Massachusetts ACCESS Law
Common Questions and Answers (Q&A)

Massachusetts law (Chapter 120 of the Acts of 2017) – also referred to as the ACCESS Law - sets forth specific requirements for contraceptive coverage by insurance companies in Massachusetts. Under the law, insurance carriers providing health insurance coverage to fully insured individuals must cover at least one (1) of the federally approved contraceptive drugs, devices, and other products as listed in the federal Birth Control Guide - https://www.fda.gov/consumers/free-publications-women/birth-control - without cost sharing; must allow for a 12-month supply of an approved prescription contraceptive drug; and must cover patient education and counseling on contraception. The law also requires coverage for FDA-approved over-the-counter emergency contraception when acquired with a prescription or pursuant to a standing order.

The Division of Insurance provides the following Q&A to help insurance companies, providers, pharmacists, and consumers understand the contraceptive access rights provided under the ACCESS law. This and other Massachusetts insurance laws apply to fully insured health plans issued under Massachusetts law by insurance companies, Blue Cross and Blue Shield of Massachusetts, and Health Maintenance Organizations (collectively referred to as "Insurance Carriers").

DIFFERENT TYPES OF HEALTH PLANS

Does the ACCESS law apply to all health insurance plans?
The ACCESS law applies to all fully insured health benefit plans issued to individuals and employers in Massachusetts, including health plans insured through the Massachusetts Health Connector (e.g., all ConnectorCare Health Plans). Massachusetts-issued insured health plans must provide access to mandated health benefits, including access to up to a 12-month prescription contraceptive following an initial trial period dispensing, **of not more than 3 months,** of that same prescription contraceptive ("trial period").

The ACCESS law also applies to some government programs (e.g., Medicaid (MassHealth) and plans offered by the Group Insurance Commission), but these are not subject to Division of Insurance jurisdiction.

Many large employers self-fund employee health benefits, meaning that they pay the benefits from their own resources rather than buying an insured health plan from an Insurance Carrier. These self-funded health plans are exempt from state mandated benefit requirements, including the ACCESS law.

How can someone know if their health plan is subject to the ACCESS Law?
Individuals should contact their employer's human resources representative or their health insurance plan to understand whether they are in an insured health benefit plan issued in Massachusetts that is subject to the protections of the ACCESS Law. Ask "Is my health plan fully-insured and subject to state insurance mandates, or is it self-funded?"

AVAILABLE CONTRACEPTIVES

What contraceptives are available to me/my patient under this law?
The law requires Insurance Carriers to cover every category of federally approved contraceptive drugs, devices, or other products - except male condoms - that are listed in the federal Birth Control Guide:

https://www.fda.gov/consumers/free-publications-women/birth-control. An Insurance Carrier may create a formulary of covered prescriptions or supplies, but it must cover every category, including IUDs, implantable rods, shots, oral contraceptives, patches, diaphragms, vaginal rings, sponges, and cervical caps.

Insurance Carriers may provide coverage for more than one drug, device, or other product but are not required to include all such therapeutically equivalent versions so long as at least one is included and covered without cost-sharing.

COST-SHARING

Are there any out-of-pocket costs for contraceptive coverage?
It depends. Under the law, the Insurance Carrier must provide coverage, without any cost-sharing to the individual, for at least one (1) specified federally approved contraceptive drug, device, or other product in a federally defined category as listed in the federal Birth Control Guide - https://www.fda.gov/consumers/free-publications-women/birth-control. Insurance Carriers may provide coverage for more than one drug, device, or other product in a federally defined category but are not required to include all such therapeutically equivalent versions so long as at least one is included and covered without cost-sharing. Consumers can contact their Insurance Carrier to learn which drug, device, or other product is covered by their health plan without cost sharing.

Could there be instances where cost-sharing would apply for contraceptive coverage?
Carriers may not charge cost-sharing on the one specified drug, device, or other contraceptive product in a federally defined category. In general, all other drugs, devices, or contraceptive products in a federally defined category may be subject to plan cost-sharing.

