NATIONAL WOMEN'S LAW CENTER
Justice for Her. Justice for All.

MARCH 2021

REPRODUCTIVE RIGHTS & HEALTH

APPENDIX: EXAMPLES OF POLICIES ON EXCEPTIONS PROCESSES

There are different ways to draft a law or regulation on exceptions processes. We have included a few examples to give you a sense of how some states have approached it. You can also find the ACA guidance, which sets the minimum that all states must follow, here on page 4–5. Keep in mind that some of these policies are imperfect or might not fit the specific needs in your state. Reach out to the National Women's Law Center for support on developing language for your state.

NEW YORK (REGULATIONS)[1]

(a) ...If the covered therapeutic and pharmaceutical equivalent versions of a drug, device, or product are not available or are deemed medically inadvisable, an insurer shall provide coverage for an alternate therapeutic and pharmaceutical equivalent version of the contraceptive drug, device, or product without cost-sharing.

(b)(1) ...[A]n insured, an insured's designee, or an insured's health care provider may submit a request to an insurer for coverage of a noncovered contraceptive drug, device, or product. Such request shall indicate whether the covered contraceptive drug, device, or product is not available or is medically inadvisable for the insured. An insurer may require that the request for coverage be in writing. The insurer shall use the exception form promulgated by the superintendent if the insurer requires a written request.
(2) If the attending health care provider, in his or her reasonable professional judgment, determines that the use of a non-covered therapeutic or pharmaceutical equivalent of a drug, device, or product is warranted, the health care provider's determination shall be final.

(3)(i) The insurer shall provide coverage of the non-covered contraceptive drug, device, or product within 72 hours of receipt of a standard request not based on exigent circumstances. The insurer shall provide coverage of the non-covered contraceptive drug, device, or product within 24 hours of receipt of an expedited request based on exigent circumstances. In both situations, the insurer shall provide such coverage without cost-sharing.

(ii) For purposes of this paragraph, "exigent circumstances" means a circumstance under which an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or is undergoing a current course of treatment using a non-covered contraceptive drug, device, or product.

OREGON[2]

If a contraceptive drug, device or product covered by the health benefit plan is deemed medically inadvisable by the enrollee's provider, the health benefit plan must cover an alternative contraceptive drug, device or product prescribed by the provider.

DELAWARE[3]

If the FDA has approved 1 or more therapeutic equivalents of a contraceptive drug, device, or product, the health benefit plan is not required to include all such therapeutically equivalent versions in its formulary as long as at least 1 is included and covered without cost-sharing and in accordance with this section.... If, however, an individual's attending provider recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, regardless of whether the contraceptive has a therapeutic equivalent, the health benefit plan shall provide coverage for the prescribed contraceptive drug, device, or product without cost-sharing.

WASHINGTON, DC[4]

(C) If the covered contraceptive drug, device, product, or service is deemed medically inadvisable by a provider, the health insurer shall defer to the determination and judgment of the attending provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements; and

(D) Nothing in this section shall prohibit a health insurer from requiring the use of a generic prescription drug when providing coverage for preventive contraceptive drugs, devices, products, or services, so long as such health insurer:

> (i) Has a process for a member to seek medically necessary coverage of a covered brand name contraceptive drug, device, product or service coverage as determined by the member's prescribing provider; and
>
> (ii) Provides coverage for a brand name contraceptive drug, device, product or service coverage when there is no generic substitute available in the market.

NEW HAMPSHIRE[5]

Notwithstanding any other provision of law, if there is a therapeutic equivalent of a drug or device for an FDA-approved contraceptive method, an insurer may impose cost-sharing requirements as long as at least one drug or device for that method is available without cost-sharing; provided that if an individual's provider recommends a particular FDA-approved contraceptive drug or device based on a medical determination, the insurer shall provide coverage for the prescribed contraceptive drug or device without cost-sharing.

NEW MEXICO[6]

An insurer may discourage brand-name pharmacy drugs or items by applying cost sharing to brand-name drugs or items when at least one generic or therapeutic equivalent is covered within the same method of contraception without patient cost sharing; provided that when an insured's health care provider determines that a particular drug or item is medically necessary, the individual or group health insurance policy, health care plan or certificate of insurance shall cover the brand-name pharmacy drug or item without cost sharing. Medical necessity may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider.

D. An insurer shall grant an insured an expedited hearing to appeal any adverse determination made relating to the provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

(1) be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an insured, the insured's representative or the insured's health care provider;

(2) defer to the determination of the insured's health care provider; and

(3) provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim involving an urgent health care need.

MAINE[7]

B. If there is a therapeutic equivalent of a contraceptive supply within a contraceptive method approved by the federal Food and Drug Administration, a health maintenance organization may provide coverage for more than one contraceptive supply and may impose cost-sharing requirements as long as at least one contraceptive supply within that method is available without cost sharing.

C. If an individual's health care provider recommends a particular contraceptive supply approved by the federal Food and Drug Administration for the individual based on a determination of medical necessity, the health maintenance organization shall defer to the provider's determination and judgment and shall provide coverage without cost sharing for the prescribed contraceptive supply.

ILLINOIS[8]

(ii) If an individual's attending provider recommends a particular service or item approved by the United States Food and Drug Administration based on a determination of medical necessity with respect to that individual, the plan or issuer must cover that service or item without cost sharing. The plan or issuer must defer to the determination of the attending provider.

(iii) If a drug, device, or product is not covered, plans and issuers must have an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome on the individual or a provider or other individual acting as a patient's authorized representative to ensure coverage without cost sharing.

****

1 N.Y. Comp. Codes R. & Regs. tit. 11, § 52.74. These are administrative regulations implementing the statute (N.Y. Ins. Law § 3221(l)(16); § 3216(i)(17)(E)(v)).

2 Or. Rev. Stat. Ann. § 743A.067.

3 Del. Code Ann. tit. 18, § 3342A(b)(1).

4 D.C. Code Ann. § 31-3834.03(a)(2).

5 N.H. Rev. Stat. Ann. § 415:18-i.

6 N.M. Stat. Ann. § 59A-22-42.

7 Me. Rev. Stat. tit. 24-A, § 2756 (individual health policies and contracts); § 2847-G (group and blanket health insurance)

8 215 Ill. Comp. Stat. Ann. 5/356z.4.