Aetna Co-Pay and Medical Exception for Contraceptives Policy (Affordable Care Act - Preventive Care Services)

Purpose:
The purpose of this policy is to define covered products and to create a pathway for approval of a copay exception in situations where a contraceptive not normally covered at zero dollar copay is determined to be medically necessary.

BACKGROUND:
According to the updated guidance, the Affordable Care Act requires that the plans and issuers must cover without cost sharing at least one form of contraception in each of the methods (currently 18 methods) that the FDA has identified under the current Birth Control Guide. Within each method, plans and issuers may utilize reasonable medical management techniques. A plan or issuer generally may impose cost sharing (including full cost sharing) on some items and services to encourage an individual to use other specific items and services within the chosen contraceptive method.

The contraceptive methods currently identified by the FDA with at least one form within each method that Aetna covers at zero dollar member cost share for women and medically documented transgender members:

(1) sterilization surgery for individuals with female reproductive organs;
(2) surgical sterilization implants for individuals with female reproductive organs;
(3) implantable rod;
(4) IUD copper;
(5) IUD with progestin;
(6) shot/injection;
(7) oral contraceptives (combined pill);
(8) oral contraceptives (progestin only);
(9) oral contraceptives extended/continuous use;
(10) patch;
(11) vaginal contraceptive ring;
(12) diaphragm;
(13) sponge;
(14) cervical cap;
(15) female condom;
(16) spermicide;
(17) emergency contraception (Plan B/Plan B One Step/Next Choice);
(18) emergency contraception (Ella).

In accordance with the Affordable Care Act, claims for Non-Preferred Brand or formulary excluded contraceptives that meet medical exception criteria below are eligible to members at zero copay.

MEDICAL EXCEPTION COVERAGE POLICY:
Aetna will cover generic and preferred brand products in categories listed above for members with no cost sharing when medically necessary for use as contraception regardless of gender identity.

Aetna will cover non-preferred brand & formulary excluded products in categories listed above with no cost

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sharing for members who meet the following criteria:

- Member is female or medically documented as transgender, AND
- Product is medically necessary for use as contraception, AND
- Documented contraindication, allergy or intolerance to one preferred contraceptive alternative, OR documented failure of an adequate trial of one month of one preferred contraceptive alternative, OR otherwise determined by the member's provider that the contraceptives covered standardly as preventive are not medically appropriate

AUTHORIZATION PERIOD AND LIMITATIONS

Initial Approval: 3 years
Extended Approval: 3 years, based on continued therapeutic response

This policy applies in the following situations:

- The prescription is medically necessary for contraception. The member requesting the prescription is identified as female or identified as male but is a transgendered or gender dysphoric.
- When a contraceptive not normally covered at a zero dollar copay is medically necessary for a member.

WHY ARE EXCEPTIONS TO THE $0 COVERAGE REQUIREMENT REQUIRED?

The ACA requires that health plans provide coverage of contraceptives with no cost sharing requirements to the member. The purpose of this policy is to allow any contraceptive to be covered at a zero dollar copay if the preferred alternatives are not acceptable or the physician determines that a non-preferred contraceptive is medically necessary.

WHAT IS INVOLVED IN OBTAINING A MEDICAL NECESSITY REVIEW OR COPAY EXCEPTION?

For a request for either a medical necessity review or a copay exception for a non-preferred or non-formulary drug, the prescribing doctor must contact Aetna Precertification to request approval of the drug to be covered without a member cost share. The request will be reviewed within 72 hours. If the request is marked urgent (eg. emergency contraceptives), it will be reviewed within 24 hours.

HOW IS NOTIFICATION OF THE MEDICAL NECESSITY OR COPAY EXCEPTION DETERMINATION COMPLETED?

- If the request is approved, the physician will be notified. The requested drug will then be covered with no member cost share. Notification to members will also be provided when required by the state.
- If the request is denied, both the member and the physician will be notified. In the notification, Appeal rights and process will be outlined and provided.

REFERENCES:

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4. PDR® Electronic Library™ [Internet database]. Greenwood Village, Colo: Thomson Micromedex. Updated periodically
5. Clinical Pharmacology [Internet database]. Gold Standard Inc. Tampa, FL. Updated periodically.
6. Women's Preventive Services Guidelines. http://www.hrsa.gov/womensguidelines/ Updated periodically.
7. FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXVI). May 11, 2015. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf