Guttmacher Policy Review
GPR
Fall 2013 | Volume 16 | Number 4

Implementing the Federal Contraceptive Coverage Guarantee: Progress and Prospects

By Adam Sonfield

The biggest pieces of the Affordable Care Act (ACA)—otherwise known as "Obamacare"—went live in the fall of 2013, although not without a fair share of drama. Ultraconservatives in Congress shut the federal government down for two weeks in a fit of pique as they tried, unsuccessfully, to coerce President Obama into agreeing to repeal or gut the law. Despite the political turmoil, the insurance marketplaces opened on schedule, because the vast majority of funding under the ACA does not require annual congressional approval. Yet, the rollout of the marketplaces was far from smooth, as the online enrollment systems were riddled with issues, particularly in the states that refused to set up their own marketplaces and are instead relying on the federal government to manage those systems.

Meanwhile, numerous features of the ACA already in effect are actually working as its authors intended and having tangible benefits for U.S. women and men. The federal contraceptive coverage guarantee—part of a broader requirement for private health plans to cover dozens of key preventive care services without out-of-pocket costs for patients—is one such provision. By January 2013, it had been phased in to include insurance plans covering tens of millions of Americans, and there is now an array of evidence, both quantitative and anecdotal, that it is having a positive impact—even if its implementation has not been flawless.

Encouraging Signs

Even before the federal contraceptive coverage requirement took effect, coverage of a wide range of contraceptive methods was already standard in U.S. private health plans,[1,2,3] and 28 states had their own requirements that plans cover the full range of prescription contraceptive methods.[4] Where the federal requirement broke new ground was in its prohibition of copayments, deductibles or other forms of patient cost-sharing. That policy change was made so that women and couples may choose a method they can use consistently and effectively without having to worry about cost.

A new Guttmacher Institute analysis provides the first quantitative evidence that the cost-sharing protections have taken root in U.S. private insurance.[5] The article draws on information collected from an ongoing, nationally representative survey of women aged 18–39, and compares women's responses in fall 2012 (before the contraceptive coverage requirement took effect for most women) and spring 2013 (after the requirement came into force for millions).

Among women who reported using oral contraceptives—the most popular reversible method in the United States—and having private health insurance at both times, the proportion who paid zero dollars out of pocket increased substantially, from 15% to 40% (see chart).[5] By comparison, there was no significant change in the proportion of publicly insured or uninsured pill users who paid nothing out of pocket—as would be expected, because women in those groups were not affected by the new policy. An increase was also seen for vaginal ring users with private insurance (from 23% to 52%); however, no such change was seen for users of the injectable or IUD.

That this progress for pill and ring users has happened so rapidly—in just the first several months that the requirement has been in wide effect—bodes well for the health and well-being of U.S. women, couples and families. An extensive body of research shows that contraceptive use helps women avoid unintended pregnancy and improve birth spacing, which results in substantial health, social and economic benefits, and that insurance coverage of preventive care like contraception is important to facilitating its use.[6,7,8] The speed with and degree to which women have been availing themselves of this benefit also demonstrate its popularity and that it is meeting a real demand.

This impact is certain to grow as more private health plans become subject to the ACA's requirements. Existing plans are exempt from the requirement, so long as they make no significant negative changes, such as benefit reductions or cost-sharing increases. This grandfathered status was included in the ACA as a temporary measure, to minimize disruptions in health insurance as the new federal rules were phased in. Grandfathered plans are rapidly disappearing: According to annual studies of employer-sponsored health plans, the number of covered workers enrolled in grandfathered plans decreased from 48% in 2012 to 36% in 2013.[9]

