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Federal Support for Reproductive Health Services: Frequently Asked Questions

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This report provides answers to frequently asked questions concerning the provision, funding, and coverage of reproductive health services. The report is organized by the federal program that pays for or directly provides these services. It concludes with questions about coverage requirements for reproductive health services under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), and discussions of various federal programs that provide grants to non-governmental entities to provide reproductive health services.

General Questions

What Are Reproductive Health Services?

Reproductive health services are preventive, diagnostic, and treatment services related to the reproductive systems, functions, and processes of men and women. These include, but are not exclusive to, services related to contraception (family planning), sexually transmitted infections (STIs)/sexually transmitted diseases (STDs), and screening and treatment for cancers of the reproductive organs and the breast.¹

What Are Contraceptive Services?

A contraceptive is a product or service intended to lower a woman's risk of becoming pregnant. Contraceptive products and services are evaluated by the Food and Drug Administration (FDA). FDA approves those products and services that demonstrate safety and effectiveness.

Federal funding or reimbursement, when provided for contraception, is generally limited to those products and services that are FDA-approved. Such products and services vary in type, and include drugs, medical devices, combinations of the two, and surgical procedures. FDA has identified 20 different types of contraceptives, shown in the text box at right.

Types of Contraceptives, as Defined by the Food and Drug Administration

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

Source: FDA, "Birth Control Guide," <http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf>

¹ Adapted by Congressional Research Service from the Association of Reproductive Health Professionals, Position Statements, <https://www.arhp.org/about-us/position-statements>.

Can Federal Funds Be Used to Pay for Abortions?

Under federal law, federal funds are generally not available to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life. This restriction is the result of statutory and legislative provisions like the Hyde Amendment, which has been added to the annual appropriations measure for the Department of Health and Human Services (HHS) since 1976. Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Treasury, and the Department of Justice. Other codified restrictions limit the use of funds made available to the Department of Defense (DOD) and the Indian Health Service (IHS).

Department of Defense (DOD)

Does the DOD Provide Women's Preventive Health Services?

Although not subject to the ACA's requirements regarding coverage of women's preventive health services, TRICARE—the DOD-administered health insurance program for uniformed service personnel, retirees, and their family members²—covers a range of women's preventive health services, including breast and cervical cancer screening at no charge.³ (For more information on the Affordable Care Act's requirements, see "Federal Mandates for Private Insurance Coverage.")

With respect to breast cancer screening, TRICARE covers annual physical examinations for women beginning at age 40 and at a physician's discretion for women younger than 40 who are at high risk of developing breast cancer. TRICARE also covers annual mammograms for women beginning at age 40, or at age 30 for those at high risk of developing breast cancer.

With respect to cervical cancer screening, TRICARE covers Pap smear testing for women 18 years of age or older. The frequency of Pap smear testing may be at the discretion of the patient and clinician, but not less frequently than every three years. Human Papillomavirus (HPV) testing is covered as a cervical cancer screening only when performed in conjunction with a Pap smear, and only for women aged 30 and older.

Female members of the uniformed services on active duty typically receive these services directly from military treatment facilities. Family members and retirees may also receive services outside of military treatment facilities, typically from private sector providers.

² CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Don J. Jansen.

³ Department of Defense, *TRICARE Policy Manual*, Chapter 7, Section 2.1, February 1, 2008, http://manuals.tricare.osd.mil/DisplayManualFile.aspx?Manual=TP08&Change=137&Type=AsOf&Filename=C7S2_1.PDF&highlight=xml%3dhttp%3a%2f%2fmanuals.tricare.osd.mil%2fPdfHighlighter.aspx%3fDocId%3d40212%26Index%3dD%253a%255cIndex%255cTP08%26HitCount%3d14%26hits%3daa%2bfa%2b1f2%2b250%2b295%2b2b8%2b43b%2b4fb%2b552%2b11a6%2b11bc%2b11d7%2b122b%2b1462%2b.

Does the DOD Provide Family Planning Services?

