



# 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.<sup>1</sup>

### What Are Contraceptive Services?

A contraceptive is a product or service intended to lower a woman's risk of becoming pregnant. Prior to marketing in the United States, contraceptive products are reviewed by the Food and Drug Administration (FDA). Federal funding or reimbursement, when provided for contraception, is generally limited to certain surgical procedures and those products that are FDA approved or cleared for marketing. Such products vary in type, and include drugs, medical devices, or combinations of the two.

For contraceptive drugs, FDA *approves* those products that demonstrate *substantial evidence* that the drug is safe and effective for the purpose in the new drug application.<sup>2</sup> For high-risk (class III) contraceptive devices, FDA *approves* those products that demonstrate *reasonable assurance* of safety and effectiveness. For moderate-risk (class II) contraceptive devices, FDA *clears* those products that demonstrate substantial equivalence to a device already on the market

#### 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>.

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

<sup>2</sup> For more information on FDA drug regulation, see CRS Report R41983, *How FDA Approves Drugs and Regulates Their Safety and Effectiveness*, by (name redacted)

(a predicate device).<sup>3</sup> FDA's Office of Women's Health has identified 20 different types of contraceptives, shown in the text box above.

## 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), the Indian Health Service (IHS), and the Department of Veterans Affairs.

## Department of Defense (DOD)

### Does the DOD Provide Reproductive 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 members<sup>4</sup>—covers a range of women's preventive health services, including breast and cervical cancer screening at no charge.<sup>5</sup> (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.

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<sup>3</sup> For more information about medical device regulation, see CRS Report R42130, *FDA Regulation of Medical Devices*, by (name redacted) . Examples of contraceptive devices that are class III (high risk) include IUDs, tubal occlusion devices (such as Essure), and the female condom. Examples of contraceptive devices that are class II (moderate risk) include the diaphragm and the condom. For IUD regulation, see 21 CFR 884.5360; for tubal occlusion device regulation, see 21 CFR 884.5380; for female condom regulation, see female condom 21 CFR 884.5330, for diaphragm regulation, see 21 CFR 884.5350, and for condom regulation, see 21 CFR 884.5300.

<sup>4</sup> CRS Report RL33537, *Military Medical Care: Questions and Answers*, by (name redacted)

<sup>5</sup> Department of Defense, *TRICARE Policy Manual*, Chapter 7, Section 2.1, February 1, 2008.

## Does the DOD Provide Contraceptive 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.<sup>6</sup>
- Reversal of a surgical sterilization procedure (male or female).

In January 2016, DOD announced that effective February 1, 2016, Levonorgestrel, an over-the-counter emergency contraceptive to prevent pregnancy, also known as “Plan B,” would be covered without a prescription as a regular TRICARE benefit.<sup>7</sup> There are no age restrictions or costs.

The National Defense Authorization Act for Fiscal Year 2016 (P.L. 114-92) requires the Secretary of Defense to establish and disseminate clinical guidelines on contraception and contraception counseling as well as to make contraceptive counseling available to women members of the Armed Forces.<sup>8</sup>

## 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. TRICARE also covers medical and/or mental health services related to the covered abortion.

Abortion counseling, referral, preparation, and follow-up for a non-covered abortion are not eligible for reimbursement. TRICARE does not cover (1) services and supplies related to a non-covered abortion, (2) counseling, referral, preparation and follow-up for a non-covered abortion, and (3) abortions for fetal abnormality or for psychological reasons.

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<sup>6</sup> Department of Defense, *TRICARE Policy Manual*, Chapter 4, Section 17.1, February 1, 2008.

<sup>7</sup> Tricare, “Tricare OTC Coverage Changes February 1,” January 21, 2016, <http://www.tricare.mil/OTCChanges012116>.

<sup>8</sup> For additional information, please see page 35 of CRS Report R44120, *FY2016 National Defense Authorization Act: Selected Military Personnel Issues*, coordinated by (name redacted)

## Department of Veterans Affairs (VA)

### Does the VA Provide Reproductive Health Services?

The VA uniform “medical benefits package” (codified at Title 38 C.F.R. §17.38)<sup>9</sup> provides reproductive health services, such as routine physical exams, cervical cancer screening, evaluation and treatment of vaginal infections, pelvic pain and abnormal uterine bleeding, treatment of erectile dysfunction, reproductive mental health, and sexually transmitted disease (STD) screening, among other services, to eligible veterans who are enrolled in VA’s health care system.<sup>10</sup>

### Does the VA Provide Contraceptive Services?

The VA provides family planning services to eligible veterans enrolled in the VA health care system, as part of the VA’s uniform “medical benefits package” (codified at Title 38 C.F.R. §17.38). This medical benefits package includes preconception education and contraceptive services, including intrauterine devices (IUDs) and contraceptive implants, and female and male sterilization procedures (such as tubal sterilization and vasectomy).<sup>11</sup> It also includes certain infertility services (see **Table 1** and **Table 2**) and certain interventions, but currently excludes in vitro fertilization (IVF).<sup>12</sup> The VA makes emergency contraception available to its beneficiaries at its pharmacies, but requires that a VA health care provider enter an order into the veteran’s medical record for it to be dispensed.

