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Federal Support for Reproductive Health Services: Frequently Asked Questions

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SUMMARY

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Federal Support for Reproductive Health Services: Frequently Asked Questions

Federal support for reproductive health services—preventive, diagnostic, and treatment services related to reproductive systems, functions, and processes—is administered in different ways, largely because federal agencies, departments, and programs have different missions.

Congress has considered bills related to various aspects of reproductive health care. This includes bills that expand or restrict the types of reproductive health services available, how they are paid for or provided, and the restrictions in place on paying for or providing certain types of reproductive health services. The Supreme Court's recent decisions regarding *Dobbs v. Jackson Women's Health Organization*; the consolidated cases *U.S. Food and Drug Administration (FDA) v. Alliance for Hippocratic Medicine and Danco Laboratories L.L.C. v. Alliance for Hippocratic Medicine*; and *Moyle v. United States* have raised questions about access to contraception and abortion services.

This report provides answers to frequently asked questions concerning the coverage, funding, and provision of reproductive health services in the United States. Specifically, it discusses six categories of reproductive health services with regard to whether the federal government pays for these services, requires certain health insurance plans to cover them, or provides them. The six categories addressed in this report are

1. contraception;
2. abortion and abortion counseling;
3. infertility-related services;
4. maternity services;
5. reproductive health screening, preventive services, and treatment; and
6. gender-affirming services.

After providing an overview of the reproductive health services discussed, the report

- describes the services that federal payment programs will cover when provided to enrolled beneficiaries;
- answers questions about federal requirements for private health insurance coverage of reproductive health services;
- describes whether and how federal programs that provide health services directly to a set of beneficiaries deliver or pay for the six types of reproductive health services; and
- provides short summaries of various federal programs that administer grants to nongovernmental entities to provide specific types of reproductive health services.

Contents

Tables

Appendixes

Contacts

Introduction

Reproductive health services are preventive, diagnostic, and treatment services related to reproductive systems, functions, and processes. Federal support for these services is administered in different ways because federal agencies, departments, and programs have different missions.

This report first defines six different types of reproductive health services that may receive federal support, noting restrictions where relevant. The six types of reproductive health services discussed in this report are

1. contraception;
2. abortion and abortion counseling;
3. infertility-related services;
4. maternity services;
5. reproductive health screening, preventive services, and treatment; and
6. gender-affirming services.[1]

The report next describes the role that the federal government has in paying for services provided to beneficiaries enrolled in federal health insurance programs, requiring payment for services by certain private health insurance plans, and providing domestic reproductive health services through federal agencies and programs.[2] The report then discusses grant programs that focus on one or more specific reproductive health topics (e.g., breast cancer screening) and grant programs that have a broader focus but may provide or pay for some types of reproductive health services. The report concludes with three appendixes: **Appendix A** presents a table of federal statutory coverage requirements of private health insurance; **Appendix B** identifies acronyms used in this report; **Appendix C** lists CRS experts on the various reproductive health topics discussed in this report.

On June 24, 2022, the U.S. Supreme Court issued its opinion in *Dobbs v. Jackson Women's Health Organization*, concluding that the U.S. Constitution does not confer a right to an abortion.[3] During subsequent terms, the Court heard and issued decisions on several cases regarding reproductive health care.[4] The Court's decisions have raised questions about access to contraception, abortion, and reproductive health services, and Congress has considered legislation on reproductive health care in a new federal landscape.

Throughout this report, CRS has taken the primary approach of using gendered terms in the same manner as the terms are used in the statute, rules, regulations, and guidance of specific agencies and grant programs. That is to say, the usage of the terms such as "woman," "man," "female," "male," "pregnant woman," "pregnant person," and "individuals who are pregnant," in each

[1] Gender-Affirming Services are medical and surgical interventions designed to help match an individuals' primary and secondary sex characteristics with their gender identity. Services include, but are not limited to, hormone therapy and surgical procedures. For more information, see "What Are Gender-Affirming Services?" in this report.

[2] The enrollment estimates provided for federal programs covered in this report are not additive, as individuals can have multiple types of health coverage. In addition, the methodological approaches used to determine the estimates may limit comparisons between different coverage types.

[3] CRS Legal Sidebar LSB10768, *Supreme Court Rules No Constitutional Right to Abortion in Dobbs v. Jackson Women's Health Organization*.

[4] See, for example, CRS Legal Sidebar LSB11196, *Supreme Court Allows Emergency Abortions in Idaho but Leaves Litigation Unresolved*, and CRS Legal Sidebar LSB11183, *Medication Abortion Access Remains Unchanged as Supreme Court Rejects Legal Challenge on Standing Grounds*.

section have been made consistent with each federal agency's or grant program's official terminology.[5]

General Questions

What Are Reproductive Health Services?

Reproductive health services are preventive, diagnostic, and treatment services related to reproductive systems, functions, and processes. These services include, but are not exclusive to, those related to family planning; sexually transmitted infections (STIs)/sexually transmitted diseases (STDs);[6] screening and treatment for diseases, including cancers, of the reproductive organs and breast tissues; and gender-affirming services.[7]

Family planning services, which are a subset of reproductive health services, include health-promoting preventive, diagnostic, and treatment services that help individuals and/or families decide on whether or when to become pregnant. Such services may include using contraceptives, infertility treatments, preconception care, pregnancy counseling, and counseling on healthy sexual behaviors.[8]

What Are Contraceptive Services?

Contraceptive services include contraceptive counseling services and use of contraceptive products or methods to prevent or delay pregnancy. *Contraceptive counseling* includes a health care provider's assessment of a client in determining which methods are safe, effective, and available for the client; counseling of the client in determining whether a contraceptive method will meet the client's need and, if so, which method to choose; education of the client on how to use the method consistently and correctly; the provision of the contraceptive product or method; and follow-up care.[9]

A *contraceptive* is a product or method intended to lower the possibility of becoming pregnant.[10] Contraceptive products vary in type and include drugs (e.g., oral contraceptives) and medical

[5] For more information about terminology related to gender and gender identity, see the following resource: Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health, "Terminology," December 23, 2022, https://www.cdc.gov/healthyyouth/terminology/sexual-and-gender-identity-terms.htm.

[6] Some assert there to be a distinction between sexually transmitted infections (STIs) and sexually transmitted diseases (STDs). Others use the terms interchangeably. The federal programs described in this report use the terms interchangeably. As a result, this report presents either term as it is used in the program being discussed, without suggesting a distinction between the terms. The difference between the two is that an STI is a "virus, bacteria, fungus, or parasite people can get through sexual contact." All STDs start out as infections, but not all STIs develop into diseases. For example, a Human Papillomavirus Virus (HPV) infection is classified as an STI, but if it develops into genital warts or cervical cancer, it is then considered an STD. See CDC, "About Sexually Transmitted Infections (STIs)," March 25, 2024, https://www.cdc.gov/sti/about/index.html#cdc_disease_basics_overview-sti-or-std.

[7] Department of Health and Human Services (HHS), Office of the Assistant Secretary of Health (OASH), Office of Population Affairs (OPA), *Reproductive Health*, https://opa.hhs.gov/reproductive-health.

[8] Loretta Gavin, Susan Moskosky, and 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), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf. Adoption is not discussed in this report because, although it is included as a family planning service, it is not an explicit health service.

[9] Ibid.

[10] Some types of contraceptives may also reduce risk of contracting certain STIs. STIs are discussed in the "What Are Reproductive Health Prevention and Treatment Services?" section of this report.

devices (e.g., internal condom). Some contraceptive products have both a drug and device component (e.g., contraceptive patch). Prior to commercial availability in the United States, contraceptive products are reviewed by the Food and Drug Administration (FDA) of the U.S. Department of Health and Human Services (HHS). Federal funding or payment for contraception is generally limited to certain medical or surgical procedures and to those products that are FDA-approved, cleared, or authorized for marketing. Contraceptive methods can include fertility awareness-based family planning methods. These utilize fertility-awareness tracking through monitoring of symptoms and biological markers to determine periods during the menstrual cycle when the possibility of pregnancy is lowest.[11] Fertility-awareness tracking can be tracked manually or with the assistance of a mobile medical application (app).[12]

For contraceptive drugs, FDA approves those products that demonstrate substantial evidence that the drug is safe and effective for the purpose stated in the new drug application.[13] 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 (a predicate device).[14]

FDA has identified 19 different contraceptive methods.[15] (See **Table 1**, which lists those methods from those most effective at preventing pregnancy to those least effective and provides a description for each method.)[16] For example, for each of the first five methods listed, according to FDA, less than one pregnancy per 100 women per year would be expected, in contrast to the last method listed (spermicide alone), in which up to 28 pregnancies per 100 women per year would be expected under typical use.[17] Intrauterine devices (IUDs) and implants are long-acting reversible contraceptives (LARCs) and are highly effective in preventing pregnancy and can last for several years. FDA has approved emergency contraceptives (EC), which may be used if the regular form of birth control fails (e.g., condom breakages). FDA states that EC "prevents about 55-85% of predicted pregnancies," and "should not to be used as a regular form of birth control."[18] FDA also states that approved contraceptive methods, including EC and IUDs, are not

[11] CDC, "Contraception and Birth Control Methods," August 6, 2024, https://www.cdc.gov/contraception/about/.

[12] FDA, "FDA allows marketing of first direct-to-consumer app for contraceptive use to prevent pregnancy," press release, August 10, 2018, https://www.fda.gov/news-events/press-announcements/fda-allows-marketing-first-direct-consumer-app-contraceptive-use-prevent-pregnancy.

[13] For more information, see CRS Report R41983, *How FDA Approves Drugs and Regulates Their Safety and Effectiveness*, and CRS In Focus IF11083, *Medical Product Regulation: Drugs, Biologics, and Devices*.

[14] CRS Report R42130, *FDA Regulation of Medical Devices*. Examples of contraceptive devices that are class III (high risk) include some intrauterine devices (IUDs), tubal occlusion devices (such as Essure, which was discontinued by Bayer in 2018), and the female condom. Examples of contraceptive devices that are class II (moderate risk) include the diaphragm and the male condom. For IUD regulation, see 21 C.F.R. §884.5360; for tubal occlusion device regulation, see 21 C.F.R. §884.5380; for female condom regulation, see 21 C.F.R. §884.5330.; for diaphragm regulation, see 21 C.F.R. §884.5350; and for condom regulation, see 21 C.F.R. §884.5300.

[15] Note that FDA approves, clears, and grants marketing authorization for individual contraceptive *products*, not *methods*. For purposes of this report, which includes birth control options broader than products, such as sterilization, the term *methods* is used.

[16] FDA, *Birth Control Guide*, May 10, 2024, https://www.fda.gov/media/150299/download.

[17] Ibid.

[18] Ibid.

abortifacients[19] within the meaning of federal law.[20] These contraceptive products, including EC pills, are not effective if the patient is already pregnant (where *pregnancy* "encompasses the period of time from implantation until delivery.")[21] **Table 1** displays the FDA's descriptions of contraceptive methods and their effectiveness, and language reflects that of the FDA birth control resources. Effectiveness estimates are the number of women per 100 who become pregnant over the course of one year using the same method given typical use of that method.

Table 1. Contraceptive Methods: Effectiveness and Definitions

Method	Number of Pregnancies Expected (per 100 women over one year)	Description
Sterilization surgery for women	Less than 1	Tubal ligation (cutting or tying of fallopian tubes); sealing of fallopian tubes with clips, clamps, rings, or with an instrument that uses electric current.
Sterilization surgery for men	Less than 1	Vasectomy; blocking of vas deferens (tubes that carry seminal fluid).
Intrauterine device (IUD) copper	Less than 1	T-shaped copper device inserted into the uterus; prevents sperm from reaching the egg and may prevent implantation. Can be used for a maximum of 10 years.
IUD with progestin	Less than 1	T-shaped device containing the hormone progestin inserted into the uterus; prevents sperm from reaching the egg and thins the lining of the uterus. Can last eight years or more depending on the type.
Implantable rod	Less than 1	Small progestin-containing rod placed under the skin of the upper arm; stops ovaries from releasing eggs; thickens cervical mucus (preventing sperm from reaching the egg). Can be used for up to three years.
Shot/Injection	4	Intramuscular or subcutaneous injection of the hormone progestin; one shot is needed every three months.
Oral contraceptive (combined pill)	7	Daily pill containing estrogen and progestin hormones; prevents ovaries from releasing eggs; thickens cervical mucus (preventing sperm from reaching the egg). Taken for three weeks with a week break in between.
Oral contraceptive (progestin only)	7	Daily pill containing progestin hormones; thickens cervical mucus (preventing sperm from reaching the egg); some types may prevent ovaries from releasing eggs, but these types are less common. Some types are taken continuously, while others are taken for three weeks with a week break in between.

[19] Abortifacient drugs are those for which the main or side effect is a medical abortion. EC, for instance, prevents pregnancy by delaying ovulation and will not affect an existing pregnancy. For additional information on how EC works, see, for example, FDA, "Plan B One-Step (1.5 mg levonorgestrel) Information," December 23, 2022, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/plan-b-one-step-15-mg-levonorgestrel-information. For more information on medical abortions, see the section of this report titled "What Are Abortions and Abortion Counseling Services?"

[20] FDA, "Prescription Drug Products; Certain Combined Oral Contraceptives for Use as Postcoital Emergency Contraception," 62 *Federal Register* 8610-8612, February 25, 1997.

[21] 45 C.F.R. §46.202(f).

Method	Number of Pregnancies Expected (per 100 women over one year)	Description
Patch	7	Skin patch containing estrogen and progestin hormones that is worn on the upper arm, upper back, lower abdomen, or buttocks; prevents ovaries from releasing eggs; thickens cervical mucus (preventing sperm from reaching the egg). Each new patch is worn for three weeks at a time, with a week break in between.
Vaginal contraceptive ring	7	Flexible ring worn intravaginally that releases progestin and estrogen hormones; prevents ovaries from releasing eggs; thickens cervical mucus (preventing sperm from reaching the egg). Each new ring is worn for three weeks at a time, with a week break in between.
Software application for contraception	7-8	Medical software application (app) that can be used as a method of contraception to prevent pregnancy by predicting fertile days using information entered by the user such as daily basal body temperature and menstrual cycle information; recommends when to refrain from unprotected sex or to use contraception.
Male condom	13	Thin film sheath placed over the penis; over-the-counter barrier method that prevents sperm from reaching the egg.
Diaphragm with spermicide	17	Dome-shaped flexible disk worn intravaginally to cover the cervix, with spermicide foam, cream, or jelly inside of it; barrier method that prevents sperm from reaching the egg; spermicide kills sperm cells. Worn for a maximum of 24 hours.
Sponge with spermicide	17	Disk-shaped sponge-like device worn intravaginally, with spermicide foam, cream, or jelly inside of it; barrier method that prevents sperm from reaching the egg; spermicide kills sperm cells. Worn for a maximum of 30 hours.
Cervical cap with spermicide	22-23	Latex or silicon cup that covers the cervix, with spermicide foam, cream, or jelly inside of it; barrier method that prevents sperm from reaching the egg; spermicide kills sperm cells. Worn for a maximum of 48 hours.
Internal (female) condom	21	Thin lubricated pouch placed inside the vagina; over-the-counter barrier method that prevents sperm from reaching the egg.
Spermicide alone	21-28	Sperm cell killing foam, cream, jelly, film, or tablet placed intravaginally; over-the-counter product.

Emergency Contraceptives (EC)	Pregnancies Prevented	Description
EC (Levonorgestrel 1.5mg [one pill] or Levonorgestrel 0.75mg [two pills])	7 out of every 8 women who would have gotten pregnant will not become pregnant after taking this EC.	Progestin hormone pill(s); should be taken within 72 hours of birth control failure or unprotected sex; primarily works to stop or delay ovaries from releasing eggs. Levonorgestrel 1.5mg (one pill) is available over-the-counter for patients without age restrictions (e.g., Plan B One Step, Next Choice One Dose) Levonorgestrel 0.75mg (two pills) is available over-the-counter for patients 17 years old or older, and by prescription for patients under age 17.

Method	Number of Pregnancies Expected (per 100 women over one year)	Description
EC (Ulipristal Acetate)	6 or 7 out of every 10 women who would have gotten pregnant will not become pregnant after taking this EC.	Pill that blocks progesterone hormone; should be taken within 120 hours of unprotected sex; works primarily by stopping or delaying ovaries from releasing eggs; may also work by changing the lining of the uterus that may affect implantation; available by prescription (e.g., Ella).

Sources: FDA, "Birth Control," May 10, 2024, https://www.fda.gov/consumers/womens-health-topics/birth-control. FDA, "Plan B One-Step (1.5 mg levonorgestrel) Information," December 23, 2022, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/plan-b-one-step-15-mg-levonorgestrel-information. FDA, "ella (ulipristal acetate) tablet," full prescribing information, August, 2010, https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf.

Notes: Table language reflects that of the FDA Birth Control resources and chart. It is organized from most to least effective contraceptive (sterilization is most effective; ECs are least effective). Number of pregnancies prevented per 100 people using that method over the course of a year is not available for EC because EC is not meant for routine or continuous use like other methods included in this table.

Though not mentioned in the FDA "Birth Control Guide," other forms of sterilization surgery exist and may be used as a primary form of contraception. These procedures include hysterectomy (removal of uterus)[22] and bilateral salpingectomy (removal of fallopian tubes), often with bilateral oophorectomy (removal of both ovaries).[23] These surgeries are also commonly used to treat medical conditions, such as reproductive cancers.

[22] U.S. National Library of Medicine, "Hysterectomy," January 26, 2021, https://medlineplus.gov/hysterectomy.html.

[23] Harvard Health Publishing, "Will removing your fallopian tubes reduce your risk of ovarian cancer?," October 13, 2020, https://www.health.harvard.edu/womens-health/will-removing-your-fallopian-tubes-reduce-your-risk-of-ovarian-cancer. Salpingectomy and oophorectomy may also be used to prevent or treat certain reproductive cancers.

Opill: First Over-the-Counter Birth Control Pill

In July 2023, FDA approved the first over-the-counter (OTC) birth control pill, Opill (norgestrel). Opill is a daily oral contraceptive and the first in the United States to be approved for use without a prescription. This progestin-only oral contraceptive can be purchased without a prescription at pharmacies, drug stores, and online. The efficacy of norgestrel was previously established with the original approval of the drug in 1973. The manufacturer of norgestrel applied to switch the product from prescription-only to over-the-counter. In order for the product to be approved for OTC use, FDA requires the manufacturer to demonstrate the product can be used safely and effectively in a nonprescription setting and without the supervision from a health care professional. In a decisional memo, FDA found "the potential benefits of an increase in the ability for consumers to prevent unintended pregnancy (with its attendant medical, economic, and societal harms) outweigh the potential risks of the product in the nonprescription setting" and ultimately approved the drug to be available OTC. Some contraceptives, including condoms and ECs, are available without a prescription.

Sources: FDA, "FDA Approves First Nonprescription Daily Oral Contraceptive," press release, July 13, 2023, https://www.fda.gov/news-events/press-announcements/fda-approves-first-nonprescription-daily-oral-contraceptive. FDA, "Decisional Memorandum, New Drug Application 17031 Supplement 41 Application for Full Prescription-to-Nonprescription Switch of Norgestrel Tablets 0.075 mg," decisional memo, July 13, 2023, https://www.accessdata.fda.gov/drugsatfda_docs/nda/2023/017031Orig1s041SumR.pdf. FDA, "Prescription-to-Nonprescription (Rx-to-OTC) Switches," May 06, 2022, https://www.fda.gov/drugs/drug-application-process-nonprescription-drugs/prescription-nonprescription-rx-otc-switches.

Note: The availability and price of Opill are determined by the manufacturer.

What Are Abortions and Abortion Counseling Services?

An abortion, which is used to terminate a pregnancy, may be medically induced or surgically performed. A medically induced abortion (also called a medical abortion) is a nonsurgical intervention that is effective within the first 10 weeks of a pregnancy.[24] To terminate a pregnancy medically, mifepristone (also known as RU-486) and misoprostol are prescribed[25] in combination.[26] Mifepristone is a progesterone hormone blocker and is FDA-approved for the termination of pregnancy,[27] and misoprostol is used off-label to induce uterine contractions, though its approved use is to prevent stomach ulcers.[28] This intervention can include a follow-up appointment with a health care provider to confirm termination of the pregnancy. Surgical

[24] FDA, "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation," March 23, 2023, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation. The administration of medication or medications to induce an abortion, at less than 10 weeks' gestation, typically involves the use of mifepristone and misoprostol; at more than nine weeks' gestation, medication abortion typically involves the use of vaginal prostaglandins. Katherine Kortsmit, Antoinette T. Nguyen, Michele G. Mandel, et al., "Abortion Surveillance — United States, 2021," *Morbidity and Mortality Weekly Report*, vol. 72, no. SS-9 (November 24, 2023), pp. 1-29.

[25] Mifepristone is subject to restricted distribution pursuant to the drug's FDA-mandated Risk Evaluation and Mitigation Strategies (REMS) program. Formerly, the drug could be prescribed only by certified health care providers and dispensed only in-person at specially certified health care settings, among other requirements. In 2021, FDA reviewed the Mifepristone REMS program and determined that certain elements of the program would be updated. The REMS program was updated to remove the in-person drug-dispensing requirement. Additionally, the update allows for the dispensing of Mifepristone in certified pharmacies subject to manufacturers' proposals. See FDA, "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation," March 23, 2023, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

[26] Mifepristone is the generic form of Mifeprex. FDA, "Questions and Answers on Mifeprex," September 1, 2023, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex.

[27] Mifeprex (mifepristone) label, https://www.accessdata.fda.gov/drugsatfda_docs/label/2000/20687lbl.pdf.

