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Contraceptive Coverage Under the Affordable Care Act: A Review of Health Insurance Plans in Five States
Kaiser Family Foundation
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[START RECORDING]

ALINA SALGANICOFF, PH.D.: Good morning.

PANEL: Good Morning.

ALINA SALGANICOFF, PH.D.: Good? Okay. Welcome everyone, I am Alina Salganicoff, I am Vice President and Director of Women's Health Policy, here at the Kaiser Family Foundation. On behalf of the foundation it is my pleasure to welcome you here to the Barbara Jordan Conference Center—I love this segment—The Barbara Jordan Conference Center welcome.

We are here today to focus our attention on the Contraceptive Coverage Provision of the Affordable Care Act (ACA). As many of you know, in the past year, much of the national spotlight has been on how this requirement has been interpreted to affect the religious rights of businesses and other religiously affiliated organizations. This issue is still very much in play, particularly in the courts, and now with regards to non-profit organizations.

Today, however, we wanted to focus our attention on how this particular provision has been implemented by health plans, and how the plan coverage decisions, that plans make, can affect women's coverage and their contraceptive coverage.

So, as I am sure you all know the ACA broke new ground. For the first time now, requiring private plans to cover evidence based preventive services. This includes all the US Preventive Services Task Force recommendations that are highly

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rated—that is either an A or B recommendation—as well as immunizations that [are] recommended by the Advisory Committee on Immunization Practices.

In addition there are eight new services that were included that were recommended by HRSA, and one of those recommendations was the coverage of all FDA approved contraceptive services and supplies—and they must be covered, and covered without cost sharing.

Seems straight forward right? As we are going to learn the interpretation and the implementation of this provision do make a difference.

So, the contraceptive coverage provision became effective in August of 2012, and while the nation is very sharply divided about Obama Care—and we have heard a lot about that—actually the polling that has been done around this particular provision, shows that about two-thirds of the public actually support—and sometimes strongly—support this provision. I would say that it is pretty hard these days to find the public in agreement on— two-thirds of the public in agreement on- any particular issue. I think that really shows some strong support.

In addition we have started to see the results of this provision in terms of savings to women. Several studies have been published that now show that women have fewer out of pocket costs for contraceptives. Hopefully, we are going to

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see a stronger uptake in the use of the most effective methods of contraceptives. Those are the methods that are also the most expensive. And—in our goal—is to ultimately see a drop in the unintended pregnancy rate.

What we wanted to learn when we started this project is how this particular provision is being implemented by the plans. There have been several news articles that have been reported in the past year or so that say some women are experiencing difficulties in getting no cost coverage for their contraceptives. But, we wanted to—more systematically—to review how this provision is being operationalized by the plans.

So today—first my colleague, Laurie Sobel, who was the lead author on the study, is going to present the key findings. And, I do want to acknowledge publicly our co-authors from the Lewin Group—where are you? In the back, Jennifer Wiens, Kimsung Hawks [, and Linda Shields—who are with us in person.

They along with Laurie and Nisha Kurani , who is also here on the Kaiser's staff—we slog through a lot of insurance documents. As an aside, we spent the better part of a year working on this project, and this today, was the first time that we actually met in person. So, thank you.

After Laurie presents the findings, we are going to have a panel discussion with three experts that have really very different real-world perspectives on this issue.

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We are lucky to have with us today Doctor Edward Anselm, who is the consultant medical director for Health Republic Insurance of New Jersey. He also has served as the Chief Medical Officer of several health plans, including Health Plan and Fidelis Care of New York. Everyone's full bio is available in your packets.

Next to him is Doctor Peggy Ye, who is going to be—who is going to help us understand the coverage issues and how they are playing out on the front lines of Obama Care. Ye is an obstetrician gynecologist, in clinical practice at the Med Star Washington Hospital Center.

To her left is Gretchen Borchelt. She is the Vice President for Health and Reproductive Rights at the National Women's Law Center. At the Center, Gretchen oversees the centers' advocacy policy and education strategies on health and reproductive health.

For several years now, the National Women's Law Center has also been operating a hotline for women, to assist them when they experience difficulties in accessing preventive services under the ACA. So, Gretchen is also going to be able to share with us some of the experiences that women have faced.

After the discussion we will have open questions from the audience, so I am sure to leave some time for questions. We have a lot of experts in the audience as well, and I want

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you to have the opportunity to also contribute. So without further ado, I am going to turn it over to Laurie.

LAURIE SOBEL, J.D.: Thank you Alina. Good morning everyone.

AUDIENCE: Good morning.

LAURIE SOBEL, J.D.: Wow, lively crowd. I was not expecting that. I am really excited to be with you today to share our findings, about how carriers are implementing the contraceptive coverage requirement. I am going to start with reviewing the provision, then talk about our study, our methodology and then get into the nitty-gritty of our findings.

So, as Alina just mentioned and as I am sure all of you know, the ACA does require coverage of the full range of FDA approved contraceptive methods without cost-sharing for women. While this requirement seems straight forward, as Alina mentioned, there have been quite a few media reports of women not being able to access the contraceptive method of their choice, without cost-sharing.

So, let us take a look at why that might be. When you look at this provision and you break it down, you have to first look and say, what are the FDA approved methods of contraception? The FDA has a few different places on their website where they list contraceptive methods. On this screen-shot that I have here, they have broken it down into five

different methods, five different categories, where different methods fall into those categories.

The categories are barrier methods, hormonal methods, emergency contraception, implanted devices and permanent methods. As we all know there is overlap between those different categories. For example, some IUDs are hormonal, and some emergency contraceptive is hormonal, while an IUD is also an emergency contraception—the copper IUD.

If you look at this next screen, which I am sure you can see very clearly, this is a FDA poster where they list nineteen different methods of contraception for women. This makes it a little bit easier to see, but many of these methods we included in our study. They list everything from sterilization to emergency contraception on this site. So the FDA has different places where they list what is considered an approved FDA method of contraception for women.

Next, which is really what the heart of our study is about, is that plans are allowed to use reasonable medical management for any preventative service, including contraception, when the recommendation or guideline for that preventative service does not specify the frequency, method, treatment, or setting for that specific guideline. What is reasonable medical management? It is a new term and it was not defined in the regulation or the guidelines. So, we are left

looking at medical management and then trying to wonder what the word 'reasonable' in front of it might mean.

We all know what medical management is, we have all experienced it as consumers, when a health plan tries to steer us towards lower cost drugs or services. An example of medical management includes tiering.

So you have a formula, where usually the lower cost drugs are on the lower tiers and we are told that generics are preferred over brand names, for the most part.

There is step therapy, where a consumer must try a certain drug or device before having access to a different drug or device, and try the first one and have it not work for them. Some times that is called 'fail first'.

There is prior authorization, which requires the clinician to submit evidence of medical necessity for a particular drug or device, and then of course limits on quantity or supply.

So, this is really the heart of what we are trying to figure out, is how plans are plying reasonable medical management to the contraceptive coverage under the ACA.

Here is a little bit about our study and what we were trying to do.

We chose five states with a mixture of health insurance market places. So, we chose California, Georgia, Michigan, New Jersey, and Texas. We then created a master list of all the

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health insurance carriers in that state, from that we created a list of twenty-four carriers. Many of which operate in more than one state. We invited those twenty-four carriers to participate in our study. Nine of them agreed to be interviewed, and then we did document review for an additional eleven plans. The total numbers of carriers, in our study, are twenty different carriers. They represent two-hundred different lines of business across the country, and most of the health insurance carriers in the country are included in this study.

This is the list of the methods that we include, and you will notice the oral contraceptive pill is not included. We tried to start going down that path and just realized we would never finish if we included the oral contraceptive pills. We do include the vaginal ring, the patch, injections, implants, hormonal IUDs, the copper IUD, emergency contraception- both of the progesterone based pills as well as the ulipristal acetate formulation- as well as sterilization.

We also asked plans about related issues to contraceptive coverage, so this is well-woman visits, the process for waving coverage. So, if the woman needs something that is not normally covered, what is the process for waiving those limitations, as well as the process for handling religious accommodations, and I will talk more about each of those when we get to those slides.

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So, now we are going to get into the findings. Before I go through the actual findings for the Nuvaring, I am going to use this slide to explain—because the next few slides are going to have this same format. What each of these symbols mean, and just give a few caveats of not to do math on these slides.

So, [audio gap 00:11:48—00:11:51] a plan is covering a particular method [audio gap 00:11:52—00:11:56] is. The dollar sign means that they are charging cost-sharing. The caution sign means that there is step therapy or prior authorization, and the 'X' means that it is not covered.