Under the regulations at 32 C.F.R. §199.4(e)(3), TRICARE provides the following family planning benefits:

- Surgical inserting, removal, or replacement of intrauterine devices.
- Measurement for, and purchase of, contraceptive diaphragms (and later re-measurement and replacement).
- Prescription contraceptives.
- Surgical sterilization (either male or female).

The family planning benefit does not include the following:

- Prophylactics (condoms).
- Spermicidal foams, jellies, and sprays not requiring a prescription.
- Services and supplies related to noncoital reproductive technologies, including but not limited to artificial insemination (including any costs related to donors or semen banks), in-vitro fertilization, and gamete intrafallopian transfer.⁴
- Reversal of a surgical sterilization procedure (male or female).

Does the DOD Provide Abortions or Abortion Counseling?

Under 10 U.S.C. §1093, the medical facilities and funds available to the DOD may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term, or in a case in which the pregnancy is the result of an act of rape or incest. Abortion counseling, referral, preparation, and follow-up for a non-covered abortion are not eligible for reimbursement. Drugs such as Mifeprex and misoprostol may be cost-shared when the pregnancy is the result of an act of rape or incest.⁵

Department of Veterans Affairs (VA)

Does the VA Provide Reproductive Health Services, Abortions, and Abortion Counseling?

The VA provides reproductive health services to eligible veterans enrolled in the VA health care system, as provided in the VA's uniform "medical benefits package" currently codified at Title 38

⁴ Department of Defense, *TRICARE Policy Manual*, Chapter 4, Section 17.1, February 1, 2008, p. 2, http://manuals.tricare.osd.mil/DisplayManualPdfFile/TP08/137/AsOf/TP08/C4S17_1.PDF#xml=http://manuals.tricare.osd.mil/PdfHighlighter.aspx?DocId=40125&Index=D:\Index\TP08&HitCount=5&hits=80+81+82+16b+17a+.

⁵ Department of Defense, *TRICARE Policy Manual*, Chapter 4, section 18.3, March 18, 2013, p. 1, http://manuals.tricare.osd.mil/DisplayManualPdfFile/TP08/113/AsOf/tp08/c4s18_3.pdf.

C.F.R. §17.38.⁶ However, the medical benefits package does not include (1) abortions and abortion counseling or (2) in vitro fertilization (IVF).⁷ Furthermore, with the VA's decision to exclude abortions, as required by the Veterans Health Care Act of 1992 (P.L. 102-585), from the medical benefits package, the VA also made a decision to no longer perform therapeutic abortions. Therefore, abortifacients such as RU 486 (mifepristone) are not available through VA pharmacies.⁸

Indian Health Service (IHS)

Does the IHS Provide Reproductive Health Services?

The Indian Health Service provides health care directly or provides funds for Indian Tribes or Tribal Organizations to operate health care facilities. The IHS does not provide a standard medical benefit that includes or excludes certain services. Instead, services available vary by facility, and some facilities may provide reproductive health services.⁹ Among other services, the IHS reports that it provides specific women's health services such as mammograms and prenatal care. The IHS also funds or operates programs to screen individuals at risk of HIV/AIDS and provide treatment services as necessary.¹⁰

Does the IHS Provide Abortions?

The IHS is prohibited from using any of its appropriated funds to perform or pay for abortion services.¹¹

Medicaid

Does Medicaid Cover Abortion Services?

Like other federal programs, Medicaid is subject to the Hyde Amendment. (See “Can Federal Funds Be Used to Pay for Abortions?”)¹² Medicaid program guidance further specifies that the Hyde Amendment does *not* prohibit a “state, locality, entity, or private person” from paying for

⁶ CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala.

⁷ 38 C.F.R. § 17.38(c).

⁸ Department of Veterans Affairs, Veterans Health Administration, “Health Care Services For Women Veterans,” VHA Handbook 1330.01, May 21, 2010.

⁹ CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by Elayne J. Heisler.

¹⁰ U.S. Department of Health and Human Services (HHS), Indian Health Service (IHS), *Fiscal Year 2016 Indian Health Service Justification of Estimates*, <http://www.ihs.gov/BudgetFormulation/documents/FY2016BudgetJustification.pdf>.