[28] FDA, "Misoprostol (marketed as Cytotec) Information," press release, July 10, 2015, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/misoprostol-marketed-cytotec-information.

abortion procedures vary depending on which week of pregnancy a patient is in. These procedures can include aspiration of the uterus, dilation of the cervix, and evacuation procedures.[29]

Abortion counseling, sometimes called all-options pregnancy counseling, is, in general, a discussion between a clinician and a patient about abortion as a potential option in pregnancy decisionmaking.[30] Abortion services may be affected by state laws limiting abortion based on gestational age or other determinations. For a survey of laws restricting or prohibiting abortion, see CRS Report R47595, *State Laws Restricting or Prohibiting Abortion*.

Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?

Federal funds are available under limited circumstances to pay for abortion. Specifically, under federal law, certain federal funds may only be used to pay for abortions in cases of rape, incest, or endangerment of a mother's life. This restriction is the result of statutory and legislative provisions such as the Hyde Amendment (see **text box**), which has been added to the annual appropriations measure for the Departments of Labor, HHS, and Education, and Related Agencies (LHHS) since 1976.[31] Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Treasury, and the Department of Justice (DOJ).[32] Other codified restrictions limit the use of funds made available to the Department of Defense (DOD), the Department of Veterans Affairs (VA), and the Indian Health Service (IHS).[33]

These provisions and agency guidance may additionally specify conditions under which abortion counseling may or may not be offered by federal agencies and grant programs.[34]

Hyde Amendment

Following the Supreme Court's *Roe v. Wade* decision, some of the first federal legislative responses involved restrictions on the use of federal funds to pay for abortions. In 1976, Representative Henry J. Hyde offered an amendment to the Departments of Labor and Health, Education, and Welfare, Appropriation Act, 1977, that restricted the use of appropriated funds to pay for abortions provided through the Medicaid program. In 1980, the Supreme Court upheld the validity of the Hyde Amendment, concluding that the funding restriction was constitutional. Under this provision, federal funds may only be used to pay for abortions in cases of rape, incest, or endangerment of a mother's life.

Sources: P.L. 94-439, §209, 90 Stat. 1418, 1434 (1976).

Notes: For additional discussion of abortion funding restrictions, see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*.

[29] Katherine Kortsmit, Antoinette T. Nguyen, Michele G. Mandel, et al., "Abortion Surveillance — United States, 2021," *Morbidity and Mortality Weekly Report*, vol. 72, no. SS-9 (November 24, 2023), pp. 1-29.

[30] American College of Obstetricians and Gynecologists, *Pregnancy Choices: Raising the Baby, Adoption, and Abortion*, FAQ, April 2024, https://www.acog.org/womens-health/faqs/pregnancy-choices-raising-the-baby-adoption-and-abortion.

[31] See P.L. 94-439, §209, 90 Stat. 1418, 1434 (1976).

[32] For additional discussion of abortion funding restrictions, see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*, and CRS In Focus IF12167, *The Hyde Amendment: An Overview*.

[33] See, for example, 10 U.S.C. §1093(a) ("Funds available to the Department of Defense 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.").

[34] See, for example, 42 C.F.R. §59.5 ("Each project supported under [Part 59] must: ... not provide abortion as a method of family planning. A project must: offer pregnant clients the opportunity to be provided information and counseling regarding each of the following options: prenatal care and delivery; infant care, foster care, or adoption, and pregnancy termination.").

What Are Infertility Services?

Infertility is a reproductive health disorder generally defined as the inability to conceive pregnancy after a certain time period that is age dependent of attempting to conceive.[35] Infertility affects people of all genders and can be caused by reproductive organ damage, hormone imbalance, genetic disorders, or certain medical treatments.[36] Treatments for infertility thus may involve surgery, hormone/medication therapy, genetic counseling, or medical procedures such as intrauterine insemination (IUI).[37] Treatment may also involve Assisted Reproductive Technologies (ARTs), which are generally defined as "all fertility treatments in which either eggs or embryos are handled."[38] In Vitro Fertilization (IVF), the most commonly used ART, is a procedure designed to help initiate a pregnancy via transfer of fertilized embryo(s) into a uterus.[39] Other ARTs include gamete and zygote intrafallopian transfer[40] and elective single embryo transfer.[41]

The three federal agencies that currently regulate the use of ARTs are the Centers for Disease Control and Prevention (CDC),[42] the Centers for Medicare & Medicaid Services (CMS), and the FDA. According the American Society of Reproductive Medicine, the professional organization that represents ART providers and clinics, the agencies' roles are as follows:

> The Centers for Disease Control and Prevention (CDC) collects and publishes data on ART procedures. The Food and Drug Administration (FDA) controls approval and use of drugs, biological products, and medical devices and has jurisdiction over screening and testing of reproductive tissues, such as donor eggs and sperm. The Centers for Medicare and

[35] CDC, "Infertility: Frequently Asked Questions,' May 15, 2024, https://www.cdc.gov/reproductive-health/infertility-faq/.

[36] Ibid.

[37] CDC, "What is Infertility?," April 20, 2022, https://www.cdc.gov/reproductivehealth/features/what-is-infertility/index.html. "Intrauterine insemination (IUI) is an infertility treatment that is often called artificial insemination. In this procedure, specially prepared sperm are inserted into the woman's uterus. Sometimes the woman is also treated with medicines that stimulate ovulation before IUI."

[38] CDC, "What is Assisted Reproductive Technology?," October 8, 2019, https://www.cdc.gov/art/whatis.html. IVF is traditionally administered in "cycles." In a single cycle, one egg or many eggs are retrieved from an ovary and externally fertilized. The fertilized embryo or embryos are implanted into the uterus and monitored for development. More than one cycle may be necessary to achieve pregnancy.

[39] American Society of Reproductive Medicine, "What is In Vitro Fertilization (IVF)?" infographic, https://www.reproductivefacts.org/globalassets/_rf/news-and-publications/infographics/invitro-fertilization/ivf-infographic.png.

[40] CDC, "2021 Assisted Reproductive Technology: Fertility and National Summary Report," 2023, https://www.cdc.gov/art/reports/2021/pdf/Report-ART-Fertility-Clinic-National-Summary-H.pdf. Gamete and zygote intrafallopian transfers are procedures in which "gametes or zygotes [are] transferred into the fallopian tubes rather than the uterus."

[41] CDC, "Single Embryo Transfer," August 3, 2017, https://www.cdc.gov/art/patientresources/transfer.html. CDC defines this procedure as follows: "Elective single-embryo transfer (eSET) is a procedure in which one embryo, selected from a larger number of available embryos, is placed in the uterus or fallopian tube. The embryo selected for eSET might be from a previous IVF cycle (e.g., cryopreserved embryos [frozen]) or from the current fresh IVF cycle that yielded more than one embryo. The remaining embryos may be set aside for future use or cryopreservation."

[42] P.L. 102-493 mandates CDC surveillance of Assisted Reproductive Technologies and, "Requires each assisted reproductive technology program to report annually to the Secretary of Health and Human Services (Secretary), through the Centers for Disease Control, regarding: (1) pregnancy success rates; and (2) each embryo laboratory used by the program and whether it is certified (or has applied for certification) under this Act." In the years following the statute's enactment, Congress changed the agency's name to the "Centers for Disease Control and Prevention."

Medicaid Services (CMS) is responsible for implementation of the Clinical Laboratory Improvement Act to ensure the quality of laboratory testing.[43]

What Are Maternity Services?

Maternity services, also referred to in this report as maternal health services, encompass a range of preventive, diagnostic, and treatment services to monitor the health of the pregnant individual and the fetus. These services include interventions provided during pregnancy (i.e., prenatal or antepartum care), services provided during labor and delivery (i.e., intrapartum care), and services provided after birth (i.e., postpartum or postnatal care).[44] Other maternity services may include support provided by entities such as doulas[45] or lactation specialists, as well as other care coordination and educational services (e.g., childbirth preparation classes). Specific services and the timing and frequency of visits can vary based on the needs of the pregnant individual and the fetus, as well as the maternity care setting.

Prenatal care services monitor the pregnant individual's physical and psychological health as well as the overall health of the fetus. Prenatal services typically include the routine monitoring of vital signs such as maternal blood pressure and temperature, as well as physical and laboratory assessments to screen, diagnose, and manage maternal or fetal risks, conditions, disorders, or infections.[46] Patient education is provided on a range of topics, including nutrition and the use of prenatal vitamins (e.g., folic acid supplementation[47]), counseling against the use of harmful substances, and referrals to relevant medical or social services.[48] Ultrasonographic technology (i.e., ultrasound) is typically used to confirm pregnancy and assess the overall health and growth of the fetus.[49]

[43] American Society for Reproductive Medicine, *Oversight of Assisted Reproductive Technology*, Birmingham, AL, Updated 2021, https://www.asrm.org/globalassets/asrm/asrm-content/about-us/pdfs/oversiteofart.pdf.

[44] Although not formally part of maternity care, *preconception care*, defined as a woman's health before she becomes pregnant, is considered the first step in planning a healthy pregnancy. The goal of preconception care (also referred to as *pre-pregnancy care*), is to identify health conditions, lifestyle factors, and other risk factors that may affect the health of a future pregnancy. For more information, see Office of the Assistant Secretary for Health (OASH): Office on Women's Health, *Preconception health*, February 22, 2021, https://www.womenshealth.gov/pregnancy/you-get-pregnant/preconception-health, and ACOG, *Good Health Before Pregnancy: Prepregnancy Care*, January 2024, https://www.acog.org/womens-health/faqs/good-health-before-pregnancy-prepregnancy-care.

[45] A doula is a trained nonmedical professional who can provide physical, emotional, and informational support to a birthing person and their family before, during, and after childbirth. See DONA International, "What is a Doula," https://www.dona.org/what-is-a-doula-2/.

[46] Sharon Murray et al., "Antepartum Assessment, Care, and Education," in *Foundations of Maternal-Newborn and Women's Health Nursing*, 8th ed. (St. Louis, MI: Elsevier, 2023), pp. 123-139. Women's Preventive Services Initiative (WPSI), *Recommendations for well-woman care: clinical summary tables*, ACOG Foundation, Washington, DC, 2024, pp. 38-44, https://www.womenspreventivehealth.org/wp-content/uploads/FINAL-WPSI-Clinical-Summary-Tables-2024.pdf.

[47] U.S. Preventive Services Task Force, "Folic Acid Supplementation to Prevent Neural Tube Defects: Preventive Medication," August 1, 2023, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication. See text box below for more information about the U.S. Preventive Services Task Force.

[48] Russell S. Kirby and Sarah Verbiest, "The Reproductive and Perinatal Health of Women, Pregnant Persons, and Infants," in *Kotch's Maternal and Child Health: Problems, Programs, and Policy in Public Health*, 4th ed. (Burlington, MA: Jones & Bartlett, LLC, 2022), pp. 185-187.

[49] Sharon Murray et al., "Prenatal Diagnosis and Fetal Assessment During the Antepartum Period," in *Foundations of Maternal-Newborn and Women's Health Nursing*, 8th ed. (St. Louis, MI: Elsevier, 2023), pp. 177-180.

Intrapartum care includes the range of services provided from the onset of labor through the delivery of the newborn.[50] These services include the monitoring of various maternal and fetal vital signs, the management of pain and other conditions that may arise during labor, and services specific to the method of delivery (e.g., vaginal vs. Cesarean section birth).[51]

Postpartum care broadly includes services provided immediately after delivery, as well as those provided anywhere from six weeks to one year after birth. Postpartum services may include mental health screenings (e.g., those that identify perinatal depression), physical health exams, social assessments, counseling and/or initiation of contraception, and the management of other chronic medical conditions that may have been initiated or exacerbated by pregnancy.[52]

In June 2022, the Biden Administration released the "White House Blueprint for Addressing the Maternal Health Crisis," which outlines a whole-of-government approach toward improving maternal morbidity and mortality rates. Among the five priority goals is Goal 1: "Increase access to and coverage of comprehensive high-quality maternal health services, including behavioral health services."[53] Under this goal, the Blueprint prioritizes the expansion of insurance coverage for maternity services from pregnancy up to a minimum of one year postpartum, emphasizes the importance of obstetric readiness in areas without hospital-based obstetric services and linkages to specialized maternity services, and describes the importance of expanding access to family planning services, including contraceptive services and pre-pregnancy care.[54]

What Are Reproductive Health Prevention and Treatment Services?

Prevention and screening services in reproductive health seek to prevent, detect, or treat infections, cancers, and other disorders involving the reproductive system. Common reproductive infections include STIs [55] such as chlamydia, gonorrhea, human immunodeficiency virus (HIV)/ acquired immune deficiency syndrome (AIDS), and human papillomavirus (HPV).[56] Other reproductive disorders include malignant cancers of the reproductive tract and breast, benign cysts and tumors, and infertility.[57]

[50] For the purposes of this report, postnatal services provided to the infant following delivery are not considered part of the broader definition of *maternity services*.

[51] The American College of Obstetricians and Gynecologists (ACOG), "Labor & Delivery," https://www.acog.org/womens-health/pregnancy/labor-and-delivery.

[52] WPSI, *Recommendations for well-woman care: clinical summary tables*, ACOG Foundation, Washington, DC, 2024, pp. 38-44, https://www.womenspreventivehealth.org/wp-content/uploads/FINAL-WPSI-Clinical-Summary-Tables-2024.pdf. ACOG, "Optimizing Postpartum Care: Committee Opinion No. 736," 2018, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care (reaffirmed 2021).

[53] The White House, "Fact Sheet: President Biden's and Vice President Harris's Maternal Health Blueprint Delivers for Women, Mothers, and Families," press release, June 24, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/06/24/fact-sheet-president-bidens-maternal-health-blueprint-delivers-for-women-mothers-and-families/.

[54] The White House, *White House Blueprint for Addressing the Maternal Health Crisis*, June 2022, pp. 19-26, https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf.

[55] CDC, "About Sexually Transmitted Infections," March 25, 2024, https://www.cdc.gov/sti/about/. "Sexually transmitted diseases (STDs), also known as sexually transmitted infections or STIs, are very common. Millions of new infections occur every year in the United States."

[56] CDC, "About Genital HPV Infection," February 6, 2024, https://www.cdc.gov/sti/about/about-genital-hpv-infection.html. Human immunodeficiency virus (HIV) and human papillomavirus (HPV) infections can cause certain cancers.

[57] CDC, "Common Reproductive Health Concerns for Women," May 15, 2024, https://www.cdc.gov/reproductive-health/women-health/common-concerns.html, and CDC, "Prostate Cancer Basics," August 27, 2024, https://www.cdc.gov/prostate-cancer/about/index.html.

In health care, prevention occurs along a continuum, depending on the outcomes to be prevented.[58] For example, vaccinations can prevent infectious diseases, chemotherapy can prevent a cancer-related death, and hospice care can prevent pain and distress.[59] In common usage, health care services are generally described as either prevention or treatment, as follows:

- **Preventive services**, which are furnished in the absence of symptoms, are sometimes called *primary prevention* and *secondary prevention*. Primary prevention includes interventions that are typically applied to the whole population, such as vaccinations that decrease the risk for illness. Secondary prevention consists of *screening*—diagnostic tests that detect disease early, when treatment may be more likely to achieve remission or cure—and *post-exposure prophylaxis (PEP)*—usually a drug(s) or vaccine given following exposure to an infectious disease to prevent illness.[60] For example, women planning to become pregnant or who are early in pregnancy can take a folic acid supplement for the purpose of preventing birth defects.[61] The United States Preventive Services Task Force (USPSTF; see **text box** below) evaluates evidence and makes recommendations for the effective use of preventive services in primary care settings.
- **Treatment services** are surgical and medical (including pharmaceutical) interventions to control or cure a disease, manage its symptoms, or both. Treatment services are sometimes referred to as *tertiary prevention*. They are furnished to patients who have symptoms or diagnostic findings of actual illness. *Monitoring*, the use of diagnostic services to track the course of a disease or remission, is considered a form of treatment, thus it is not discussed separately in this report.

Clinical Preventive Services Recommendations: Key Advisory Bodies

Several nonfederal panels make clinical preventive service recommendations, including the U.S. Preventive Services Task Force (USPSTF) and the Women's Prevention Services Initiative (WPSI), which inform clinical practice and are referenced in federal law to define certain requirements for coverage of or payment for clinical preventive services.

U.S. Preventive Services Task Force (USPSTF)

The U.S. Preventive Services Task Force is an independent, volunteer panel of experts in prevention, evidence-based medicine, and epidemiology that makes evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. Depending on available evidence, recommendations are tailored to specific populations, such as age groups.

USPSTF recommendations "apply only to people without recognized signs or symptoms of the disease or health condition, focus on screening to identify disease early and interventions to prevent the onset of disease, [and] address services offered in the primary care setting or services to which patients can be referred by primary care professionals."

The USPSTF assigns grades to preventive services based on evidence of effectiveness balanced against potential harm. A and B grade recommendations are given to those services that the task force most highly recommends

[58] CRS Video WVB00063, *Public Health 101: Overview of the U.S. System and Review of Federal Vaccine Policy*, slide 7 and accompanying audio.

[59] Health programs and payers may categorize these services differently than prevention services, such as screening, diagnostic, or treatment services.

[60] CDC, *Prevention: Picture of America,* April 19, 2016, p. 1, https://stacks.cdc.gov/view/cdc/142637/cdc_142637_DS1.pdf.

[61] American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and American Society for Reproductive Medicine, "Committee Opinion: Prepregnancy Counseling," *Obstetrics and Gynecology*, vol. 133, no. 1 (January 2019).

implementing for preventive care. These preventive services have a high or moderate net benefit for patients based on available evidence.

Women's Preventive Services Initiative (WPSI)

The Women's Preventive Services Initiative is a coalition of health professional organizations representing women's health care clinicians and patient advocates with expertise in women's health. WPSI is tasked with developing, reviewing, and updating the *Women's Preventive Services Guidelines* (Guidelines), which were initially established in 2011 to provide evidence-based recommendations specific to women's health in addition to recommendations made by USPSTF. WPSI reviews the Guidelines at least once every five years, or upon the availability of new evidence, as well as new preventive services topics.

The Guidelines aim to serve as a basis of recommendations to improve women's health across the lifespan, and to complement, build upon, and fill gaps in existing guidelines provided by the USPSTF. The Guidelines also serve as the basis for which preventive services should be covered by certain insurers without cost-sharing, notably contraceptive services and supplies.

Sources: USPSTF, "About the USPSTF," https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf. USPSTF, "Scope of Work," *Procedure Manual,* Section 1.4, pp. 1-2, May, 2021, https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/2023-11/procedure-manual-2023.pdf. USPSTF, "13th Annual Report To Congress: High-Priority Evidence Gaps for Clinical Prevention Services" November, 2023, https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/reports-congress/thirteenth-annual-report-congress-high-priority-evidence-gaps-clinical-preventive-services. Health Resources and Services Administration (HRSA), "Women's Preventive Services Guidelines," March, 2024, https://www.hrsa.gov/womens-guidelines. HRSA, "Women's Preventive Services Initiative" Factsheet, 2023, https://www.womenspreventivehealth.org/wp-content/uploads/FINAL-2023-WPSI-Factsheet.pdf.

Notes: USPSTF is supported by the HHS Agency for Healthcare Quality and Research (AHRQ). WPSI is supported by a cooperative grant under Health Resources and Services Administration (HRSA).

A given reproductive health service may be either a preventive service, a treatment service, or both. For example, mammography may be a preventive service when used to screen for breast cancer in asymptomatic patients with no history of the disease, or a treatment service when used to monitor a breast cancer patient's treatment progress or remission. Considering the definitions above, health care services may be considered preventive or treatment services *based on their use*.[62] Often, the use (or purpose) of a service determines how it is financed. **Table 2** lists examples of diseases or conditions and their respective prevention and treatment services and their uses.

Table 2. Examples of Reproductive Health Prevention and Treatment Services

	Prevention		Treatment	
Disease or Condition	**Primary Prevention**	**Screening/Post-Exposure Prophylaxis (PEP)**	**Monitoring**	**Medical/Surgical Treatment**
Breast cancer[a]	None known, although some healthy behaviors may lower incidence	Mammography,[a] genetic counseling and testing	Mammography	Mastectomy/lumpectomy, chemotherapy, immunotherapy, radiation
Cervical cancer	Human papillomavirus (HPV) vaccine	Visual exam, cervical cytology (Pap smear), HPV testing	Visual exam, cervical cytology (Pap smear)	Surgery, chemotherapy

[62] These services additionally may be used as a diagnostic service for someone with symptoms or increased risk for a disease. Similarly, the purpose of the service such as a diagnostic test may inform how a service is provided, covered, or paid for.

Disease or Condition	Prevention		Treatment	
	Primary Prevention	Screening/Post-Exposure Prophylaxis (PEP)	Monitoring	Medical/Surgical Treatment
Human immunodeficiency virus (HIV)	Pre-exposure prophylaxis (PrEP),[b] counseling regarding safe sexual practices, bloodborne pathogens protections[c]	Human immunodeficiency virus (HIV) testing, PEP[d]	Viral load testing, other bloodwork, retesting following exposure	Combination drug therapy, management of HIV-associated conditions
Gonorrhea[e]	Counseling regarding safe sexual practices	Testing following possible exposure or if at risk, PEP	Repeat testing, especially for antibiotic-resistant strains	Antibiotic therapy

Source: Prepared by CRS.