In the report that you have, we have noted where a plan charges cost-sharing and requires step therapy or prior authorization. For ease of this presentation, I have separated them out. So, if a plan charges cost-sharing and does step therapy, they are going to be counted twice in these slides.

Also, just to note, this information was just really, really difficult to get. So, you are going to see on a lot of these slides, there are unknowns for some carriers, and so if you are trying to do the math to get to twenty, you are not going to get there, so, do not try.

Let us start with the Nuvaring. This slide shows our findings for the Nuvaring. The vaginal ring only comes in the form of the Nuvaring. There is no generic. It is a hormonal contraceptive that comes in the form of a small flexible ring

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that is inserted vaginally by a woman once every three weeks, and then discarded for the fourth week of the month.

This method was the method that was the least likely to be covered by carriers without cost-sharing or limitations. Twelve of the twenty carriers that we reviewed covered the Nuvaring without limitations or cost-sharing. Five plans only covered the Nuvaring with cost-sharing. Three plans required step therapy or prior authorization and one plan, does not cover the Nuvaring.

Next we looked at the patch, which is applied to women's skin and is also a hormonal contraceptive. I should note that we looked at the Ortho-Evra and generic, but the manufacturer of the brand name has discontinued manufacturing. So, in the not too distant future the patch will only come in the generic form.

Fifteen carriers cover at least one type of patch, without cost-sharing or limitations. Six of those cover both the generic and the brand name. Nine of those cover one or the other. Three carriers cover the patch, but only with cost-sharing. So, women in those plans would only be able to get the patch with cost-sharing.

Next we looked at injections. We looked at three different products: the Depo-Provera, the generic Depo-Provera, and the Depo-SubQ Provera 104. There are some differences between the Depo-Provera and the Depo-SubQ Provera 104. First,

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the dosage is a lot lower for the Depo-SubQ Provera 104; it is also a subcutaneous shot, which is a lot less painful than the intramuscular shot that the Depo-Provera provides. So—and the Depo-Provera and the generic are considered equivalent. So, eighteen carriers cover one of those without cost-sharing, one or both without cost-sharing or any limitations. The Depo-SubQ Provera 104 had a lot less coverage. Seven carriers cover it without limitations or cost-sharing, five carriers cover it with cost-sharing, and six carriers do not cover it at all.

Next we looked at implants. An implant is a thin plastic hormone releasing rod that is inserted under the skin of a woman's arm by a health care provider. We looked at the Implanon and the Nexplanon. The difference between the two is that the Nexplanon is visible through a CT scan, ultra scan or MRI, and also has a different applicator.

You should note that this is part of the category that people refer to as LARCs, long acting reversible contraceptives. And it is highly effective. The implants actually have the lowest failure rate of all of the FDA approved contraceptives at just .05-percent.

For the Implanon, eleven carriers cover it without limitations or cost-sharing. Four carriers do not cover it at all. The Nexplanon has ten carriers covering it without limitations or cost-sharing, three carriers do not cover it at all. So, the overall coverage for both implants is that ten

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carriers cover both, without limitations or cost-sharing. One carrier covers only one implant with no cost sharing and no limitations. One carrier required prior-authorization for both implants. Notably two carriers do not cover either implant, and here is where we were not able to get information. We were unable to ascertain coverage for either implant for four carriers.

Moving on to the IUDs, but first this slide shows the results for the hormonal IUDs and there is also the copper IUDs, which I will cover as well.

There are two types of brand names that were available at the time of this study, the Mirena and the Skyla. Since then the FDA has recently approved a third hormonal IUD the Liletta that was approved in February. Again, these are long acting reversible contraceptives that are highly effective.

The Mirena has thirteen carriers covering it without limitations or cost-sharing, one carrier requires prior authorization, but no cost sharing.

Skyla had ten carriers covering it without limitations or cost-sharing, and one carrier requires prior authorization, but no cost sharing. Three carriers do not cover the Skyla.

So, taken together, the two hormonal forms of IUD, ten carriers cover both without limitations or cost-sharing, three carriers cover only one hormonal IUD and we were unable to ascertain coverage for four carriers.

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Next we are looking at the copper IUD. This is the only non-hormonal IUD available; it is under the brand name Paragard and I should mention that there are no generics for any of the IUDs, they are all brand name.

For the Paragard, fourteen carriers cover the Paragard with no limitations and no cost-sharing, one carrier does not cover Paragard, and again this is the only non-hormonal IUD available, and we were unable to ascertain coverage for four carriers.

All together for all three IUDs, ten carriers. So half the carriers that we looked at cover all three, without limitations or cost-sharing. Four carriers cover only one IUD, without limitations or cost-sharing and we were unable to ascertain coverage for four carriers.

Next we are looking at the emergency contraceptive pills. We looked at three different versions of it, the Plan B, which is the progesterone based pill, then the generics for Plan B, which are also progesterone based, and considered equivalent to the Plan B, and then the Ella, which has a different formulation. It is the ulipristal acetate formulation.

Plan B— five carriers cover Plan B without limitations or cost-sharing. Ten carriers do not cover it at all. Then you have the generic emergency contraceptive where almost all the carriers—19 carriers cover the generic progesterone based

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emergency contraceptive pills without cost-sharing or any other limitations.

The Ella has a lot less coverage and it is important to note here that recent studies have suggested that women with BMI's higher than 25 might have better success on Ella than on the progesterone based emergency contraceptive pills. Effectiveness for women with BMI's over 30 wanes on either emergency contraceptive, but for many women with high BMIs it is the suggested emergency contraceptive pill.

Eleven carriers cover Ella without limitations or cost-sharing. Six carriers cover it and charge cost sharing, and two carriers do not cover it at all.

Finally, the final method that we looked at is sterilization and this was by far the most difficult method to get any information about. Partly because there are two pieces to it; there is the procedure and then the ancillary services. And also, for the plans that we were doing document review, these types of things are not usually listed within the plan documents.

We had a lot of difficulty getting information on this. We were able to determine that ten carriers do cover sterilization, without limitations or cost-sharing, and an additional three covered it, but we were not able to determine the cost sharing and we were not able to get any information about the coverage for seven carriers.

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The ancillary services, which are needed for all sterilizations, which are anesthesia, supplies, and follow up care— five carriers specify that coverage is covered without cost-sharing, one carrier does not cover these services, and we were not able to ascertain coverage for the rest of the carriers.

We have gone through all of the methods that we looked at and now we are going to look at some of the issues that would affect a woman's ability to actually get the coverage for the method that she needs, given the limitations that she might experience within her plan.

The first thing that we looked at in this realm is the process for waiving coverage limitations. When the Department of Labor put up the FAQs they specified that if a woman needs a method that is not covered without cost-sharing or has limitations within her plan and it is necessary for her to get it, the plan has to have a process for waving their normal limitations.

None of the carriers that we reviewed have established a formal wavier process for preventative services. They refer consumers to their usual appeal process, and because of that it is unclear whether any carrier has established an expedited appeal process that would be timely enough for a woman to get emergency contraceptives that are not covered under the policy. And just to put this in context, Ella costs between $45 and

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$70- that is a big barrier for many women and she needs to get it within five days of having unprotected sex. So, if there is no expedited appeals process, a woman might really be out of luck with regard to emergency contraception.

Next we looked at well woman visits. The HRSA guideline specifies that an annual well woman visit is required. HHS then specified in the FAQs that if a woman needs more than one well woman visit per year in order to get all of her preventative services that those should be covered without cost-sharing. We asked carriers how to handle this. While none of the carriers have explicit policies that limit the number of well woman visits, and they stated that they would cover all visits for preventative services without cost sharing, so that is good news. Also, they cover all visits necessary for contraception and follow-ups. Insertion, removal, additional counseling, follow-ups on side effects, those are all covered without cost-sharing.

It is not entirely clear how carriers handle approving additional well woman visits. And we did hear from one carrier that it really depends upon how the provider bills it. If the provider builds it as a preventative service, then it will be covered without cost-sharing. If they do not, then the woman might experience some cost sharing.

Finally we asked the plans that we interviewed, because this is obviously not listed in the plan documents. This part

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of it was limited to the plans that we actually talked to, about how they are handling requests from employers that have religious objections to providing the coverage to their employees directly.

Just to give some background, as I am sure many of you know, the law does allow non-profit religiously affiliated employers to request an accommodation, so that they do not provide the contraceptive services directly to their employees and their employee's dependents, but rather, they either have to self certify that they have a religious objection and they meet the other qualifications to their insurance company or they have to let HHS know in writing of their objection.