**Table 1. Selected Diagnostic Procedures and Tests for Infertility Provided by VA**

Female Veterans	Male Veterans
Genetic counseling and testing	Evaluation of erectile dysfunction
Hysterosalpingogram (HSG)	Genetic counseling and testing
Infertility counseling	Infertility counseling
Laboratory blood testing (e.g. Follicle-stimulating hormone (FSH); luteinizing hormone (LH))	Seman analysis
Saline infused Sonohysterogram	Transrectal and/or scrotal ultrasonography

**Source:** Department of Veterans Affairs, Veterans Health Administration, *Infertility and Assisted Reproductive Technologies*, Fact Sheet, January 2015.

**Notes:** This is not an exhaustive list of all the test and procedures.

<sup>9</sup> CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by (name redacted)

<sup>10</sup> Department of Veterans Affairs, Veterans Health Administration, Women’s Health Services, *State of Reproductive Health In Women Veterans-VA Reproductive Health Diagnoses and Organization of Care.*, February 2014, p. 30.

<sup>11</sup> *Ibid.* p. 20.

<sup>12</sup> 38 C.F.R. §17.38(c). See Figure 4 in CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by (name redacted)

**Table 2. Selected Medical Procedures for Treatment of Infertility Provided by VA**

Female Veterans	Male Veterans
Hormonal therapies (Controlled ovarian hyper-stimulation)	Hormonal therapies (e.g., clomiphene citrate, human chorionic gonadotropin (HCG) phosphodiesterase 5 (PDE5) medications, testosterone)
Intrauterine insemination (IUI), also known as artificial insemination (AI)	Sperm cryopreservation for medically indicated conditions
Reversal of tubal ligation (Tubal Reanastomosis)	Surgical correction of structural pathology (i.e., varicocele, Peyronie's Repair, among others)
Surgical correction of structural pathology consistent with standard of care including operative laparoscopy and operative hysteroscopy	Vasectomy reversal (vasectomy, varicocele, vasovasostomy)

**Source:** Department of Veterans Affairs, Veterans Health Administration, *Infertility and Assisted Reproductive Technologies*, Fact Sheet, January 2015.

**Notes:** This is not an exhaustive list of all the infertility related medical procedures.

## Does the VA Provide Abortions or Abortion Counseling?

The VA provides a uniform “medical benefits package”<sup>13</sup> that does not include abortions and abortion counseling.<sup>14</sup> Furthermore, with the VA’s decision to exclude abortions, as required by the Veterans Health Care Act of 1992 (P.L. 102-585),<sup>15</sup> from the medical benefits package, the VA also made a decision to no longer perform therapeutic abortions (i.e., abortions that are performed in instances when needed to save the life of a mother). As a consequence of this, abortifacients such as RU 486 (mifepristone) are not available through VA pharmacies.<sup>16</sup>

<sup>13</sup> Codified in Title 38 C.F.R. §17.38; see also CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by (name redacted)

<sup>14</sup> 38 C.F.R. §17.38(c).

<sup>15</sup> The Health Care Services for Women Act, November 4, 1992, P.L. 102-585, Title I, §106, 106 Stat. 4847, provided:

“(a) General authority. In furnishing hospital care and medical services under chapter 17 of title 38, United States Code [38 USCS §§1701 et seq.], the Secretary of Veterans Affairs may provide to women the following health care services:

“(1) Papanicolaou tests (pap smears).

“(2) Breast examinations and mammography.