Notes: This table provides illustrative examples only and is not intended to be comprehensive.

a. CDC, "Breast Cancer Basics," February 22, 2024, https://www.cdc.gov/breast-cancer/about/index.html.

b. CDC, "Preventing HIV with PrEP," January 18, 2024, https://www.cdc.gov/hiv/prevention/prep.html. "PrEP is for adults and adolescents without HIV who may be exposed to HIV through sex or injection drug use. PrEP may be an option to help protect pregnant people and their babies from getting HIV while trying to get pregnant, during pregnancy, or while breastfeeding." There are currently three medications with FDA approval for use as PrEP: Truvada, Descovy, and Apretude.

c. Occupational Safety and Health Administration (OSHA), "Bloodborne Pathogens and Needlestick Prevention," https://www.osha.gov/bloodborne-pathogens.

d. CDC, "Preventing HIV with PEP," January 25, 2024, https://www.cdc.gov/hiv/prevention/pep.html. HIV PEP medications should be started within 72 hours of a possible exposure.

e. CDC, "About Gonorrhea" February 15, 2024, https://www.cdc.gov/gonorrhea/about/index.html.

On December 17, 2020, HHS released a National Strategic Plan for improving STI education, prevention, and treatment in the United States for 2021-2025.[63] This action plan specifically targets rising rates of chlamydia, gonorrhea, syphilis, and HPV through five main objectives: (1) STI prevention; (2) reduction of adverse outcomes through expanded prevention and health care delivery; (3) accelerate progress in STI research, technologies, and innovations; (4) reduction of STI-related health disparities and inequalities; and (5) integration of existing STI prevention programs. On June 8, 2023, HHS released the STI Federal Implementation Plan to detail how federal departments and agencies will carry out the objectives in the National Strategic Plan.[64] In addition to the STI Federal Implementation Plan, HHS, FDA, CDC, and other federal departments and agencies implement task forces, issue programmatic guidance, and provide training on emerging STI issues, like the recent increase in cases of infants born with syphilis, known as *congenital syphilis*.[65]

[63] HHS, "Sexually Transmitted Infections National Strategic Plan for the United States: 2021–2025," 2020, https://www.hhs.gov/sites/default/files/STI-National-Strategic-Plan-2021-2025.pdf.

[64] HHS, "HHS Releases First-Ever STI Federal Implementation Plan," press release, June 8, 2023, https://www.hhs.gov/about/news/2023/06/08/hhs-releases-first-ever-sti-federal-implementation-plan.html.

[65] See for instance, the report from the National Syphilis and Congenital Syphilis Syndemic Federal Task Force, *Considerations for the Implementation of Point of Care (POC) Tests for Syphilis* , HHS, June 2024, https://www.hhs.gov/sites/default/files/nscss-considerations-for-the-implementation-of-syphilis-poc-tests.pdf.

What Are Gender-Affirming Services?

Gender-affirming services, also known as *gender-affirming care*, are medical, surgical, mental health, and nonmedical interventions designed to help align an individuals' physical traits with their gender identity.[66] Although gender-affirming services do not always involve reproductive health care services, they are covered by this report because services can involve care affecting reproductive organ systems, and because these health services are of legislative interest to Congress. *Gender affirmation* refers to the process of recognizing or affirming people in their gender identity.[67] Gender affirmation is not only something experienced by transgender and gender diverse (TGD) individuals but also by individuals whose sex assigned at birth aligns with their gender identity. *Sex assigned at birth* refers to a person's sex usually being assigned or determined at birth based on the appearance of external genitalia.[68] *Gender-identity* refers to an individual's deeply felt, internal, intrinsic sense of their own gender.[69] Although health services that are gender-affirming are not synonymous with transition-related care, this report uses the terms "gender-affirming services" or "gender-affirming care" to refer to such services unless specified in relevant statute, rules, regulations, and guidance.

Use of gender-affirming services may stem from a diagnosis of *gender dysphoria*, a feeling of significant discontent with their biological sex and/or birth gender, although not all individuals who experience feelings of distress related to their gender or who have a diagnosis stemming from that distress seek or receive gender-affirming services.[70] Additionally, not all TGD individuals experience gender dysphoria or feelings of distress. TGD individuals may still seek out or receive gender-affirming care. Gender-affirming care is highly individualized and TGD people may vary in the gender-affirming and transition-related services they do or do not seek out with consultation from their health care provider(s).

Gender-affirming care treatment includes primary care, mental health services, hormone therapy, and surgical and postoperative care.[71] Gender-affirming primary care is primary care with specific attention to the sometimes unique needs of TGD individuals and can involve appropriate preventive services such as cancer screenings, mental health screenings, and ongoing hormone therapy support depending on the provider's scope of care and knowledge. Clinical guidance for the care and treatment of TGD individuals in the primary care setting recommends that the general health of TGD individuals should be attended to within the primary care setting, without differentiation from services offered to people who are not TGD for physical and mental health issues. Depending on the scope of the health provider and their knowledge of providing gender-

[66] Office of Population Affairs (OPA), OASH, "Gender-Affirming Care and Young People," https://opa.hhs.gov/sites/default/files/2022-03/gender-affirming-care-young-people-march-2022.pdf. Not all gender-affirming services are intended to align an individual's sex with their gender and may support a person in feeling less distressed about a potential misalignment of their sex and gender.

[67] E. Coleman, A.E. Radix, W.P. Bouman, et al., "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," *International Journal of Transgender Health*, vol. 23 (2022), p. S252. https://www.wpath.org/publications/soc.

[68] Ibid.

[69] Ibid.

[70] HHS, OPA, OASH, "Gender-Affirming Care and Young People," https://opa.hhs.gov/sites/default/files/2022-03/gender-affirming-care-young-people-march-2022.pdf.

[71] E. Coleman, A.E. Radix, W.P. Bouman, et al., "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," *International Journal of Transgender Health*, vol. 23 (2022), https://www.wpath.org/publications/soc.

affirming care, transition-related care, such as hormone therapy, is also possible in primary care.[72] Although some care for TGD individuals can take place in primary care setting, gender-affirming care can require the coordination of multiple health care specialists. TGD individuals seeking care may be referred to multidisciplinary gender clinics where providers of varying specialties can coordinate an individual's gender-affirming care treatment and services.[73]

Being transgender or gender diverse is not in itself a mental health disorder. As mentioned earlier in this section, TGD individuals may experience gender dysphoria or feelings of prolonged distress related to feelings of gender incongruence. Gender-affirming mental health care can involve the treatments and management of prolonged feelings of distress and other mental health issues.[74] Gender-affirming surgical interventions and postoperative care can involve altering physical features to align an individual's gender identity.[75] Surgeries include, but are not limited to, those that alter the face, the chest/breasts, or genitals. The availability of gender-affirming treatments may vary and depend on a health care provider's training and knowledge in providing gender-affirming treatments, state scope of practice laws, professional guidance, and laws specifying access of such care.

Section 1557 of the Patient Protection and Affordable Care Act (ACA)[76]

Section 1557 of the ACA (§1557) prohibits discrimination on the basis of race, color, national origin, sex, disability, and age in programs and activities administered by an executive agency or a state or federal health insurance exchange, as well as in federally funded health programs and activities.[77] HHS has primary rulemaking authority for implementing Section 1557. HHS issued Section 1557 regulations in 2016, 2020, and 2024.[78] Each administration since the ACA's passage has taken a different approach to implementing the law. Administrations have disagreed on, among other things, which entities the law covers and on whether Section 1557 prohibits discrimination on the basis of gender identity, sexual orientation, or termination of pregnancy. HHS appears to have consistently interpreted Section 1557 to prohibit discrimination on the basis of pregnancy and related medical conditions (with some variation as to how HHS has approached discrimination on the basis of pregnancy termination). In its most recent rulemaking, finalized in May 2024, HHS interpreted Section 1557 to prohibit discrimination on the basis of gender identity, sexual orientation, and pregnancy and related conditions, including pregnancy termination.[79]

In some circumstances, Section 1557 may require covered entities, including federal health and health insurance programs, to provide or cover certain reproductive health services, including gynecological services, gender-affirming care, fertility services, or contraceptive services. The circumstances in which such services or coverage would be required under Section 1557 are fact specific and beyond the scope of this report. According to HHS, a

[72] Kevan Wylie, Gail Knudson, Sharful Islam Khan, et al., "Serving transgender people: clinical care considerations and service delivery models in transgender health," *The Lancet*, vol. 388, no. 10042 (2016), pp. 401-411.

[73] Rebecca M. Warwick and Daniel E. Shumer, "Gender-affirming multidisciplinary care for transgender and non-binary children and adolescents," *Children's Health Care*, vol. 52, no. 1 (2021), pp. 91-155.

[74] "Conversion" therapy aimed at attempting to change a person's gender identity is not recognized as valid clinical treatment of gender dysphoria by health professional organizations, and the American Psychological Association recommends against the use of gender identity change efforts and that such efforts put TGD individuals at significant risk of harm. See American Psychological Association, "Serving transgender people: clinical care considerations and service delivery models in transgender health," February 2021, https://www.apa.org/about/policy/guidelines-psychological-assessment-evaluation.pdf.

[75] University of Michigan Medicine, "Gender Confirmation Surgery," (accessed July 1, 2022), https://www.uofmhealth.org/conditions-treatments/transgender-services/gender-confirmation-surgery.

[76] Questions from congressional clients regarding legal issues addressed in this textbox may be directed to Abigail A. Graber, CRS Legislative Attorney, who authored solely this textbox.

[77] 42 U.S.C. §18116.

[78] HHS, "Nondiscrimination in Health Programs and Activities," 89 *Federal Register* 37522, May 6, 2024 ("2024 Section 1557 Rule"); HHS, "Nondiscrimination in Health Programs and Activities," 85 *Federal Register* 37160, August 18, 2020; HHS, "Nondiscrimination in Health Programs and Activities," 81 *Federal Register* 31376, May 18, 2016.

[79] 2024 Section 1557 Rule, *supra* footnote 78, at 37556, 37699.

covered entity's refusal to provide, cover, or refer for abortions does not, in and of itself, violate Section 1557. For more on Section 1557, see CRS Legal Sidebar LSB11169, *HHS Finalizes Rule Addressing Section 1557 of the ACA's Incorporation of Title IX* (May 28, 2024 version).

Medicaid

Medicaid, authorized in SSA Title XIX, is a federal-state program that jointly finances primary and acute medical services, as well as long-term services and supports (LTSS) to a diverse low-income population, including eligible children, pregnant women, adults, individuals with disabilities, and people aged 65 and older.[80] Participation in Medicaid is voluntary for states; all states, the District of Columbia, and five U.S. territories choose to participate.

Medicaid is jointly financed by states and the federal government. States must follow federal rules to receive federal matching funds, but states have the flexibility to design their own versions of Medicaid within the federal statute's framework. This flexibility results in variability across state Medicaid programs in terms of eligibility and covered benefits, among other criteria. In FY2023, Medicaid provided health care services to an estimated 97 million individuals[81] at a total cost of approximately $894 billion (including federal and state expenditures).[82]

Medicaid provides a health care safety net for low-income populations, playing a more significant role for certain subpopulations.[83] For example, in 2022 approximately 21% of the U.S. population received Medicaid coverage.[84] In that same year, Medicaid provided health coverage for approximately 60% of all nonelderly individuals with incomes below 100% of the federal poverty level (FPL).[85] For some types of services (including reproductive health services), Medicaid is a significant payer. For instance, Medicaid paid for approximately 41% of all births in the United States in 2022.[86] According to the most recent data available, Medicaid provided 75% of all public expenditures on family planning services in FY2015.[87]

[80] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*.

[81] This enrollment figure is measured according to average monthly enrollment and represents the number of beneficiaries with full and partial benefits who are enrolled on an average monthly basis. This enrollment measure differs from person-year equivalents, which represent the average program enrollment over the course of a year and from ever-enrolled counts, which measure the number of people covered by Medicaid for any period of time during the year. Congressional Budget Office (CBO) Baseline Projections, *Medicaid*, June 2024, at https://www.cbo.gov/system/files/2024-06/51301-2024-06-medicaid.pdf.

[82] CMS, Form CMS-64 data as of May 29, 2024, athttps://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

[83] The health care safety net consists of those organizations and programs, in both the public and private sectors, with a legal obligation or a commitment to provide direct health care services to uninsured and underinsured populations.

[84] U.S. Census Bureau, American Community Survey Tables for Health Insurance Coverage, Table HI-05_ACS, *Health Insurance Coverage Status and Type of Coverage by State and Age for All Persons: 2022*, at https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.

[85] KFF, *Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL), as of 2022*, State Health Facts, accessed June 18, 2024, at https://www.kff.org/other/state-indicator/nonelderly-up-to-100-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[86] Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, Valenzuela CP. *Births: Final data for 2022*. National Vital Statistics Reports; vol 73, no 2. Hyattsville, MD: National Center for Health Statistics, at https://dx.doi.org/10.15620/cdc:145588.

[87] Guttmacher Institute, *Publicly Supported Family Planning Services in the United States*, October 2019, at https://www.guttmacher.org/sites/default/files/factsheet/publicly-supported-fp-services-us.pdf.

The State Children's Health Insurance Program (CHIP)

CHIP is a federal-state program that provides health coverage to certain uninsured, low-income children and pregnant individuals in families that have annual income above Medicaid eligibility thresholds but do not have health insurance. Like Medicaid, CHIP is jointly financed by the federal government and the states and is administered by the states. In FY2023, CHIP covered health care services for an estimated 7 million individuals at an estimated cost of $23 billion, with the federal government paying approximately $17 billion of that total.

Participation in CHIP is voluntary, and all states, DC, and five territories participate. As with Medicaid, the federal government sets basic requirements for CHIP, but states have the flexibility to design their own versions of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs.

CHIP Program Design

States may design their CHIP programs in one of three ways: a CHIP Medicaid expansion, a separate CHIP program, or a combination approach in which the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. CHIP benefit coverage depends on program design. CHIP Medicaid expansions must follow the federal Medicaid rules for benefits. For separate CHIP programs, benefits are permitted to look more like private health insurance.

Under separate CHIP programs, child health assistance is defined at 42 C.F.R. §457.402 and includes services such as physician and surgical services, prenatal care, and pre-pregnancy family planning services and supplies. The law requires separate CHIP programs to cover certain services, including emergency services, well baby and well-child care (including age-appropriate immunizations), and dental services. If offered, mental health services must meet federal mental health parity requirements. As with Medicaid, federal funds may not be used for abortion services, except in the case of a pregnancy resulting from rape or incest, or when necessary to save the mother's life.

According to a 2017 study that looked at the types of reproductive health services covered under separate CHIP plans, states generally provide routine gynecologic exams and obstetric care, STI/STD screening and treatment, age-appropriate sexuality education, family planning, pregnancy testing, and pregnancy care, among other services.

CHIP Coverage of Pregnant Individuals

Under separate CHIP programs, states may extend CHIP coverage to uninsured low-income pregnant individuals through various authorities: (1) the CHIP state plan option for pregnant individuals, (2) the Section 1115 waiver authority, and/or (3) the unborn child pathway. Under the state plan option, states are permitted to cover pregnant individuals through a state plan amendment when certain conditions are met. The period of coverage associated with the state plan option includes pregnancy through the postpartum period (through 60 days postpartum), and benefits include all services available to CHIP children in the state as well as prenatal, delivery, and postpartum care. States are permitted to provide different benefits to pregnant individuals than CHIP children.

Under CHIP-funded pregnancy-related Section 1115 demonstration waivers, with CMS approval, states define the eligibility criteria and benefit coverage (including duration of postpartum care), among other waiver features. States may target the benefit coverage to meet particular health care needs (e.g., treatment for pregnant women with substance use disorders).

States also are permitted to provide CHIP coverage to pregnant individuals (including individuals aged 19 and older) by extending coverage to unborn children as permitted through federal regulation. Coverage available to such individuals may be limited to prenatal and delivery services but still is used in a number of states because it permits the extension of CHIP coverage to a pregnant individual regardless of that person's immigration status.

The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) permits states to offer 12 months of continuous postpartum coverage, regardless of changes in circumstances (with exceptions), under Medicaid and CHIP. States that elect this option under Medicaid must elect the parallel state plan option under CHIP. Coverage includes CHIP child health assistance available under the CHIP state plan for targeted low-income children or targeted low-income pregnant individuals through the 12-month postpartum period. However, states are permitted to provide more generous postpartum coverage.

Sources: CHIP average monthly enrollment from CBO, "CHIP Baseline Projections," June 2024, at https://www.cbo.gov/system/files/2024-06/51296-2024-06-chip.pdf. CHIP expenditures estimates from CMS, Form CMS-64 Data and Net CHIP Expenditures, May 29, 2024, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html. For more on the types of reproductive health services covered under separate CHIP plans, see National Health Law Program, *CHIP Provides Critical Reproductive Health Care to Adolescents and Pregnant Women*, September 12, 2017, at https://healthlaw.org/chip-provides-critical-reproductive-health-care-to-adolescents-and-pregnant-women/.

Does Medicaid Cover Reproductive Services?

Medicaid coverage includes a variety of primary and acute-care services, including a wide range of reproductive health services. Not all Medicaid enrollees have access to the same set of services. An enrollee's eligibility pathway (i.e., the eligibility category listed in statute) determines the available services, and the services available to enrollees vary by state. In general, federal law provides two primary benefit packages for state Medicaid programs: (1) traditional benefits and (2) alternative benefit plans (ABPs).[88] For certain subgroups, states may offer a targeted benefit package (e.g., individuals eligible only for family planning services and supplies, certain low-income pregnant women who are entitled to limited pregnancy-related services, and women needing treatment for breast or cervical cancer). In addition, states can use waiver authority[89] to tailor benefit packages to specified Medicaid subgroups or to offer services outside of those permitted under the Medicaid statute (e.g., Section 1115 demonstration waivers for individuals living with or at risk for HIV and hepatitis, and Section 1115 demonstrations to extend family planning services to otherwise ineligible women who lose Medicaid coverage after the 60-day postpartum period).

Traditional Benefits

Under traditional Medicaid, states are required to cover a wide array of mandatory services[90] for all categorically needy individuals.[91] In addition, states may provide optional services—that is, services that states can choose whether to provide under their state plans.[92] Examples of *mandatory service categories* likely to include reproductive health services are inpatient hospital services; physician services; family planning services; and early and periodic screening, diagnosis, and treatment (EPSDT) for persons under age 21 (this benefit is described in more detail below). Examples of *optional service categories* likely to encompass reproductive health services include clinic services; prescription drugs; and other diagnostic, screening, preventive, and rehabilitative services.

Some Medicaid service categories have an obvious connection to reproductive health, while others do not. This is because many of the benefit categories listed in statute identify a type of provider or care setting rather than a type of service. For example, a wide variety of qualified providers may deliver reproductive health services under Medicaid, including different types of physicians (e.g., obstetricians, gynecologists, anesthesiologists, maternal-fetal medicine specialists) and other qualified providers identified by the state as participating in Medicaid (e.g., nurse midwives). Moreover, enrollees may access reproductive health services in a variety of settings, such as a hospital, an outpatient setting, or a rural health clinic.

[88] SSA §1937 [42 U.S.C. §1396u-7].

[89] SSA authorizes several waiver and demonstration authorities that allow states to operate their Medicaid programs outside of federal rules. The primary Medicaid waiver authorities include Section 1115, Section 1915(b), and Section 1915(c).

[90] SSA §§1902(a)(10)(A) before (i) [42 U.S.C. §§1396a(a)(10)(A) before (i)]; 1905(a)(1)-(5), (17), (21), (28), (29) [42 U.S.C. §§1396d(a)(1)-(5), (17), (21), (28), (29)]; 42 C.F.R. §§440.210; 440.220.

[91] *Categorically needy* refers to certain groups of families and children, aged, blind, or disabled individuals, and pregnant women listed in SSA §1902(a)(10)(A) [42 U.S.C. §§1396a(a)(10)(A)], who comprise required and optional Medicaid eligibility groups. 42 C.F.R. §435.4.

[92] SSA §1905(a)(6)-(16), (18)-(20), (22)-(27) [42 U.S.C. §§1396d(a)(6)-(16), (18)-(20), (22)-(27)]; 42 C.F.R. §440.225.

Within the general Medicaid service categories listed in statute, states define the specific features of each covered benefit within four broad federal guidelines.[93] The breadth of coverage for a given benefit can, and does, vary from state to state, even for mandatory services.

Under these broad categories, states offer several Medicaid services to meet a person's reproductive health needs, including

- well-care visits,
- breast and cervical cancer screenings,
- HIV screening and treatment,
- counseling and treatment for STIs,
- domestic violence screening,
- breastfeeding services and supplies,
- smoking cessation programs,
- contraception,
- medically necessary hysterectomies,
- reproductive health-related education and outreach activities, and
- infertility treatments.

(Information on Medicaid coverage of specific types of reproductive health services appears below.)

Medicaid-eligible children under age 21 are entitled to EPSDT,[94] which includes health screenings and services such as assessments of a child's physical and mental health development, laboratory tests, appropriate immunizations, and health education, among others. States are required to provide all federally allowed treatment to address problems identified through screenings, even if the required treatment is not otherwise covered under a given state's Medicaid plan. Reproductive health services, which are part of the screening and treatment services available under ESPDT, include screenings and treatment for STIs, coverage of the HPV vaccine, family planning services and supplies and related services, and sexuality education and counseling.[95]

[93] First, each service must be *sufficient in amount, duration,* and *scope* to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity. Second, within a state, services available to the various population groups must be equal in amount, duration, and scope. This requirement is the *comparability rule*. Third, with certain exceptions, the amount, duration, and scope of benefits must be the same statewide, referred to as the *statewideness* rule. Fourth, with certain exceptions, enrollees must have *freedom of choice* among health care providers or managed care entities participating in Medicaid.