No one really knows how many non-profits, outside of the ones that are litigating, have asked for an accommodation. And so we asked he carriers and we found out that the carriers said only a very small fraction of employers have requested the accommodation.

Carriers are also allowed to request an adjustment to their fees under the Federally Facilitated Marketplace; if they are a third party administrator and they have paid for contraceptive coverage for the employees of one of these employers. And none of the carriers are seeking reimbursement for that mechanism, and only one carrier has indicated that it adjusted premiums based on the request for an accommodation.

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What we learned, getting this information is really difficult. There was really a lot of good news. Many plans are covering many contraceptive methods without cost-sharing, but there is a lot of variation. And, not all carriers are covering all methods without limitations. The choice of plans that a woman makes—so when you are shopping for a plan or you are on a plan, might limit your coverage choices and then ultimately your *actual* choice, because many of the methods are out of price range for many women.

There is a lot more details in the report if you want to take time later to read that, but I hope this gives us an overview and a good spring board for our panel discussion. Thank you.

ALINA SALGANICOFF, PH.D.: Thank you. You guys turn your mics on, okay?

PANEL: Okay.

ALINA SALGANICOFF, PH.D.: Is this working now? Is it on? Yes—okay, great. Thank you Laurie. After all the time we spent kind of going through and figuring out how to categorize everything, you did a fabulous job putting it all together.

What I would like to do now is take some time to get some thoughts and experiences from our panelists. The first question I have for all of you is, how does this resonate to your experiences both in plans, in practice and experiences

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that women are having. Does it surprise you or not? Do you want to start Doctor Anselm?

EDWARD ANSELM, M.D.: Hi, yes. Well it does not surprise me. First, you mentioned the word variation. And variation is the enemy of quality. But the only way you can find out about a problem is by studying it. I just want to applaud the effort in starting what I hope is a larger and more detailed and granular narrative around the availability of these services.

They are very controversial; I received independent calls from consumers or interested citizens encouraging me not to cover abortion services and suggesting that we not apply certain aspects of the rules that we are trying to implement. There is a great deal of controversy around this.

I also note that a substantial number of plans were reluctant to be interviewed for this process.

ALINA SALGANICOFF, PH.D.: Yes.

EDWARD ANSELM, M.D.: And I think that just the reflection of inherent controversy or the perception of a controversy that many corporations—

ALINA SALGANICOFF, PH.D.: Around the contraception issue.

EDWARD ANSELM, M.D.: Yes, yes.

ALINA SALGANICOFF, PH.D.: Not so much discover it. Do you think it would have been easier to get this information on,

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let us say, another issue? Like smoking cessation for example? Would that have been easier? Or you think around contraceptive—

EDWARD ANSELM, M.D.: Well, all preventative services are new to health insurance companies.

ALINA SALGANICOFF, PH.D.: Yes.

EDWARD ANSELM, M.D.: So, maybe we should talk about something else other than prevention. Prevention is a great leap forward here in our country, under the Affordable Care Act, and only a recent discovery that is should be fully available.

Yes, if you were going to ask me about coverage for bariatric surgery, for example, then you know, you just pick up a phone or you can go to a health plan's website and find out what is going on.

ALINA SALGANICOFF, PH.D.: Right. Doctor Ye?

PEGGY PENG YE, M.D., M.P.H.: Yes, I think this report really confirms what we are seeing on the ground. In the office, I know that before the ACA contraceptive mandate came into play, I would always have to check in with my front desk; look at the insurance, like you know, is this going to be covered? Do we need to call the insurance company? Start getting my front office staff on the phone with the insurance company, to see if they covered a certain contraceptive option that a patient was thinking about.

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We would leave the patient in the room, while we are on the phone with the insurance company; see a couple of other patients before we went back and talked to her. Now we have really made a huge difference, most of the time, if I see the insurance company I know that they are going to cover a contraceptive method and then I can take care of that patient right there, instead of having my office staff trying to you know, wait.

So I think this really confirms our experience in that the contraceptive mandate is really working well. You know, there are certainly some small pockets where there are some idiosyncratic methods that really are not covered for, kind of, strange reasons that do not really have great medical basis. But overall, I think that it has made a great impact.

ALINA SALGANICOFF, PH.D.: I will echo that—what you just said, I think we cannot underestimate what a huge game changer this is for women. Millions of women with private insurance now are able to choose the method of birth control that is best for them without having to factor costs into the equation. And that makes a huge difference in their lives and their health and in the well being of their family.

GRETCHEN BORCHELT, J.D.: I want to echo how important this benefit is for women across the board. But, on the other side, what your report finds is basically what we know to be

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true. There are still some women that are not fully benefitting from this tremendous advance for women's health.

Women are not getting the birth control method covered at all; they still have to pay cost-sharing. The waiver process is not in place in a lot of these plans, and that means for these women, this is not a real benefit for them. I do not think these are just problems, I do not think these are just barriers; these are violations of the law. These plans that are doing this are violating the ACA. They need to come into compliance.

The benefit went into effect in August 2012. Yes it is new, yes it takes some time to implement, but these plans need to come into compliance. State regulators need to step up and enforce it and make sure that the plans are complying with the way they should.

ALINA SALGANICOFF, PH.D.: Right, well we are going to get into a lot of these issues. I wanted to start with Doctor Anselm. I think for most of us, understanding what goes on behind the scenes in plans, is kind of like a big black box. We are all fine when what we have is covered, but when the decisions that plans make to deny coverage for something that we feel that we need or our provider feels that we need, and it is kind of mysterious why it is or it is not happening.

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Can you tell us a little bit about the process that plans or the medical directors go through in terms of determining coverage decisions?

EDWARD ANSELM, M.D.: When you have a new program and a new technology and you set a service, what is required is the development of the medical coverage policy. Medical coverage policy should define how the health plan approaches it. At least in general terms so that consumers and physicians can understand what is covered and most importantly, what is not.

Specifically these coverage guidelines should outline the reasons why something might not be covered and then go into the details of the coverage techniques that were discussed in the slide. The tiering of course is against the law, because there is no cost sharing involved. And, generics would be preferred, because, you know, it makes sense to use something cheaper than more expensive. Step therapy, you know, the 'fail first' in contraception just does not resonate for me.

You know the idea that you have to try something—you know sometimes people do not tolerate a medication and so on. That is another example of failure, but none-the-less it makes sense. Prior authorization. Well, in the case of emergency contraception, you know that is a critical factor, but even in other instances there is a hassle factor.

Health plans are famous for the hassle factor. It turns out there is a lot of money that can be spent wisely or

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inefficiently within health care. And health plans medical policies represent efforts to try to do that, and they create processes, either claims operations or prior approval processes that result in the correct outcome in the most efficient manner.

Therefore, I am totally surprised by some of the findings in this paper, because the techniques mentioned therein are not intellectually defensible. At the end of the day, if you want to have a prior authorization process, you should be able to defend it. To your colleagues, to your peers, to your regulators and so on. So it should be sufficiently clear why you are doing something, and should result in a defensible denial on an overwhelming proportion of the cases. Otherwise, you are just hassling the doctor.

When you take these considerations into effect, and you look at the time available to do things and the value that is inherent in oral contraceptive technologies, it is a commonly use procedure, there is a tremendous cost spread, you have to sit down and say, do I have the time between now and when I have to file my plan, to develop a defensible medical policy that I could implement successfully through my computer claims systems.

The challenge though is to do this on time and to do this correctly. So, on the pharmacy side, I took the path of expediency and just said; it is all in. I do not have the time

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to think this through and I do not think it is defensible. I do not think it is defensible to make these distinctions, even though there are substantial variations in cost.

I think at the end of the day I wanted to be defending this. Second, verily, I did not want to defend it, because this is a subject of great public scrutiny, and who wants that attention? Health plans should want to be friendly towards women, because women make the choices in health care as in which plan to take.

Furthermore we do not want to antagonize our physicians, because we need them to participate with our plans. So, it is a lot easier to try and set up a process where the answer is yes. It always amazes me how health plans can come up with a system that is structured to come up with an answer that is 'no'.

ALINA SALGANICOFF, PH.D.: Did this particular provision, you know, a lot of plans were covering contraceptives before the ACA. They were not all doing it without cost-sharing, and there was no requirement that they do it, but a lot of them were. Did this present special challenges in terms of the implementation?

EDWARD ANSELM, M.D.: Well, the hard part is getting the claim systems right. It is really easy to say they are all in and they are all zero to your pharmacy benefits manager—that was really easy. The hard part is making certain when a

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preventive service is delivered that it is coded and billed correctly. You can set up your claims system to do so, and that takes a lot of checking and a tremendous amount of detail. But, it still requires the physician to or the billing manager to set it up correctly.

