HINMAN STRAUB PC
ATTORNEYS AT LAW

121 State Street
Albany, New York 12207-1693
Tel: 518-436-0751
Fax: 518-436-4751

MEMORANDUM

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HINMAN STRAUB CONTACT PEOPLE: Cheryl Hogan and Sean Doolan

RE: Explanation of Department of Financial Services Final Regulations Regarding Coverage of Contraceptives and Medically Necessary Abortions

TOTAL PAGES: 4

In June, 2017, the Department of Financial Services ("DFS") issued two final regulations regarding coverage of contraceptives and abortions. These regulations were proposed in January of this year (as explained in our memorandum dated January 24, 2017) and were recently finalized and adopted by the DFS. Few changes were made to the final versions of these regulations.

The final regulations are explained below.

1. Coverage of Contraceptives

Currently, the Insurance Law requires Plans to cover contraceptive drugs and devices approved by the FDA, as well as women's preventive care provided for in comprehensive guidelines supported by the health resources and services administration ("HRSA"). These requirements were added to the Insurance Law to conform to the Affordable Care Act ("ACA").

The proposed regulation provides that Plans must cover an initial three-month supply of such contraceptives and, for subsequent dispensing of the same contraceptive covered under the same policy, Plans must cover the entire prescribed supply, up to 12 months, at the same time. In other words, Plans would have to permit and cover a three-month supply of contraceptives, followed by up to a 12-month supply. In DFS' Assessment of Public Comments, it explains that it interprets the regulation as allowing a fill of the remainder of a 12-month supply (i.e., a nine-month supply) or a full 12-month supply after the initial three-month supply. The requirement to cover up to a 12-month supply is a new requirement; it is not required under the ACA.

The final regulation removes the requirement that was included in the proposed regulation that required the 12-month supply to be prescribed by the same provider that prescribed the three-month supply. DFS noted that women often see different providers within the same practice or switch providers, and considered the requirement that the prescription be issued by the same provider burdensome.

As had been proposed, the regulation also adopts provisions from an ACA FAQ which require Plans to cover, without cost sharing, at least one form of contraception within each of the methods of contraception that the FDA has identified. Additionally, if a woman's provider indicates that a particular contraceptive method that would otherwise require cost sharing is medically necessary, the Plan must defer to the provider's recommendation and must provide first dollar coverage of such method. The regulation only applies this provision to in-network coverage; therefore, Plans would not have to provide out-of-network contraceptive coverage for all FDA-approved methods or provide first dollar coverage of a contraception based on a provider's recommendation.

For contraceptive forms that are covered without cost sharing, the final regulation includes a provision that requires Plans to cover, without cost sharing, insertion or implantation of the contraceptive, as well as services related to follow up and management of side effects, counseling for continued adherence, and device removal. The addition of this language is consistent with FAQs issued by the federal Department of Labor, which specify that coverage of a contraceptive form without cost sharing includes clinical services, including patient education and counseling needed for the provision of the contraceptive method.

The regulation takes effect on August 27, 2017, and applies to all policies issued, renewed, or modified after this date.

2. Coverage of Medically Necessary Abortions

This regulation codifies the Department of Financial Services' position that Plans are required to cover medically necessary abortions. The regulation itself does not provide a definition of "medically necessary," nor does it require Plans to defer to a provider's statement of medical necessity. However, in DFS' response to comments on the proposed regulation, it stated that:

> Medical necessity determinations are regularly made in the normal course of insurance business by a patient's health care provider in consultation with the patient, subject to the utilization review and external appeal procedures in Article 49 of the Insurance Law and Article 49 of the Public Health Law. The Department has therefore clarified the proposed amendment to incorporate this standard and to also explicitly state that determinations of medical necessity cannot be made or impacted by any other individual, including, without limitation, a patient's employer or the group policyholder or contract holder covering the patient.

Despite this language, however, the final regulation as published in the State Register is unchanged from the proposed regulation. Therefore, Plans are able to rely on the regulation as published, without regard to DFS' language in the Assessment of Public Comment.

As proposed, the regulation goes beyond current law by requiring all medically necessary abortions to be covered without any cost sharing, including deductibles. "High deductible health plans" as defined by the IRS can, however, subject medically necessary abortions to deductibles.

The final regulation includes a religious employer exemption that is more narrow than had been originally proposed. That is, the final regulation does not include language permitting "qualified religious organizations" to be exempt from the mandate. Rather, only "religious employers," which is defined consistent with the contraceptive mandate, can be exempt.[1] Plans must obtain annual certifications from these groups indicating that they are religious employers and that they object to covering abortions on religious grounds. Plan must then automatically issue riders to all members of the groups at issue at no cost. This is unlike the current religious employer

[1] A "religious employer" is an employer for whom the inculcation of religious values is its purpose and it primarily employs and serves people who share the same religious tenets.

exemption for contraceptive services, which requires members of the group to purchase a rider from the Plan. The rider must clearly and conspicuously specify that the religious employer does not administer medically necessary abortion benefits, but that the insurer is issuing a rider for coverage of medically necessary abortions. The rider must include the insurer's contact information for questions.

The regulation takes effect on August 20, 2017, and applies to policies issued, renewed, or modified after this date.