[94] See generally SSA §1905(a)(4)(B) [42 U.S.C. §1396d(a)(4)(B)], SSA §1902(a)(43) [42 U.S.C. 1396a(a)(43)], SSA §1905(r) [42 U.S.C. §1396d(r)] and 42 C.F.R. Part 441, Subpart B, CMS, *EPSDT: A Guide for States*, June 2014, at https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

[95] CMS identifies the American Academy of Pediatrics (AAP) "Bright Futures" guidelines as an example of a recognized and accepted clinical practice guideline for EPSDT screenings. Bright Futures encourages providers to offer reproductive and sexual health services, including STI screening, HPV vaccines, sexuality education and counseling, and pregnancy testing. For more information, see Joseph F. Hagan Jr., et al., *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, AAP, 4th Edition, 2017, at https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/.

Alternative Benefit Plans (ABPs)

As an alternative to providing the mandatory and selected optional benefits listed in statute under traditional Medicaid, states can enroll specified groups in ABPs. However, states that choose to implement the ACA (P.L. 111-148, as amended) Medicaid expansion are required to enroll individuals newly eligible for Medicaid through the expansion in ABPs (with exceptions for selected special-needs subgroups).[96]

Under ABPs, states must provide comprehensive benefit coverage that is based on one of three commercial insurance products, including (1) the standard Blue Cross/Blue Shield preferred provider option service plan offered through the Federal Employees Health Benefit Program-equivalent health insurance coverage; (2) the commercial health maintenance organization with the largest insured commercial, non-Medicaid enrollment in the state; or (3) the health benefits plan offered to state employees. A fourth option, "Secretary-approved," coverage is also available to states.[97]

ABPs must qualify as either *benchmark*, where the benefits are at least equal to one of the statutorily specified benchmark plans (listed above), or *benchmark-equivalent*, which means the benefits include certain specified services and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages. In addition, ABPs must include a variety of specific services, including services under Medicaid's EPSDT benefit[98] and family planning services and supplies for individuals of reproductive age.[99] Finally, states are generally permitted to offer additional benefits beyond those required by law.

Unlike traditional Medicaid benefit coverage, ABPs must cover at least the 10 categories of health care services—known as the essential health benefits (EHBs)—as defined in ACA Section 1302(b).[100] However, as with traditional Medicaid, states generally specify the amount, duration, and scope of benefit coverage within these broad categories in the Medicaid state plan.

Certain EHB categories are particularly relevant to coverage of reproductive health services. For example, under the "maternity and newborn care" category, states are required to cover prenatal care, labor and delivery, and postpartum care services. Under the "preventive and wellness services and chronic disease management" EHB category, states are required to cover specified preventive services without beneficiary cost sharing.[101] (Information on Medicaid coverage of specific types of reproductive health services appears below.)

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[96] For more information, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[97] For more information, see CRS Report R45412, *Medicaid Alternative Benefit Plan Coverage: Frequently Asked Questions*.

[98] SSA §1937(a)(1)(A)(ii) [42 U.S.C. §1396u-7(a)(1)(A)(ii)].

[99] SSA §1937(b)(7) [42 U.S.C. §1396u-7(b)(7)]; 42 C.F.R. §440.345(b).

[100] Federal requirements related to the EHBs generally apply to certain private health insurance plans. The 10 categories of EHB are (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) prescription 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. For more information about private health insurance EHB requirements, see the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report. For Medicaid ABP requirements regarding the EHBs, see SSA §1937(b)(5) [42 U.S.C. §1396u-7(b)(5)]; 42 C.F.R. §440.347.

[101] Under Medicaid, cost-sharing protections listed in SSA §§1916 and 1916A [42 U.S.C. §1396o and 42 U.S.C. §1396o-1] generally apply to preventive services provided in ABPs. In addition, cost sharing may not be applied to preventive services that are within the definition of EHBs (described in 45 C.F.R. 147.130). For more information, see CMS, "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, (continued...)

Under ABPs, states are permitted to waive the statewideness and comparability requirements that apply to traditional Medicaid benefits. This flexibility allows states to define the populations served and the specific benefit packages that apply. [102] States can design different ABPs for different beneficiary subgroups.

Comparing Medicaid Traditional Benefit Coverage of Reproductive Health Services to ABPs

It is difficult to compare the ways in which coverage of reproductive health under traditional Medicaid benefits are similar to and different from ABP benefits. Although both coverage types offer many of the same benefits, the scope of coverage under each type may vary from state to state. This variability largely reflects the choices permitted by federal law in defining the amount, duration, and scope of benefits offered under the state plan. (The sections below, where possible, highlight key differences in the federal requirements regarding the scope of traditional Medicaid benefits and ABP benefits.) For example, while both coverage types require states to cover family planning services, under traditional Medicaid, states generally have the discretion to identify the specific services they will cover. By contrast, under ABPs, states are required to provide all of the FDA-approved contraceptive methods (see **Table 1** in the "What Are Contraceptive Services?" section of this report), as prescribed, to meet the Medicaid EHB preventive services requirement.[103] (For more information, see the "Does Medicaid Cover Contraceptive Services?" section of this report.)

State coverage of a specific benefit may also vary depending on a given enrollee's eligibility pathway. For example, under traditional Medicaid, federal requirements permit states to cover the HPV vaccine for adults aged 22 and older at state option. By contrast, under ABPs, states are required to cover the HPV vaccine for adults aged 22 and older under the Medicaid EHB preventive health service requirement. Finally, regardless of coverage type, states are required to cover the HPV vaccine for most children through age 21 (as age-appropriate) under EPSDT. (For more information, see the "Does Medicaid Cover Reproductive Health Screening and Preventive Services?" section of this report.)

In addition, states are permitted to rely on different statutory authorities to direct federal Medicaid funds to pay for certain services. In the case of doula services,[104] for example, Minnesota[105] covers doulas under Medicaid's traditional mandatory pregnancy-related services category, while Oregon[106] covers them under Medicaid's traditional optional preventive services category. New York, by contrast, covers doula services for certain enrollees under Medicaid's optional other diagnostic, screening, preventive and rehabilitative services benefit category.[107] In each of these

Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule," *Federal Register*, vol. 78, no. 135, July 15, 2013. The preventive services that must be covered are listed in their entirety at Healthcare.gov, "Preventive health services," at https://www.healthcare.gov/coverage/preventive-care-benefits/.

[102] SSA §1937(a)(1) [42 U.S.C. §1396u-7(a)(1)].

[103] CMS, "Re: Medicaid Family Planning Services and Supplies," State Health Officials (SHO) letter, SHO # 16-008, June 14, 2016, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.

[104] See footnote 45 for additional details.

[105] See Minnesota CHIP state plan Attachment 3.1-A, Page 66i, at https://www.medicaid.gov/medicaid/spa/downloads/MN-23-0018.pdf.

[106] See Oregon CHIP state plan, Transmittal # 22-0019, Attachment 4.19-B, Page 1a.6, at https://www.medicaid.gov/medicaid/spa/downloads/OR-22-0019.pdf.

[107] Anoosha Hasan, *State Medicaid Approaches to Doula Service Benefits*, National Academy for State Health Policy, (continued...)

scenarios, different federal requirements shape how these states incorporate this provider type under their state plan.

Where Do Medicaid Enrollees Receive Reproductive Health Care Services?

Medicaid enrollees receive reproductive health care from a range of Medicaid providers, including private physicians, nurse midwives, birth attendants, and other health professionals working within their scope of practice under state law.[108] Medicaid beneficiaries access reproductive health services in various types of facilities, including health departments, community health centers, certain school-based health clinics, urgent care or retail clinics, emergency rooms and other clinics.[109]

In general, under Medicaid's "freedom of choice of provider" requirement, states must permit enrollees to receive services from any willing Medicaid-participating provider,[110] and states cannot exclude providers solely on the basis of the range of services they provide.[111] Medicaid managed care enrollees may be restricted to providers in a given managed care plan network,[112] except in the case of family planning services.[113] 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.[114]

April 16, 2024, at https://nashp.org/state-tracker/state-medicaid-approaches-to-doula-service-benefits/. See also New York CHIP state plan, Attachment 3.1-A Supplement, at https://www.medicaid.gov/medicaid/spa/downloads/NY-24-0003.pdf.

[108] For example, see SSA §1905(a)(17) [42 U.S.C. §1396d(a)(17)] and 42 C.F.R. §§440.165, 441.21 for rules regarding Medicaid coverage of services provided by a nurse-midwife.

[109] Michelle Long, Brittni Frederiksen, Usha Ranji, et al., *Experiences with Health Care Access, Cost, and Coverage: Findings from the 2022 KFF Women's Health Survey*, KFF, December 20, 2022, https://www.kff.org/womens-health-policy/report/experiences-with-health-care-access-cost-and-coverage-findings-from-the-2022-kff-womens-health-survey/.

[110] 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. (SSA §1902(a)(23) [42 U.S.C. §1396a(a)(23)]; 42 C.F.R. §431.51.

[111] SSA §1902(a)(23) [42 U.S.C. §1396a(a)(23)]; 42 C.F.R. §431.51. See also Center for Medicaid, CHIP and Survey & Certification (CMCS), "Re: Update on Medicaid/CHIP," CMCS Informational Bulletin, June 1, 2011, at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/6-1-11-Info-Bulletin.pdf.

[112] Medicaid enrollees generally receive benefits via one of two service delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, Medicaid enrollees get most or all of their services through a managed care organization under contract with the state.

[113] SSA §1902(a)(23)(B) [42 U.S.C. §1396a(a)(23)(B)]; 42 C.F.R. §431.51(b)(2); and 42 C.F.R. Part 438.

[114] 42 C.F.R. §431.51.

Does Medicaid Cover Contraceptive Services?

States are required[115] to provide family planning services and supplies to prevent or delay pregnancy under both traditional and ABP benefit coverage for most individuals[116] of reproductive age (including minors) who desire such services and supplies.[117] States are not permitted to charge point-of-service cost sharing (e.g., copays, coinsurance) for Medicaid family planning services and supplies, regardless of the type of coverage.[118] Family planning services and supplies must be available to Medicaid enrollees without undue burden, coercion, or mental pressure.[119] Such state plan services include education and counseling on methods of contraception. States are required to cover follow-up care and services necessary to stop or modify birth control methods, such as the removal of LARCs.[120] States may pay for sterilization services only if certain specified conditions are met.[121] In addition, Medicaid beneficiaries must be free to choose the provider of their choice and the method of family planning to be used.[122]

Although the term "family planning services" is not defined in Medicaid statute or program regulations, 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 reimbursement rate (i.e., the federal medical assistance percentage [FMAP] rate) available to states for these services.[123] Specifically, states may receive a 90% FMAP rate for items and procedures for family planning purposes (e.g., counseling services and patient education, examination and treatment by medical professionals, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent

[115] SSA §1902(a)(10)(A) in the matter before (i), [42 U.S.C. §1396a(a)(10)(A) in the matter before (i)], and 1905(a)(4)(C) [42 U.S.C. §1396d(a)(4)(C)]. "Under section 1905(a)(4)(C) of the Social Security Act (the Act), family planning services and supplies must be included in the standard Medicaid benefit package and in alternative benefit plans (ABPs)." (See HHS, CMS, "Re: Medicaid Family Planning Services and Supplies," SHO letter, SHO#16-008, June 14, 2016, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.)

[116] SSA §1902(a)(10)(C) [42 U.S.C. §1396a(a)(10)(C)] permits states to offer family planning services and supplies to medically needy Medicaid enrollees at state option. Medically needy individuals are individuals who are otherwise eligible for Medicaid but who have incomes too high to qualify for Medicaid. These individuals may qualify for Medicaid by meeting the medically needy income standard, or by spending down their income to the medically needy income standard by incurring and paying for medical expenses.

[117] For more information, see HHS, CMCS Informational Bulletin, *SUBJECT: Medicaid Family Planning Services and Supplies: Requirements and Best Practices*, August 8, 2024, at https://www.medicaid.gov/federal-policy-guidance/downloads/cib08082024.pdf. In FY2015, Medicaid accounted for 75% of U.S. public family planning expenditures. Guttmacher Institute, *Publicly Supported Family Planning Services in the United States*, October 2019, at https://www.guttmacher.org/sites/default/files/factsheet/publicly-supported-fp-services-us.pdf.

[118] SSA §§1916(a)(2)(D), 1916(b)(2)(D), and 1916A(b)(3)(B)(vii) [42 U.S.C. §§1396o(a)(2)(D), 1396o(b)(2)(D), 1396o–1(b)(3)(B)(vii)]; 42 C.F.R. §447.56(a)(2)(ii).

[119] SSA §1905(a)(4)(C) [42 U.S.C. §1396d(a)(4)(C)]; 42 C.F.R. §441.20.

[120] For more information, see HHS, CMS, "Re: Medicaid Family Planning Services and Supplies," SHO letter, SHO#16-008, June 14, 2016, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf. Also see CMS, Frequently Asked Questions (FAQs), "Medicaid Family Planning Services and Supplies," January 11, 2017, at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/faq11117.pdf.

[121] 42 C.F.R. §§441.253-441.256.

[122] SSA §1902(a)(23) [42 U.S.C. §1396a(a)(23)]; 42 C.F.R. §441.20, and 42 C.F.R. §431.51.

[123] For more information on the types of family planning benefits covered under state Medicaid programs, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, KFF, February 17, 2022, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/. See also HHS, CMS, "Re: Medicaid Family Planning Services and Supplies," SHO letter, SHO#16-008, June 14, 2016, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.

conception, and infertility services, including sterilizations and sterilization reversals),[124] and for related administrative costs.[125] By contrast, family planning-related services are reimbursable at the state's regular FMAP rate.[126] Family planning-related services generally align more with reproductive health and screening services (e.g., medical diagnosis, treatment, and preventive services) and are provided because they were identified, or diagnosed, during a family planning visit.[127] (Family planning-related services are discussed in more detail in the "Does Medicaid Cover Reproductive Health Screening and Preventive Services?" section of this report.)

The specific benefits that states offer under the family planning service category vary. For Medicaid enrollees who receive traditional state plan coverage, states may identify the specific services and supplies they cover (including EC),[128] as long as the services meet basic federal requirements (e.g., they are determined by CMS to be sufficient in amount, duration, and scope to reasonably achieve their purpose,[129] and beneficiaries are permitted to choose which family planning method to use). States generally cover a broad range of medically approved methods, procedures (e.g., sterilization), and devices to prevent conception under traditional Medicaid, including over-the-counter contraceptive methods (e.g., male/female condoms, spermicide, the sponge, EC) and prescription contraceptives (e.g., oral contraceptives, LARCs, patch, diaphragm, injectable, IUDs).[130]

Prescription drugs are considered an optional Medicaid service, but all states cover them.[131] State coverage of various FDA-approved prescription contraceptives under traditional Medicaid is generally established through national drug rebate agreements between drug manufacturers and

[124] SSA §1903(a)(5) [42 U.S.C. §1396b(a)(5)]; CMS, State Medicaid Manual §4270.B.1 at https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927.

[125] 42 C.F.R. §433.15(b)(2).

[126] For FY2024, states' regular FMAP rates range from 50.00% to 77.27%, depending on the state's per capita income as compared with the national average. FMAPs may also vary by population (e.g., services to some persons newly eligible under the ACA Medicaid expansion are reimbursed at a 90% FMAP rate for 2020 and subsequent years). See CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[127] CMS, "Re: Family Planning Services Option and New Benefit Rules for Benchmark Plans," SHO Letter, SMDL#10-013 ACA# 4, July 2, 2010, at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf, and HHS, CMS "Re: Family Planning and Family Planning Related Services Clarification," SHO Letter, SMDL#14-003 ACA# 31, April 16, 2014, at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf.

[128] For more information on state coverage of emergency contraception (EC) as of July 1, 2021, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, KFF, February 17, 2022, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

[129] CMS, State Medicaid Manual §4270.B.1, at https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927.

[130] For more on the range of family planning benefits covered by states under traditional Medicaid, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, KFF, February 17, 2022, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

[131] States are also permitted to cover over-the-counter (OTC) drugs, including oral contraception and emergency contraception under Medicaid. As family planning services and supplies described in SSA §1905(a)(4)(C) [42 U.S.C. §1396d(a)(4)(C)], Medicaid coverage of OTC oral contraception and emergency contraception must be provided without enrollee cost sharing, as per SSA §§1916(a)(2)(D), 1916(b)(2)(D), and 1916A(b)(3)(B)(vii) [42 U.S.C. §§1396o(a)(2)(D), 1396o(b)(2)(D), 1396o–1(b)(3)(B)(vii)]; 42 C.F.R. §447.56(a)(2)(ii) and 42 C.F.R. § 438.108). For more information, see HHS, CMCS Informational Bulletin, *SUBJECT: Medicaid Family Planning Services and Supplies: Requirements and Best Practices*, August 8, 2024, at https://www.medicaid.gov/federal-policy-guidance/downloads/cib08082024.pdf.

the HHS Secretary under the Medicaid Drug Rebate program.[132] States are permitted to rely on utilization controls, such as preferred drug lists and prior authorization, to encourage providers to prescribe certain drugs over others. However, in general, Medicaid covers most FDA-approved drugs produced by manufacturers that enter into rebate agreements with HHS, which results in enrollee access to a wide range of prescription drugs.[133]

For Medicaid enrollees who receive ABP coverage, states must cover family planning services and supplies that meet Medicaid EHB preventive services requirements, including coverage of at least one form of contraception within each of the contraceptive methods, as prescribed, approved by FDA (see **Table 1** in "What Are Contraceptive Services?"),[134] and all of the services recommended by the USPSTF (e.g., counseling on STIs and HIV and screening for breast and cervical cancers). (See the USPSTF text box in the "What Are Reproductive Health Prevention and Treatment Services?" section).[135] In addition, states may provide targeted family planning services under Medicaid for populations who are not otherwise eligible for traditional Medicaid (e.g., nonpregnant, nondisabled childless adults) through special waivers of federal law (i.e., Section 1115 family planning waivers).[136] States have discretion to determine the populations and benefits covered under Section 1115 family planning waivers. However, such coverage is time-limited and must be budget-neutral to the federal government, whereby the estimated federal spending under the waiver cannot exceed the estimated federal cost of the state's Medicaid program without the waiver.

The ACA established an optional Medicaid eligibility group for family planning services so that states 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).[137] The ACA family planning eligibility group includes individuals (men and women) (1) who are not pregnant and (2) whose income does not

[132] Drug manufacturers enter into national rebate agreements with the HHS Secretary under the Medicaid Drug Rebate Program. The program requires a drug manufacturer to enter into, and have in effect, a national rebate agreement with the HHS Secretary to rebate a portion of the Medicaid payment for the drug to the states based on a statutory formula. States then share the rebate they receive from pharmaceutical manufacturers with the federal government as a way to offset the costs of prescription drugs under the Medicaid program in exchange for state Medicaid coverage of most of the manufacturer's drugs. For more information, see CRS Report R43778, *Medicaid Prescription Drug Pricing and Policy*.

[133] Rachel Dolan, *Understanding the Medicaid Prescription Drug Rebate Program*, KFF, Issue Brief, November 2019, at http://files.kff.org/attachment/Issue-Brief-Understanding-the-Medicaid-Prescription-Drug-Rebate-Program.

[134] For more information, see CMS, "RE: Family Planning and Family Planning Related Services Clarification," State Medicaid Directors Letter (SMDL), SMDL#14-003 ACA# 31, April 16, 2014, at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf. See also CMS, "Re: Medicaid Family Planning Services and Supplies," SHO letter, SHO # 16-008, June 14, 2016, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.

[135] For more on the range of family planning benefits covered by states under Medicaid ABPs, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, KFF, February 17, 2022, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

[136] Section 1115 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. As of January 2024, eleven states have CMS approval for Medicaid Section 1115 family planning waivers. For more information, see, KFF, State Health Facts, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid," at https://www.kff.org/medicaid/state-indicator/family-planning-services-waivers/.

[137] As of January 2024, 18 states have CMS approval for Medicaid family planning state plan amendments. For more information, see KFF, State Health Facts, "States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid," at https://www.kff.org/medicaid/state-indicator/family-planning-services-waivers/.

exceed the highest income eligibility level established by the state for pregnant women.[138] Benefits for this eligibility group are limited to family planning services and supplies and related medical diagnosis and treatment services.[139] Unlike Section 1115 family planning demonstration waivers, family planning coverage under the state plan authority is not time-limited or subject to budget neutrality.

Comparing family planning coverage across the various types of Medicaid benefit coverage (i.e., traditional Medicaid, ABP coverage, Section 1115 family planning waivers, or the optional ACA family planning eligibility group) reveals a key difference: under ABPs, states must comply with the Medicaid EHB preventive service requirements that establish a federal coverage floor of FDA-approved contraceptives (see **Table 1** in "What Are Contraceptive Services?") and the USPSTF services.[140] Under the other coverage types, states have more discretion when defining covered benefits. The multiple eligibility pathways and related service coverage options make it difficult to assess the relative richness of the benefit coverage within and across states. However, findings from a 2021 50-state survey of Medicaid fee-for-service (FFS) coverage of select family planning services highlight the mandatory nature of various types of contraceptive coverage under ABPs, as well as state choices in offering different types of contraception under the other coverage types. The survey also captures differences across coverage types in terms of utilization controls (e.g., whether prescription required, brand/type restrictions, quantity or frequency limits, medical necessity requirements), which states use to control costs or otherwise influence how beneficiaries use the benefit.[141]

Does Medicaid Cover Abortions or Abortion Counseling?

Like other HHS programs, Medicaid is subject to the Hyde Amendment, which prohibits the use of federal funds for abortions, except in the cases of rape, incest, or endangerment of a woman's life (for more information on the Hyde Amendment, see the "Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?" section of this report). The Hyde Amendment does not restrict federal funding for the cost of treating a physical disorder, injury, or illness, including a life-endangering condition that is caused by or arises from pregnancy, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. Moreover, Medicaid program regulations permit federal reimbursement for the termination of ectopic pregnancies, which are nonviable and endanger the life of the mother.[142]

In addition, the Hyde Amendment does not prohibit a "state, locality, entity, or private person" from paying for abortion services, or managed care providers from offering abortion coverage,

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[138] SSA §1902(a)(10) in subdivision (XVI) after (G) [42 U.S.C. §1396a(a)(10) in subdivision (XVI) after (G)].