“(3) General reproductive health care, including the management of menopause, but not including under this section infertility services, **abortions** [*emphasis added*], or pregnancy care (including prenatal and delivery care), except for such care relating to a pregnancy that is complicated or in which the risks of complication are increased by a service-connected condition.” Veterans’ Health Care Eligibility Reform Act of 1996 (P.L. 104-262), required VA to establish and implement a national enrollment system and soon thereafter VA established through regulations a Uniform Medical Benefits package. VA’s Uniform Medical Benefits package included pregnancy and delivery services as authorized by law and certain medically necessary infertility services. See Title 38 Code of Federal regulations (C.F.R) Sections 17.38(a)(1)(xiii) and 17.38(b) [care needed to promote, preserve, or restore health]. Abortions, abortion counseling, and in-vitro fertilization (IVF) were expressly excluded from the medical benefits package. See Title 38 C.F.R, Section 17.38(c)(1) & (2).

<sup>16</sup> Department of Veterans Affairs, Veterans Health Administration, “Health Care Services For Women Veterans,” VHA Handbook 1330.01, May 21, 2010.



## 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.<sup>17</sup> Among other services, the IHS reports that it provides specific women's health services such as mammograms and other preventive screenings. The IHS also funds or operates programs to screen individuals at risk of HIV/AIDS and provide treatment services as necessary.<sup>18</sup>

### Does the IHS Provide Emergency Contraception?

The IHS provides emergency contraception (Plan B One-Step®, [Levonorgestrel] emergency contraception [EC] pill) through its pharmacies, emergency departments, and health clinics. In June 2013, the FDA approved Plan B One Step as an over-the-counter drug. This presented a challenge for IHS in making the drug available to its beneficiaries, given that the agency generally does not dispense drugs without a provider order to do so.<sup>19</sup> In October of 2015, IHS amended its internal policies to make emergency contraception available without a provider visit or a need for the patient to register with the facility.<sup>20</sup>

### Does the IHS Provide Abortions?

The IHS is prohibited from using any of its appropriated funds to perform or pay for abortion services.<sup>21</sup> IHS funds may be used in cases used 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. IHS has developed and implemented protocols for its physicians to determine and certify cases when an abortion could be paid for because the IHS physician has determined that the mother's health would be endangered were the fetus to be carried to term.<sup>22</sup>

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<sup>17</sup> CRS Report R43330, *The Indian Health Service (IHS): An Overview*, by (name redacted) .

<sup>18</sup> U.S. Department of Health and Human Services (HHS), Indian Health Service (IHS), *Fiscal Year 2017 Indian Health Service Justification of Estimates*, <https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2017CongressionalJustification.pdf>.

<sup>19</sup> See, for example, Mary Annette Pember, "Emergency Contraception Finally Available Through All IHS Facilities," *Indian Country*, October 19, 2015, <http://indiancountrytodaymedianetwork.com/2015/10/19/emergency-contraception-finally-available-through-all-ihs-facilities-162134>.

<sup>20</sup> U.S. Department of Health and Human Services (HHS), Indian Health Service (IHS), *Indian Health Manual: Part 1-General, Chapter 15-Emergency Contraception*, [https://www.ihs.gov/IHM/index.cfm?module=dsp\\_ihm\\_pc\\_p1c15](https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p1c15).

<sup>21</sup> 25 U.S.C. §1676.

<sup>22</sup> U.S. Department of Health and Human Services (HHS), Indian Health Service (IHS), *Indian Health Manual: Part 1-General, Chapter 13-Maternal and Child Health* [https://www.ihs.gov/IHM/index.cfm?module=dsp\\_ihm\\_pc\\_p3c13#3-13.14](https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p3c13#3-13.14).

IHS will also provide health services necessary to terminate an ectopic pregnancy<sup>23</sup>—a pregnancy that occurs outside the womb (uterus), which is life-threatening to the mother.<sup>24</sup>

## Medicaid

### 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) and who desire such services and supplies.”<sup>25</sup> 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.<sup>26</sup> 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.<sup>27</sup> Benefits for this new eligibility group are limited to family planning services and supplies and related medical diagnosis and treatment services.<sup>28</sup> In all cases, states are not permitted to charge cost-sharing for Medicaid family planning services and supplies.<sup>29</sup>

### What Types of Contraceptive Services and Supplies Does Medicaid Cover?

States have discretion in identifying the specific services and supplies (including emergency contraception) covered under the traditional Medicaid state plan.<sup>30</sup> Family planning services and

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<sup>23</sup> U.S. Department of Health and Human Services (HHS), Indian Health Service (IHS), Indian Health Manual: Part 1- General, Chapter 13-Maternal and Child Health” [https://www.ihs.gov/IHM/index.cfm?module=dsp\\_ihm\\_pc\\_p3c13#3-13.14](https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p3c13#3-13.14).

<sup>24</sup> National Institutes of Health, National Library of Medicine, MedlinePlus Medical Encyclopedia, <http://www.nlm.nih.gov/medlineplus/encyclopedia.html>.

<sup>25</sup> 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>.

<sup>26</sup> 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.

<sup>27</sup> Section 1902(a)(10)(G) as added by Section 2303(a)(3) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

<sup>28</sup> Section 1902(ii)(1) of the Social Security Act.

<sup>29</sup> 42 C.F.R. §447.56(a)(2)(ii) and 42 C.F.R. §438.108.

<sup>30</sup> 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/medicaid-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/medicaid/state-medicaid-coverage-of-family-planning-services/>.

supplies include items and procedures for family planning purposes (i.e., contraceptive care<sup>31</sup>), 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).<sup>32</sup> 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.<sup>33</sup> Medicaid alternative benefit plans (ABPs)<sup>34</sup> must cover family planning services and supplies, among other requirements.

As an alternative to traditional state plan services, states may offer ABPs.<sup>35</sup> ABPs must cover at least the 10 essential health benefits (EHBs).<sup>36</sup> In addition, ABP 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 below in the subsection “What Types of Services Must Be Covered?” in the section “Federal Mandates for Private Insurance Coverage.”) Among other requirements, ABPs must also cover family planning services and supplies, including FDA-approved contraceptives<sup>37</sup> (such as emergency contraception<sup>38</sup>) generally for women with a prescription.<sup>39</sup>

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<sup>31</sup> Beneficiaries must be permitted to choose the method of family planning they desire, and free from coercion or mental pressure when accessing family planning services (42 C.F.R. §441.20).

<sup>32</sup> Section 1905(a)(4)(C) of the Social Security Act.

<sup>33</sup> 42 C.F.R. §§441.253 through 441.256.

<sup>34</sup> 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.

<sup>35</sup> 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.

<sup>36</sup> 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.

<sup>37</sup> For more information, see Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid, Letter to State Medicaid Directors, RE: Family Planning and Family Planning Related Services Clarification, SMDL#14-003 ACA# 31, April 16, 2014 available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf>.

<sup>38</sup> For more information on state coverage of emergency contraception, see Kaiser Family Foundation, Emergency Contraception, July 25, 2016 available at <http://kff.org/womens-health-policy/fact-sheet/emergency-contraception/>.

<sup>39</sup> In general, emergency contraception is available without a prescription for women over the age of 17. For more information on emergency contraception’s availability over the counter, see Food and Drug Administration, “FDA Approves Plan B One-Step Emergency Contraceptive for Use Without a Prescription for All Women of Child-bearing Potential,” press release, June 20, 2013, <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm358082.htm>. Based on survey information, it appears as though some state Medicaid programs also cover non-prescription emergency contraception, for more information, see Princeton University, Office of Population Research & Association of Reproductive Health Professionals, *The Emergency Contraception Website*, available at <http://ec.princeton.edu/info/Medicaid.html>.

## 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.<sup>40</sup> By contrast, family planning-related services are reimbursable at the state's regular FMAP rate.<sup>41</sup> Family planning-related services are generally provided because they were identified, or diagnosed, during a family planning visit. Such services may include the following.<sup>42</sup>

- 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.
- 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.
- Family planning-related services that were provided as part of, or as follow-up to, the family planning visit in which a sterilization procedure took place.

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<sup>40</sup> Section 1903(a)(5) of the Social Security Act.

<sup>41</sup> For FY2017, states' regular FMAP rates range from 50.00% to 74.63%, 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)*, by (name redacted).

<sup>42</sup> 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 available at <http://downloads.cms.gov/cmssgov/archived-downloads/SMDL/downloads/SMD10013.pdf>, and Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid, Letter to State Medicaid Directors, RE: Family Planning and Family Planning Related Services Clarification, SMDL#14-003 ACA# 31, April 16, 2014 available at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf>.

## Does Medicaid Cover Abortion Services?

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports (LTSS), to a diverse low-income population. Like other HHS programs, Medicaid is subject to the Hyde Amendment (see “Can Federal Funds Be Used to Pay for Abortions?”).<sup>43</sup> Medicaid program guidance further specifies that the Hyde Amendment does not prohibit a “state, locality, entity, or private person” from paying for abortion services, nor does it prohibit managed care providers from offering abortion coverage or affect 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).<sup>44,45</sup> (Also see “Does Medicaid Cover Mifepristone (Mifeprex or RU-486)?”)