ALINA SALGANICOFF, PH.D.: Can you give us an example of when you can get the appropriate. I mean you talked about your own decision making process. When it might be appropriate for a plan to apply medical management to contraceptives?

EDWARD ANSELM, M.D.: I give you an example: if someone wanted an inpatient stay in order to implant a device. It is an office based procedure and certainly people would not want to authorize an overnight hospital stay, to perform the procedure, unless there was a really good reason to do so.

ALINA SALGANICOFF, PH.D.: Yep.

EDWARD ANSELM, M.D.: Right? So that an example where, yes, we will take care of this in the outpatient setting without prior approval, but if you want a hospital day, well then, let us talk about it. But there is always a—and the standard appeal process does hold—I mean there are time frames, probably not for all contraceptives—emergency contraceptive—but there are time frames for standard appeals and expedited appeals.

Most of the plans that participate in this study are NCQA accredited, and so they do try to get it right, and they

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are on the hook for trying to get it right. But, I agree that anytime there is a barrier to care, the delayed service and opportunity get it wrong.

ALINA SALGANICOFF, PH.D.: Okay, great. Doctor Ye, you talked a little bit about some of the changes that you have been seeing in your practice. Have you seen changes in the types of contraceptives that women are using, and how does that translate day-to-day for many of your women patients?

PEGGY PENG YE, M.D., M.P.H.: Yes, absolutely. Before the ACA a lot of methods were available to patients, but particularly the more expensive types like the long acting reversible contraceptive, the IUDs and the implants. Those tend to be at much higher cost-sharing for patients or not covered or have these step-wise therapies or prior authorizations and that kind of thing.

It is really since the ACA. You know there are a lot of different things that kind of go into the increased demand for the long acting reversible contraceptives, but certainly the accessibility, the cost and the availability is a big part of it. And that has really sky rocketed patient demand and the ability for us to place them.

The cost-sharing—you know the fact that patients do not really have to pay for it and provide cost-sharing has really significantly increased their interest—that and the ability for us to provide it on the same day as that visit.

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So, a patient comes in for a contraceptive counseling, I talked to her about all of her options and she wants the IUD. Before—if there was a prior authorization or other types of approval processes, I would have to send her home and she would have to come back once all the paperwork was done. Now, with the ACA, for most insurance plans I can place it that day. Without having to, you know, have this hassle of calling insurance companies and filling out all this paperwork.

I would say that the biggest impact really has been with the LARC methods.

ALINA SALGANICOFF, PH.D.: With the LARC methods—have you experience any difficulties that patients may have experienced. You know we have documented some barriers—

PEGGY PENG YE, M.D., M.P.H.: Right, I would say luckily most of the—like I said—the ACA has really been a huge benefit for patients. There are still some patients out there that kind of do fall through the cracks. So we have had some patients who are insured under religious organizations, and so it is not an even accommodation. They are exempt from the contraceptive requirement.

So, those patients who maybe want an IUD those costs can be astronomical, which is going to have to be paid out of pocket and they can be $500, $600 just for the device. Unfortunately she would make too much money to qualify for a

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lot of the grants that are available for low cost LARC methods, but still has no insurance coverage. And then the other one—

ALINA SALGANICOFF, PH.D.: That was not a medical management issue that was the fact that it was not covered.

PEGGY PENG YE, M.D., M.P.H.: Absolutely.

ALINA SALGANICOFF, PH.D.: Because her—

PEGGY PENG YE, M.D., M.P.H.: Because of—

ALINA SALGANICOFF, PH.D.: —her plan was exempted.

PEGGY PENG YE, M.D., M.P.H.: —the insurance plan.

ALINA SALGANICOFF, PH.D.: So it was a different plan.

PEGGY PENG YE, M.D., M.P.H.: correct.

ALINA SALGANICOFF, PH.D.: Yes.

PEGGY PENG YE, M.D., M.P.H.: Right.

ALINA SALGANICOFF, PH.D.: Yes.

PEGGY PENG YE, M.D., M.P.H.: Your report does not [inaudible 00:41:27] that ACA only applies to private insurances. So patients insured under Medicaid or Medicaid Expansion are also an out of pocket expense that patients that are kind of lost and that looses benefits.

ALINA SALGANICOFF, PH.D.: That is the next project we will do.

PEGGY PENG YE, M.D., M.P.H.: Yes.

Panel: [Laughs].

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PEGGY PENG YE, M.D., M.P.H.: A big one—another big one.

ALINA SALGANICOFF, PH.D.: Yes.

PEGGY PENG YE, M.D., M.P.H.: But it does apply to the Medicaid expansion.

ALINA SALGANICOFF, PH.D.: It should apply to—

PEGGY PENG YE, M.D., M.P.H.: It could—expansion population—

ALINA SALGANICOFF, PH.D.: —expansion population.

PEGGY PENG YE, M.D., M.P.H.: Yes.

ALINA SALGANICOFF, PH.D.: Yes.

PEGGY PENG YE, M.D., M.P.H.: Yes, yes.

ALINA SALGANICOFF, PH.D.: But the regular—

PEGGY PENG YE, M.D., M.P.H.: Regular population.

ALINA SALGANICOFF, PH.D.: —Medicaid population.

PEGGY PENG YE, M.D., M.P.H.: That is not.

ALINA SALGANICOFF, PH.D.: Yes. Gretchen in terms of the women who are reaching out to the National Women's Law Center, what have been their particular challenges there—

GRETCHEN BORCHELT, J.D.: Yes so—

ALINA SALGANICOFF, PH.D.:—that have not been resolved?

GRETCHEN BORCHELT, J.D.: —The National Women's Law Center has a hotline, a toll free hotline, women can call, CoverHer. They also have a website and we have an email

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address and it is there for women who are having trouble getting their birth control benefit. Or, if women want to tell us how successful they have been getting their benefit and what difference it has made for them.

We do hear from women every day who are so appreciative to have this benefit. It means that they can finally afford to get the birth control that is the best for them, the most effective. Which often times is the most expensive, so they can finally get it. They do not have to choose any more between paying for birth control and paying for things like groceries. They can plan their family so they can further their own education opportunities.

So it really has made a difference for these women in terms of their health, their financial security, their education, their career—as I said it really is a game changer for women. But, we also hear from women every day who are having trouble getting the benefit and we have heard stories from every woman in the United States—not every woman, I should not say that —

Panel: [Laughs].

Audience: [Laughs].

GRETCHEN BORCHELT, J.D.: —we have heard from women from every state in the country.

ALINA SALGANICOFF, PH.D.: That would be very bad.

GRETCHEN BORCHELT, J.D.: That would be terrible.

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ALINA SALGANICOFF, PH.D.: Need a couple of hotline counselors on that one.

GRETCHEN BORCHELT, J.D.: That would take all of our jobs all of the time. So these women are spending hours on the phones with their insurance companies, trying to figure out what their coverage policy is.

ALINA SALGANICOFF, PH.D.: Yes.

GRETCHEN BORCHELT, J.D.: It is hard to figure out as you said; it is very difficult. And they are spending this time, they are trying to get their birth control covered—it is just that they are getting the run around. They get conflicting information from their insurance company. Some women are told that their method just is not covered at all. Others are told, well if you want a method without cost sharing, you need to switch methods.

And I am pretty sure that we can all agree that your insurance plan should not be the decider of which birth control method you get. But that, basically, is the box they are putting women into. And then other women are getting a birth control method covered like the IUD, but sometimes are not getting the services that go with it covered. So, they are getting a huge bill at the end of that. There are definitely still problems, we are hearing about them every day.

The good news is that women are talking to their insurance companies about the problems. They are appealing.

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And they have had successes in getting the coverage for the birth control method they need. But I think the important point is that it should not always be up to the women to advocate, advocate and advocate, but the plans need to be complying in the first place.

ALINA SALGANICOFF, PH.D.: How much would you say—because another issue, which has come up a lot, is around insurance literacy? Understanding what your plan covers, what it does not cover, are you in a grandfathered plan? How—how much is, you know—or that you are in a plan, you know, you have an exemption versus how much of this is actually the plan?

GRETCHEN BORCHELT, J.D.: Yes, so there is a mix of all—

ALINA SALGANICOFF, PH.D.: Right.

GRETCHEN BORCHELT, J.D.: —of those things. I mean we hear from women who just are like; I hear that there is free birth control, what is that? You know some basic education—there are still grandfathered plans, so that is always one of the first questions we ask the women. So, you know we do have to take them through the steps of, okay, there is the grandfathering, there is a religious employer exemption; there are accommodations, so there are steps to go through. And certainly the plan information is very confusing. You alluded to how difficult it was. We are doing our own plan review, we just completed. We are going to release the report in two

weeks, but that supports a lot of what you are saying here. We have a staff of experts, really, and we had trouble reading these plan documents.