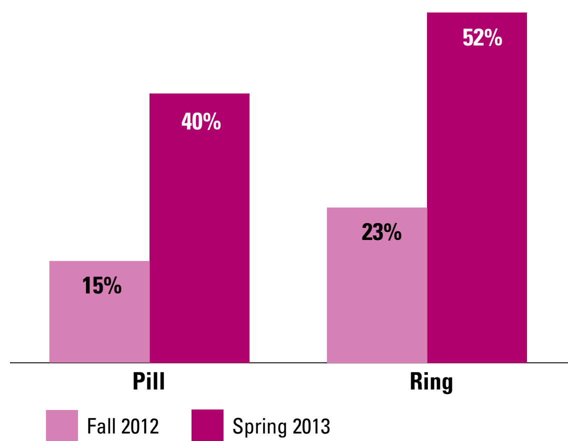
Yet, even after all plans eventually lose grandfathered status, the proportion of women paying nothing out of pocket will never reach 100%. For example, some women will choose a brand-name drug with a generic equivalent, in which case their health plan could legally ask for a copayment, according to a set of "frequently asked questions" about the ACA's preventive services requirements issued by the Obama administration in February 2013.[10] Others might choose to receive contraceptive services from an out-of-network provider; again, according to the administration's guidance, cost-sharing (or denial of coverage entirely) is allowed in such cases, unless there are no in-network providers for the given service.

Inadequate Implementation

Beyond these expected limits to the requirement's reach, however, there is evidence that some private health plans are not adequately

RAPID CHANGE

The proportion of privately insured contraceptive pill and ring users who paid nothing out of pocket for their method increased substantially in the initial months of the new federal requirement.



Source: reference 5.

complying with what the law clearly requires. For example, the fact that the Guttmacher Institute's study found no significant change over time among privately insured injectable users or IUD users in the proportion who paid nothing out of pocket indicates that health plans may not be applying the cost-sharing protections to "the full range" of female contraceptive methods approved by the Food and Drug Administration (FDA), as the administration has said the law stipulates.[10] Even a modest copayment for an IUD would be in violation of the ACA, if the plan is not grandfathered and the IUD is provided in-network. There are three brand-name IUDs on the market and no generic equivalents, so insurers should not be able to exclude any IUD from coverage or require any patient cost-sharing for one.

Guttmacher's findings concerning IUDs and injectables are in line with anecdotal evidence reported in the media that some plans were requiring patient cost-sharing for certain methods or taking other steps that appear contrary to a simple reading of the federal mandate to cover "the full range" of methods.[11] Insurance company documents available to consumers online as of December 2013 confirm that the rules are being interpreted inconsistently.

Some of the discrepancies between health plans' policies and the federal requirement may stem in part from the fact that the federal government waited until February 2013 to release any type of detailed guidance. For example, according to UnitedHealthcare documents, the company initially interpreted the ACA's preventive services requirement as excluding all over-the-counter (OTC) items.[12] That included not only OTC contraceptive items (such as contraceptive films, foams and gels, female condoms and most types of emergency contraceptive pills), but also several other OTC products that have been required under the ACA since late 2010 (such as folic acid to prevent birth defects and aspirin to prevent heart disease). Newer documents from UnitedHealthcare indicate that the company has revised its policy in response to the February 2013 guidance and now covers these OTC products when the enrollee receives a prescription.[13,14]

Another reason that health plans may be interpreting the contraceptive coverage requirement inconsistently is that the federal guidance is not perfectly clear. It allows health plans to apply "reasonable medical management techniques," but says little about what that means.[10] The only specific details given are that plans may use drug formularies that require copayments for brand-name drugs that have generic equivalents, and that they must have a process to waive such restrictions when a woman's provider determines it is necessary to do so.