¹¹ 25 U.S.C. § 1676.

¹² In FY2014, states claimed federal financial participation (FFP) for 118 abortions: 64 were due to endangerment to the life of the mother, 52 were due to rape, and 2 were due to incest. Department of Health and Human Services, Office of the Assistant Secretary for Financial Resources, *FY 2016 Moyer Material*, February 15, 2015, p. 81.

abortion services, nor does it prohibit managed care providers from offering abortion coverage or impact a state's or locality's ability to contract with a managed care provider for such coverage with state-only funds (as long as such funds are not the state share of Medicaid matching funds).^{13,14}

Through program regulations,¹⁵ and later revised through program guidance, Medicaid enrollees and providers may be required to comply with reasonable documentation requirements to assure that the abortion meets the Hyde amendment criteria. However, such documentation requirements may not prevent or impede coverage for abortions and may be waived if the treating physician certifies that the patient was unable to comply.¹⁶

Does Medicaid Cover Medically Necessary Procedures to Terminate an Ectopic Pregnancy?

An ectopic pregnancy is a pregnancy that occurs outside the womb (uterus). It is life-threatening to the mother.¹⁷ Medicaid federal financial participation (FFP) is available for medical procedures necessary for the termination of an ectopic pregnancy.¹⁸

Does Medicaid Cover Mifepristone (Mifeprex or RU-486)?

Medicaid federal financial participation (FFP) is available for mifepristone only when its use is consistent with the Hyde Amendment restrictions (i.e., that limit federal funds to pay for abortions, except in cases of rape, incest, or endangerment of the mother's life). However, states must comply with state laws that set limitations on its use (e.g., requirements regarding parental notification and informed consent).¹⁹

Does Medicaid Cover Family Planning Services and Supplies?

States are required to provide family planning services and supplies to Medicaid-eligible "individuals of child-bearing age (including minors who can be considered to be sexually active)

¹³ Department of Health and Human Services, Health Care Financing Administration, Center for Medicaid and State Operations, *Dear State Medicaid Director Letter*, February 12, 1998, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd021298.pdf>.

¹⁴ Although FFP is forbidden for most abortions, 17 state Medicaid programs fund all or most "medically necessary" abortions with state-only funds. Four states do so voluntarily, and 13 states do so pursuant to a court order. For more information, see Guttmacher Institute, State Policies in Brief, *State Funding of Abortion Under Medicaid*, July 1, 2015, http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf

¹⁵ 42 C.F.R. § 441.203, 45 C.F.R. § 74.20, 42 C.F.R. § 441.208 and 42 C.F.R. § 441.206.

¹⁶ Department of Health and Human Services, Health Care Financing Administration, Center for Medicaid and State Operations, *Letter to Medicaid Directors*, February 12, 1998, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd021298.pdf>.

¹⁷ National Institutes of Health, National Library of Medicine, MedlinePlus Medical Encyclopedia, <http://www.nlm.nih.gov/medlineplus/encyclopedia.html>.

¹⁸ 42 C.F.R. § 441.207.

¹⁹ Department of Health and Human Services, Health Care Financing Administration, Center for Medicaid and State Operations, *Letter to State Medicaid Directors*, SMDL# 01-018, March 30, 2001, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd033001.pdf>.

and who desire such services and supplies.”²⁰ States are permitted to provide targeted family planning services under Medicaid for populations who are not otherwise eligible for traditional Medicaid (e.g., nonpregnant, non-disabled childless adults) through special waivers of federal law.²¹ Finally, the ACA established a new optional Medicaid eligibility group for family planning services so that states would no longer have to rely on time limited waiver authority to extend limited benefit coverage for family planning services and supplies to targeted eligibility groups (including groups who were not traditionally eligible for Medicaid). The ACA family planning eligibility group includes individuals (men and women) (1) who are not pregnant and (2) whose income does not exceed the highest income eligibility level established by the state for pregnant women.²² Benefits for this new eligibility group are limited to family planning services and supplies and related medical diagnosis and treatment services.²³ In all cases, states are not permitted to charge cost-sharing for Medicaid family planning services and supplies.