I think the insurance companies could do a lot to make the information more easily accessible and available for women to understand, but the bottom line still is the information does not help much if the plan is just not providing the benefits and not complying with the law. So, again, it gets back to plan compliance.

ALINA SALGANICOFF, PH.D.: Okay. This gets back to the issue of communications. I think a lot of this is new, the transparency. Why do you think it is? That it is so difficult for plans to be transparent about this particular issue?

GRETCHEN BORCHELT, J.D.: It, as you said, it is very common, you know, a lot of women are using contraception—

EDWARD ANSELM, M.D.: Well, I think the basic issue on health literacy is that whether or not you have been using health insurance for a period of time or whether you are new to the market as many, many people are. I think the terms, rules, and structures that we put in place are really complicated.

We send out thick program documents, which are written in legalese, and not accessible to individuals. And there is no opportunity to say what does this mean for you and how does this become valuable for you? So then, even though we provide the information, I would say, in some form on our websites, and

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sent to their homes, people do not have the time to read a thick document and figure out what part of it is for them.

I think that is the basic gap over simplifying a large issue about not knowing what a deductible is. But not knowing what is covered.

ALINA SALGANICOFF, PH.D.: Yes.

EDWARD ANSELM, M.D.: I have to say there is a certain extent that the provider community has been inconsistent in working with patients to enhance their literacy round these issues. Their role is to just try and serve the patients as best they can, but sometimes there are opportunities missed in the doctor's office.

I think that the more we get feedback on this subject, the more we learn about it; the more we can try to do better. I think it is always going to be imperfect, because people are not going to attend to things until it is too late.

ALINA SALGANICOFF, PH.D.: And Doctor Ye, I was wondering, you know, you said some plans we just know—how do you find—how do you know, like whether something is covered or not? You know on your website I saw there is your profile, and there is the list of—I do not know—it is like 30-plans that your practice accepts. How do you know?

PEGGY PENG YE, M.D., M.P.H.: Well sadly, it is really kind of through trial and error. So, like I said, since the ACA we have had, you know, most of our devices and

contraception covered. A lot of times I just prescribe—it is working the way that it should, right? I prescribe the patient the method or the device or whatever she wants after we have had that consultation and then we will find out in two or three months, if it does not get paid. So, it is usually retrospectively that we find out.

Sometimes if there is a concern, like times those devices that cost a little bit more, those we actually get on the phone if there is some insurance plan that we do not see very often, just to make sure. So, a lot of it is for the devices on our part to kind of make sure the insurance kind of covers it before we place it.

On the flip side, things that I give a prescription for, pills, the patch, the ring, you know, I give the patient that prescription, and when she takes it to the pharmacy and finds out that it is not covered, that is when we find out. She may or may not call me back and let me know that it is not covered. A lot of times patients may just say, oh, it is not covered, I did not really like any of the other options and then forego that contraception.

So, a lot of times it is kind of trial and error, unfortunately. Again, things are improving quite a bit, so that we are not relying on that quite as much, but a lot of times it is either, you know, if it is something that we are

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unfamiliar with, us calling, or the patient calling. Or we place it and see.

ALINA SALGANICOFF, PH.D.: Now, we were not able to. We initially were very ambitious and really wanted to do oral contraceptives. We did kind of go into a big hole and climbed out and said, okay, it is too hard.

But I did want to get your thoughts about oral contraceptives and are there particular challenges there? For all three of you, just so we touch on that, because that is still the leading way that women get their contraceptives. Their particular issues—

PEGGY PENG YE, M.D., M.P.H.: Well I think specifically with oral contraceptives, you know, because there are so many formulations out there, that that part you know is really still kind of based on a formulary. Like we have in the past, and so that is, you know, if the patient wants it, an oral contraceptive, then I definitely go look on the insurance formulary if I can find it. Sometimes it is integrated into our electronic medical record. So that is when I have to really work on doing the research to be able to find an oral contraceptive on her insurance.

You said there is a wide variety, so if what I was particularly recommending for a patient is not covered, there generally is a substitute that I can use. But that in particular again, is kind of, have [audio gap 00:50:57—

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00:50:59] day in terms of what we do in the office, making sure that the woman is guided on the formulary.

EDWARD ANSELM, M.D.: [Inaudible 00:51:06] more transparency around this kind of issue, because finding out in the pharmacy that it is not covered is going to be a big problem for adherence to any medication. That is another reason for us to be inclusive of a process that allows all its medication to be covered.

The question is, again, what if a patient is already on a drug, and you are writing a renewal. Why should a health plan create a barrier for that? You see in other words I really think that the rationalization for all of the coverage decisions, whether a medical or pharmacy should be made increasingly transparent. Because I hate to see disruptions in care, if I cannot get my drug would you want to change your patient's medication? Well, yes, they are similar, but you know, it is working so why not continue?

I really think that one of the outcomes of this sort of discussion is an enhanced level of transparency around, you know, the medical management rational for all the things that we do.

GRETCHEN BORCHELT, J.D.: And also, where it has come up for us through the CoverHer hotline is that we see generic only policies in plans and for some oral contraceptives, there is no generic. And so, the women need that brand covered and that is

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a problem that we see in that plans are unwilling to cover it in that instance, which they are supposed to be doing, according to the guidance of the birth control benefits.

ALINA SALGANICOFF, PH.D.: Finally, one of the things that I learned a lot about in this project was the whole issue around how different methods are classified and round medical management. I served on the IOM Committee and you know, when we made our recommendations on all FDA approved contraceptive methods, we assumed that it was all the different methods—or at least I will speak for myself—that is what my understanding was.

We did an interview with a medical director at one of the large national plans, who said they do not cover the ring, because they said it was the same delivery mechanism for the same hormones that are available through oral contraceptives. The rational was the same for the patch. I was surprised, because I did not perceive that as a medical management issue. He was pretty clear about that. I just kind of wondered, your thoughts—I know you do a lot of work on—we talked about the smoking cessation—

EDWARD ANSELM, M.D.: Yes.

ALINA SALGANICOFF, PH.D.: Think there are a lot of parallels there.

EDWARD ANSELM, M.D.: Sure.

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ALINA SALGANICOFF, PH.D.: Can you talk a little bit about kind of the issue around the delivery systems for all of you.

EDWARD ANSELM, M.D.: Well regarding that particular—

ALINA SALGANICOFF, PH.D.: Yes.

EDWARD ANSELM, M.D.: —example, the human capacity to rationalize is vast.

Panel: [Laughs].

Audience: [Laughs].

EDWARD ANSELM, M.D.: And what you describe to me is intellectually indefensible and would not stand appeal. So, why have it? You know, why have it? I think the whole point is just to make these things transparent.

When health plans get a lot of feedback that things are not working, on a local level, from consumers, form the press, who now might get interested in this sort of narrative, well, you know what they got to modify it. Your study is a snap shot of the very beginning of a process and since that time, I bet a number of them have gotten wiser with the feedback that they have gotten.

I think that we have to think about medical management, the reasonable medical management as process. We all need feedback and so when the physician sees a large number of appeals on that particular type of case, then you realize it cost me $600 a piece to do these appeals.

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ALINA SALGANICOFF, PH.D.: For the plan.

EDWARD ANSELM, M.D.: Yes right, and therefore why would I want to spend the time and the money doing them when I am going to lose at the end of the day. I think it is a process and we just have to embrace the fact that we took a great leap forward, historically, and that we are continuing to learn about how to do this better. I think this report is an important part of that process.

PEGGY PENG YE, M.D., M.P.H.: You know, I agree. I found it very, very surprising that they kind of made this distinction that is was the Nuvaring and the patch are really the same medication as birth control pills, because we all know that it really is not, at all. The way that it is delivered, just changes all the pharmaceutical properties, and the way that the body handles it.

ALINA SALGANICOFF, PH.D.: Yes.

PEGGY PENG YE, M.D., M.P.H.: I found that incredibly surprising, and I agree, just really indefensible. It just makes no sense medically to us. So, one other thing kind of paralleling, I noted in the report was a lot of sterilization procedures are covered and they did not make any distinction about how the sterilization procedure was done. Because, the one, I think one is—

ALINA SALGANICOFF, PH.D.: Short.

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PEGGY PENG YE, M.D., M.P.H.: Right. So that one person, one interviewee said that, you know, it is kind of up to the physician to kind of decide what the best way is. And I find that really similar. In the end you are getting hormonal contraception. Does it matter which way, whether you get it by pills or by patch or ring.

