Health insurance and Medicaid coverage of contraceptives in Vermont

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Health insurance coverage requirements (8 V.S.A. § 4099c)

- Health insurance plans must provide coverage for ***outpatient contraceptive services, including sterilizations***, and provide coverage for the purchase of all ***prescription contraceptives and prescription contraceptive devices*** approved by U.S. Food and Drug Administration (FDA)

- Health insurance plans must provide coverage with ***no deductible, coinsurance, co-payment, or other cost-sharing requirement*** for at least one drug, device, or other product in each contraceptive method for women identified by FDA and prescribed by a health care provider

    - There are currently ***18 FDA-identified methods*** of contraception for women:
        1. Sterilization surgery, such as tubal ligation
        2. Sterilization implant, though the only FDA-approved product, Essure, is no longer being sold in the U.S.
        3. Intrauterine device (IUD) containing progestin (this is a long-acting reversible contraceptive (LARC))
        4. IUD containing progestin (LARC)
        5. Implantable rod containing progestin (LARC)
        6. Contraceptive injection containing progestin
        7. Oral contraceptives ("the Pill") – combined pill
        8. Oral contraceptives ("the Pill") – extended/continuous use combined pill
        9. Oral contraceptives ("the mini Pill") – progestin only
        10. Contraceptive patch
        11. Vaginal contraceptive ring
        12. Diaphragm with spermicide
        13. Contraceptive sponge with spermicide
        14. Cervical cap with spermicide
        15. Female condoms
        16. Spermicide alone
        17. Emergency contraception ("morning after pill") – levonorgestrel
        18. Emergency contraception ("morning after pill") – ulipristal acetate

    - The coverage must include ***patient education and counseling*** by the provider regarding appropriate use of the contraceptive method prescribed

    - If there is a therapeutic equivalent of a drug/device for an FDA-approved method, the plan can cover more than one drug/device for that method and impose cost-sharing requirements, as long as at least one drug/device for that method is available without cost-sharing

- If the provider recommends a particular service/drug/device based on medical necessity, the plan must defer to the provider's judgment and provide coverage without cost-sharing

- Health insurance plans must provide coverage without cost-sharing for ***voluntary sterilization procedures*** for men and women

    - Coverage without cost-sharing for vasectomies is not part of ACA requirements, and will not be required if it would disqualify a high-deductible health plan from eligibility for a health savings account under federal law

- Health insurance plans must provide coverage without cost-sharing for ***clinical services*** associated with providing the contraceptive drugs, devices, products, and procedures and related follow-up services, including:

    - management of side effects
    - counseling for continued adherence
    - device insertion and removal

- Health insurance plans ***and Medicaid*** must provide coverage for a supply of prescribed contraceptives ***intended to last for 12 months***

    - Health care provider decides whether to dispense or furnish them all at once or over the course of the 12 months

Medicaid coverage of contraception

- Vermont Medicaid provides coverage for "family planning" services and supplies ***without co-payment requirements***

- "Family planning" services and supplies include all of the 18 FDA-identified methods of contraception for women list above

    - No coverage is currently available for the sterilization implant (#2 above) because there is no product currently available; if there were one, it would be covered

- Medicaid covers sterilization for men and women ***only if the following conditions are met***:

    - The beneficiary has voluntarily given informed consent and signed a consent for sterilization form in accordance with federal regulations
    - The beneficiary is mentally competent
    - The beneficiary is at least 21 years old when the consent is obtained
    - Between 30 and 180 days have passed between the date of the informed consent and the date of the sterilization, except in cases of premature delivery or emergency abdominal surgery