Through program regulations,<sup>46</sup> and later revised through program guidance, Medicaid enrollees and providers may be required to comply with reasonable documentation requirements to ensure that the abortion meets the Hyde amendment criteria and is eligible for Medicaid federal financial participation (FFP). 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.<sup>47</sup>

## 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) regardless of the funding source.<sup>48</sup>

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<sup>43</sup> In FY2015, states claimed federal financial participation (FFP) for 153 abortions: 108 were due to endangerment to the life of the mother, 44 were due to rape, and 1 was due to incest. Department of Health and Human Services, Office of the Assistant Secretary for Financial Resources, *FY 2017 Moyer Material*, February 22, 2015, Addendum: Abortion-Related Reporting.

<sup>44</sup> 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>.

<sup>45</sup> 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*, June 1, 2016. <https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid>.

<sup>46</sup> 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.

<sup>47</sup> 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>.

<sup>48</sup> 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>.

## 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.<sup>49</sup> Medicaid federal financial participation (FFP) is available for medical procedures necessary for the termination of an ectopic pregnancy.<sup>50</sup>

## What Types of Reproductive Health Services Does Medicaid Cover?

Under traditional Medicaid, states cover a wide array of mandatory services (e.g., inpatient hospital care, lab and x-ray services, pregnancy-related services and physician care). In addition, states may provide optional services (e.g., personal care services, prescription drugs, preventive services, clinic services, and infertility treatments). A number of these services can be used to meet a person's reproductive health needs. As discussed more fully below (see "What Types of Contraceptive Services and Supplies Does Medicaid Cover?") coverage of family planning services and supplies is a required Medicaid service.

Medicaid-eligible children under age 21 are entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT), which includes health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services. States are required to provide all federally allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state's Medicaid plan. Reproductive health services are included among the screening and treatment services available under ESPDT.

As an alternative to traditional state plan services, states may offer alternative benefit plans (ABPs).<sup>51</sup> ABPs must cover at least the 10 essential health benefits (EHBs).<sup>52</sup> In addition, ABP 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.")

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<sup>49</sup> National Institutes of Health, National Library of Medicine, MedlinePlus Medical Encyclopedia, <http://www.nlm.nih.gov/medlineplus/encyclopedia.html>.

<sup>50</sup> 42 C.F.R. §441.207.

<sup>51</sup> 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.

<sup>52</sup> 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.

## Who Provides Family Planning and Reproductive Health Services 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,<sup>53</sup> and a majority (77%) of Medicaid women of childbearing age access care through some type of managed care arrangement.<sup>54</sup> In general, under Medicaid's "freedom of choice of provider" requirement, states must permit enrollees to receive services from any willing Medicaid-participating provider,<sup>55</sup> and states cannot exclude providers solely on the basis of the range of services they provide.<sup>56</sup> Medicaid managed-care enrollees may be restricted to providers in the plan's network, except in the case of family planning services.<sup>57</sup> 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 of their choice (as long as the provider participates in the Medicaid program), even if they are not considered "in-network" providers.<sup>58</sup>

## Medicare Coverage<sup>59</sup>

### Do Medicare Beneficiaries Use Reproductive Health Services?

The majority of Medicare beneficiaries are 65 years old or older. However, more than 900,000 women under age 45 (i.e., of reproductive age) were eligible for Medicare in 2013, as a result of

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<sup>53</sup> 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>.

<sup>54</sup> 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>.

<sup>55</sup> 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 C.F.R. §431.51, 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>).

<sup>56</sup> Sections 1902(a)(23) and 1932(a) of the Social Security Act and 42 C.F.R. §431.51. See also Department of Health and Human Services; Centers for Medicare and Medicaid Services; Letter to State Medicaid Directors; SMD #16-005; Re: Clarifying "Free Choice of Provider" Requirement in Conjunction with State Authority to Take Action against Medicaid Providers; April 19, 2016, available at <https://www.medicare.gov/federal-policy-guidance/downloads/smd16005.pdf>.

<sup>57</sup> See Section 1902(a)(23)(B) of the Social Security Act; 42 C.F.R. §431.51(b)(1); and 42 C.F.R. Part 438.

<sup>58</sup> Section 1902(e)(2) of the Social Security Act.

<sup>59</sup> Medicare benefits in general are summarized in CRS Report R40425, *Medicare Primer*, coordinated by (name redacted).

disability.<sup>60</sup> 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.<sup>61</sup>

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.<sup>62</sup>

## **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.<sup>63</sup> 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.

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<sup>60</sup> Data from the Center for Medicare & Medicaid Services, “2014 CMS Statistics,” [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2014\\_final.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2014_final.pdf).

<sup>61</sup> CMS, Medicare National Coverage Determination for Sterilization (230.3), <http://www.cms.gov/medicare-coverage-database/>.