The method of getting it should still be covered. It is kind of a similar thing to me I think. There are also other medications that are available in different formulations, different forms. Tablets, patch, films, and you know gels. A lot of those are covered as well, I really agree it was very surprising and I am interested in hearing if it will be reversed with all these appeals.

GRETCHEN BORCHELT, J.D.: Yes. I cannot say that it is surprising to us. And we know some major plans nationwide have these five categories that they claim are all the methods, and we just strongly disagree that those are the methods. I think that if you talk to any woman, and you say, oh, is talking a pill the same as putting a patch on or putting a ring in your vagina, she will say no, those are not the same thing. Those are different methods, and each one needs to be covered. So again, I think the plans here are not complying with the law.

The good news is that we know, in our report, and we are going to talk about at least one success story that we have heard where they had broken down into the five categories, and

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when women complained again that they were not getting coverage of the ring, oh well, now the ring is a new category. But the patch is still not [interposing].

ALINA SALGANICOFF, PH.D.: I am wondering how much relates to when Laurie presented the FDA slide. And I think that part of the issue is the transitional issue around the Affordable Care Act. None of the US Preventative Services Taskforce recommendations were developed as coverage determination. They were designed to provide guidance in primary care clinical practice, about what preventative services providers should offer to their patients.

Similarly when the FDA put their information with the five different categories this was designed to be a consumer information tool, which it sounds like the plans have used and adapted as a decision making tool in terms of making their coverage policy and then they have the poster in another location, which does differentiate and actually differentiates between two different IUDs and so you know, and two different methods of emergency contraceptives.

So I think that there is kind of a lack of clarity and also differences in terms of how the—when the plans are interpreting them and the way the guidance—and you know, I do not know—the guidance is also, very general. I do not know if—I am sure there are people here in the audience who also have

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some thoughts about that, but if you want to comment a little bit about that as well?

GRETCHEN BORCHELT, J.D.:I do appreciate—I mean the ACA is a very big law with a lot of requirements right? And it is going to take some time for everybody to come into compliance with all of them. But I do think this report shows and the report we are about to release shows that there are insurance companies that are using what they see as 'wiggle room' or not clarity, lack of clarity in the guidance, to impose some policies that we think, are clear violations of the law.

I think there is a definite role for HHS and the departments to step up clarify their guidance, make sure it is clear that they are talking about the FDA poster. Those unique methods- that is what we mean, when we say all methods have to be covered. That plans need to have a waiver in place. They can address more specifically the kinds of problems that your report calls out.

ALINA SALGANICOFF, PH.D.: Yes.

GRETCHEN BORCHELT, J.D.:I think. And certainly there is a role for state regulators too; they have their primary responsibility for insuring enforcement of this benefit. They can help out with that as well.

ALINA SALGANICOFF, PH.D.: Laurie do you want to tell a little bit about how California has addressed this issue?

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LAURIE SOBEL, J.D.: So, the great state of California has issued—passed a law that is going to go into effect January 2016, and rather than saying all FDA approved methods, the law says all FDA drugs, devices and other products for women, including all FDA contraceptive drugs, devices and products available over the counter as prescribed by the enrollee's provider.

And so, the law mimics the federal law, but calls out each of those categories rather than trying to leave up to the imagination what methods are—or up to the confusing differentiation on the FDA website.

Then it further says that each plan must cover at least one or more therapeutic equivalents of a contraceptive drug. So, two things are equivalent. Like a Plan B and the generic. They have a choice if they want it covered, just the generic or Plan B, or both.

In that case though, if for some reason they cover the generic, and then the generic is not available to a woman or she has an adverse reaction to it, they then are required to cover the brand name, Plan B, and then without cost-sharing, subject to utilization management. So in that very limited situation when they cover the therapeutical equivalent and they do not cover the other therapeutical equivalent. So Plan B and the generic, they can then use some kind of utilization

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management before a woman can get the other therapeutic equivalent.

So it really diminishes the scope of when a plan can use any type of utilization management for the coverage. Because they have to cover each therapeutic—every drug that does not have a therapeutic equivalent, and if they have the therapeutical equivalent then they can cover just one of them.

ALINA SALGANICOFF, PH.D.: So the differentiation, for example, in California, around injections, for example where there, you could cover the Depo-Provera, but the SubQ—they are not generic equivalents so the plans would have to cover both methods, whereas in the federal, right now it would be just one of the methods. So it gets even more granular in terms of the requirements.

LAURIE SOBEL, J.D.: Right and it also addresses the ring, the patch—

ALINA SALGANICOFF, PH.D.: The belt.

LAURIE SOBEL, J.D.: —the belt, they would all be covered, because they are not therapeutically equivalent. To be therapeutically equivalent you have to have the same formulation and the same delivery mechanism.

ALINA SALGANICOFF, PH.D.: Oh. I think now what I would like to do is open it up to the questions to the audience. If you would like to come—there are microphones that are coming around, if you could introduce yourself and your

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affiliation that would be terrific. We are webcasting this, so it would be a lot easier. Yes, if you speak up, stand up and speak.

SUSAN WOOD: Susan, oh, sorry. Susan Wood, George Washington University, School of Public Health.

Lots and lots of really interesting stuff, and those plan documents, if you—well, it would be lovely to be able to get all those medical decisions—medical policies, but those are impossible to get. But, thank you for the hard work that you did for this.

I have a question about whether you looked across all the methods to say how many companies covered all of them or 90-percent of them, which were the—and then are you willing to name the good guys and less good guys?

AUDIENCE: [Laughs] Ooh!

ALINA SALGANICOFF, PH.D.: Do you want to take that one?

LAURIE SOBEL, J.D.: The plans that we interviewed we promised confidentiality for. So, we have not named any plans. We can say that most of the large carriers in the country are included in the plans. We have the information about plans and what they are covering, but we did not want to identify them, so we did not include in the report how many in like each plan, what you would be lacking.

SUSAN WOOD: But were there a cluster of plans that covered—like had most of them covered and then a cluster of

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plans that they really had full coverage, or was it more evenly distributed?

LAURIE SOBEL, J.D.: It was more evenly distributed.

SUSAN WOOD: [Inaudible 01:04:14]?

LAURIE SOBEL, J.D.: I would say that there was only a handful that covered everything without cost-sharing or limitations, and most plans had either a limitation or cost-sharing for at least one method.

CINDY PIERSON: Yes. Cindy. Cindy Pierson, National Women's Health Network, thank you. As Susan said, you know it is—we all hear the stories, but now you have got some data and this will help. Regulators could have stepped up before now. Many of us have been talking to them and encouraging, and some of them have sent representatives here. I do not think that we will get any exact answers today, but hopefully those representatives will go back and inform their people that pressure is growing on them to step up and fix this problem.

And as Gretchen has said so powerfully, get these plans to comply with the law. But one thing that really stands out, in my experience, the calls we get, the women we talk to at the National Women's Health Network, that did not show up in your interviews and review of the documents is the denial of the visit for the IUD insertion.

Your report implies that the least of the plans that you interviewed and reviewed documents, they believe they are

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covering it. Our experience of talking to women is that is a very, very common interview, where people get treated unfairly.

LAURIE SOBEL, J.D.: I wonder if that is a coding issue.

ALINA SALGANICOFF, PH.D.: Yes. That you wanted to comment on that?

EDWARD ANSELM, M.D.: I think that this is really about, and my experience of that particular technical issue is that it has to be coded correctly in the health plans system. And then it has to be coded correctly as a preventative service in the doctor's office. And only when both things work, will there be zero co-payment for the visit.

None-the-less, one can only—in the systems where you have advocacy, one can only encourage the clients to appeal, to have a refund, so that they can be appropriately covered. Again, it is just part of the feedback loop that we need to create.

CINDY PIERSON: I know I do not have the mic in my hand so I apologize to the rest of the house folks, but the stories we here are—great physicians like [inaudible 01:06:39]?

CINDY PIERSON: On the phone. With the plan at the time and being told no. So, obviously the physician's office is able to describe it appropriately as part of a contraceptive as preventive care. So it is inside the plan with that necessary coding has not happened. But then why do they tell you in the

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report Laurie that or in their documents, that it is covered, which implies that they have it coded correctly?

LAURIE SOBEL, J.D.: My guess is that they think they are covering it and that there has not been enough communication. This goes back to the issue of communication with the doctor's office to adequately educate doctors on how it needs to be coded. I do not know the specifics, I can just tell you what we found in the study, is that they think they are covering it.

ALINA SALGANICOFF, PH.D.: Yes they were pretty clear about what they were not covering. So, we did not have any reason to believe that they would say that. I mean they were very open about that.