In certain circumstances, a doctor may prescribe other than the specified drug, device or contraceptive product because the doctor finds it medically necessary for the patient. In this case, this drug, device, or contraceptive product would not be subject to cost-sharing if the health plan finds that it is medically necessary. If the health plan does not find the drug, device, or contraceptive method to be medically necessary, then the member may have cost-sharing.

It is important to note that consumers may also be able to seek a medical necessity determination for a contraceptive not covered by their health plan, which would be without cost-sharing (Refer to "**Alternate Contraceptives,**" below, for more information).

ALTERNATE CONTRACEPTIVES

What is the process if I/ my patient cannot use the contraceptive type covered by the health plan for medical reasons?
If an individual's doctor recommends a particular FDA-approved contraceptive based on a medical determination with respect to that individual, then - regardless of whether the contraceptive has a therapeutic equivalent - the Insurance Carrier should offer coverage with no cost sharing, subject to the plan's utilization management procedures. The Insurance Carrier must provide the individual with the ability to appeal any denial from the Insurance Carrier.

What can be done if an Insurance Carrier denies the request for a specific contraceptive drug or device?
If an Insurance Carrier denies coverage for a specific contraceptive because it does not consider it to be medically necessary, the individual has the right to request an expedited external appeal coordinated

through the Office of Patient Protection at https://www.mass.gov/request-an-external-review-of-a-health-insurance-decision.

EMERGENCY CONTRACEPTIVES, FEMALE AND MALE STERILIZATION

Does this law require coverage for emergency contraceptives?
Massachusetts law requires Insurance Carriers to cover FDA-approved emergency contraception whether with a prescription or dispensed by a licensed pharmacist, consistent with the requirements of M.G.L. c. 94C, § 19A. Individuals do not need a prescription from a health care provider to obtain emergency Levonorgestrel-based ("LNG-based") emergency contraceptives, such as Plan B, at a pharmacy, as these are approved for over-the-counter sale.

Pharmacists can acquire a standing order, consistent with the requirements of M.G.L. c. 94C, § 19A, to dispense emergency contraception, and they are encouraged to do so. If a consumer asks a pharmacist and finds that the pharmacist does not have a standing order for emergency contraception, the consumer may need a prescription in order to receive insurance coverage at the point of sale. If insurance coverage is unavailable at the time of sale, then after the purchase the consumer can seek reimbursement from the Insurance Carrier for over-the-counter emergency contraception coverage.

The ACCESS law's 12-month provisions for coverage do not apply to emergency contraceptives; however, emergency contraceptives may still be available without a copay, as discussed above.

Does this law require coverage for voluntary female sterilization procedures?
Yes, without cost-sharing.

Does this law require coverage for voluntary male sterilization procedures?
Although not specifically covered by this law, many health plans provide coverage for male sterilization procedures. An individual should contact their health plan for more information about coverage under their plan.

ACCESS TO PRESCRIPTION CONTRACEPTIVES FOR A 12-MONTH PERIOD

Are there any limitations to which contraceptives can be dispensed up to a 12-month supply?
The 12-month supply provision of the ACCESS law applies to prescription, self-administered birth control methods such as oral contraceptives (birth control pills), patches, injectables, and rings. An individual can only be dispensed a 12-month supply after the individual has been prescribed and has used the contraceptive during their trial period.

The 12-month supply provision of the ACCESS law does not apply to IUDs and implants because they are inserted and typically last for extended periods, usually more than a year.

If a provider currently writes a contraceptive Rx prescription for 90 days with 3 refills, can the patient ask the pharmacist for a 12-month supply or a lesser amount?
Yes. After receiving the trial period, individuals may request that a pharmacy dispense the 12-month supply all at once or in intervals, such as monthly, or every three months. Prior authorization from the Insurance Carrier is not needed. However, because pharmacy regulations do not permit a prescription to be written for a term of more than one year, the patient will need separate prescriptions for the trial period and the 12-month supply.

The following chart clarifies prescription amounts commensurate with a 12-month supply. Because different types of oral contraceptives come in different amounts of pills per pack, the Insurance Carrier should ensure plans cover a 12-month supply.

