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Contraceptive Coverage and Women's Preventative Care for Dependents

By Emily Tonkovich

On May 11th, the Departments of Labor, Health and Human Services, and Treasury released guidance clarifying the rules related to the coverage of contraceptives.

The guidance states that insurers must cover, without cost-sharing, at least one form of contraception in each of the 18 FDA identified categories. For instance, an insurer could not cover oral contraceptives without cost-sharing and then impose cost-sharing on all other forms of hormonal contraceptives (such as implants, the ring, and the patch).

However, within each category, insurers can use "reasonable medical management" techniques. This means insurers may impose cost-sharing on some items to encourage women to use other items within the contraceptive category. For example, an insurer could impose cost-sharing on brand name contraceptives when a generic version of the same contraceptive is available.

The insurer must also make exceptions to any cost-sharing requirement if a woman's provider determines a particular contraceptive is medically necessary for her. So, if a woman's provider determines she needs the brand-name version due the side-effects she experienced on the generic version, then the insurer would need to cover the brand-name version for her without cost-sharing.

The guidance also reiterated that under the Affordable Care Act insurers must cover, without cost-sharing, the recommended women's preventive care services for dependent children. This includes the recommended services related to pregnancy such as preconception and prenatal care. Prior to the passage of the Affordable Care Act, while insurers were required to cover pregnancy-related benefits for employees and spouses, they were not required to extend these benefits to dependent children.

Benefit Review Services, Inc.
43370 Mound Road
Sterling Heights, MI 48314
586.997.1700
www.benefitreview.com

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