EDWARD ANSELM, M.D.: Yes, they just—just a comment on that.

ALINA SALGANICOFF, PH.D.: Yes.

EDWARD ANSELM, M.D.: The complexities—I never thought I would have to go back and learn Co-Ball again, but the complexities of making sure that the things you say to your programmers are translated into operational and successful policies on the other side are innumerable. And I do not know that everyone has gotten to that. That is where the feedback is really important.

PEGGY PENG YE, M.D., M.P.H.: And one last comment on that too, I think you know, we probably all have had

experience, my office certainly has, but every time you talk to a different person they give you a different answer. And so I think that also depends upon the person at the other end of the phone line about how much in-depth they are at going in to looking in the plan, and looking into the right codes.

I agree there probably is maybe a difference in the communication as well as making sure that they are the right codes and such. I have not personally had a significant issue with that in the past or from my experience, but you know I am also not the patient who gets the bill at the end of the day.

ALINA SALGANICOFF, PH.D.: Yes, I was wondering in terms of what types of communications happen within a plan in terms of the decisions that you make as a medical director around coverage, and how that goes to member services and communicated to the physicians. How much of that is wires getting crossed as well?

EDWARD ANSELM, M.D.: Well we do go through processes of plan review and design, but we can always get better at that. And, you know, I just got some great feedback on my formulary- we could really organize the categories a little bit better. And I think that there is no perfect way to do things and I think we are all continuing to learn.

I think there are 400-health plans that are each figuring that out on their own, and maybe the more guidance we

get from central regulatory authority, be it the federal government, the state, the better.

I think that it is very, very difficult to cover everything at the level of literacy, clarity and availability that you need. I think that every health plan makes good faith efforts to allow their members to understand what services are available, but recognize that that is an imperfect, but still improving process. Okay?

ALINA SALGANICOFF, PH.D.: Sure. Quest—

KIMBERLY LEONARD: Hi.

ALINA SALGANICOFF, PH.D.: Oh, okay.

KIMBERLY LEONARD: Kimberly Leonard, Health Care Reporter with *US News* and *World Report*.

A couple of questions, first of all do we have a sense as to how many women are affected by this or what percentage? I am not sure if that is in the report or not, so I was wondering whether grandfathered plans played a role in all of this.

LAURIE SOBEL, J.D.: We do not have the numbers of women, but I can say again, that it—many of the largest carriers—most of the largest carriers in the country are included in the study. So, it is large numbers of women, but I could not give you a specific number.

And grandfather plans are not included, because we asked them for their coverage policies for all new plans. So,

the grandfather plans are not—did not skew the results in any way.

ALINA SALGANICOFF, PH.D.: Yes, and I would just add that one of the things that we learned is that, because this is a very common—because contraception is so common, that most of the plans make coverage across all their lines of business. So it happens at the national level. It is not like; we are doing this in Indiana, this in California, and this in Texas.

EDWARD ANSELM, M.D.: Right.

ALINA SALGANICOFF, PH.D.: And it is just so it is yes, and we do not have our—the numbers for that unfortunately. I would like to take a question over on this side, in the back there. Yes.

JANE WISHNER: Yes, I am Jane Wishner, I am with the Health Policy Center at the Urban Institute and I wanted to follow up on the point you were just making about similarity across plans and across markets, and ask a couple of questions about that.

It sounds like in looking at your methodology that you did find that contraceptive coverage was not used to kind of, vary benefit design across different markets. And so that was one question. The second is the differences between employer sponsored insurance and the marketplace plans, in particularly, the whole issue of transparence in the market places and health insurance exchanges.

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So, when an individual is choosing a plan, it seems that some of the issues that you have identified are also relevant to other challenges in terms of transparency of who is in network as a provider, what is in the formulary. Did you find any difference between the employer plans, which for many employees, for many women, may not be something they chose, it is a question of what is covered. But when you are going about open enrolment and choosing a plan is there better access to information in terms of contraceptive coverage?

LAURIE SOBEL, J.D.: So when I said we found that carriers really set these policies at the national level and did not vary them either by group market, small market, individual market, they created them and they were good for them in basically all regions that they offer coverage and for all plans. And that was surprising to us. We thought they might vary it depending—but it kind of makes sense, because the requirement is the same for all of those markets under the ACA. So, we did not see any difference. But the transparency, I think it is equally hard for all policy holders to figure out what their coverage is.

Many of the documents are the same for group coverage as for individual coverage. Maybe some of the market places might be helping with some of the transparency, but we did not see that.

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ALINA SALGANICOFF, PH.D.: Did you want to add something?

EDWARD ANSELM, M.D.: So in filing documents for New York and New Jersey, which I have done, you have to define a benefit set around the product type, and offer that same product type in the employer market and in the individual market, it is identical. And then there is a level of consistency, if you are going to have a medical policy and a claims policy to be fairly consistent, in that dimension, because if you want to do it differently you have to explain *why* you will do it differently.

Even though I critique the medical policies that plans may have, they at least inspire to be internally consistent and apply to all lines of business around a given health plan.

ALINA SALGANICOFF, PH.D.: We had another question here, and then over there.

EMMA PATEL: Emma Patel at George Mason University, School of Public Policy. I was really interested when you said that long acting reversible contraceptives had the largest impact after the Affordable Care Act, specifically IUDs. There are not a ton of hormonal, two right now, and Mirena and Skyla and then one Liletta, that was just FDA approved. Do you see any challenges for new IUDs that are FDA approved like Liletta getting covered under health plans now opposed to Affordable

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Care Act, when there are already Mirena and Skyla already covered? Do you have any comments on that?

LAURIE SOBEL, J.D.: I actually do expect that there is going to be issues. I think that we—some of the research has shown that there are IUD same coverage for either the Mirena or the Skyla so those are two hormonal methods that already exist. So, adding a third hormonal method for an IUD is going to be very similar.

There is always, you know, that Liletta just came on the market and so there is always going to be a little bit of time period before it is going to be covered by a lot of insurances. But there is already kind of that transition. I would not be surprised if that coverage is going to be delayed significantly.

ALINA SALGANICOFF, PH.D.: Oh, I am sorry, in the middle there, I am sorry, she was at the—popped her hand up and then yes—

LAURIE SOBEL, J.D.: In the middle aisle yes?

ALINA SALGANICOFF, PH.D.: She is trying really hard [laughs].

LAURIE SOBEL, J.D.: Yes.

ALINA SALGANICOFF, PH.D.: I see you.

SPEAKER: Fine. Hi Alina, Gwen [inaudible 01:15:57] Health Care, so just want to add my sentiments and thank you for this important research to Kaiser.

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My question—you started out in referring to insurance plans, were tackling new preventative services, and you said that is new. I am just curious, do you have a sense if there is the same variability for the other preventative services that have been added that there is for contraception? I am just curious about that, I know that is not what this study was intended to do. And sort of a second part, does the insurance industry at large, do they discuss the contraceptive coverage topic? Do you anticipate that they would or would not take a public position on that?

EDWARD ANSELM, M.D.: Well, let me answer the first quest—second question first. I do not—I have gone to many national meetings and I do not think I have ever attended a forum where it was discussed across plans of what we might cover.

Not infrequently in these debates and these discussions there is a conflict of trade agreements. I think that is misguided. I think we are in the wrong trade if we have a conflict to talk about what is good for our patients, but that is another story.

I would say generally speaking, health plans do not have a discussion about this particular type of subject, although they may.

To answer the first question, we do know that there is tremendous variation in implementation around preventive

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services. The American Lung Association came out last week with a report studying coverage for smoking cessation medications. And so there are seven FDA approved medications and not unlike our own study, all are should be covered according to the Preventive Services Taskforce. So there is another example where there is a tremendous variation, alright, and is there an explanation for that? I would love to see it.

GRETCHEN BORCHELT, J.D.: I would like to add if I may, so as I mentioned we have a report coming out in two weeks about the contraceptive coverage provision, but we have a companion report that looks across plans at a range of women's services and whether plans are complying with, not only the preventive services, but other services that are important women that the Affordable Care Act requires, like maternity care. And unfortunately we found violations across the board pretty much. In the well woman visit we actually found some limitations in the plan documents, maternity care problems. So we did find a number of violations.

ALINA SALGANICOFF, PH.D.: Another question? Susan.

SUSAN FOGEL: Okay.

ALINA SALGANICOFF, PH.D.: We need—in the mi—yes. In the middle, perfect.

SUSAN FOGEL: Thank you so much, I am Susan Fogel with National Health Law Program and we were very excited to have

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sponsored California's bill along with the California Family Health Council.