[139] "Family planning related services are medical, diagnostic, and treatment services provided pursuant to a family planning visit that address an individual's medical condition and may be provided for a variety of reasons including, but not limited to: treatment of medical conditions routinely diagnosed during a family planning visit, such as treatment for urinary tract infections or sexually transmitted infection; preventive services routinely provided during a family planning visit, such as the HPV vaccine; or treatment of a major medical complication resulting from a family planning visit." See CMS, "Re: Medicaid Family Planning Services and Supplies," SHO letter, SHO # 16-008, June 14, 2016, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf.

[140] For a summary of federal coverage requirements for Medicaid family planning services, by coverage type, see Usha Ranji, Yali Bair, and Alina Salganicoff, *Medicaid and Family Planning: Background and Implications of the ACA*, Kaiser Family Foundation, February 2016, p. 18, at http://files.kff.org/attachment/issue-brief-medicaid-and-family-planning-background-and-implications-of-the-aca.

[141] For more information, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, KFF, February 17, 2022, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

[142] 42 C.F.R. §441.207.

nor does it 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).[143] Some states rely on state-only funds to pay for abortions that do not meet the Hyde amendment exceptions.

Through program regulations,[144] 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 reimbursement. 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.[145]

Following the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*,[146] coverage of Hyde-permissible abortions under Medicaid has shifted. According to a recent study, abortion remains legal (subject to specified criteria such as gestational age) in 36 states and the District of Columbia. Among these states as of March 2024, 19 states and the District of Columbia follow the Hyde Amendment restrictions when paying for abortion services for Medicaid enrollees, and 17 states use state-only funds to pay for abortions beyond the Hyde Amendment limitations (nine of which do so pursuant to a court order).[147]

Does Medicaid Cover Infertility Services?

States are permitted to cover fertility diagnosis services (e.g., lab tests, semen analysis, and imaging studies) and infertility treatment services (e.g., medications, surgeries, ARTs such as IUI or IVF) at state option under all coverage types (i.e., traditional Medicaid, ABPs, Section 1115 Medicaid family planning waivers, and the optional ACA family planning eligibility group).[148] Although state Medicaid programs are required to cover most manufacturers' prescription drugs to receive rebates under the Medicaid Drug Rebate Program, states are permitted to exclude or otherwise restrict coverage of outpatient fertility drugs.[149]

Does Medicaid Cover Maternity Services?

Medicaid is a significant payer of maternal health services and births in the United States. According to CDC, Medicaid paid for approximately 41% of all births in the United States in

[143] Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 1998, (P.L. 105-78) Section 509 and 510. These restrictions have been continued in the HHS Appropriations Acts, most recently through the enactment of the Further Consolidated Appropriations Act, 2022 (P.L. 117-103). See also HHS, Health Care Financing Administration (HCFA), Center for Medicaid and State Operations (CMSO), SMDL, February 12, 1998, at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd021298.pdf.

[144] 42 C.F.R. §§441.203, 441.206 and 441.208.

[145] HHS, HCFA, CMSO, SMDL, February 12, 1998, at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd021298.pdf.

[146] For more information, see CRS Legal Sidebar LSB10768, *Supreme Court Rules No Constitutional Right to Abortion in Dobbs v. Jackson Women's Health Organization*.

[147] Alina Salganicoff, Laurie Sobel, Ivette Gomez, et al., *The Hyde Amendment and Coverage for Abortion Services Under Medicaid in the Post-Roe Era*, KFF, March 14, 2024, at https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services-under-medicaid-in-the-post-roe-era/.

[148] For more information of state coverage of fertility services by program type, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, KFF, February 17, 2022, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

[149] SSA §1927(d)(2)(B) [42 U.S.C. §1396r-8(d)(2)(B)].

2022.[150] In general, Medicaid benefits for pregnant women can differ by eligibility pathway across and within states.[151]

Medicaid Eligibility Pathways

Medicaid's mandatory poverty-related pregnant women pathway provides access to pregnancy coverage under traditional Medicaid for pregnant women with incomes less than 133% of FPL,[152] and up to 185% of FPL at state option.[153] As of July 2023,[154] the Medicaid upper-income eligibility threshold for pregnant women ranged from 133% of FPL in four states (Idaho, Louisiana, Oklahoma, and South Dakota) to 375% of FPL (in Iowa).[155] Coverage for these women may include full Medicaid benefit coverage, or states may limit services to those related to pregnancy.[156] In either case, coverage generally begins at the time of application and ends after 60 days postpartum. While states may impose cost sharing in the form of program participation fees (e.g., premiums) for pregnant women with incomes above 150% FPL, pregnant women are exempt from point-of-service cost sharing (e.g., copays, coinsurance) for pregnancy-related services, including tobacco cessation counseling.[157]

Women who are otherwise eligible for Medicaid (e.g., who meet the financial eligibility criteria of a state's former Aid to Families with Dependent Children [AFDC] program, or who are eligible through a family coverage pathway) and become pregnant are generally permitted to retain their

[150] Osterman MJK, Hamilton BE, Martin JA, Driscoll AK, and Valenzuela CP, *Births: Final data for 2022*, National Vital Statistics Reports, vol 73, no 2, Hyattsville, MD: National Center for Health Statistics, at https://dx.doi.org/10.15620/cdc:145588.

[151] For more information on Medicaid's pregnancy coverage, see Medicaid and CHIP Payment and Access Commission (MACPAC), *MACPAC Report to the Congress*, Chapter 3: Issues in Pregnancy Coverage under Medicaid and Exchange Plans, March 2014, at https://www.macpac.gov/wp-content/uploads/2014/03/Issues-in-Pregnancy-Coverage-under-Medicaid-and-Exchange-Plans.pdf. See also Maggie Clark, *Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options*, Georgetown University Health Policy Institute, Center for Children and Families, November 5, 2020, at https://ccf.georgetown.edu/2020/11/05/medicaid-and-chip-coverage-for-pregnant-women-federal-requirements-state-options/.

[152] SSA §§1902(a)(10)(A)(i)(III) [42 U.S.C. §1396a(a)(10)(A)(i)(III)]; 1902(a)(10)(A)(i)(IV) [42 U.S.C. §1396a(a)(10)(A)(i)(IV)]; 1902(l)(2)(A) [42 U.S.C. §1396a(l)(2)(A)]; and 1905(n) [42 U.S.C. §1396d(n)].

[153] SSA §§1902(a)(10)(A)(ii)(I) [42 U.S.C. §1396a(a)(10)(A)(ii)(I)]; 1902(a)(10)(A)(ii)(IV) [42 U.S.C. §1396a(a)(10)(A)(ii)(IV)]; 1902(a)(10)(A)(ii)(IX) [42 U.S.C. §1396a(a)(10)(A)(ii)(IX)]; and 1902(l)(2)(A)(ii)(I) [42 U.S.C. §1396a(l)(2)(A)(ii)(I)].

[154] MACPAC, *MACStats*, EXHIBIT 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State, July 2023, at https://www.macpac.gov/wp-content/uploads/2023/12/EXHIBIT-35.-Medicaid-and-CHIP-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Children-and-Pregnant-Women-July-2023.pdf.

[155] Prior to the enactment of the ACA, states had the flexibility to determine what types of income to include or disregard when determining Medicaid income eligibility for most nondisabled Medicaid eligibility groups, and income counting rules varied greatly across Medicaid eligibility categories and across states. Under the ACA, states are required to transition to a new Medicaid eligibility income-counting rule based on Modified Adjusted Gross Income (MAGI) to establish uniform standards for what income to include or disregard in determining Medicaid eligibility for most Medicaid eligibility categories. In transitioning to MAGI, states converted their old income-counting rules to MAGI-based income standards set by each state in coordination with CMS. As a result, the upper-income eligibility thresholds for pregnant women is effectively higher than 185% of FPL statutory maximum in a number of states. For more information, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*.

[156] SSA §§1902(a)(10) in subdivisions (V), (VII) after (G) [42 U.S.C. §1396a(a)(10) in subdivisions (V), (VII) after (G)], see also MACPAC, Pregnant Women, at https://www.macpac.gov/subtopic/pregnant-women/.

[157] SSA §1902(e)(5) [42 U.S.C. §1396a(e)(5)].

existing full Medicaid state plan coverage (whether provided under traditional Medicaid or ABP coverage) until that individual's next eligibility redetermination (up to 12 months).[158]

States have the option, when certain conditions are met, to extend full Medicaid benefit coverage during pregnancy and throughout the 12-month postpartum period to women who received Medicaid coverage while pregnant. In addition to any available pregnancy-related services and 60-day postpartum care that a woman might be entitled to under the Medicaid state plan (or waiver), pregnancy and postpartum coverage under this state plan option includes the full Medicaid benefit coverage that is available to other mandatory eligibility groups (or substantially equivalent benefit coverage as determined by the HHS Secretary). Such coverage is available during the pregnancy through the last day of the month of the 12-month period beginning on the last day of the individual's pregnancy.[159]

Many *qualified aliens*, such as Legal Permanent Residents who entered the United States after August 22, 1996,[160] are prohibited from receiving Medicaid for five years (often referred to as the five-year bar).[161] States are permitted to provide Medicaid coverage to certain lawfully residing pregnant women within the five-year waiting period when certain conditions are met (e.g., the state offers coverage to all such individuals who meet the definition of lawfully residing, or applicants meet state residency requirements).

For nonpregnant women who would be eligible for Medicaid but for their citizenship status, states are required to pay for services to treat an emergency medical condition under emergency Medicaid.[162] For pregnant women, emergency Medicaid includes services covered under the state plan, including routine prenatal care, labor and delivery, and routine postpartum care. States may provide additional services to treat conditions that may complicate the pregnancy or the delivery.[163]

Benefit Coverage

Medicaid's pregnancy-related benefit under traditional Medicaid covers services that are "necessary for the health of a pregnant woman and fetus, or have become necessary as a result of

[158] Women who are otherwise eligible for Medicaid (under the ACA Medicaid expansion pathway, for example) and who become pregnant are generally permitted to retain their existing Medicaid benefit coverage unless the woman self-identifies as pregnant and requests a change in her Medicaid coverage category. In this example, the individual would be entitled to ABP coverage, and such coverage would continue until her next eligibility redetermination (i.e., coverage may extend after the 60-day postpartum period). Source: CMS, "Medicaid Program; Eligibility Changes," 77 *Federal Register* 17149, March 23, 2012.

[159] As of May 10, 2024, the District of Columbia, the United States Virgin Islands and 46 states (Alabama; Alaska; Arizona; California; Colorado; Connecticut; Delaware; Florida; Georgia; Hawaii; Illinois; Indiana; Kansas; Kentucky; Louisiana; Maine; Maryland; Massachusetts; Michigan; Minnesota; Mississippi; Missouri; Montana; Nebraska; Nevada, New Hampshire; New Jersey; New Mexico; New York; North Carolina; North Dakota; Ohio; Oklahoma; Oregon; Pennsylvania; Rhode Island; South Carolina; South Dakota; Tennessee; Texas, Utah, Vermont; Virginia; Washington; West Virginia; and Wyoming) have CMS approval to extend Medicaid and CHIP coverage from 60 days to 12 months postpartum under the "extended postpartum coverage option." For more information, see National Academy for State Health Policy, State Tracker, *State Efforts to Extend Medicaid Postpartum Coverage*, Updated 5/10/2024, at https://nashp.org/state-tracker/view-each-states-efforts-to-extend-medicaid-postpartum-coverage/.

[160] *Qualified aliens* in statute (8 U.S.C. §1641(b)) are Legal Permanent Residents, refugees, aliens paroled into the United States for at least one year, aliens granted asylum or related relief, certain abused spouses and children, and Cuban-Haitian entrants. For more information, see CRS Report RL34500, *Unauthorized Aliens' Access to Federal Benefits: Policy and Issues*.

[161] 8 U.S.C. §1613.

[162] SSA §1903(v)(3) [42 U.S.C. §1396b(v)(3)].

[163] 42 C.F.R. §440.255(b)(2).

the woman having been pregnant."[164] Coverage varies by state. States use the targeted pregnancy benefit coverage that is available through Medicaid's poverty-related pregnant women pathways to provide enhanced pregnancy-related benefits (e.g., prenatal vitamins, genetic counseling, smoking cessation services, nutrition counseling, dental care, child birth education classes, doula services, depression screening, breastfeeding support and supplies, case management, postpartum home visits).[165] States also rely on various Medicaid waiver authorities to undertake demonstration projects that in the HHS Secretary's judgement further the goals of the Medicaid program by providing targeted benefits to pregnant women (e.g., Substance Use Disorder Section 1115 demonstrations that target pregnant and postpartum women, among other populations).[166] Finally, states rely on a number of Medicaid care delivery models (e.g., pregnancy medical home) and payment initiatives (e.g., value-based payment) to promote positive health outcomes for pregnant women and newborns.[167]

Pregnant women are among the groups who are exempt from mandatory enrollment in ABPs; however, special federal rules apply to those who are eligible for and choose to participate in such coverage. Specifically, ABPs must cover at least the 10 categories of health care services—known as the EHBs—as defined in Section 1302(b) of the ACA (for more information, see the text box "Section 1557 of the Patient Protection and Affordable Care Act (ACA)" in the "What Are Gender-Affirming Services?" section of this report).[168] Under the maternity and newborn care and preventive services EHB coverage categories, Medicaid ABPs must cover several services related to maternity care at no cost to the enrollee, including but not limited to prenatal visits, folic acid supplements, and breastfeeding support services.

Comparing Medicaid Maternity Coverage Across Coverage Types

Coverage of Medicaid maternity services can and does vary within and across states based on enrollees' eligibility pathways. According to a 2015 survey of Medicaid FFS pregnancy and perinatal benefits by coverage type (i.e., traditional Medicaid, ABP coverage, and pregnancy-only Medicaid), most states cover basic prenatal services such as ultrasounds, prenatal vitamins, prenatal genetic testing, and postpartum visits. However, coverage of maternity-related services after delivery (e.g., parenting classes, breastfeeding and lactation support services) is less

[164] 42 C.F.R. §440.210(a)(2)(i).

[165] For more information on the kinds of pregnancy benefits that states offer under their Medicaid programs, Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey, KFF, May 2022, at https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-Related-Services-Findings-from-a-2021-State-Survey.pdf. See also CMS, *SHO# 21-007 RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP),* December 7, 2021, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.

[166] For more information, see CMS, "Section 1115 Demonstrations," at https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html.

[167] For examples of state efforts to improve maternal and child health outcomes, see MACPAC, *Report to the Congress*, Chapter 5: Medicaid's Role in Maternal Health June 2020, at https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf. Also see, CMS, *SHO# 21-007 RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP),* December 7, 2021, at https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf.

[168] Federal requirements related to the EHBs generally apply to certain private health insurance plans. The 10 categories of EHB are (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) prescription 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. For more information about private health insurance EHB requirements, see the "Does Federal Law Require Private Health Insurers to Cover Reproductive Health Services?" section of this report. For Medicaid ABP requirements regarding the EHBs, see SSA §1937(b)(5) [42 U.S.C. §1396u-7(b)(5)]; 42 C.F.R. §440.347.

common. The survey also found that while coverage requirements differ across eligibility pathways, in general, states aligned their pregnancy and perinatal benefit coverage across the coverage types captured in the survey (i.e., traditional Medicaid, ABP coverage, and pregnancy-only Medicaid).[169]

Does Medicaid Cover Reproductive Health Screening and Preventive Services?

In general, Medicaid covers a wide array of reproductive health screenings, preventive services, and treatment of conditions identified during screenings. Coverage varies within and across states.

Traditional Benefits

An enrollee's eligibility pathway determines the reproductive health screenings, preventive services, and treatments for conditions identified during these screenings that are available. Different federal rules may apply, depending on the eligibility pathway and/or service category under which the benefit is offered. States are permitted to rely on different statutory authorities to direct federal Medicaid funds to pay for similar services.

For example, states must cover certain screening services (e.g., mammograms, cervical cancer screenings and diagnostic services) as a mandatory family planning benefit without enrollee cost sharing for individuals eligible under Medicaid's pregnancy-related eligibility pathways and traditional Medicaid, or under EPSDT for children through age 21. These screenings may be offered at state option as a targeted benefit under a Section 1115 family planning waiver, or under the optional ACA family planning eligibility group.

In each case, states define the specific features of each covered benefit within the broad federal rules that apply for each eligibility pathway and covered benefit. The breadth of coverage for a given benefit can, and does, vary from state to state, even for mandatory services. Examples of Medicaid services that states offer as a part of reproductive health screenings, preventive services, and treatment of conditions identified during screenings under traditional Medicaid include physicians visits; well-care visits; breast and pelvic exams; laboratory tests; medical diagnosis, screening, and treatment services for conditions including breast and cervical cancer, HIV/AIDS, and STI; domestic violence screening and related treatment; EPSDT services; and preventive services routinely provided during a family planning visit, such as the HPV vaccine.[170]

[169] For more information on Medicaid state coverage of routine prenatal services, counseling and support services, delivery and postpartum care, and breastfeeding supports by coverage type, see Kathy Gifford, Jenna Walls, Usha Ranji, et al., *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey*, Kaiser Family Foundation (KFF), April 27, 2017, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/. For more recent survey data tracking Medicaid state coverage of pregnancy-related services, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey*, KFF, May 19, 2022, at https://www.kff.org/report-section/medicaid-coverage-of-pregnancy-related-services-findings-from-a-2021-state-survey-report/. However, this source does not track coverage differences across Medicaid coverage types.

[170] For examples of the types of Medicaid services that states offer as a part of reproductive health screenings, preventive services, and treatment of conditions identified during screenings, see Kaiser Family Foundation, *Issue Brief, Women's Sexual and Reproductive Health Services: Key Findings from the 2017 Kaiser Women's Health Survey*, March 13, 2018, at https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2017-kaiser-womens-health-survey/.

ABPs

For program enrollees who receive care through ABPs, the "preventive and wellness services and chronic disease management" EHB category requires states to cover all preventive services without enrollee cost-sharing per Public Health Service Act (PHSA) Section 2713 (See "Overview: Coverage of Certain Preventive Services Without Cost Sharing"). These EHB coverage requirements represent a floor for all ABP benefit coverage. Examples of ABP reproductive health screening, preventive services, and treatment for conditions identified under these screenings under this EHB coverage category include screening, counseling and treatment for STIs, universal HIV screening and treatment, breast and cervical cancer screenings and follow-up treatment, gynecological exams and Pap smears, well-woman visits, vaccines (e.g., HPV), and domestic and interpersonal violence screenings and related treatment.

Comparing Medicaid Reproductive Health Screenings and Preventive Services Across Coverage Types

Comparing reproductive health screenings and preventive services coverage across the various types of Medicaid benefit coverage (i.e., traditional Medicaid, ABP coverage, Section 1115 family planning waivers, or the optional ACA family planning eligibility group) reveals a key difference: under ABPs, states must comply with the EHB requirement for states to cover all required preventive services without beneficiary cost sharing. Under the other coverage types, states have more discretion when defining covered benefits. As with many of the other reproductive health benefits addressed in this report, Medicaid's multiple eligibility pathways and service coverage options make it difficult to assess the differences in coverage of these benefits within and across states.[171]

Does Medicaid Cover Gender-Affirming Services?

Medicaid benefits are subject to Section 1557 of the ACA, which prohibits discrimination based on race, color, national origin, sex, disability, and age in programs and activities administered by an executive agency or a state or federal health insurance exchange, as well as in federally funded health programs and activities, (see text box "Section 1557 of the Patient Protection and Affordable Care Act" in section "What Are Gender-Affirming Services?").[172] Medicaid covers a broad range of medically necessary physical and mental health care services for transgender, nonbinary, and gender-nonconforming individuals. Like other Medicaid benefits, coverage of such services may vary state by state and within states across eligibility pathways, benefit categories, and by coverage type.[173] Examples of Medicaid-covered services for such individuals include surgical interventions, speech and language interventions, behavioral health services, hormone therapy, fertility services, and hair removal.[174] A 2022 study identified 25 states and the

[171] For more information, see Assistant Secretary for Planning and Evaluation, Office of Health Policy, *Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act*, Issue Brief, January 11, 2022, at https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf.

[172] For more information, see CRS Video WVB00695, *Section 1557 and Medical Care for Transgender People: Select Legal Issues*, May 2, 2024.

[173] For more information, see Movement Advancement Project, *Health Care Laws and Policies: Medicaid Coverage for Transition-Related Care*, at https://www.lgbtmap.org/img/maps/citations-medicaid.pdf.

[174] For more information on the types of gender-affirming care that are covered under Medicaid and a list of states that cover these services under their Medicaid programs, see Ivette Gomez, Usha Ranji, Alina Salganicoff, et al., *Update on*
(continued...)

District of Columbia as including (or in the process of extending coverage for) gender-affirming care under Medicaid, seven states expressly exclude such coverage, and Medicaid coverage of gender-affirming care is unclear in 18 states.[175]

Medicare

Medicare is a federal program that pays for covered health care services for qualified beneficiaries, namely individuals aged 65 and older and permanently disabled individuals under the age of 65. It consists of four parts (A through D), which cover hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, hospice care, and preventive benefits, among other services and supplies.[176] In general, the specific items and services covered by the program are required to be reasonable and necessary for the diagnosis or treatment of illness or injury, or for the prevention or early detection of an illness or disability. As such, covered items and services depend on different factors, such as age, disease status, and other characteristics.