What Types of Family Planning Services and Supplies Does Medicaid Cover?

States have discretion in identifying the specific services and supplies covered under the traditional Medicaid state plan.²⁴ Family planning services and supplies include items and procedures for family planning purposes (i.e., contraceptive care), as well as medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting (e.g., health education and promotion, and testing and treatment for sexually transmitted infections).²⁵ Medicaid programs may also cover sterilization services; however, federal law requires states to impose a minimum of a 30-day waiting period between the date the individual provides informed consent and the date of the procedure.²⁶

As an alternative to traditional state plan services, states may offer alternative benefit plans (ABPs).²⁷ ABPs must cover at least the 10 essential health benefits (EHBs).²⁸ In addition, ABP

²⁰ Section 1905(a)(4)(C) of the Social Security Act. In FY2010, Medicaid accounted for 75% of U.S. public family planning expenditures (including federal, state, and local government spending), according to Adam Sonfield and Rachel Benson Gold, “Public Funding for Family Planning, Sterilization and Abortion Services,” FY1980-2010, Guttmacher Institute, March 2012, <http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf>.

²¹ Targeted family planning waivers may offer a limited set of services (i.e., family planning services and supplies and related services) to a specific population identified in the waiver special terms and conditions. These individuals may not be eligible for full Medicaid state plan services.

²² Section 2303 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

²³ Section 1902(ii)(1) of the Social Security Act.

²⁴ For more on the range of benefits covered by states, see Usha Ranji, Yali Bair, and Alina Salganicoff, “Medicaid and Family Planning: Background and Implications of the ACA,” Kaiser Family Foundation, July 8, 2015, <http://kff.org/womens-health-policy/issue-brief/mcicaid-and-family-planning-background-and-implications-of-the-aca/>; and Kaiser Family Foundation and George Washington University Medical Center School of Public Health and Health Services, “State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings,” November 2009, <http://kff.org/mcicaid/state-mcicaid-coverage-of-family-planning-services/>.

²⁵ Section 1905(a)(4)(C) of the Social Security Act.

²⁶ 42 C.F.R. §§ 441.253 through 441.256.

²⁷ States that choose to implement the ACA Medicaid expansion are required to provide the individuals newly eligible for Medicaid through the expansion Medicaid services through ABPs (with exceptions for selected special-needs subgroups). States also have the option to provide ABP coverage to other subgroups.

coverage must comply with the federal requirements for mental health parity, and special rules apply with regard to prescription drugs, rehabilitative and habilitative services and devices, and preventive care. The special rules for preventive care require coverage of a number of reproductive health care services for women, including well-woman visits, contraception, and breast and cervical cancer screening, as well as sexually transmitted disease screening for women and men, among other services. (The preventive services that must be covered are discussed later in this report in “What Types of Services Must Be Covered?” in the section on “Federal Mandates for Private Insurance Coverage.”) ABP plans must also cover family planning services and supplies, among other requirements.²⁹

Are There Different Medicaid Federal Reimbursement Rates for Different Types of Family Planning Services?

The Medicaid program distinguishes between items and procedures for *family planning purposes* (i.e., contraceptive care), and *family planning-related services* (i.e., services provided in a family planning setting as part of or as follow-up to a family planning visit) to determine the federal medical assistance percentage (FMAP) rate available. Specifically, states may receive a 90% FMAP rate for items and procedures for family planning purposes.³⁰ By contrast, family planning-related services are reimbursable at the state’s regular FMAP rate.³¹ Family planning-related services are generally provided because they were identified, or diagnosed, during a family planning visit. Such services may include the following:³²

- Drugs for the treatment of sexually transmitted diseases (STD) or sexually transmitted infections (STI), except for HIV/AIDS and hepatitis, when the STD/STI is identified/diagnosed during a routine/periodic family planning visit.
- Some states and family planning programs encourage men to have an annual visit at the office/clinic. Such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.

(...continued)

²⁸ The 10 essential health benefits required under the ACA include (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services (including behavioral health treatment), (6) prescribed drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

²⁹ For more information, see CRS Report R43357, *Medicaid: An Overview*.