We took to heart the IOM report and our slogan basically was, all means all, it is a very simple message. We found in California—you know I was really happy to see that your findings and how it affirmed the much more—much less rigorous research that we did, but we found tiering even though it is non—what did you say? Just no common sense—

GRETCHEN BORCHELT, J.D.: Indefensible.

SUSAN FOGEL: —we found that even though tiering makes no sense when you say no cost-sharing, what we found was one or two plans, no co-payment, but you had to meet your deductible first. So, they have reinterpreted what no cost sharing means.

Lots of prior authorization, lots of failure to cover, but also a lot of step therapy. And, as you were pointing out, Gretchen, you have to take pills and fail. Meaning what? You got sick, had an allergic reaction or you got pregnant and then you could get a ring I guess as a postpartum method.

AUDIENCE: [Laughs].

PANEL: [Laughs].

SUSAN FOGEL: One of the questions that I did have was, we found that not everything was covered as a pharmacy benefit—

LAURIE SOBEL, J.D.: Yes.

SUSAN FOGEL: —but perhaps as a medical benefit, and I am wondering if you found that and as Doctor Anselm was

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pointing out, just to add to less and less transparency, obviously women would look at the formulary if they knew how to find it, and did you find anything hidden in that way?

LAURIE SOBEL, J.D.: Definitely. Most commonly the LARC's were not on the formularies, they were considered a medical service, because they are provided by the doctor. And so often times, but not always, often times those were not on the formulary and they were part of a medical service. Certainly sterilization, the procedure as well as the ancillary services, are considered medical, and so that is why we had so much difficulty finding out about sterilization. [Inaudible 01:21:11].

LAURIE SOBEL, J.D.: Yes.

EDWARD ANSELM, M.D.: Well, generally speaking it would be my preference to have something on the pharmacy benefit rather than the medical benefit, because all too often there is a markup. As whatever contract the doctor may have, is maybe a markup on the procedure, on an implantable device. So we can get it cheaper through our pharmacy. So if that is the way they have to get it, then my goal is to make it fully available, to create no barriers, but it certainly if someone chooses to get it from our pharmacy, I am delighted, because they just saved $100.

SUSAN FOGEL: But then they would have to make two visits.

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LAURIE SOBEL, J.D.: Right.

EDWARD ANSELM, M.D.: Agreed.

SUSAN FOGEL: Right I mean so it would work—for the plan it works, but in terms—

EDWARD ANSELM, M.D.: Right.

SUSAN FOGEL: —of for a woman, she would have to go to the pharmacy and get that.

GRETCHEN BORCHELT, J.D.: And you would have to pay for two visits is the plan.

LAURIE SOBEL, J.D.: Yes.

EDWARD ANSELM, M.D.: Hm, um—

GRETCHEN BORCHELT, J.D.: You would.

LAURIE SOBEL, J.D.: Yes.

EDWARD ANSELM, M.D.: Anyway—

AUDIENCE/PANEL: [Laughs].

EDWARD ANSELM, M.D.: —I am lowering the barriers. Sometimes the cost difference is more substantial than $100.

LAURIE SOBEL, J.D.: Yes. You have to remember that, yes.

ALISON STEVENS: Hi, Alison Stevens with Women's eNews. My question is for Gretchen. I am wondering if you have any sense of or data on whether women of color are experiencing limitations or cost-sharing more so than other women. And also

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just what the implications of this variation are for women of color.

GRETCHEN BORCHELT, J.D.: Well I would certainly invite anyone on the panel to answer. I do not know that we have, you know, specific data, but obviously we know across the board, women of color experience disparities at a greater rate. And, I would expect that to be true for implementing this benefit as well.

I think that the impact on women of colors this [audio gap 01:22:54] really advances women's health and lives in a number of ways and helps their bottom line, helps their family's health, helps their ability to participate equally in society, in terms of finishing their careers. Finishing their education and furthering their career, I think that is generally true for everyone.

LAURIE SOBEL, J.D.: Yes we were not able to—I mean we could not tell what the numbers looked like for the plan. This is an issue that cuts across for all women.

ALINA SALGANICOFF, PH.D.: Question over there in the back.

RACHEL SUPPÉ: Rachel Suppé with Reproductive Health Technologies Project. My question is for Laurie, I was wondering if you could clarify—when you were talking about Plan B and generic EC pills, did you mean they were covered if the woman had a prescription or if she was purchasing them OTC and then submitting them for

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reimbursement? And as a follow up to everyone, I was wondering if you had any more details you could share about insurance coverage of OTC EC products. I know the HRSA language says as prescribed by so and so, but I would argue that that can be interpreted broadly. So, any information you may have on that would be great.

LAURIE SOBEL, J.D.: In the report for—I assume that you are talking about in our spending is not what I was talking about for the California Law.

RACHEL SUPPÉ: Right.

LAURIE SOBEL, J.D.: So, for our findings, that is with a prescription, we do have some information in the report about plans policies for the over the counter and those vary from—they are different from what I presented, for the coverage.

PEGGY PENG YE, M.D., M.P.H.: And then I think for your general question in terms of EC's now, the effect now that they have gone OTC, at least for Plan B. I have heard varying things also from—

LAURIE SOBEL, J.D.: Yes.

PEGGY PENG YE, M.D., M.P.H.: —insurance plans, about whether they need prescription or if it is OTC, then they are not going to cover it. It depends upon what insurance plan. So, as a general rule, I continue to write prescriptions for patients.

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LAURIE SOBEL, J.D.: Right, and there is no requirement that it be covered unless, I mean, as much as we know that it would be good practice.

ALINA SALGANICOFF, PH.D.: Some of the plans—one of the plans actually had a system where at the pharmacy you want to talk about that example that was interesting?

LAURIE SOBEL, J.D.: Sure so they had a form where the woman went to the pharmacy and picked up something over the counter. They had an actual form where they could then ask for reimbursement after the fact.

EDWARD ANSELM, M.D.: I like it.

ALINA SALGANICOFF, PH.D.: You like it? Uh, question over there, yes.

REBECCA DAVIDSON: Hi, I am Rebecca Davidson of the Pharmaceutical Researchers and Manufacturers of America. I was wondering, particularly to Gretchen/Laurie, I know it was not part of your study but I was wondering if you had experienced women experiencing the barrier of basically only getting their contraceptive covered if they had mail order prescriptions. That is something that we heard about in the news, and I did not know if either of you had sort of seen it on the ground, or if in your research like if the plan documents that, if that was something that you had come across.

LAURIE SOBEL, J.D.: We did not come across that.

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GRETCHEN BORCHELT, J.D.: We heard some reports of problems with the mail order in our Cover Her Hotline. It is affecting some women, but I do not know how wide spread it is, but it certainly came up.

JULIE GONEN: Good morning—Julie Gonen with the Center for Reproductive Rights. I think this question is primarily for Gretchen. I know that the guidance under the ACA is fairly vague right now, but I guess what I am wondering is where maybe you guys see the line between reasonable medical management and non compliance with the law. I know that we are not at the point like where California is going, but if a plan only does cover one implant or one IUD as was found, where is the tipping point between, well, that method is available versus—or do you think that everything should be covered under the ACA, the way you read it now?

GRETCHEN BORCHELT, J.D.: Well, I think the guidance is clear that if there are some reasonable medical management techniques then there has to be a waiver process. So, if they cover one version, but a woman needs a different method, or a different, you know, the generic versus the brand, she should be able to get that. And the problem is, as the report found, plans just do not have that waiver process. So actually I think prob [audio gap 01:27:16] but I think that the California law is really a clarification of what the guidance is and spells it out so there is no doubts.

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I would not define the California law a step further, I would just say it is a clarification of what the federal guidance is.

ALINA SALGANICOFF, PH.D.: Okay, you got a question?

BETSY WIEN: Betsy Wien with the American Congress of OBGYNs and I just had a question of whether you found there was an upper age limit cut off? We had heard about a year ago that plans were cutting off around 44, 45 even though there are some older women who are still fertile and are at risk of pregnancy, and whether, either Gretchen you have heard this on your hotline, or whether you saw evidence that there are clinical policy guidelines that the insurers that do not follow our guidelines?

LAURIE SOBEL, J.D.: We did not find that.

GRETCHEN BORCHELT, J.D.: We have found that yes.

ALINA SALGANICOFF, PH.D.: I have not heard that. Other questions? No? Well, actually we are right on time. So if there are no further questions, I would like to thank everyone for really a really interesting disc—and far reaching discussion. Thank you to the audience, and thank you to our spectacular panelists. Thank you.

[END RECORDING]

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