer on Medicaid Managed Care Contracting*, <https://healthlaw.org/resource/model-medicare-managed-care-contract-provisions-a-primer-on-medicare-managed-care/> (last visited Dec. 17, 2018) [hereinafter NHeLP Model MMC Contract].
- ⁷⁶ *Id.*
- ⁷⁷ *Id.*
- ⁷⁸ Sarah Somers, Nat’l Health Law Prog., *Health Advocate: Medicaid Managed Care* (Sept. 2012), <https://healthlaw.org/resource/health-advocate-medicare-managed-care/>.
- ⁷⁹ NHeLP Model MMC Contract, *supra* note 75.
- ⁸⁰ NHeLP Guide to Accountability, *supra* note 49.
- ⁸¹ *Id.*
- ⁸² *Id.*
- ⁸³ E.g., the Virginia Freedom of Information Act provides that “all public records shall be open to inspection and copying by any citizens of the Commonwealth,” but it grants no such right to non-Virginians. Va. Code Ann. §2.2–3704(A).
- ⁸⁴ NHeLP Guide to Accountability, *supra* note 49.

- ⁸⁵ Jane Perkins & Sarah Somers, Nat'l Health Law Prog., Issue Brief: *Obtaining Information About Medicaid Prescription Drug Denials Prepared by the NHeLP Sunshine and Accountability Project* (Feb. 2010), https://9kqpww4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/Obtaining_Information_About_Medicaid_Prescription_Drug_Denials.pdf [hereinafter NHeLP Sunshine and Accountability Project].
- ⁸⁶ The Kennedy Forum, *A Consumer Guide to Drug Formularies: Understanding the Fundamentals of Behavioral Health Medications* (Aug. 2017), https://chp-wp-uploads.s3.amazonaws.com/www.paritytrack.org/uploads/2017/08/170824-KF-Consumer-Guide-Drug-Form-Issue-Brief-0817_4.pdf.
- ⁸⁷ *Id.* See also, e.g., Anthem BlueCross BlueShield, *National Drug List* (Oct. 2018), https://fm.formularynavigator.com/FBO/143/National_5_Tier_ABCBS.pdf.
- ⁸⁸ 42 C.F.R. § 438.10(h)(4).
- ⁸⁹ *Id.*
- ⁹⁰ In private plans, out-of-network services must be fully covered if there is no available in-network provider. In MMC plans, enrollment in a managed care plan cannot restrict the choice of family planning services providers to in-network providers, and federal regulations require states to provide information to enrollees on how to obtain family planning services outside the managed care network. 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. §§ 431.51(b)(2), 438.10(f)(6)(vii).
- ⁹¹ Jane Perkins & Wayne Turner, Nat'l Health Law Prog., *NHeLP and The AIDS Institute Complaint to HHS Re HIV/AIDS Discrimination by Florida Insurers* (May 2014), <https://9kqpww4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2014/05/HIV-OCR-complaint-5-29-14-Final.pdf>.
- ⁹² The Kennedy Forum, FAQ Sections, <https://www.parityregistry.org/faq/> (last visited Nov. 13, 2018).
- ⁹³ NHeLP MMC Final Rule, *supra* note 48.
- ⁹⁴ *Id.*
- ⁹⁵ *Id.*
- ⁹⁶ *Id.*
- ⁹⁷ Legal Action Center, *Red Flags Companion* (2018), <https://lac.org/wp-content/uploads/2018/02/Red-Flags-Companion.pdf>.
- ⁹⁸ Am. Coll. of Obs. & Gyns., *Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy* (Oct. 2015), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co642.pdf?dmc=1&ts=20181217T1653340486>.
- ⁹⁹ *Id.*
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