The majority of Medicare beneficiaries are 65 years old or older. However, in 2022, approximately 7.6 million beneficiaries under age 65 were enrolled in Medicare Part A and/or B as a result of disability, including an unspecified number of people of reproductive age.[177]

Does Medicare Cover Reproductive Health Services?

Medicare covers some types of reproductive health services. Cost sharing—a deductible and co-insurance—applies to some, such as many physician services, and is waived for others, such as most preventive services. Covered services, described further below, include prenatal and maternity care, and preventive services. Other services, such as contraception, abortion, infertility services, and gender-affirming services, may be covered in specified circumstances.

Many reproductive health services are recommended for Medicare beneficiaries who are older than reproductive age, including breast and gynecological exams for women, and STI 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 oral contraceptives covered through

Medicaid Coverage of Gender-Affirming Health Services, KFF, October 11, 2022, at https://www.kff.org/womens-health-policy/issue-brief/update-on-medicaid-coverage-of-gender-affirming-health-services/. Also see Candace Gibson and Priscilla Huang, *Medicaid as an LGBTQ Reproductive Justice Issue: A Primer*, National Health Law Program, June 21, 2019, at https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/. The above-cited Movement Advancement Project, a nonprofit advocacy and research organization, also tracks Medicaid Coverage of Transgender-Related Care at https://www.lgbtmap.org/img/maps/citations-medicaid.pdf and https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies/medicaid.

[175] Christy Mallory and William Tentindo, UCLA School of Law; Williams Institute, "Medicaid Coverage for Gender-Affirming Care," December 2022, at https://williamsinstitute.law.ucla.edu/publications/medicaid-trans-health-care/.

[176] CRS In Focus IF10885, *Medicare Overview*.

[177] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 6, 2024, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

Medicare Part D prescription drug coverage. These and other forms of contraception may be covered to varying extents under Medicare Advantage (MA, or Part C) plans, which are health plans offered by private companies that contract with Medicare to provide covered benefits.

Male or female sterilization (e.g., vasectomy, tubal ligation) 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 pregnancy or any associated effects of a pregnancy.[178]

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.[179]

Does Medicare Cover Abortions or Abortion Counseling?

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.[180] Consistent with typical Medicare-covered physician services, a Medicare-covered abortion could include care activities such as taking a patient's medical and situational history, determining how the coverage criteria may apply, and discussing what specific procedures are under consideration, the potential complications, and follow-up.

Does Medicare Cover Infertility Services?

The Medicare Benefit Policy Manual states that "reasonable and necessary services associated with treatment for infertility are covered under Medicare. Infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally is expected to be fertile to seek medical consultation and treatment."[181] The infertility services covered are not specified, and the term "reasonable and necessary" is not defined in this context. The lack of clarity around what constitutes "reasonable and necessary" services can result in different interpretations by Medicare administrators.

Does Medicare Cover Maternity Services?

The Medicare Benefit Policy Manual states that Medicare covers the "events of pregnancy" from diagnosis through prenatal care, delivery, and necessary postnatal care of the mother.[182] Coverage applies whether the pregnancy ends in live birth, miscarriage, or therapeutic abortion (i.e., where the life of the mother would be endangered if the fetus were brought to term). Of note, covered

[178] CMS, Medicare National Coverage Determination for Sterilization (230.3), https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=13.

[179] Henry J. Kaiser Family Foundation, "Coverage of Sexual and Reproductive Health Services in Medicare," April 30, 2024, https://www.kff.org/medicare/issue-brief/coverage-of-sexual-and-reproductive-health-services-in-medicare/.

[180] CMS, Medicare National Coverage Determination for Abortion (140.1), June 19, 2006, https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=127&ncdver=2&bc=0.

[181] CMS, *Medicare Benefit Policy Manual*, Ch. 15 – Covered Medical and Other Health Services, March 07, 2024, p. 9, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.

[182] Ibid., p. 8.

services do not apply to care for a child; rather, they are limited to care of the mother, who is the Medicare beneficiary.

Does Medicare Cover Reproductive Health Screening, Prevention, and Treatment Services?

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 STIs, and prostate cancer screening.[183] 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 Gender-Affirming Services?

Medicare coverage of gender-affirming surgery is generally determined by Medicare Administrative Contractors (MACs) or MA plans, as is common for many Medicare-covered services. Prior to 2014, Medicare excluded coverage of affirmation-related medical care as "experimental."[184] The HHS Departmental Appeals Board lifted that exclusion in 2014; as a result, MACs were able to determine coverage of gender-affirming surgery on a case-by-case basis.[185] In 2016, CMS announced that it would not issue a national coverage determination (NCD) for gender-affirming surgery, instead allowing MACs and MA plans to continue to determine whether surgery is medically necessary on a case-by-case basis.[186]

Medicare coverage of nonsurgical gender-affirming services includes primary care and mental health services and counseling. Hormone therapy is also covered, although the specific drugs and beneficiary out-of-pocket costs vary by Part D plan or MA plan with Part D drugs.[187] Certain services that may be considered gender-affirming are not covered under Medicare if they are primarily cosmetic.[188]

[183] CMS, "Medicare Preventive Services," interactive chart, May 2024, https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html.

[184] Eleesha Lockett, "Gender Affirmation: Does Medicare Cover It?" *Healthline*, Updated July 22, 2024, https://www.healthline.com/health/medicare/does-medicare-cover-gender-affirmation.

[185] Department of Health and Human Services, Department Appeals Board, Appellate Division, *NCD 140.3, Transexual Surgery*, Docket No. A-13-87, Decision No. 2576, May 30, 2014, https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

[186] CMS, Medicare Coverage Database, "Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)," August 30, 2016, https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282.

[187] Michael T. Solotke, Patrick Liu, and Sanket S. Dhruva, et al., "Medicare Prescription Drug Plan Coverage of Hormone Therapies Used by Transgender Individuals," *LGBT Health*, vol. 7, no. 3 (April 7, 2020), p. 139, https://www.liebertpub.com/doi/epdf/10.1089/lgbt.2019.0306.

[188] Social Security Act Section 1862(a)(10) excludes cosmetic surgery from coverage under Medicare.

Federal Regulation of Private Health Insurance

Private health insurance is the predominant source of health insurance coverage in the United States. Nearly 190 million individuals in the United States had private health insurance as of the first quarter of 2022, according to health insurance data aggregator Mark Farrah Associates.[189]

Broadly, private health insurance includes *group plans* (largely made up of employer-sponsored insurance) and *nongroup plans* (i.e., plans that a consumer purchases directly from an insurer). Group plans may be *fully insured* or *self-insured*,[190] and fully insured plans may be purchased in the *large-group* or *small-group markets*.[191] The nongroup and small-group markets include plans both on and off the *health insurance exchanges*.[192]

Federal requirements on private health insurance plans may apply to some or all of the plan types noted above (i.e., nongroup plans, fully insured small- and large-group plans, and self-insured group plans).[193] For the federal reproductive health coverage requirements discussed in this section, applicability to each coverage type is noted. In general, states also have authority to regulate all but self-insured group plans.[194] While the focus of this report is federal requirements, some examples of relevant state requirements are also discussed in this section.

Some plans within a market segment may be exempt from requirements that otherwise apply to plans in that market segment. For example, *grandfathered plans* are nongroup or group plans in which at least one individual was enrolled as of enactment of the ACA, and which continue to meet certain criteria.[195] Plans that maintain their grandfathered status are exempt from some, but not all, federal requirements. For the reproductive health coverage requirements discussed in this section, applicability to grandfathered plans is noted.

[189] See Appendix A of CRS Report R47507, *Private Health Insurance: A Primer* for additional estimates. Mark Farrah Associates data is available by subscription at Health Coverage Portal, https://www.markfarrah.com/.

[190] When group plan sponsors purchase coverage from insurers and offer it to their employees or other groups, these plans are referred to as *fully insured*. Employers or other plan sponsors that *self-insure* set aside funds to pay for health benefits directly, and they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan.

[191] The (fully insured) *group market* is divided into segments based on size: the small-group market and the large-group market. In general, for purposes of health insurance requirements, *small groups* are those with 50 or fewer individuals (e.g., employees). However, states can define small groups as having 100 or fewer individuals. The definition of *large group* is 51 or more individuals, or 101 or more individuals, depending on the definition of small group. Groups of any size may self-insure, and federal requirements on self-insured plans generally do not depend on group size.

[192] The individual exchanges and small business health options program (SHOP) exchanges are virtual marketplaces in which consumers and small businesses, respectively, can shop for and purchase private health insurance coverage. Plans sold in the individual and SHOP exchanges have to meet all the requirements applicable to the nongroup and small-group markets, respectively. Additional requirements apply only to exchange plans. See CRS Report R44065, *Overview of Health Insurance Exchanges* for more information on these federally- and state-run marketplaces, and the private health insurance plans (qualified health plans) sold in them.

[193] In this section, references to "plans" include applicable group health plans and insurers. For more information about federal and state regulation of different types of plans, see the "Background" section of CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[194] States play a central role in the regulation of private health insurance, and they may enact their own requirements on nongroup and/or fully insured group plans.

[195] The ACA was enacted on March 23, 2010. For more information about grandfathered plans, as well as certain other types of plans that do not have to comply with some or all federal health insurance requirements, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

Plans may voluntarily cover benefits, subject to applicable federal and state laws. This includes providing coverage that exceeds federal or state requirements, or providing coverage where there is no requirement to do so, as long as there is no prohibition on such coverage.

Does Federal Law Require Private Health Insurance Coverage of Reproductive Health Services?

Various federal laws address private health insurance coverage of different types of reproductive health services. (For background on this term, see the "What Are Reproductive Health Services?" section of this report.)

Two federal requirements—coverage of essential health benefits (EHBs) and coverage of certain preventive services without cost sharing—are applicable to multiple types of reproductive health services.[196] These provisions, along with other federal requirements applicable to specific types of reproductive health services, are discussed below.

Where there is a benefit coverage requirement, one or more details may be specified. For example, coverage requirements may or may not specify any *cost-sharing* requirements or limitations. In general, private health insurance cost sharing includes deductibles, coinsurance, and copayments, up to annual out-of-pocket limits.[197] Coverage requirements may depend on how or where the service or item is furnished (e.g., by an *in-network* versus *out-of-network* provider).[198] Coverage requirements may also specify whether plans are allowed to impose medical management requirements, such as prior authorization requirements.[199] To the extent that a reproductive health benefit coverage requirement specifies one or more of these details, they are discussed below and summarized in **Table A-1**.

Overview: Coverage of the Essential Health Benefits (EHB)

The ACA requires certain plans to offer a core package of 10 categories of health care services, known as the *essential health benefits* (EHB).[200] However, states, rather than the federal government, generally specify the benefit coverage requirements within those categories. Current

[196] The provisions described here have some direct relevance to coverage of reproductive health services, among other services. Other federal requirements on private health insurance may also be more generally related to coverage of reproductive health services. For example, the requirement to cover pre-existing health conditions could be relevant to an enrollee who has pre-existing reproductive health conditions. For more information about provisions not discussed in this report, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[197] In general, beginning with each plan year, an enrollee pays 100% of costs for covered health care benefits until the costs meet a certain threshold amount, called a *deductible*. Exceptions apply. After reaching the deductible, the enrollee pays *coinsurance* (a percentage amount) or *co-payments* (a flat amount) for covered benefits and the plan pays the rest. If an enrollee's spending meets an *annual out-of-pocket limit*, the plan generally will pay 100% of covered costs for the remainder of the plan year. For more information, see CRS Report R47507, *Private Health Insurance: A Primer*, section on "Cost-Sharing Requirements."

[198] Under private insurance, benefit coverage and enrollee cost sharing are often contingent upon whether the service or item is furnished by a provider that the insurer has contracted with (i.e., whether that provider is in network for a given plan). In instances where a contract between an insurer and provider does not exist, the provider is considered out of network. For more information, see CRS Report R47507, *Private Health Insurance: A Primer*, section on "Provider Networks."

[199] In general, medical management requirements include different types of standards or processes through which plans aim to ensure appropriate use of covered benefits and to control costs. For example, some plans require enrollees to obtain prior authorization from the plan, or approval of benefit coverage before receiving care, as a condition of covering specified benefits. See CRS Report R47507, *Private Health Insurance: A Primer*, section on "Covered Benefits."

[200] 42 U.S.C. §300gg-6 and 42 U.S.C. §18022.

regulation allows each state to select an EHB "benchmark plan." The benchmark plan serves as a reference plan for applicable plans in that state, which must provide EHB coverage that is "substantially equal" to such coverage in the benchmark plan, as specified in regulations. Because states select their own EHB-benchmark plans, EHB coverage varies considerably from state to state.[201]

EHB categories particularly relevant to reproductive health services include "maternity and newborn care" (further discussed in the maternity services question in this section) and "preventive and wellness services and chronic disease management" (which incorporates the preventive services provision discussed below). Other EHB categories may also include benefits relevant to reproductive health.[202]

Cost-sharing and medical management requirements are possible for most categories of EHB, subject to applicable federal and state requirements. Federal requirements limit cost sharing on the EHB.[203] Coverage and cost sharing for EHB services furnished by out-of-network providers may vary.

All nongrandfathered nongroup and small-group plans are required to cover the EHB.

Overview: Coverage of Certain Preventive Services Without Cost Sharing

The ACA, via Section 2713 of the PHSA, also requires most plans to cover specified preventive services and items without cost sharing, "such as a copayment, coinsurance, or a deductible."[204] This includes, at a minimum, four categories of statutorily required coverage:

1. evidence-based items or services recommended with an A or B rating by the USPSTF;[205]
2. immunizations with a recommendation by the Advisory Committee on Immunization Practices (ACIP), adopted by CDC, for routine use for a given individual;[206]
3. additional evidence-informed preventive care and screenings for infants, children, and adolescents as recommended in guidelines supported by the Health Resources and Services Administration (HRSA);[207] and

[201] For more information on the process for defining the essential health benefits (EHB) in each state, as well as each state's benchmark plan, see CMS, CCIIO, "Information on Essential Health Benefits (EHB) Benchmark Plans," at https://www.cms.gov/cciio/resources/data-resources/ehb.

[202] The 10 categories of EHB are (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) prescription 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.

[203] See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, regarding several federal requirements relevant to consumer cost sharing on the EHB (e.g., maximum annual limitation on cost-sharing, minimum actuarial value requirements, and prohibition on lifetime and annual coverage limits).

[204] 42 U.S.C. §300gg-13; 45 C.F.R. §147.130.

[205] United States Preventive Services Task Force (USPSTF), "A & B Recommendations," at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

[206] Advisory Committee on Immunization Practices (ACIP), "ACIP Vaccine Recommendations and Guidelines: Vaccine-Specific Recommendations," at https://www.cdc.gov/acip-recs/hcp/vaccine-specific/. Also see CDC, "Immunization Schedules," at https://www.cdc.gov/vaccines/hcp/imz-schedules/. Per 45 C.F.R. §147.130(a)(1)(ii), an immunization recommendation is considered to be "for routine use" if it is listed on the CDC Immunization Schedules.

[207] Health Resources and Services Administration (HRSA), "Bright Futures," at https://mchb.hrsa.gov/programs-
(continued...)

4. additional preventive care and screenings for women as recommended in guidelines supported by HRSA. [208]

Examples of reproductive health preventive services and items in these four categories include (1) screening and counseling for STIs; (2) universal HIV screening; (3) breast cancer screening, genetic testing, and preventive medications such as Tamoxifen (to lower the risk of developing breast cancer among women with specified risk factors); (4) gynecological exams and Pap smears; (5) well-woman visits; (6) a variety of prenatal care services; and (7) contraception.[209] These services are further discussed under the relevant questions in this section.

If there are changes in recommendations or guidelines in any of these categories (e.g., the USPSTF announces a new A or B rating), plans generally are required to provide relevant coverage as of plan years that begin on or after the date that is one year after the change.[210]

Plans are also required to cover, without cost sharing, items and services that are "integral to the furnishing of a recommended preventive service, regardless of whether the item or service is billed separately."[211] See the questions in this section on contraceptive coverage and reproductive health prevention and treatment services for examples of this.[212] Different rules apply with regard to cost-sharing for office visit charges.[213]

As specified in regulations and guidelines, plans are able to use "reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service," to the extent not specified in the relevant recommendation.[214] The aforementioned two questions in this section also have examples of this.

By regulation, plans are generally not required to cover preventive services furnished out of network.[215] However, if the plan does not have an in-network provider who can furnish a recommended preventive service, the plan must provide coverage without cost-sharing when such service is furnished by an out-of-network provider.

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impact/bright-futures. See linked "Periodicity Schedule." HRSA has a cooperative agreement with the American Academy of Pediatrics (AAP) to update and make new recommendations on pediatric preventive services. The AAP convenes a panel of experts for this purpose. HRSA reviews and determines whether to adopt these recommendations.

[208] HRSA, "Women's Preventive Services Guidelines," https://www.hrsa.gov/womens-guidelines. Also see Women's WPSI, "Recommendations," at https://www.womenspreventivehealth.org/recommendations/. HRSA has a cooperative agreement with the American College of Obstetricians & Gynecologists (ACOG) to update and make new recommendations per the Women's Preventive Services Guidelines. In turn, ACOG has convened the WPSI, a "coalition of national health professional organizations and patient advocates with expertise in women's health," for this purpose. HRSA reviews and determines whether to adopt WPSI's recommendations. For additional background, see WPSI, "About WPSI," 2024, at https://www.womenspreventivehealth.org/about-wpsi/.

[209] The preventive services that must be covered are listed in their entirety at Healthcare.gov, "Preventive health services," https://www.healthcare.gov/preventive-care-benefits/.

[210] 45 C.F.R. §147.130(b).

[211] Departments of Labor, HHS, and the Treasury, "FAQs about Affordable Care Act Implementation Part 64," January 22, 2024, at https://www.cms.gov/files/document/faqs-part-64.pdf (hereinafter referred to as "ACA FAQ 64, January 2024"). See page 2, including footnote 8.

[212] See "Does Federal Law Require Private Health Insurance Coverage of Contraceptive Services?" and "Does Federal Law Require Private Health Insurance Coverage of Reproductive Health Screening, Prevention, and Treatment Services?" in this report.

[213] 45 C.F.R. §147.130(a)(2). In general, whether cost sharing for office visits is allowed or prohibited depends on whether the preventive service or item was the primary purpose of the visit, and whether the service or item was billed or tracked separately from the office visit.

[214] 45 C.F.R. §147.130(a)(4).

[215] 45 C.F.R. §147.130(a)(3).

The requirement to cover specified preventive services without cost sharing is incorporated into the EHB category "preventive and wellness services and chronic disease management."[216] These incorporated benefits are the only EHB that are federally required to be covered without cost sharing.

The preventive services coverage requirement does not apply *only* to plans subject to the EHB requirements; rather, it generally applies to nongrandfathered large-group, small-group, self-insured, and nongroup plans, unless a particular employer or insurer qualifies for an exemption set out in federal regulations.[217]

Additionally, some entities subject to the requirement have sued HHS and obtained judicial injunctions that bar the federal government from enforcing particular parts of the coverage requirement with respect to those entities.[218] For example, in June 2024, the U.S. Court of Appeals for the Fifth Circuit ruled that a for-profit corporation, a professional association, and a group of individual plaintiffs need not comply with coverage requirements stemming from the category of USPSTF-recommended items and services.[219] The court reasoned that an injunction was appropriate because members of the USPSTF were unconstitutionally appointed.[220]

ACA Section 1557

As stated earlier in this report, ACA Section 1557 applies various antidiscrimination requirements to "health programs or activities" that receive federal financial assistance, as specified.[221] There have been questions about the applicability of this provision to different types of private health insurance plans, and whether the provision requires coverage of certain benefits, such as abortion, infertility treatments, or gender-affirming care. ACA Section 1557 is generally beyond the scope of this report, but other CRS products provide overviews of the provision and its recent and prior rulemaking, including implications for private health insurance coverage.[222]

Does Federal Law Require Private Health Insurance Coverage of Contraceptive Services?

One of the required categories of preventive services coverage without cost-sharing is the services and items recommended per HRSA-supported guidelines on women's preventive health care services.[223] Since 2011, these Women's Preventive Services Guidelines have included contraception.[224]

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[216] 45 C.F.R. §156.115(a)(4), referencing 45 C.F.R. §147.130.

[217] 42 U.S.C. §300gg-13; 45 C.F.R. §147.130-133. See "Are There Exemptions for the Federal Contraceptive Coverage Requirement?" below for further discussion of exemptions provided in regulations.

[218] For example, Mar. for Life v. Burwell, 128 F. Supp. 3d 116, 134 (D.D.C. 2015).

[219] Braidwood Mgmt., Inc. v. Becerra, 104 F.4th 930, 957 (5th Cir. 2024), *petition for cert. filed*, No. 24-316 (U.S. Sept. 19, 2024).

[220] *Id.* at 935. Legislative attorneys in CRS's American Law Division are available to discuss the *Braidwood* litigation and its potential consequences related to the preventive services coverage requirement.

[221] 42 U.S.C. §18116. See text box "Section 1557 of the Patient Protection and Affordable Care Act (ACA)" in "What Are Gender-Affirming Services?" section of this report.

[222] CRS Legal Sidebar LSB11169, *HHS Finalizes Rule Addressing Section 1557 of the ACA's Incorporation of Title IX*.

[223] 42 U.S.C. §300gg-13(a)(4). See the "Overview: Coverage of Certain Preventive Services Without Cost Sharing" section of this report.

[224] HRSA, "Women's Preventive Services Guidelines," initially released August 1, 2011, at https://www.hrsa.gov/womens-guidelines-historical-files.