Plan documents demonstrate a wide variety of interpretations. For example, multiple insurers—including Aetna,[15] Cigna,[16] UnitedHealthcare[13] and several Blue Cross Blue Shield affiliates[17,18]—appear to be excluding the contraceptive ring and patch from coverage at no cost-sharing, apparently under the theory that because they use the same hormonal ingredient used in certain oral contraceptives, they do not qualify as distinct methods. That interpretation contradicts the way contraceptive methods are categorized by medical experts, including the FDA itself, which treats them as distinct methods because of their mechanism of delivery.[19] Similarly, multiple insurers are excluding the newest emergency contraceptive, ella, from their $0 formulary tiers,[15,20] despite the fact that it has a different active ingredient than Plan B and is listed by the FDA as a distinct method.[19] Both of these practices also go against advice provided to insurance companies by CVS Caremark, one of the largest pharmacy benefit management companies in the United States.[21]

Women's health advocates are working hard to address these implementation problems. The National Women's Law Center (NWLC) has been particularly active, setting up e-mail and toll-free telephone hotlines for women who believe their health plan may have inappropriately interpreted the contraceptive coverage requirement. To further assist women, the NWLC has put together a toolkit to inform them about their rights under the law and to help them get the coverage to which they are entitled.[22] It answers questions about the preventive coverage requirement generally and the contraceptive coverage requirement specifically, summarizes the available federal guidance about how the law is supposed to be implemented, walks women through how to talk to their health plans on the phone to ask about their coverage, and provides instructions and draft letters to appeal a wide range of inappropriate health plan decisions.

Enter the U.S. Supreme Court

The extent to which the federal contraceptive coverage guarantee will help U.S. women also hinges on the outcome of a heated battle in the courts. The requirement has been beset by controversy since it was initially proposed by Sen. Barbara Mikulski (D-MD). Social conservatives and their allies in Congress argue that it constitutes religious discrimination and have been demanding that it be repealed entirely or that it exempt all employers that assert a religious or moral objection, regardless of the views and health care needs of employees and their families.

In June 2013, the Obama administration issued final regulations aimed at striking a balance between respecting religion and ensuring women's seamless coverage of contraception, in recognition of the government's interest in further facilitating access to this basic health care service. Those regulations provide a complete exemption for health plans offered by houses of

worship and other religious employers, narrowly defined. They also provide an accommodation for a broader range of religiously affiliated nonprofit organizations, such as universities, hospitals and social relief agencies. Employees of those organizations still are guaranteed coverage of contraceptive services without out-of-pocket costs, but that coverage must be provided by the organization's insurance company. The organization itself would not have to "contract, arrange, pay or refer" for any contraceptive coverage to which they object on religious grounds.

Several groups that had criticized earlier proposals from the Obama administration—including the Catholic Health Association, which represents Catholic hospitals and health facilities nationwide—have been satisfied by this compromise, but many of the administration's most vocal critics continue to object in the strongest terms. Conservatives in Congress continue to exploit every opportunity—including during the posturing over ending the government shutdown—to press for a sweeping exemption. However, solid opposition from the Senate and the president make a legislative change that would effectively render contraceptive coverage optional and subject to the whims of employers a nonstarter.

Much more threatening have been the legal challenges working their way through federal courts around the country. Seventy lawsuits against the provision were pending as of November 2013, according to a running tally by the American Civil Liberties Union (ACLU).[23] Sixty percent of these cases—including those furthest along—have been brought by for-profit companies, which are eligible for neither the exemption nor the accommodation. Although the companies suing have challenged the requirement on multiple grounds, the central parts of their challenges revolve around a 1993 federal law called the Religious Freedom Restoration Act (RFRA). That law says that the government may not "substantially burden a person's exercise of religion." A central question in these court challenges is whether a company qualifies under RFRA as a "person" that can have religious beliefs and put them into practice. Courts had never ruled so before these challenges, but some argue that the Supreme Court's 2010 ruling in *Citizens United*—that corporations were persons in the context of the First Amendment's guarantee of free speech—has cast doubt on that precedent.

Given the split decision among the five appeals courts that have already ruled on this question, it was no surprise that the Supreme Court recently decided that it would hear two challenges: *Sebelius v. Hobby Lobby Stores,* in which the Tenth Circuit sided with an Oklahoma-based craft supply chain store, and *Conestoga Wood Specialties v. Sebelius,* in which the Third Circuit ruled against a Pennsylvania-based furniture manufacturer. The cases are expected to be heard in spring 2014, with a final ruling most likely in June. Although it does not appear that the fate of the contraceptive coverage requirement itself is on the line, what is at stake is how many women will be able to obtain coverage and how expansive that coverage might be.