³⁰ Section 1903(a)(5) of the Social Security Act.

³¹ For FY2015, states’ regular FMAP rates range from 50.00% to 73.58%, depending on the state’s per capita income. FMAPs may also vary by population (for example, services to some persons newly eligible under the ACA Medicaid expansion are reimbursed at a 100% FMAP rate for 2014 through 2016 and phasing down to 90% for 2020 and subsequent years). See CRS Report R43847, *Medicaid’s Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

³² Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid, CHIP and Survey & Certification, Letter to State Health Officials, RE: Family Planning Services Option and New Benefit Rules for Benchmark Plans, SMDL#10-013 ACA# 4, July 2, 2010. For more information, see <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>

- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit.
- Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to a family planning service in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancers.
- Treatments for major complications such as the treatment of a perforated uterus due to an intrauterine device insertion, severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage, or surgical or anesthesia-related complications during a sterilization procedure.
- States must cover family planning-related services that were provided as part of, or as follow-up to, the family planning visit in which the sterilization procedure took place.

Who Provides Reproductive Health Care for Medicaid Beneficiaries?

Medicaid enrollees receive reproductive health care from a range of Medicaid providers, including private physicians, federally qualified health centers, family planning clinics, health departments, and other clinics,³³ and a majority (77%) of Medicaid women of childbearing age access care through some type of managed care arrangement.³⁴ In general, under Medicaid's "freedom of choice of provider" requirement, states must permit enrollees to receive services from any willing Medicaid-participating provider,³⁵ and states cannot exclude providers solely on the basis of the range of services they provide.³⁶ Medicaid managed-care enrollees may be restricted to providers in the plan's network, except in the case of family planning services. For family planning services, Medicaid enrollees (regardless of whether they receive services through the managed care delivery system or not) may obtain family planning services from the provider

³³ A 2013 survey found that, among Medicaid-enrolled women aged 15-44 who had their most recent gynecological exam in the past three years, 57% received the service in a private physician's office or HMO, 13% from a community health center or public clinic, 5% from a family planning or Planned Parenthood clinic, and 5% from a school or college-based or urgent care/walk-in facility. The rest received the gynecological exam from other places or did not answer the question. Alina Salganicoff et al., "Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women's Health Survey," Kaiser Family Foundation, Washington, DC, May 2014, <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf#page=33>.

³⁴ Usha Ranji, Yali Bair, and Alina Salganicoff, *Medicaid and Family Planning: Background and Implications of the ACA*, The Kaiser Family Foundation, Issue Brief, July 2015, <http://files.kff.org/attachment/issue-brief-medicare-and-family-planning-background-and-implications-of-the-aca>.

³⁵ Under federal law, Medicaid enrollees may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required ... who undertakes to provide him such services." This provision is often referred to as the "any willing provider" or "free choice of provider" provision. (Section 1902(a)(23) of the Social Security Act, 42 CFR § 431.5, see also Department of Health and Human Services, Center for Medicaid, CHIP and Survey & Certification, *CMCS Informational Bulletin*, Update on Medicaid/CHIP, June 1, 2011, <http://www.medicare.gov/Federal-Policy-Guidance/downloads/6-1-11-Info-Bulletin.pdf>).

³⁶ Sections 1902(a)(23) and 1932(a) of the Social Security Act and 42 C.F.R. § 431.51.

of their choice (as long as the provider participates in the Medicaid program), even if they are not considered “in-network” providers.³⁷

Medicare Coverage³⁸

Do Medicare Beneficiaries Use Reproductive Health Services?

The majority of Medicare beneficiaries are 65 years old or older. However, almost 1 million women aged 18 to 44 (i.e., of reproductive age) were eligible for Medicare in 2011, as a result of disability.³⁹ Many reproductive health services are recommended for Medicare beneficiaries who are older than childbearing age. (Examples include breast and gynecological exams for women, and sexually transmitted infections screening and treatment for men and women.) As a result, any type of reproductive health service may be sought or advised for at least some Medicare beneficiaries.