<sup>62</sup> 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/>.

<sup>63</sup> CMS, “Preventive Services,” interactive chart for the Medicare Fee-for-Service Program, January 2015, [http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf).



## 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.<sup>64</sup>

## Title X Family Planning Program

### What Is the Title X Family Planning Program?

Enacted in 1970 as Title X of the Public Health Service Act, the Family Planning Program provides grants to public and nonprofit agencies for family planning services, research, and training. Administered by HHS, it is the only domestic federal program devoted solely to family planning and related preventive health services.<sup>65</sup>

Title X grants are awarded to a variety of entities, including state, local, and territorial health departments; hospitals; non-profit community health agencies; Planned Parenthood Federation of America affiliates; and family planning councils.<sup>66</sup> Title X grantees can provide family planning services directly or they can delegate Title X monies to other entities to provide services. In 2014, Title X provided services to 4.1 million clients through more than 4,000 service sites located in the 50 states, the District of Columbia, and the U.S. territories and Freely Associated States.<sup>67</sup>

### What Contraceptive Services Do Title X Projects Provide?

Title X family planning services grants fund family planning and related preventive health services, such as contraceptive services. Title X regulations require funded projects to “provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents).”<sup>68</sup> Title X clinical guidelines advise providers that “contraceptive services should include consideration of a full range of FDA-approved contraceptive methods, a brief assessment to identify the contraceptive methods that are safe for the client, contraceptive counseling to help a client choose a method of contraception and use it correctly and consistently, and provision of one or more selected contraceptive method(s), preferably on site, but by referral if necessary.”<sup>69</sup>

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<sup>64</sup> CMS, Medicare National Coverage Determination for Abortion (140.1), June 19, 2006, <http://www.cms.gov/medicare-coverage-database/>.

<sup>65</sup> CRS Report RL33644, *Title X (Public Health Service Act) Family Planning Program*, by (name redacted)

<sup>66</sup> A full list of grantees is available at HHS, Office of Population Affairs, “Title X Family Planning Directory of Grantees,” May 2016, <http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/title-x-directory-grantees.pdf>.

<sup>67</sup> Christina Fowler, Julia Gable, Jiantong Wang, and Beth Lasater, *Family Planning Annual Report: 2014 National Summary*, RTI International, Research Triangle Park, NC, August 2015, pp. 7-8, <http://www.hhs.gov/opa/pdfs/title-x-fpar-2014-national.pdf>. A searchable directory of Title X providers is at HHS, Office of Population Affairs, *Title X Grantees List*, <http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/title-x-grantees-list/>.

<sup>68</sup> 42 C.F.R. §59.5(a)(1). The availability of specific contraceptive methods varies by site.

<sup>69</sup> Title X clinical guidelines are laid out in Loretta Gavin, Susan Moskosky, Marion Carter, et al., “Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs,” *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), pp. 1-29, <http://www.cdc.gov/mmwr/preview/mmwrhtml/> (continued...)

Title X contraceptive services offered to males include condoms, education and counseling, and, in some cases, vasectomy services.<sup>70</sup>

Title X projects are required to provide services 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. For unemancipated minors who request confidential services, eligibility for discounts is based on the minor's own income.<sup>71</sup>

## Do Title X Projects Provide Emergency Contraception?

Title X clinical guidelines advise providers that they “may inform clients about the availability of emergency contraceptive pills and may provide clients an advance supply of emergency contraceptive pills on-site or by prescription, if requested.”<sup>72</sup> One survey found that 87% of Title X sites had provided emergency contraception onsite in the previous three months.<sup>73</sup>

## What Reproductive Health Services Do Title X Projects Provide?

Title X family planning services grants fund family planning and related preventive health services, including reproductive health services such as breast and cervical cancer screening and prevention; sexually transmitted disease (STD) and HIV prevention education, counseling, testing, and referral; preconception health services; and counseling on establishing a reproductive life plan. Title X provides services to men and women. Services offered to men include education and counseling, STD testing and treatment, and HIV testing.<sup>74</sup>

Title X projects are required to provide services 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

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rr6304a1.htm. See also HHS, Office of Population Affairs, *Title X Family Planning Program Priorities*, <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-priorities>.

<sup>70</sup> *Male Services*, <http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/male-services>.

<sup>71</sup> 42 C.F.R. §59.2, §59.5.

<sup>72</sup> Loretta Gavin, Susan Moskosky, Marion Carter, et al., “Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs,” *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), pp. 1-29, <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>.

