



## REPRODUCTIVE RIGHTS & HEALTH

# EXCEPTION POLICIES: ADVOCATING FOR NO-COST COVERAGE OF NONCOVERED CONTRACEPTIVES

Each person who seeks to use birth control should be able to get the specific type they need, without cost being a barrier. But many insurance plans only cover one contraceptive (or just a few contraceptives) per method category. For people who need a specific contraceptive that is not usually covered, this practice leaves them to choose between using a contraceptive that is not right for them, paying out of pocket, or forgoing birth control entirely when the cost is prohibitive. The Affordable Care Act and several state laws, however, require insurance companies to make an exception for someone who needs a contraceptive that is not usually covered and waive cost-sharing, a process referred to as an exceptions policy. Exceptions policies (sometimes called waivers) help people get no-cost coverage of specific contraceptives even when an insurance plan would normally impose cost-sharing. In many states, however, this requirement is not well known or fully enforced, making it necessary for the state insurance department to take action. This resource provides state advocates with guidance on what exceptions policies do and how to work with state agencies to have insurers adopt them.

## WHY EXCEPTIONS POLICIES ARE IMPORTANT

Emma went to her OB-GYN to talk about birth control options and mentioned that she gets painful, heavy periods. After discussing all the options, Emma and her doctor decided that she would use a specific brand of progestin IUD that is FDA-approved to ease heavy periods. Emma knew that her insurance plan was supposed to cover birth control without cost-sharing, so she was surprised when the charge for her new IUD ran up to several hundred dollars. When Emma called her insurer, they told her that they only covered one progestin IUD, a brand that is less effective for treating painful periods than the one her doctor prescribed. Emma could not afford to pay out of pocket, but she did not want to switch to a form of birth control that was not right for her. An exceptions process would allow Emma to get cost-free coverage of the IUD she needs.

The Affordable Care Act (ACA) requires most insurance plans to cover without cost-sharing at least one contraceptive in each [FDA-approved method category](#) (except for vasectomies and condoms). For example, the combined oral contraceptive is a standalone method category, so an insurer must cover at least one type of combined oral contraceptive without cost-sharing. Insurers are, however, usually allowed to impose cost-sharing on the dozens of other types of combined oral contraceptives.

But what many people do not know is that **when someone needs a specific contraceptive within a category, plans need to have a process in place to waive cost-sharing** if that contraceptive is not typically covered cost-free. This cost-sharing exception is required under the ACA (clarified by [guidance issued in 2015](#)), which sets a baseline for all states, as well as under many state laws.

There are many reasons why people might need a specific type of contraception within a method category. For example, some people experience negative side effects using a generic version of a contraceptive and so need a brand name version, while others may need a particular contraceptive because its positive side effects can treat other conditions, like painful or irregular periods, endometriosis, or acne. Some need a specific formulation of a contraceptive, like a higher or lower estrogen dose, a need that is especially likely to arise for disabled people, chronically ill people, and transgender men and non-binary people. And some may have a hard time using the covered type of birth control correctly or consistently and so need to switch to another type.

## THE PROBLEM

Although insurance companies need to waive cost-sharing in these sorts of circumstances, many plans do not have an exceptions policy. Many insurance companies, birth control users, and providers are not aware of this requirement, and often the state agency does not enforce it.

This means that many people are still paying out-of-pocket for birth control. People contacting the National Women's Law Center's CoverHer hotline have reported that their insurance company told them that no exceptions process exists. Others were asked to complete paperwork that does not comply with the federal government's guidance.

For example, an insurance company told one woman that in order to get coverage for the contraceptive she needed, she would have to show that the birth control covered by the plan had led to "therapeutic failure(s)" (meaning that the contraceptive failed to work—that is, that she became pregnant) or "adverse event(s)."<sup>2</sup> Health care providers have reported to CoverHer that they have been required to provide "chart notes to verify past medication trials."<sup>3</sup>

People who cannot afford the out-of-pocket costs that result from these barriers may be forced to use a contraceptive that does not meet their needs, making it more likely that they will use it inconsistently or stop using it entirely.<sup>4</sup> And for some, not being able to use the specific contraceptive they need means not being able to use contraception at all. Excluding a specific contraceptive from full coverage—an arbitrary insurance limit on people's access to birth control—undermines the ACA birth control benefit's goal of eliminating precisely this type of barrier. Requiring insurance companies to have exception procedures in place is a key part of furthering that goal.

## THE SOLUTION

Advocates can work with their state insurance department to improve insurers' compliance with exceptions policies.<sup>5</sup> The state insurance department should adopt a specific procedure that insurance companies must follow when someone requests a specific contraceptive. This policy makes it more likely that insurance companies will be aware of their legal obligation, makes it easier for birth control users and providers to request an exception, and helps state agencies enforce the requirement. Any insurance department can adopt a standard exceptions process as part of its implementation and enforcement of the ACA, and in 13 states and DC there are also state laws that reinforce or build on the ACA's baseline requirements.<sup>6</sup>

The state insurance department can implement the exceptions requirement by adopting regulations or policies, including by creating a standard form that birth control users and prescribers can submit to the insurance company. The department should also review insurance plans' exceptions procedures during their regular enforcement activity, like when approving plans each year. Additionally, the department should engage in public education aimed at birth control users, prescribers, pharmacists, and insurers about the option to get a cost-sharing exception.

## COMPONENTS OF THE POLICY

This section provides an overview of some elements a good policy might have. At minimum, the policy should codify the basic requirements in the ACA guidance, which says that plans:

- Must have an exceptions process to cover a specific contraceptive if it is not usually covered without cost-sharing
- Cannot second-guess the attending health care provider's determination of what contraceptive is appropriate for someone (which can be based on a wide range of factors, like potential side effects, how permanent or reversible the product is, and how easy it would be for the individual to use it appropriately)
- Must have an "easily accessible, transparent, and sufficiently expedient" process that is not "unduly burdensome"
- May use a standard form as part of the waiver process, like a form based on the [Medicare Part D exceptions form](#)

We discuss these and other policy components in more detail below. The National Women's Law Center can work with you to develop specific language that fits your goals and the context of your state. We have included some examples of language from different states. With the exception of New York, which is the only state to have adopted administrative regulations as of publication, these excerpts are taken from statutes that may still need to be implemented.

**Require the insurance company to defer to the determination of the provider.** The policy should make it clear that an insurer cannot second-guess the health care provider's determination that a specific contraceptive is appropriate.

**NEW YORK:** "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.**"<sup>7</sup>

**Clarify that the health care provider's determination can be based on a wide range of considerations.** These include possible side effects, the birth control user's personal goals and preferences, how easy it would be for them to use the contraceptive properly, and other factors. Providers do not

need to go so far as to show that it would be impossible or unsafe for a patient to use the covered contraceptive, and they do not need to show that the patient already tried to use it unsuccessfully. Some state laws describe the provider as determining that the non-covered contraceptive is "medically necessary." When used in non-contraceptive contexts, this term often means that a patient *must* take a product to treat a condition; when it is used in the contraceptive context, it is especially important to avoid confusion by explicitly clarifying that provider can take the full range of non-medical considerations into account. Other states describe the provider's determination using broader language, including that the specific contraceptive needed is "medically advisable"<sup>8</sup> or "medically appropriate."<sup>9</sup>

**DELAWARE:** "If...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."<sup>10</sup>

## THE ROLE OF THE PROVIDER

Exceptions policies make the provider's determination the final arbiter so that insurance companies do not impose their own decision about which contraceptive is appropriate. The provider, however, should still play only a helper role by giving an individual the tools to decide which contraceptive is right for their own needs, goals, and preferences. Unfortunately, not everyone has a provider who fully supports their decision-making autonomy, and not everyone has a provider who will proactively advocate for their needs by requesting an exception. People of color, disabled people, and people with other marginalized identities, who face higher rates of mistreatment in health care settings, may be particularly likely to lack a supportive provider or to face coercion. So a high priority in the implementation of this policy needs to be ensuring that its benefits are applied equitably.

As you work on developing and implementing your state's exceptions process, think about ways to put more control in birth control users' hands so that access to the right contraceptive does not solely depend on one's provider. It is also key to keep the exceptions process as straightforward as possible so that providers are more open to using it. And it is important to approach this policy as just one part of a broader campaign to expand access to patient-centered care and improve provider competency.

**ILLINOIS:** “Medical necessity’ ... includes, but is not limited to, **considerations such as severity of side effects, differences in permanence and reversibility of contraceptive, and ability to adhere to the appropriate use of the item or service,** as determined by the provider.”<sup>11</sup>

**Require insurance companies to cover alternatives when the covered contraceptive is not reasonably available.**

Sometimes—especially in rural and hard-to-reach areas—the covered contraceptive is not easily available, like when it is on backorder or not carried by pharmacies. The exceptions process should apply to these situations as well.

**NEVADA:** “If a covered therapeutic equivalent...**is not available** or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.”<sup>12</sup>

**Require insurance plans to provide information on their exceptions process to enrollees and health care providers.**

The exceptions process will not work if people do not know about it. Plans should provide clear guidance on the exceptions process through multiple sources, such as the formulary and the insurance company’s website.