While the controversy over conscience and contraception occupies the political and media spotlight, the issues and implications these cases raise could reach a multitude of legal protections for employees, consumers and communities against abusive and discriminatory corporate practices. Indeed, similar issues were raised in a case decided by the New Mexico Supreme Court in August 2013, *Elane Photography v. Vanessa Willock.* There, a photography studio was sued for refusing to take pictures for same-sex wedding ceremonies, in violation of the state's law prohibiting discrimination based on sexual orientation. Justice Richard C. Bosson, in a concurring opinion, cut to the heart of the matter:

> On a larger scale, this case provokes reflection on what this nation is all about, its promise of fairness, liberty, equality of opportunity, and justice. At its heart, this case teaches that at some point in our lives all of us must compromise, if only a little, to accommodate the contrasting values of others. A multicultural, pluralistic society, one of our nation's strengths, demands no less. The Huguenins [the plaintiffs] are free to think, to say, to believe, as they wish; they may pray to the God of their choice and follow those commandments in their personal lives wherever they lead. The Constitution pro-

> tects the Huguenins in that respect and much more. But there is a price, one that we all have to pay somewhere in our civic life.
>
> In the smaller, more focused world of the marketplace, of commerce, of public accommodation, the Huguenins have to channel their conduct, not their beliefs, so as to leave space for other Americans who believe something different. That compromise is part of the glue that holds us together as a nation, the tolerance that lubricates the varied moving parts of us as a people. That sense of respect we owe others, whether or not we believe as they do, illuminates this country, setting it apart from the discord that afflicts much of the rest of the world. In short, I would say to the Huguenins, with the utmost respect: it is the price of citizenship.

It is difficult to see how any aspect of the ACA's contraceptive coverage guarantee imposes a substantial burden on the ability of any individual employers to exercise their own religious or moral beliefs. Rather, as in the New Mexico case, it would require them or the corporation they own to make, at most, a modest compromise in their public conduct—contributing toward insurance that would cover the cost of contraception for their employees and employees' family members who choose to use it—"to leave space for other Americans who believe something different." Next year, the U.S. Supreme Court will decide for the nation whether it agrees.

www.guttmacher.org

REFERENCES

1. Sonfield A et al., U.S. insurance coverage of contraceptives and the impact of contraceptive coverage mandates, 2002, *Perspectives in Sexual and Reproductive Health,* 2004, 36(2):72–79.

2. Claxton G et al., *Employer Health Benefits: 2010 Annual Survey,* Menlo Park, CA: Kaiser Family Foundation and Chicago, IL: Health Research and Educational Trust, 2010, <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8085.pdf>, accessed Dec. 3, 2013.

3. Mercer, *Hot Topics in Health Care: Pharmacy Benefits,* New York: Mercer, 2008.

4. Guttmacher Institute, Insurance coverage of contraceptives, *State Policies in Brief (as of December 1, 2013)*, 2013, <http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf>, accessed Dec. 3, 2013.

5. Finer LB, Sonfield A and Jones RK, Changes in out-of-pocket payments for contraception by privately insured women during implementation of the federal contraceptive coverage requirement, *Contraception,* 2013, doi: 10.1016/j.contraception.2013.11.015, <www.guttmacher.org/pubs/journals/j.contraception.2013.11.015.pdf>, accessed Dec. 11, 2013.

6. Guttmacher Institute, Testimony of Guttmacher Institute, submitted to the Committee on Preventive Services for Women, Institute of Medicine, 2011, <http://www.guttmacher.org/pubs/CPSW-testimony.pdf>, accessed Dec. 3, 2013.

7. Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/health-benefits.pdf>, accessed Dec. 3, 2013.

8. Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children,* New York: Guttmacher Institute, 2013, <www.guttmacher.org/pubs/social-economic-benefits.pdf>, accessed Dec. 3, 2013.

9. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2013 Annual Survey,* Menlo Park, CA: Kaiser Family Foundation and Chicago, IL: Health Research and Educational Trust, 2013, <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf>, accessed Dec. 3, 2013.

10. Employee Benefits Security Administration, Department of Labor, FAQs about Affordable Care Act implementation part XII, 2013, <http://www.dol.gov/ebsa/faqs/faq-aca12.html>, accessed Dec. 3, 2013.

11. Cunningham PW, Obamacare's confusing birth control rules, *POLITICO,* July 23, 2013, <http://www.politico.com/story/2013/07/aca-birth-control-rule-creates-confusion-94573.html>, accessed Dec. 3, 2013.

12. UnitedHealthcare, Pharmacy benefit contraceptive coverage required Aug. 1, 2012, no date, <http://www.uhc.com/pharmacy/news_and_updates/contraceptive_coverage_required_aug._1.htm>, accessed Dec. 3, 2013.

13. UnitedHealthcare, Preventive care medications: traditional prescription drug list (PDL) $0 cost-share medications & products, Oct. 2013, <https://www.myuhc.com/content/myuhc/Member/Assets/Pdfs/M51372-S_Trad._PDL_Med_lists_Member_lowres.pdf>, accessed Dec. 3, 2013.

14. UnitedHealthcare, Preventive care medications: advantage prescription drug list (PDL) $0 cost-share medications & products, Sept. 2013, <http://www.uhc.com/live/uhc_com/Assets/Documents/AdvDruglist_MemberFAQ.pdf>, accessed Dec. 3, 2013.

15. Aetna, 2013 women's contraceptive drugs and devices list, June 2013, <https://pbm.aetna.com/portal/asset/2013HCRContraceptiveslist.pdf>, accessed Dec. 3, 2013.

16. Cigna, No cost preventive medications by drug category, Nov. 2012, <http://www.cigna.com/pdf/839232_HCR_Preventive_Care_V02.pdf>, accessed Dec. 3, 2013.

17. Florida Blue, Women's preventive services drug and device list, Nov. 2013, <http://www.bcbsfl.com/DocumentLibrary/Providers/Content/RxF_WomensPreventive.pdf>, accessed Dec. 3, 2013.

18. Blue Cross and Blue Shield of Nebraska, Contraceptive drugs and methods pharmacy list, Sept. 2012, <https://www.nebraskablue.com/~/media/pdf/Member/36138_090512.pdf>, accessed Dec. 3, 2013.

19. Food and Drug Administration, Birth control guide, June 2013, <http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf>, accessed Dec. 3, 2013.

20. Blue Shield of California, Women's preventive health $0 co-pay contraceptive drugs & devices list, Sept. 2013, <https://www.blueshieldca.com/bsca/documents/pharmacy/ContraceptiveDrugsDevicesList.pdf>, accessed Dec. 3, 2013.

21. CVS Caremark, Interim final rules for non-grandfathered group health plans and health insurance issuers coverage of preventive services under the Patient Protection and Affordable Care Act: women's preventive services, Apr. 2013, <http://www.caremark.com/portal/asset/HCR_Prev_Svcs_List_Contraceptives.pdf>, accessed Dec. 3, 2013.

22. National Women's Law Center, *Getting the Coverage You Deserve: What to Do If You Are Charged a Co-Payment, Deductible, or Co-Insurance for a Preventive Service,* 2013, <http://www.nwlc.org/sites/default/files/pdfs/final_nwlclogo_preventiveservicestoolkit_9-25-13.pdf>, accessed Dec. 3, 2013.

23. American Civil Liberties Union, Challenges to the federal contraceptive coverage rule, Nov. 26, 2013, <https://www.aclu.org/reproductive-freedom/challenges-federal-contraceptive-coverage-rule>, accessed Dec. 3, 2013.