<sup>73</sup> Marion W. Carter, Loretta Gavin, Lauren B. Zapata, et al., “Four aspects of the scope and quality of family planning services in US publicly funded health centers: Results from a survey of health center administrators,” Table 2, *Contraception*, in press, available online April 25, 2016, <http://dx.doi.org/10.1016/j.contraception.2016.04.009>. The survey's respondents included 1,045 Title X sites. The survey was conducted June 2013 to May 2014, and reflects practices prior to the release of current Title X clinical guidelines in April 2014. Prior guidelines did not address advance provision of emergency contraception, but noted that “certain oral contraceptive regimens have been found by the Federal Food and Drug Administration to be safe and effective for use as postcoital emergency contraception when initiated within 72 hours after unprotected intercourse.” U.S. Department of Health and Human Services, Office of Family Planning, *Program Guidelines for Project Grants for Family Planning Services*, January 2001, <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-guidelines/2001-ofp-guidelines-complete.html>.

<sup>74</sup> 42 C.F.R. §59.5. Title X clinical guidelines are laid out in Loretta Gavin, Susan Moskosky, Marion Carter, et al., “Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs,” *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), pp. 1-29, <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm>. See also HHS, Office of Population Affairs, *Title X Family Planning Program Priorities*, <http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-priorities>; *Male Services*, <http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/male-services>.

the federal poverty level. For unemancipated minors who request confidential services, eligibility for discounts is based on the minor's own income.<sup>75</sup>

## Does the Title X Family Planning Program Fund Abortions?

By law, Title X funds may not be used for abortions.<sup>76</sup> The prohibition on abortion does not apply to all the activities of a Title X grantee, but only to activities that are within the Title X project. The grantee's abortion activities must be "separate and distinct" from the Title X project activities.<sup>77</sup>

Program regulations require Title X projects to offer pregnant women information and counseling on each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. If the woman requests such information and counseling, the project must give "neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling."<sup>78</sup>

## What Legislative Mandates Apply to the Use of Title X funds?

The Consolidated Appropriations Act, 2016 (P.L. 114-113), which provided full year funding for FY2016, continues requirements on the use of Title X funds included in previous years' appropriations laws:

- Title X funds may not be spent on abortions.
- All pregnancy counseling must be nondirective.
- Funds may not be spent on "any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office."
- Grantees must certify that they encourage family participation when minors decide to seek family planning services.
- Grantees must certify that they counsel minors on how to resist attempted coercion into sexual activity.
- Family planning providers are not exempt from state notification and reporting laws on child abuse, child molestation, sexual abuse, rape, or incest.

The above requirements are in addition to statutory mandates in Title X of the Public Health Service Act, which, among other things, require family planning participation to be voluntary and prohibit the use of Title X funds in programs in which abortion is a method of family planning.

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<sup>75</sup> 42 C.F.R. §59.2, §59.5.

<sup>76</sup> 42 U.S.C. §300a-6. In addition, language in annual Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations bills have also prohibited the use of Title X funds for abortions. (In FY2016, this provision appeared in P.L. 114-113, Division H, Title II, 129 Stat. 2602.)

<sup>77</sup> HHS, Office of Population Affairs, "Provision of Abortion-Related Services in Family Planning Services Projects," 65 *Federal Register* 41281-41282, July 3, 2000, <https://federalregister.gov/a/00-16759>; and HHS, Office of Population Affairs, "Standards of Compliance for Abortion-Related Services in Family Planning Services Projects," 65 *Federal Register* 41270-41280, July 3, 2000, <https://federalregister.gov/a/00-16758>.

<sup>78</sup> 42 C.F.R. §59.5(i).

## 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 markets<sup>79</sup> are required to cover, without cost sharing, a specified set of preventive health services.<sup>80</sup> Many of these are reproductive health services, including, among others, (1) 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.<sup>81</sup>

In addition, the ACA requires all non-grandfathered health plans in the non-group and small-group private health insurance markets to offer a core package of health care services, known as the essential health benefits (EHB). The ACA does not specifically define this core package but rather lists 10 benefit categories from which benefits and services must be included. For the 2014-2017 coverage years, each state was required to select an EHB-benchmark plan. The benchmark plan serves as a reference plan on which non-group and small-group market plans must substantially base their benefits packages.<sup>82</sup> 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.<sup>83</sup> 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.

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<sup>79</sup> For more information about private health insurance, see CRS Report RL32237, *Health Insurance: A Primer*, by (name redacted) and (name redacted), and CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redacted).