Quantity required for a 12-month (supply	
Contraceptive type	**Quantity**
Oral contraceptives (i.e., the pill)	364 pills
Combined pill (e.g. Aranelle)*	28 pills per pack x 13 packs
Extended cycle (e.g. Seasonique)	91 pills per pack x 4 packs
Rapid cycle (e.g. Microgestin)	21 pills per pack x 18 packs
Transdermal contraceptives (i.e., the patch)	39 patches (3 patches per pack x 13 packs)
Intra-vaginal contraceptives (i.e., the ring)	13 monthly rings or 1 yearly
Injectables (e.g., DMPA-IM and subQ)	4 shots

*Some individuals may choose to rapid cycle their combined oral contraceptive pills, skipping the 7 placebo pills. In this case, the provider will explicitly state this in the prescription and 18 packs should be covered by the health plan.

Certain prescriptions are for a 28-day package. How many packages should be available for fill under the mandate, since there are 365/6 days in a 12-month year?
After the trial period, if taken as prescribed, an additional 13 packages should be available when contraceptives are dispensed in a 28-day package for a 12-month supply.

Certain health care providers prescribe that individuals take oral contraceptives daily without any placebos on days 22-28. How many packages of a 21-day supply should be available for fill under the mandate since there are 365/6 days in a 12-month year?
After the trial period of an oral contraceptive, if taken daily as prescribed, individuals are able to fill 18 packages, up to a quantity of a 12-month supply, when contraceptives are dispensed either in a 21-day package or in a 28-day package where the individual does not take the placebo pills.

After the trial period, how can the health care provider write the prescription to help facilitate the individual receiving a 12-month refill?
Because pharmacy regulations do not permit a prescription to be written for a term of more than one year, a provider must issue separate prescriptions for the trial period and the 12-month supply. These prescriptions can be written at the same time and filled sequentially.

Provided there are adequate refills left on a script, a patient may request that a pharmacist dispense a 12-month refill even if the prescription only calls for 1 or 3 months to be dispensed at a time.

Can I/my patient get both the trial period and then a 12-month refill of the same prescription in the same plan year?
Yes.

If an individual was initially dispensed a 12-month supply but switched birth control methods partway through, can the pharmacist dispense another 12-month supply of a different birth control method?
When switching to a new birth control method, the individual will not immediately be able to receive a 12-month supply on the first fill of the new birth control method. The individual must have an initial prescription of the trial period before the remainder of the 12-month supply can be filled. If switching back to any previously used birth control method that was already filled for the trial period, the individual can refill another 12-month supply of that birth control method.

What happens if I/my patient changes health plans? How does the 12-month refill work?
If an individual switches health plans, the individual is still eligible for the 12 months under the new health plan. The individual, their provider, or their pharmacy can submit documentation, including information from a prescription, to the new Insurance Carrier that establishes the use of the contraceptive for the trial period. This requirement is not prior authorization, just documentation that the individual received the same contraception from the previous plan.

An individual is only required to complete another trial period if they switch prescriptions to one not previously used, not when they switch health plans.

What should individuals do if they attempt to acquire a 12-month supply and are told that they cannot receive one?
An individual should be sure that they belong to a health plan covered by the law (refer to the question "**Does the ACCESS law apply to all health benefit plans?").**

If an individual is told by their pharmacist that the individual's health plan rejected the claim for a 12-months prescription, then the individual should contact their health plan at the phone number on their member ID card to confirm eligibility. If an individual believes they are in an eligible health plan and have been denied coverage for a 12-month supply that they have been using for the trial period, they should contact their health plan at the phone number on their membership card, or the Division of Insurance at kevin.beagan@mass.gov.

If the individual knows that they are in a health plan subject to the law and makes their pharmacist aware of this, and the pharmacist continues to tell the individual that they cannot dispense a 12-month supply - even though the individual completed a trial period of the same contraceptive - the individual should contact the pharmacy manager and then pharmacy's customer service department, if applicable. If not able to reach a successful resolution, then they should reach out to the Board of Registration in Pharmacy at (800) 414-0168 or pharmacy.admin@massmail.state.ma.us.