**Ensure that the process is fast, accessible, and easy to navigate.** Birth control can be time-sensitive, so good policies may include time limits—usually 24 or 48 hours—for insurance companies to process exception requests. The procedure for requesting an exception should be clear, standardized, and easy to find, and insurance companies should not impose unnecessary administrative burdens.

**NEW YORK:** “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.”<sup>13</sup>

**NEW MEXICO:** “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...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.”<sup>14</sup>

**Require insurance companies to use a simple, standard form.**

A uniform easy-to-understand form, like [this one](#) from New York, makes the waiver process far less complex to navigate. The state agency can create a form that insurance companies have to use, or it can give insurance companies a sample so they can create their own. To reduce the burden of filling it out—and make it more likely that providers will use it—the form should be no more than one or two pages and it should only ask for necessary information. For example, it should not require the provider to offer specific evidence or a rationale for their determination that a specific contraceptive is appropriate. Either the provider or the birth control user should be able to submit the form.

**NEW YORK:** “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.”<sup>15</sup>

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These components can be adapted to each state’s needs. Further examples of policies can be found in the appendix. NWLC is available to assist you as you explore options for exceptions policies in your state.

- 1 U.S. Department of Health & Human Services, U.S. Department of Labor, & U.S. Treasury. (May 11, 2015). FAQs on Affordable Care Act implementation (part XXVI), p. 26. Retrieved from <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvi.pdf>.
- 2 BCBS Federal Employee Program Formulary Tier Exception Member Request Form on file with National Women's Law Center.
- 3 ConnectiCare Pharmacy Prior Authorization Form: General Requests on file with National Women's Law Center.
- 4 See, e.g., Littlejohn, K. (2012). Hormonal contraceptive use and discontinuation because of dissatisfaction: Differences by race and education. *Demography*, 49(4), 1433–1452. <https://doi.org/10.1007/s13524-012-0127-7>; Reed, J. (2014). Consistent and inconsistent contraception among young women: Insights from qualitative interviews. *Family Relations*, 63(2), 244–258. <https://doi.org/10.1111/fare.12058>.
- 5 While this guide focuses on private insurance, Medicaid agencies can also adopt a standard exceptions process, including requirements for managed care organizations (private contractors who administer Medicaid plans in some states). The laws that apply to Medicaid may be different than those applying to private insurance. For example, the ACA requirements for exceptions processes apply to states with Medicaid expansion but not to non-expansion states, while the state laws that mandate exceptions in private insurance also apply to Medicaid in some states but not others.
- 6 As of March 2021, laws in the following states specifically require insurance companies to have an exceptions process: **California** (Cal. Health & Safety Code § 1367.25(a)(1)), **Connecticut** (Conn. Gen. Stat. Ann. § 38a-503e(a)), **Delaware** (Del. Code Ann. tit. 18, § 3342A(b)(1)), **Illinois** (215 Ill. Comp. Stat. Ann. 5/356z.4), **Maine** (Me. Rev. Stat. tit. 24-A, § 2756, § 2847-G), **Massachusetts** (Mass. Gen. Laws Ann. ch. 175, § 47W), **Nevada** (Nev. Rev. Stat. Ann. § 689A.0418, § 689B.0378), **New Hampshire** (N.H. Rev. Stat. Ann. § 415:18-i), **New Jersey** (N.J. Stat. Ann. § 17B:27-46.1ee, § 17B:27A-7.12), **New Mexico** (N.M. Stat. Ann. § 59A-22-42), **New York** (N.Y. Ins. Law § 3221(l)(16); § 3216(j)(17)(E)(v)), **Oregon** (Or. Rev. Stat. Ann. § 743A.067), **Vermont** (Vt. Stat. Ann. tit. 8, § 4099c), **Washington, D.C.** (D.C. Code Ann. § 31-3834.03(a)(2)).
- 7 N.Y. Comp. Codes R. & Regs. tit. 11, § 52.74 (emphasis added).
- 8 E.g., Oregon (Or. Rev. Stat. Ann. § 743A.067) and New York (N.Y. Ins. Law § 3221(l)(16)).
- 9 E.g., Nevada (Nev. Rev. Stat. Ann. § 689A.0418).
- 10 Del. Code Ann. tit. 18, § 3342A(b)(1) (emphasis added).
- 11 215 Ill. Comp. Stat. Ann. 5/356z.4 (emphasis added).
- 12 Nev. Rev. Stat. Ann. § 689A.0418 (individual policies); § 689B.0378 (group policies) (emphasis added).
- 13 N.Y. Comp. Codes R. & Regs. tit. 11, § 52.74.
- 14 N.M. Stat. Ann. § 59A-22-42.
- 15 N.Y. Comp. Codes R. & Regs. tit. 11, § 52.74 (emphasis added).