Does Medicare Cover Contraceptive Services?

There is no explicit statutory requirement for Medicare to cover contraceptive services or supplies for its enrollees. Women Medicare beneficiaries may get coverage of oral contraceptives through Medicare Part D prescription drug coverage. These and other forms of contraception may be covered to varying extents under Medicare Advantage plans, which are health plans offered by private companies that contract with Medicare to provide benefits.

Male or female sterilization (e.g., tubal ligation, vasectomy) is covered only where it is a necessary part of the treatment of an illness or injury. (For example, removal of reproductive organs may be required to treat cancers of those organs.) Sterilization is not covered as an elective procedure or for the sole purpose of preventing any effects of a future pregnancy.⁴⁰

For individuals who are dually eligible for Medicare and Medicaid, Medicare is the primary payer. Medicaid pays for any additional services that it covers, and Medicare does not, after Medicare denies payment. For example, many contraceptive products and services for those dually eligible may be paid through the more generous Medicaid benefits for these supplies and services.⁴¹

³⁷ Section 1902(e)(2).

³⁸ Medicare benefits in general are summarized in CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

³⁹ Data as reported by the Kaiser Family Foundation based on analysis of 2011 CMS Chronic Conditions Warehouse data. See the Henry J. Kaiser Family Foundation, “Private and Public Coverage of Contraceptive Services and Supplies in the United States,” July 2015, <http://kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/>.

⁴⁰ CMS, Medicare National Coverage Determination for Sterilization (230.3), www.cms.gov/medicare-coverage-database/.

⁴¹ Henry J. Kaiser Family Foundation, “Private and Public Coverage of Contraceptive Services and Supplies in the United States,” July 10, 2015, <http://kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/>.

What Other Kinds of Reproductive Health Services Does Medicare Cover?

Medicare Part B covers a number of preventive services that involve reproductive health. These include, among others, annual wellness visits, breast cancer screening, screening pelvic exams, pap smears, screening for HIV and other sexually transmitted infections (STIs), and prostate cancer screening.⁴² Cost-sharing is waived for most, but not all, of these preventive services.

In addition, Medicare Parts A or B typically cover diagnostic and treatment services furnished by a certified provider. (Cost sharing typically applies.) Such reproductive health services include diagnosis and treatment of STIs and urinary tract infections, and management of precancerous and cancerous gynecological abnormalities.

Does Medicare Cover Abortion?

Abortions are not covered Medicare procedures except (1) if the pregnancy is the result of an act of rape or incest or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.⁴³

Federal Mandates for Private Insurance Coverage

Does Federal Law Require Private Insurers to Cover Reproductive Health Services?

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) established private insurance coverage requirements for a variety of health services, including many reproductive health services. Although these requirements do not directly involve federal spending, they affect coverage, and thereby spending, in the private health insurance market.

What Types of Services Must Be Covered?

All non-grandfathered private health insurance plans offered in the nongroup, small-group, and large-group markets⁴⁴ are required to cover, without cost sharing, a specified set of preventive health services.⁴⁵ Many of these are reproductive health services, including, among others, (1)

⁴² CMS, “Preventive Services,” interactive chart for the Medicare Fee-for-Service Program, January 2015, http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf.

⁴³ CMS, Medicare National Coverage Determination for Abortion (140.1), June 19, 2006, <http://www.cms.gov/medicare-coverage-database/>.

⁴⁴ For more information about private health insurance, see CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez and Namrata K. Uberoi; and CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

⁴⁵ 45 CFR § 147.130, “Coverage of Preventive Health Services.”

screening and counseling for sexually transmitted infections (STIs); (2) universal HIV screening; (3) breast cancer screening, genetic testing, and preventive medications such as Tamoxifen, when indicated; (4) gynecological exams and pap smears; (5) well-woman visits; (6) a variety of prenatal care services; and (7) contraception.⁴⁶

In addition, all non-grandfathered private insurance plans offered in the nongroup and small-group markets (both inside and outside exchanges) must offer the essential health benefits (EHB), a group of 10 broad categories of benefits. Generally, coverage in these categories must be equal in scope to a typical employer health plan. Each state has an EHB-benchmark plan that serves as a reference plan for that state. Nongroup and small-group market plans must substantially base their benefits package on the benchmark plan for that state.⁴⁷ The EHB category “preventive and wellness services and chronic disease management” is an exception. By regulation, all EHB plans must cover, without cost-sharing, the same specified set of preventive health services described in the previous paragraph.⁴⁸ Additional services in this EHB category (such as chronic disease management) and reproductive health services in other EHB categories (such as maternity care) would be covered according to state benchmark plans.