Preventive Services Requirement: Women's Preventive Services Guidelines on Contraception

The current Guidelines on contraception, updated December 2021, recommend that "adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve birth outcomes," including screening, education, counseling, provision of contraceptives, and follow-up care, including management and removal.[225] In addition, the current Guidelines on contraception recommend "that the full range of U.S. Food and Drug Administration (FDA)-approved, -granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care."[226] This is specified to include 17 of the "methods" (i.e., categories) of contraception that are listed in the FDA's Birth Control Guide as of December 2021—including, for example, two categories of IUDs, three categories of oral contraceptives, the contraceptive patch, contraceptive rings, condoms, two categories of emergency contraception, and sterilization surgery for women. The Guidelines also recommend access to "any additional contraceptives approved, granted, or cleared by the FDA," and further provide that "instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method."[227]

Although the FDA Birth Control Guide also includes male sterilization, this is excluded from the Women's Preventive Services Guidelines on contraception because these Guidelines (and the related coverage requirement) are specific to women's preventive health. However, as of December 2021, the Guidelines on contraception for women include male condoms, in addition to female condoms.[228]

Preventive Services Requirement: Contraceptive Coverage

Through rulemaking and guidance, the Departments of Labor, HHS, and the Treasury have confirmed that applicable nonexempt[229] plans must

> (1) cover without cost sharing at least one form of contraception in each of the categories listed in the HRSA-supported Guidelines; and (2) cover without cost sharing any contraceptive services and FDA-approved, -cleared, or -granted products that an individual and their attending provider have determined to be medically appropriate for the individual, whether or not those services or products are specifically identified in the categories listed in the HRSA-supported Guidelines. The latter requirement extends to newer contraceptive

[225] HRSA, "Women's Preventive Services Guidelines," page last reviewed March 2024, at https://www.hrsa.gov/womens-guidelines. Also see WPSI, "Contraception," at https://www.womenspreventivehealth.org/recommendations/contraception/, and its linked "Evidence Review: Contraception," December 2021.

[226] Ibid.

[227] Ibid. Per the current Women's Preventive Services Guidelines, "The full range of contraceptives currently includes those listed in the FDA's Birth Control Guide: (1) sterilization surgery for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), (7) oral contraceptives (progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel), and (17) emergency contraception (ulipristal acetate); and any additional contraceptives approved, granted, or cleared by the FDA." For more information on the FDA Birth Control Guide, see the "What Are Contraceptive Services?" section in this report.

[228] Departments of Labor, HHS, and the Treasury, "FAQs about Affordable Care Act Implementation Part 54," July 28, 2022, at https://www.cms.gov/files/document/faqs-part-54.pdf (hereinafter referred to as "ACA FAQ 54, July 2022"). See footnote 16.

[229] See the "Are There Exemptions for the Federal Contraceptive Coverage Requirement?" section in this report.

> products as they are approved, cleared, or granted by the FDA, whether or not such products are identified in the categories listed in the current HRSA-supported Guidelines.[230]

Subject to regulations and guidance, plans are allowed to impose "reasonable medical management" coverage limitations within each category of contraception, as long as they do not restrict access to a category altogether. However, plans' coverage limitations are only considered "reasonable" if they make coverage exceptions for medical necessity, as specified in the inset text above, and if they include "an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome."[231]

As stated in the earlier overview of the preventive services coverage requirement, applicable plans must cover, without cost-sharing, services and items that are integral to the furnishing of a recommended preventive service. With respect to contraception, this includes, for example, pregnancy tests before the provision of contraception and anesthesia for a tubal ligation.[232]

Per additional guidance on contraceptive coverage, applicable plans are *required* to provide coverage without cost-sharing of emergency contraception that is available over-the-counter (OTC), "when the product is prescribed for an individual by their attending provider," including for advance provision. Plans are also *encouraged* to cover without cost sharing OTC emergency contraception when purchased without a prescription.[233] Applicable plans are encouraged to cover a 12-month supply of contraceptives, such as oral contraceptives, if dispensed at once.[234]

State Requirements and Additional Data

States play a central role in the regulation of private health insurance, and they may implement their own contraceptive coverage requirements on the plans they regulate.[235] According to analyses by two policy research and stakeholder groups, as of September 2023, at least 30 states and the District of Columbia (DC) require private health insurance coverage of FDA-approved prescription contraceptives if the plan otherwise covers prescription drugs; at least 12 states and DC require coverage of certain OTC contraceptives (although insurers may still require prescriptions); more than 20 states and DC require insurers to cover an extended supply of contraception when dispensed at once; and at least nine states require coverage of male sterilization. At least 20 states and DC provide contraceptive coverage exemptions for certain employers and insurers.[236]

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[230] ACA FAQ 64, January 2024, page 4. This FAQ also summarizes prior rulemaking and guidance on contraceptive coverage.

[231] ACA FAQ 64, January 2024, page 4. Also see this FAQ for discussion of reasonable and "potentially unreasonable" medical management techniques with respect to contraceptive coverage. In addition, see Questions 1-5 of this FAQ for a new "therapeutic equivalence" approach to contraceptive coverage that plans may choose to adopt.

[232] ACA FAQ 54, July 2022, question 1.

[233] ACA FAQ 54, July 2022, question 5. Also in this FAQ, per footnote 16, condoms (another type of OTC contraception) must be covered "with a prescription."

[234] ACA FAQ 54, July 2022, question 7.

[235] In general, states may regulate nongroup plans and fully insured group plans but not self-insured group plans. See the introduction to this section of this report.

[236] Guttmacher Institute, "Insurance Coverage of Contraceptives," September 1, 2023, at https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives. The Guttmacher Institute is a policy research organization focused on access to reproductive health services. See also National Conference of State Legislatures (NCSL), "State Contraception Policies," September 7, 2023, at https://www.ncsl.org/health/state-contraception-policies.

Are There Exemptions for the Federal Contraceptive Coverage Requirement?

The ACA's implementing regulations initially exempted only houses of worship and similar religious orders from the contraceptive coverage requirement (i.e., with regard to the health plans they offer to their employees).[237] Litigation and court rulings prompted a series of revised rules expanding upon these exemptions.[238] As of the date of this report, exemptions are available to most types of nonprofit and for-profit entities with sincerely held religious or moral beliefs against contraception.[239]

The current exemptions stem from two rules finalized in November 2018—one for exemptions based on religious exemptions and the other for exemptions based on moral convictions.[240] The rules essentially allow objecting employers to choose between two options. They may decline to cover the forms of contraception to which they object, in which case their employees would not receive coverage for such services through the employer's plan. Alternatively, objecting employers can utilize a previously established accommodation process that shifts the responsibility to provide contraceptive coverage to an insurer or third-party administrator, so long as that entity does not also qualify for and invoke the exemption.

A number of states challenged the 2018 rules on various legal grounds. In 2020, the Supreme Court upheld the rules, holding that the ACA authorized HHS to adopt them.[241] While some lawsuits challenging the rules are still pending in the lower courts, those cases were stayed after HHS indicated its intent to amend the 2018 rules.[242] A proposed rule published on February 2, 2023, if finalized, would rescind the moral exemption rule and revise the rule pertaining to religious exemptions.[243]

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[237] Departments of Labor, HHS, and the Treasury, "Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act," 76 *Federal Register* 46621, August 3, 2011, at https://www.federalregister.gov/documents/2011/08/03/2011-19684/group-health-plans-and-health-insurance-issuers-relating-to-coverage-of-preventive-services-under.

[238] See Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 591 U.S. 657, 663–73 (2020) (discussing iterations of the federal contraceptive coverage rules and relevant litigation).

[239] Questions from congressional clients regarding legal issues addressed in this section may be directed to Victoria L. Killion, CRS Legislative Attorney, who contributed to this section.

[240] Departments of Labor, HHS, and the Treasury, "Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act," 83 *Federal Register* 57536, November 15, 2018, at https://www.federalregister.gov/documents/2018/11/15/2018-24512/religious-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the. Departments of Labor, HHS, and the Treasury, "Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act," 83 *Federal Register* 57592, November 15, 2018, at https://www.federalregister.gov/documents/2018/11/15/2018-24514/moral-exemptions-and-accommodations-for-coverage-of-certain-preventive-services-under-the-affordable. See also Henry J. Kaiser Family Foundation, "New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women," November 19, 2018, https://www.kff.org/health-reform/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/.

[241] Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania, 140 S. Ct. 2367, 2382 (2020).

[242] See Order, Massachusetts v. HHS, No. 21-1076 (1st Cir. Aug 1, 2024) (holding appeal in abeyance for an additional 90 days); Order, Pennsylvania v. Biden, No. 2:17-cv-04540 (E.D. Pa. Jan. 3, 2022) (further staying the case and directing the federal government to file status reports every 90 days); California v. Becerra, No. 4:17-cv-05783 (N.D. Cal. May 31, 2024) (further staying the case and directing the parties to file a joint status report every four months).

[243] Coverage of Certain Preventive Services Under the Affordable Care Act, 88 Fed. Reg. 7236 (2023) (proposed rule).

Does Federal Law Require Private Health Insurance Coverage of Abortions or Abortion Counseling?

Federal law does not generally *require* or *prohibit* private health insurance coverage of abortion services. However, per the Pregnancy Discrimination Act of 1978 (PDA; P.L. 95-555), applicable employers that provide health coverage to their employees must ensure coverage for abortion in cases of life endangerment or medical complications, as specified.[244]

There are federal provisions addressing abortion coverage by private health insurance plans, including qualified health plans (QHPs), which are private health insurance plans certified to meet relevant requirements to be sold in the health insurance exchanges.[245] For example, the ACA specifies that none of its provisions "shall be construed" to require a QHP to cover abortion.[246]

In addition, while federal EHB provisions generally require nongroup and small-group plans (including QHPs) to provide coverage substantially equal to a state's selected EHB benchmark plan, there is an exception for abortion. In other words, even if a state selects an EHB benchmark plan that covers abortion services, applicable plans are not *federally* required to cover abortion, in order to meet EHB standards.[247]

State Requirements and Additional Data

States play a central role in the regulation of private health insurance, and they may implement their own abortion coverage requirements on the plans they regulate.[248] The ACA also specifies that states are allowed to prohibit abortion coverage by QHPs offered in their exchange.[249] Furthermore, federal provisions regarding abortion coverage do not preempt any state laws "regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions."[250] This means that beyond the issues discussed above, states are able to prohibit or require abortion coverage by any or all of the plans they regulate. Regarding the EHB example above, even though plans may not be federally required to cover abortion services, there may be applicable state requirements.

According to a Kaiser Family Foundation (KFF) analysis updated in July 2024, 25 states have prohibited QHPs from covering abortion, with certain exceptions. Ten of these states also prohibit other state-regulated private health insurance plans from covering abortion, with certain exceptions.[251] Per this analysis, "some states may allow abortion coverage to be purchased as a

[244] See 42 U.S.C. §2000e(k), including: "This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: *Provided,* That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion." For more information about the Pregnancy Discrimination Act of 1978, see "Does Federal Law Require Private Health Insurance Coverage of Maternity Services?"

[245] For more information on the exchanges and qualified health plans (QHPs), see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[246] 42 U.S.C. §18023(b).

[247] 45 C.F.R. §156.115(c). Also see the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report.

[248] In general, states may regulate nongroup plans and fully insured group plans but not self-insured group plans. See the introduction to this section of this report.

[249] 42 U.S.C. §18023(a).

[250] 42 U.S.C. §18023(c).

[251] KFF, "Interactive: How State Policies Shape Access to Abortion Coverage," updated July 22, 2024, at (continued...)

rider" (i.e., a separate policy). Conversely, 10 states require private health insurance plans, including QHPs, to include abortion coverage. The remaining 16 states do not require or limit private health insurance abortion coverage.

Data on private health insurance coverage of abortion may include plans subject to applicable requirements as well as plans providing coverage voluntarily. According to a KFF analysis of abortion coverage in the largest health plan offered by employers with 200 or more employees in 2023, 10% of such plans did not provide any abortion coverage, 18% provided coverage "under limited circumstances," 32% provided coverage "in most or all circumstances," and 40% of the respondents "do not know if their largest plan covers abortions, part of which could be attributed to lack of information about coverage for abortion in plan documents unless abortion is explicitly excluded."[252]

Can Federal Funds Be Used to Pay for Abortion in Private Health Insurance Plans?

There are restrictions related to the use of federal funds that reduce the cost of private health insurance coverage in the individual health insurance exchanges.

Certain consumers purchasing QHP coverage in the individual exchanges are eligible to receive premium tax credits (PTCs) from the federal government that effectively reduce the cost of specified plans. As discussed earlier in this report, there are limitations on the use of federal funds for certain abortion services.[253]

Under the ACA, individuals who receive a PTC are permitted to select a QHP that includes coverage for nontherapeutic or elective abortions. However, the issuer of such a plan cannot use any funds attributable to the tax credit to pay for such services.[254] The issuer is required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of health services other than elective abortions, and another payment that reflects an amount equal to the actuarial value of the coverage for elective abortions.[255] The issuer is required to deposit the separate payments into separate allocation accounts that consist solely of each type of payment and that are used exclusively to pay for the specified services.[256] State health insurance commissioners ensure compliance with the

https://www.kff.org/womens-health-policy/issue-brief/interactive-how-state-policies-shape-access-to-abortion-coverage/.

[252] KFF, "Coverage of Abortion in Large Employer-Sponsored Plans in 2023," February 29, 2024, at https://www.kff.org/womens-health-policy/issue-brief/coverage-of-abortion-in-large-employer-sponsored-plans-in-2023/. See Table 1 in this article for additional data by firm size, firm ownership (e.g., private or public) and region, and plan funding (e.g., self-insured or fully-insured). The article also briefly discusses changes in coverage since the *Dobbs* decision, and employer-provided financial assistance for travel out of state to obtain an abortion. For survey design and methods, see KFF, 2023 Employer Health Benefits Survey, October 2023, at https://www.kff.org/report-section/ehbs-2023-survey-design-and-methods/.

[253] See the "Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?" introductory section of this report. For more information on PTCs, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[254] 42 U.S.C. §18023(b)(2)(A) and 45 C.F.R. §156.280(e)(1).

[255] 42 U.S.C. §18023(b)(2)(B)(i); also see 45 C.F.R. §156.280(e)(2)(i) and (ii). See 42 U.S.C. §18023(b)(2)(D) and 45 C.F.R. §156.280(e)(4) regarding actuarial value estimates. Through rulemaking, different Administrations have taken varied approaches to implementing this requirement. The most recent such rule, which also discusses prior rulemaking, is HHS, "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond," 86 *Federal Register* 53412, September 27, 2021, starting at page 53447, regarding 45 C.F.R. §156.280.

[256] 42 U.S.C. §18023(b)(2)(B)(ii) and (b)(2)(C), as well as 45 C.F.R. §156.280(e)(2)(iii) and (e)(3).

segregation requirements in accordance with applicable provisions of generally accepted accounting requirements, Office of Management and Budget (OMB) circulars on funds management, and Government Accountability Office (GAO) guidance on accounting.[257]

Does Federal Law Require Private Health Insurance Coverage of Infertility Services?

No federal law specifically addresses private health insurance coverage of infertility services. However, the requirement that certain plans cover 10 categories of EHB may be relevant, depending on state implementation.[258] If a state selects an EHB benchmark plan that includes infertility services in one or more EHB categories, then applicable plans in that state must provide coverage substantially equal to the benchmark plan's coverage. EHB requirements apply to nongrandfathered plans in the nongroup and small-group markets.

State Requirements and Additional Data

States play a central role in the regulation of private health insurance, and they may implement their own infertility services coverage requirements on the plans they regulate.[259] Per an analysis by a fertility treatment stakeholder group, at least 21 states and DC have enacted requirements on private health insurance coverage of infertility services, as of late 2023.[260] These state laws vary widely in terms of their particular coverage requirements. For example, some of the laws are specific to coverage of fertility preservation services (e.g., before a covered medical treatment that could result in infertility), some generally require coverage of infertility treatments but do not mandate IVF coverage, and some require coverage of IVF and other ART services, to varying degrees. The state laws also vary terms of their applicability to (and exceptions for) different types of state-regulated plans, and their approaches to defining infertility and otherwise defining any patient requirements for coverage.

Data on private health insurance coverage of infertility services may include plans subject to applicable requirements as well as plans providing coverage voluntarily. The consulting firm Mercer fields an annual survey of employer-sponsored health plans in the United States.[261] According to its 2023 report, "Seven out of ten employers now cover some type of fertility service." As of 2023, 66% of employers with more than 500 employees provide coverage of fertility evaluation and diagnostic services, 45% of such employers provide coverage of IVF, and 19% provide coverage of elective egg freezing. Coverage limits and cost-sharing requirements may vary across these plans, subject to applicable federal or state requirements. Per Mercer, "The majority of employers that offer fertility benefits (61 percent) say that the benefits are intended to

[257] 42 U.S.C. §18023(b)(2)(E)(i) and 45 C.F.R. §156.280(e)(5).

[258] See the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report.

[259] In general, states may regulate nongroup plans and fully insured group plans but not self-insured group plans. See the introduction to this section of this report.

[260] Resolve, "Insurance Coverage by State," updated June 17, 2024, at https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/.

[261] Mercer, "National Survey of Employer-Sponsored Health Plans: 2023 Survey Report," March 2024, available for purchase at https://shop.mercer.com/catalog/national-survey-of-employer-sponsored-health-plans.html. Hereinafter referred to as "Mercer 2023 Survey Report, March 2024." According to Mercer, its "survey results have been weighted using employer size and geographic stratification to represent all employer health plan sponsors across the US with 50 or more employees. These organizations employ about 123 million full- and part-time employees." In some cases, the data are specified as applicable to employers with more than 500 or 5,000 employees.

be inclusive—in other words, eligibility is not limited to women who meet the clinical definition of infertile."

Per CRS analysis of 2024 QHP benefit coverage, there are QHPs providing infertility coverage in half of the 32 states that use the federal exchange platform Healthcare.gov. This includes three states in which fewer than half of QHPs and four states in which more than half of QHPs provide such coverage, and nine states in which all QHPs provide such coverage.[262] There are state requirements on infertility coverage in at least five of these nine Healthcare.gov states in which all QHPs provide some infertility coverage.[263]

Does Federal Law Require Private Health Insurance Coverage of Maternity Services?

There are several federal requirements relevant to private health insurance coverage of maternity services.

EHB and Preventive Services Requirements: Maternity Services

One of the categories of required EHB coverage is "maternity and newborn care."[264] This means that nongrandfathered plans in the nongroup and small-group markets must provide coverage of maternity and newborn care services substantially equal to such coverage provided by the state's EHB benchmark plan. The same is true of other EHB categories, some of which may also include services relevant to maternity care.

In addition, the preventive services provision described above includes the requirement for applicable plans to cover, without cost sharing, certain prenatal and postpartum services, as recommended.[265] For example, the recommendation on "well-woman preventive visits" includes pre-pregnancy, prenatal, postpartum, and interpregnancy visits at which relevant recommended preventive services and items can be provided.[266] There are also multiple recommendations on preventive services as specified for pregnant and postpartum individuals, including certain STI screenings, mental health and substance use screening and counseling, gestational diabetes

[262] CRS analysis of the CMS 2024 Exchange Public Use File (PUF) Datasets, "Benefits and Cost Sharing PUF" and "Plan Attributes PUF," updated April 30, 2024, at https://www.cms.gov/marketplace/resources/data/public-use-files. These files provide data on covered benefits and other plan features for the qualified health plans (QHPs) and certain other plans offered on the health insurance exchanges in the 32 states that utilize the federal platform Healthcare.gov. The files do not include the 19 state-based exchanges. For this analysis, CRS focused on "standard, on-exchange" plan variants (plan IDs ending in -01) on the individual exchanges. This included different "metal level" plans as well as catastrophic plans; it did not include any "child-only" plans. Plans included in the analysis may cover a whole state or only certain areas within a state. CRS identified plans that indicated coverage of benefit name "infertility treatment," but additional analysis would be necessary to identify variations in coverage details. For background on the exchanges and QHPs, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

[263] This is per CRS cross-reference of the resource discussed above in this section, on states with requirements on private health insurance coverage of infertility services. CRS did not further search for other state requirements that may be applicable.

[264] See the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report.

[265] See the "Overview: Coverage of Certain Preventive Services Without Cost Sharing" section of this report.

[266] Women's Preventive Services Initiative, "Well-Woman Preventive Visits," updated 2022, at https://www.womenspreventivehealth.org/recommendations/well-woman-preventive-visits/.

screening and healthy weight counseling, folic acid supplements, and breastfeeding services and supplies.[267]

Coverage of Pregnancy-Related Conditions

The Pregnancy Discrimination Act of 1978 (PDA, P.L. 95-555) requires applicable employers offering health insurance to cover "expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions" for employees enrolled in the group plan.[268] If the group plan offers coverage to employees' spouses and dependents, the requirement to cover pregnancy-related services also applies to employees' spouses, but not necessarily to other dependents, enrolled in the plan.[269]

There do not appear to be specific requirements related to cost sharing, out-of-network coverage, or medical management, other than the requirement that features of the plan related to coverage of pregnancy-related conditions must not be substantially different than they are for other medical conditions. For example, if a plan has an overall deductible, it cannot have a higher deductible for pregnancy-related services. The PDA applies to employers with 15 or more employees, whether the coverage is fully insured or self-insured.[270]

Coverage of Minimum Hospital Stay After Childbirth

The Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204, as amended) prohibits certain plans from restricting the length of a hospital stay for childbirth for either the mother or newborn child to less than 48 hours following vaginal deliveries and to less than 96 hours following caesarian deliveries.[271] In addition, prior authorization requirements for these stays are prohibited. There is an exception to the length-of-coverage requirement when providers make earlier discharge decisions in consultation with mothers. Plans are prohibited from offering incentives or penalties to providers or mothers to encourage shorter stays.