<sup>80</sup> 45 C.F.R. §147.130, “Coverage of Preventive Health Services.”

<sup>81</sup> 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).

<sup>82</sup> For more information on the essential health benefits, see CRS Report R44163, *The Patient Protection and Affordable Care Act’s Essential Health Benefits (EHB)*, by (name redacted).

<sup>83</sup> 45 C.F.R. §156.115(a)(4), “Provision of EHB,” by reference to 45 C.F.R. §147.130, “Coverage of Preventive Health Services.”

## 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.<sup>84</sup> (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.<sup>85</sup>

## 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.<sup>86</sup> Under the accommodation, a third-party plan administrator is responsible for administering and paying for contraceptive benefits.<sup>87</sup> Since ACA’s enactment, challenges to the accommodation as a violation of religious freedom have worked their way through the courts. In May 2016, the Supreme Court declined to decide on the merits of seven such cases consolidated for review, remanding the cases back to the respective courts with instructions to continue efforts to reach accommodation of the parties.<sup>88</sup>

## 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 Title X program is the one program that provides dedicated support for non-governmental entities to provide reproductive health-related services to low-income populations. Other programs provide funds to non-governmental entities for a variety of services, including those related to reproductive health and/or family planning. Below are some selected examples:

- **The Federal Health Center Program** is administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS).<sup>89</sup> The program awards grants to non-profit, tribal, or state and local government facilities to provide outpatient health services to

<sup>84</sup> 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>.

<sup>85</sup> 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.

<sup>86</sup> CRS In Focus IF10169, *The Affordable Care Act’s Contraceptive Coverage Requirement: History of Regulations for Religious Objections*, by (name redacted)

<sup>87</sup> 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.

<sup>88</sup> CRS Legal Sidebar WSLG1579, *No Answer for Now: Supreme Court Remands Nonprofit Contraceptive Coverage Challenges*, by (name redacted)

<sup>89</sup> These facilities are also called federally qualified health centers (FQHCs) or community health centers.

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.<sup>90</sup> 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 program awards funds to provide these services.<sup>91</sup> 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.<sup>92</sup>
- **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.<sup>93</sup>
- **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.<sup>94</sup>
- **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.<sup>95</sup>
- **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.<sup>96</sup>
- **The Social Services Block Grant Program**, administered by the HHS Administration for Children and Families, Office of Community Services,

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<sup>90</sup> CRS Report R43937, *Federal Health Centers: An Overview*, by (name redacted), and CRS Report R44295, *Factors Related to the Use of Planned Parenthood Affiliated Health Centers (PPAHCs) and Federally Qualified Health Centers (FQHCs)*, by (name redacted).

<sup>91</sup> For more information about the Ryan White Program, see CRS Report R44282, *The Ryan White HIV/AIDS Program: Overview and Impact of the Affordable Care Act*, by (name redacted) and (name redacted) and HRSA, “HIV/AIDS Programs,” <http://hab.hrsa.gov/>.

<sup>92</sup> HRSA, “Justification of Estimates for Appropriations Committees, FY2017,” Rockville, MD.

<sup>93</sup> CDC, “National Breast and Cervical Cancer Early Detection Program,” <http://www.cdc.gov/cancer/nbccedp/>.

<sup>94</sup> CDC, “Justification of Estimates for Appropriations Committees, FY2016,” p. 92 ff., <http://www.cdc.gov/fmo>.

<sup>95</sup> HRSA, “Justification of Estimates for Appropriations Committees, FY2017,” p. 198 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 (name redacted); and CRS Report R43930, *Maternal and Infant Early Childhood Home Visiting (MIECHV) Program: Background and Funding*, by (name redacted).

<sup>96</sup> HHS, “Justification of Estimates for Appropriations Committees, General Departmental Management, FY2017,” p. 154 ff., <http://www.hhs.gov/sites/default/files/fy2017-budget-justification-gdm.pdf>. See also CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*, by (name redacted).

provides grants to states to support a wide range of social service activities, including family planning.<sup>97</sup>

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<sup>97</sup> In FY2014, \$6.4 million, or less than 1% of SSBG expenditures, went to family planning services. For more information, see U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services, *Social Services Block Grant Program Annual Report 2014*, [http://www.acf.hhs.gov/sites/default/files/ocs/ssbg\\_2014\\_annual\\_report\\_final\\_508\\_compliant.pdf](http://www.acf.hhs.gov/sites/default/files/ocs/ssbg_2014_annual_report_final_508_compliant.pdf). See also CRS Report 94-953, *Social Services Block Grant: Background and Funding*, by (name redacted).

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