Does Federal Law Require Private Insurers to Cover Contraception?

In general, the ACA requires group health plans and health insurance issuers, unless grandfathered, to cover contraception. In May 2015, the Administration issued guidance specifying the types of contraceptives that must be covered, namely 18 types of contraception for women listed in the FDA Birth Control Guide.⁴⁹ (See “What Are Contraceptive Services?”) Because the guidance derives from a requirement in the ACA to cover women’s preventive services, male sterilization and male condoms are excluded from the coverage requirement.⁵⁰

Are Religious Exceptions Made to the Contraceptive Coverage Requirement?

The ACA’s implementing regulations essentially provide an exemption to the contraceptive coverage requirement for churches and similar religious orders, and an accommodation for certain other employers with religious objections.⁵¹ Under the accommodation, a third-party plan

⁴⁶ The preventive services that must be covered are listed in their entirety at Healthcare.gov, “Preventive Care Benefits,” <https://www.healthcare.gov/preventive-care-benefits/>. Coverage is not required for services that are furnished out of network. 45 C.F.R. § 147.130(a)(3). A final regulation clarifying coverage for services furnished out-of-network was published in July 14, 2015 (80 *Federal Register* 41318).

⁴⁷ See “Essential Health Benefits Package” in CRS Report R43854, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Namrata K. Uberoi.

⁴⁸ 45 CFR § 156.115(a)(4), “Provision of EHB,” by reference to 45 CFR § 147.130, “Coverage of Preventive Health Services.”

⁴⁹ Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury, “FAQs about Affordable Care Act Implementation, Part XXVI,” May 11, 2015, <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html#Affordable%20Care%20Act>.

⁵⁰ Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury, “Coverage of Certain Preventive Services Under the Affordable Care Act, Final Rule” 80 *Federal Register* 41318, July 14, 2015.

⁵¹ CRS Report WSLG1332, *Final Regulations on Contraceptive Accommodation Issued But Judicial Challenges*, (continued...)

administrator is responsible for administering and paying for contraceptive benefits.⁵² Challenges to the accommodation as a violation of religious freedom continue to work their way through the courts.

What Other Federal Programs Fund Reproductive Health Services?

Federal health care payment and health service delivery programs (e.g., Medicare and Medicaid, the VA, Tricare, and IHS) will cover or directly provide certain reproductive health services. In addition, the federal government provides support for non-governmental entities to provide reproductive health-related services to low-income populations. Below are some selected examples:

- **The Title X Family Planning Program**—authorized in Title X of the Public Health Service Act—provides grants to public and nonprofit agencies for family planning services, research, and training.⁵³ As a condition of these grants, Title X clinics are required to provide services—to men and women—free of charge for individuals under 100% of the federal poverty level, and to provide sliding scale fees for individuals between 100% and 250% of the federal poverty level. When serving adolescent patients, the clinics evaluate the adolescent’s income to determine eligibility for discounted services. Title X grants are awarded to a variety of entities, including health departments, family planning councils, and clinics.⁵⁴
- **The Federal Health Center Program** is administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS).⁵⁵ The program awards grants to non-profit, tribal, or state and local government facilities to provide outpatient health services to populations located in underserved areas. These facilities are required to provide services to all individuals regardless of their ability to pay and are required to be Medicaid providers.⁵⁶ Health centers focus on providing primary care services. The services available vary by facility, but health centers generally provide preventive health services such as reproductive health services, including family planning services and preventive screenings.
- **The Ryan White HIV/AIDS program**, administered by HRSA, provides HIV-related services, including testing and treatment, to a safety net population. The

(...continued)

Including Potential Supreme Court Review, Still Pending, by Cynthia Brown.

⁵² Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury, “Coverage of Certain Preventive Services Under the Affordable Care Act, Final Rule” 80 *Federal Register* 41322 ff., July 14, 2015.

⁵³ CRS Report RL33644, *Title X (Public Health Service Act) Family Planning Program*, by Angela Napili.

⁵⁴ A full list of grantees is available at HHS, Office of Population Affairs, “Title X Family Planning Directory of Grantees,” June 2015, <http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/title-x-directory-grantees.pdf>.

⁵⁵ These facilities are also called federally qualified health centers (FQHCs) or community health centers.

⁵⁶ CRS Report R43937, *Federal Health Centers: An Overview*, by Elayne J. Heisler.

program awards funds to provide these services.⁵⁷ For example, Ryan White Part C provides grants to FQHCs, family planning clinics, and community-based organizations, among others, to support outpatient HIV early intervention services to the safety net population.⁵⁸

- **The National Breast and Cervical Cancer Early Detection Program**, administered by the Centers for Disease Control and Prevention (CDC), provides access to breast and cervical cancer screening programs for underserved women in all 50 states, the District of Columbia, five U.S. territories, and 11 tribes.⁵⁹
- **Sexually Transmitted Diseases (STD) Prevention Grants**, administered by the CDC, provides funds to all 50 states, territories, and several large cities; funds may be used for screening, diagnostic testing, and partner notification, among other activities.⁶⁰
- **Title V Maternal and Child Health Block Grant**, administered by HRSA and authorized in Title V of the Social Security Act, is intended to expand access to health care services for underserved children, as well as preventive and primary care services for pregnant women and mothers. Grants are provided to states, territories, and the District of Columbia.⁶¹
- **Teen Pregnancy Prevention Program**, administered by the HHS Office of Adolescent Health, provides competitive grants and contracts to entities to deliver medically accurate, age-appropriate pregnancy prevention programs.⁶²
- **The Social Services Block Grant Program**, administered by the HHS Administration for Children and Families, Office of Community Services, provides grants to states to support a wide range of social service activities, including family planning.⁶³

⁵⁷ For more information about the Ryan White HIV/AIDS Program, see CRS Report RL33279, *The Ryan White HIV/AIDS Program*, by Judith A. Johnson; and HRSA, “HIV/AIDS Programs,” <http://hab.hrsa.gov/>.

⁵⁸ HRSA, “Justification of Estimates for Appropriations Committees, FY2016,” Rockville, MD.

⁵⁹ CDC, “National Breast and Cervical Cancer Early Detection Program,” <http://www.cdc.gov/cancer/nbccedp/>.

⁶⁰ CDC, “Justification of Estimates for Appropriations Committees, FY2016,” p. 92 ff., <http://www.cdc.gov/fmo>.

⁶¹ HRSA, “Justification of Estimates for Appropriations Committees, FY2016,” p. 206 ff., <http://www.hrsa.gov/about/budget/budgetjustification2016.pdf>. See also CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*, by Carmen Solomon-Fears; and CRS Report R43930, *Maternal and Infant Early Childhood Home Visiting (MIECHV) Program: Background and Funding*, by Adrienne L. Fernandes-Alcantara.

⁶² HHS, “Justification of Estimates for Appropriations Committees, General Departmental Management, FY2016,” p. 103 ff., <http://www.hhs.gov/sites/default/files/budget/fy2016/fy2016-general-departmental-budget-justification.pdf>. See also CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*, by Carmen Solomon-Fears.

⁶³ In FY2010, \$31.4 million, or 1% of SSBG expenditures, went to family planning services. CRS Report 94-953, *Social Services Block Grant: Background and Funding*, by Karen E. Lynch. See also “Family planning services” in HHS, Administration for Children and Families, Office of Community Services, *SSBG Legislation Uniform Definition of Services*, January 1, 2009, <http://www.acf.hhs.gov/programs/ocs/resource/uniform-definition-of-services>.

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