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[267] See footnote 205 through footnote 209 in this report for the preventive services recommendations by USPSTF, HRSA/WPSI, HRSA/Bright Futures, and ACIP. There are multiple recommendations mentioning pregnant and postpartum individuals at the USPSTF and HRSA/WPSI webpages. Certain HRSA/Bright Futures guidelines and ACIP recommendations are also relevant to pregnant and postpartum individuals.

[268] See 42 U.S.C. §2000e; 29 C.F.R. §1604.10, and, including for the language quoted above, 29 C.F.R. §1604, Appendix to Part 1604—Questions and Answers on the Pregnancy Discrimination Act, P.L. 95-555, 92 Stat. 2076 (1978) (hereinafter referred to as "29 C.F.R. §1604 Appendix"). Also see EEOC, "Enforcement Guidance on Pregnancy Discrimination and Related Issues" (particularly the "Health Insurance" section), June 25, 2015, at https://www.eeoc.gov/laws/guidance/enforcement-guidance-pregnancy-discrimination-and-related-issues; and EEOC, "Questions and Answers about the EEOC's Enforcement Guidance on Pregnancy Discrimination and Related Issues" U.S. EEOC, June 25, 2015, at https://www.eeoc.gov/laws/guidance/pregnancy_qa.cfm (hereinafter, "EEOC Enforcement Guidance" and "EEOC Q&A," respectively).

[269] See 29 C.F.R. §1604 Appendix, questions 21-23 regarding coverage of pregnancy-related conditions for spouses and dependents. Also note that other federal requirements are relevant to employers' offer of coverage for dependents. For example, most plans that offer dependent coverage are required to make that coverage available for both married and unmarried adult children under the age of 26 (42 U.S.C. §300gg-14). In addition, the employer shared-responsibility provisions generally incentivize large employers to offer adequate and affordable health insurance coverage to their full-time employees and full-time employees' children under the age of 26 (26 U.S.C. §4980H). Separately, note that the requirements to cover EHB, and to cover certain preventive services without cost sharing apply to all enrollees in a plan, including spouses and dependents. See 45 C.F.R. §156.115(a)(2) and Question 6 of Departments of Labor, HHS, and the Treasury, "FAQs About Affordable Care Act Implementation (Part XXVI)," May 11, 2015, at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf (hereinafter referred to as "ACA FAQ XXVI, May 2015").

[270] EEOC Q&A.

[271] 42 U.S.C. §300gg-25; 45 C.F.R. §146.130.

Cost sharing is allowed, as long as the cost sharing for the portions of hospital stays addressed by this law (those following deliveries) is not greater than cost sharing for preceding portions of such stays. The law does not specify whether its requirements apply out-of-network.

The law generally applies to nongroup, small-group, large-group, and self-insured plans that cover maternity-related hospital stays, regardless of grandfathered status. The law's hospital stay requirements do not apply when a state has its own law (meeting specified requirements) about such hospital stays.

State Requirements

States play a central role in the regulation of private health insurance, and they may implement their own maternity services coverage requirements on the plans they regulate.[272] The National Conference of State Legislatures (NCSL) has several state law databases that can be searched for particular topics of interest, including health insurance requirements on maternity coverage (among other benefits).[273] For example, searches in their "Health Costs, Coverage, and Delivery State Legislation" database for keywords including "maternity," "birth," and "postpartum," filtered for "market," return various results.

Does Federal Law Require Private Health Insurance Coverage of Reproductive Health Screening, Prevention, and Treatment Services?

There are certain federal requirements relevant to private health insurance coverage of reproductive health screening, prevention, and treatment services.

Preventive Services and EHB Requirements: Screening, Prevention, and Treatment Services

The preventive services provision includes the requirement for applicable plans to cover, without cost sharing, certain reproductive health screening and preventive services and items, as recommended.[274] This includes, for example, screening and counseling for STIs/STDs; universal HIV screening; PrEP medication for persons at high risk of HIV acquisition; well-woman visits; breast cancer screening, genetic testing, and preventive medications such as Tamoxifen (to lower the risk of developing breast cancer among women with specified risk factors); gynecological exams, Pap smears, and cervical cancer screenings; colorectal cancer screenings; and the HPV vaccine.[275]

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[272] In general, states may regulate nongroup plans and fully insured group plans but not self-insured group plans. See the introduction to this section of this report.

[273] See, for example, National Conference of State Legislatures (NCSL), "Health Costs, Coverage, and Delivery State Legislation," 2022-present, at https://www.ncsl.org/health/health-costs-coverage-and-delivery-state-legislation. Also see NCSL, "Health Innovations State Law Archives Database, 2015-2021," at https://www.ncsl.org/health/health-innovations-state-law-archive-database-2015-2021, and NCSL, "Maternal and Child Health Legislative Database," 2017-present, at https://www.ncsl.org/health/maternal-and-child-health-legislative-database.

[274] See the "Overview: Coverage of Certain Preventive Services Without Cost Sharing" section of this report.

[275] See footnote 205 through footnote 209 in this report for the preventive services recommendations by USPSTF, HRSA/WPSI, HRSA/Bright Futures, and ACIP. There are multiple recommendations relevant to reproductive health screening and prevention services (e.g., screenings and counseling for STIs/STDs) at the USPSTF and HRSA/WPSI webpages. Certain HRSA/Bright Futures guidelines and ACIP recommendations are also relevant.

As stated in the overview of the preventive services provision, plans are required to cover, without cost sharing, items and services that are "integral to the furnishing of a recommended preventive service, regardless of whether the item or service is billed separately." Agency guidance has clarified that this includes coverage of ancillary services such as blood testing recommended to monitor one's health status while on PrEP, and coverage of "polyp removal during or anesthesia provided in connection with a preventive screening colonoscopy," among other examples.[276]

Plans are required to provide coverage of the recommended *preventive* services and items, *as specified* in relevant recommendations. For example, the USPSTF gives an "A" rating for cervical cancer screenings every three years for asymptomatic women aged 21 to 29, and every three to five years for asymptomatic women aged 30 to 65 years, using different specified methods.[277] Plans must provide coverage accordingly, but otherwise may use "reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service."[278] If someone needs a *diagnostic* cervical cancer test based on the presence of relevant symptoms, or otherwise seeks a test outside of the recommendation, the plan may provide coverage (with or without cost-sharing), subject to any other applicable requirements.

Similarly, if a recommended preventive screening results in a diagnosis of a condition such as an STI or reproductive cancer, no federal laws specifically mandate coverage of relevant *treatment* services. However, treatments for various conditions may be covered under different EHB categories in the benchmark plans selected by states, which would require applicable plans to cover such treatments.[279]

Coverage of Reconstruction after Mastectomy

The Women's Health and Cancer Rights Act of 1998 (P.L. 105-277, as amended) states that if plans provide coverage for mastectomies, they must also cover breast reconstruction services and prostheses.[280] Cost sharing is allowed if consistent with cost sharing for other covered medical/surgical benefits. Federal guidance has provided that this coverage requirement is applicable to female and male enrollees, and the mastectomy does not need to have been connected to a cancer diagnosis.[281] The requirement applies to nongroup, small-group, large-group, and self-insured plans, regardless of grandfathered status.

State Requirements

States play a central role in the regulation of private health insurance, and they may implement their own reproductive health screening and prevention (and treatment) services coverage

[276] Departments of Labor, HHS, and the Treasury, "FAQs About Affordable Care Act Implementation Part 47," July 19, 2021, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-47.pdf. Also see ACA FAQ 54, July 2022. See question 1 in both documents.

[277] USPSTF, "Cervical Cancer: Screening," August 21, 2018, at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening.

[278] 45 C.F.R. §147.130(a)(4).

[279] See the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report.

[280] 29 U.S.C. §1185b, 42 U.S.C. §300gg-27, and 42 U.S.C. §300gg-52.

[281] See Employee Benefits Security Administration, "Compliance Assistance Guide: Health Benefits Coverage Under Federal Law…." September 2014, at https://www.dol.gov/general/topic/health-plans/womens. See Departments of Labor, HHS, and the Treasury, "FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, And Women's Health And Cancer Rights Act Implementation," April 20, 2016, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf, for additional details.

requirements on the plans they regulate.[282] For example, at one of the NCSL state legislation databases cited earlier, a search for keywords "breast" or "mammog" returns multiple recently enacted state laws, and a search for "sexually transmitted" returns several such state laws.[283]

Does Federal Law Require Private Health Insurance Coverage of Gender-Affirming Services?

No federal law specifically requires private health insurance coverage of gender-affirming services.

However, the requirement that certain plans cover 10 categories of EHB may be relevant, depending on state implementation. If a state selects an EHB benchmark plan that includes coverage of gender-affirming services in one or more EHB categories, then applicable plans in that state would be required to offer substantially equal coverage.[284]

In 2021, Colorado updated its EHB benchmark plan to explicitly include coverage of gender-affirming care services (among other updates). The changes were effective January 2023.[285] According to one stakeholder analysis submitted to CMS in January 2023, four other states' benchmark plans allow for certain coverage of gender-affirming services, and five other states' benchmark plans are silent on the topic, while 41 EHB benchmark plans include categorical exclusions of such services.[286]

Separately, federal guidance on the preventive services coverage requirement[287] has addressed coverage of sex-specific recommended preventive services, as related to an individual's sex assigned at birth, gender identity, or recorded gender. Applicable plans must provide coverage without cost-sharing of recommended preventive services that are determined "medically appropriate for a particular individual" by the individual's attending provider. This may include, for example, "a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix – and the individual otherwise satisfies the criteria in the relevant recommendation or guideline as well as all other applicable coverage requirements."[288]

[282] In general, states may regulate nongroup plans and fully insured group plans but not self-insured group plans. See the introduction to this section of this report.

[283] NCSL, "Health Costs, Coverage, and Delivery State Legislation," 2022-present, at https://www.ncsl.org/health/health-costs-coverage-and-delivery-state-legislation. Searches conducted July 9, 2024, with a filter on "market."

[284] See the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report.

[285] CMS, "Biden-Harris Administration Greenlights Coverage of LGBTQ+ Care as an Essential Health Benefit in Colorado," October 12, 2021, at https://www.cms.gov/newsroom/press-releases/biden-harris-administration-greenlights-coverage-lgbtq-care-essential-health-benefit-colorado.

[286] Whitman Walker Institute, Comment Letter to the Centers for Medicare & Medicaid Services, "RE: Request for Information on the Essential Health Benefits (87 Fed. Reg. 74097, Dec. 2, 2022)," January 31, 2023, at https://www.regulations.gov/comment/CMS-2022-0186-0663. Per the appendix to this letter, the five benchmark plans allowing for certain coverage are California, Colorado, Minnesota, New Mexico, and Vermont; the five that are silent on such coverage are Connecticut, DC, Illinois, Massachusetts, and Oregon. The Whitman Walker Institute is an LGBT health policy research organization.

[287] See the "Overview: Coverage of Certain Preventive Services Without Cost Sharing" section of this report.

[288] ACA FAQ XXVI, May 2015, Question 5. This was referenced again in ACA FAQ 64, January 2024, footnote 14.

State Requirements and Additional Data

States play a central role in the regulation of private health insurance, and they may implement their own gender-affirming services coverage requirements on the plans they regulate.[289] According to a stakeholder group tracking such laws, as of July 2024, 24 states and the District of Columbia prohibit health insurance plans from explicitly excluding coverage of gender-affirming care, and two states permit such exclusions.[290]

Data on private health insurance coverage of gender-affirming services may include plans subject to applicable requirements as well as plans providing coverage voluntarily. Per Mercer's 2023 survey report on employer-sponsored health benefits, 75% of U.S. employers with 20,000 or more employees and 52% of employers with 500 or more employees provide coverage for "gender affirmation surgery." Mercer states that "among employers covering the surgery, nearly all (93 percent) also cover some associated services, primarily behavioral health services/ counseling (89 percent) and nonsurgical gender affirmation treatment/hormone therapy (78 percent), and 64 percent cover other associated services such as reconstructive procedures or puberty suppression."[291]

Per CRS analysis of 2024 QHP benefit coverage in the 32 states that use the federal exchange platform Healthcare.gov, there are QHPs that provide at least some coverage of gender-affirming care services in all 32 such states. This includes 100% of QHPs in six states' exchanges, more than half of QHPs in 16 states' exchanges, and less than half of QHPs in 10 states' exchanges.[292]

Federal Employees Health Benefits Program (FEHB)

The Federal Employees Health Benefits (FEHB) Program provides health insurance to most federal employees, retirees, and their dependents, as well as certain Tribal employees and their families.[293] As of September 2023, FEHB covers more than 8 million people.[294]

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[289] In general, states may regulate nongroup plans and fully insured group plans but not self-insured group plans. See the introduction to this section of this report.

[290] Movement Advancement Project (MAP), "Equality Maps: Healthcare Laws and Policies: Private Insurance," at https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies. MAP is a policy research organization focused on "equality and opportunity for all."

[291] Mercer 2023 Survey Report, March 2024. See footnote 261 for additional details.

[292] CRS analysis of the CMS 2024 Exchange Public Use File (PUF) Datasets, "Benefits and Cost Sharing PUF" and "Plan Attributes PUF," updated April 30, 2024, at https://www.cms.gov/marketplace/resources/data/public-use-files. These files provide data on covered benefits and other plan features for the qualified health plans (QHPs) and certain other plans offered on the health insurance exchanges in the 32 states that utilize the federal platform Healthcare.gov. The files do not include the 19 state-based exchanges. For this analysis, CRS focused on "standard, on-exchange" plan variants (plan IDs ending in -01) on the individual exchanges. CRS identified plans that indicated coverage of benefit name "gender affirming care," but additional analysis would be necessary to identify variations in coverage details.

[293] Members of Congress and certain congressional staff no longer receive health benefits through FEHB as a benefit of their employment but may be eligible to enroll in FEHB in retirement. In addition, like most other federal agencies, the USPS offers health care benefits to its employees, retirees, and their dependents through FEHB. However, starting in 2025, USPS employees, retirees, and their dependents will no longer be eligible for FEHB coverage and will instead receive coverage through a similar, Postal Service Health Benefits Program. For more information, see CRS Report R43194, *Health Benefits for Members of Congress and Designated Congressional Staff: In Brief*, and CRS Insight IN11856, *Proposed Changes to USPS Health Benefits in the Postal Service Reform Act of 2022*, respectively. For more information on FEHB, see CRS Report R43922, *Federal Employees Health Benefits (FEHB) Program: An Overview*.

[294] U.S. Office of Personnel Management, *Federal Benefits Open Season Highlights 2024 Plan Year*, September 2023, p. 1, https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/2024-federal-benefits-open-season-highlights.pdf.

The FEHB Program is administered by the Office of Personnel Management (OPM) in accordance with statute and its implementing regulations.[295] OPM contracts with private health insurance carriers to make plans available to eligible individuals. The FEHB statute establishes the basic rules for benefits, enrollment, and participation, among other general requirements, while still allowing OPM broad authority to implement regulations, contract with carriers, establish benefits, and administer the program.

Premium costs are shared between the federal government and the employee or retiree. The government contributions toward FEHB premiums are funded through discretionary spending and mandatory spending.[296] The government's share of premiums for all retirees and for nonpostal employees is set in statute, while for United States Postal Service (USPS) employees, the USPS contribution to premiums is determined through collective bargaining agreements.

Do FEHB Plans Cover Reproductive Health Services?

FEHB plans cover reproductive health services consistent with statutory and OPM requirements. Statute specifies coverage of certain broad categories of benefits, such as hospital, surgical, physician, and obstetrical benefits.[297] In addition, plans are required or encouraged to cover additional benefits that are specified by OPM as it contracts with plans to participate in the FEHB program. For example, OPM requires FEHB plans to cover certain infertility services, and encourages them to offer other infertility benefits, as discussed below.[298]

FEHB plans also are required to cover certain preventive services without cost-sharing, and to cover the EHB, generally consistent with how such requirements apply to private health insurance plans.[299]

Outside of applicable requirements, benefits and cost-sharing vary among FEHB plans.

[295] See Title 5, Chapter 89 of the *U.S. Code*, and Title 5, Chapter 1, Subchapter B, Part 890 and Title 48, Chapter 16 of the *Code of Federal Regulations*.

[296] More specifically, agency payments for government contributions to their *nonpostal employees'* premiums are classified as discretionary spending. Payments for the government share of *nonpostal retiree* premiums are classified as mandatory spending. The government contributions for *postal employees* and *postal retirees* come from USPS revenues and the Postal Service Retiree Health Benefits Fund, respectively.

[297] 5 U.S.C. §8904.

[298] OPM, "Federal Employees Health Benefits Program Call Letter," Letter Number 2023-04, March 1, 2023, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2023/2023-04.pdf, and OPM, "Federal Employees Health Benefits Program Call Letter," Letter Number 2022-03, February 17, 2022, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2022/2022-03.pdf. Hereinafter OPM, "Federal Employees Health Benefits Program Call Letter (2024)," and OPM, "Federal Employees Health Benefits Program Call Letter (2023)," respectively.

[299] The preventive services requirement for FEHB plans is similar to the requirement applicable to private health insurance plans. For more information see OPM, "FEHB Program Carrier Letter," Letter Number 2019-01, March 14, 2019, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2019/2019-01.pdf, and "Does Federal Law Require Private Health Insurance Coverage of Reproductive Health Services?" In regards to the application of the EHB requirement to FEHB plans, see OPM, "2014 Technical Guidance and Instructions for Preparing HMO Benefit and Service Area Proposals," Letter Number 2013-09(a), April 22, 2013, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2013/v2013-09.pdf; and OPM, "2014 Technical Guidance and Instructions for Preparing Proposals for Fee-For-Service Carriers," Letter Number 2013-09(c), April 22, 2013, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2013/2013-09a2.pdf.

Do FEHB Plans Cover Contraceptive Services?

Appropriations language generally requires FEHB plans to include "a provision for contraceptive coverage."[300] In addition, FEHB plans are required to cover services and items recommended in HRSA-supported guidelines on women's preventive health care services.[301] Under this requirement, FEHB plans must cover, without cost sharing, at least one form of contraception in each of the categories listed in the HRSA-supported Women's Preventive Services Guidelines.[302] FEHB plans also are required to cover, without cost sharing, any contraceptive services and FDA-approved, -cleared, or -granted products that are determined to be medically appropriate, regardless of whether those services or products are specifically identified in the categories listed in the HRSA-supported guidelines. FEHB plans also must make available an exceptions process so that enrollees can get coverage of medically necessary services or items without cost sharing.[303] Outside of applicable requirements, benefits and cost sharing vary among FEHB plans. FEHB plans are allowed to impose "reasonable medical management" coverage limitations, though OPM strongly encourages FEHB plans to follow the "therapeutic equivalence" approach to coverage, outlined in guidance.[304] Under this approach, a FEHB plan's medical management technique would be considered reasonable if the plan covers "all FDA-approved contraceptive drugs and drug-led devices without cost-sharing, other than those where there is at least one therapeutic equivalent drug or drug-led device that is covered without cost sharing."[305] FEHB plans also would need to provide an exceptions process for therapeutic equivalents under this approach.

OPM encourages FEHB plans to recognize the "Dispense as Written" function as the prescriber's expression of medical necessity, which would result in the drug or drug-led device being covered without cost-sharing.[306] OPM also requires FEHB plans to cover over-the-counter emergency contraceptive products without cost-sharing when they are prescribed for an individual, and encourages FEHB plans to cover such products without cost-sharing when they are purchased without a prescription.[307]

[300] For example, see Section 726 in Title VII, Division B, of the Further Consolidated Appropriations Act, 2024 (P.L. 118-47).

[301] See "Does Federal Law Require Private Health Insurance Coverage of Contraceptive Services?" and OPM, "Contraceptive Coverage in the FEHB Program," Letter Number 2022-05, March 15, 2022, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2022/2022-05.pdf; OPM, "Contraception," Letter Number 2022-17, August 19, 2022, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2022/2022-17.pdf.

[302] HRSA, *Women's Preventive Services Guidelines*, page last reviewed March 2024, https://www.hrsa.gov/womens-guidelines#:~:text=Contraception.

[303] OPM, "Contraceptive Drugs and Drug-Led Devices; Member and Provider Education," Letter Number 2024-03, January 30, 2024, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2024/2024-03.pdf. Hereinafter, OPM, "Contraceptive Drugs and Drug-Led Devices; Member and Provider Education."

[304] OPM, "Contraceptive Drugs and Drug-Led Devices; Member and Provider Education."

[305] OPM would consider a contraceptive to be therapeutically equivalent to another contraceptive "if the drug products or drug-led devices are identified as therapeutic equivalents [in the FDA's Orange Book]." OPM, "Contraceptive Drugs and Drug-Led Devices; Member and Provider Education."

[306] OPM, "Contraceptive Drugs and Drug-Led Devices; Member and Provider Education."

[307] OPM, "Contraception," Letter Number 2022-17, August 19, 2022, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2022/2022-17.pdf.

Do FEHB Plans Cover Abortions or Abortion Counseling?

As a result of Hyde-Amendment-like language often included in the Financial Services and General Government (FSGG) Appropriations Act, FEHB plans are prevented from covering abortion services except in cases of rape, incest, or endangerment of a mother's life.[308]

Per the Pregnancy Discrimination Act of 1978 (PDA; P.L. 95-555), FEHB plans must provide coverage for abortion in instances "where the life of the mother would be endangered if the fetus were carried to term, or ... where medical complications have arisen from an abortion."[309]

Do FEHB Plans Cover Infertility Services?

OPM has established requirements relating to coverage of infertility services under the FEHB program. Outside of applicable requirements, benefits and cost-sharing vary among FEHB plans.

OPM requires FEHB plans to provide coverage for the following: artificial insemination (intrauterine insemination, intracervical insemination, and intravaginal insemination), drugs associated with artificial insemination procedures (when deemed medically necessary), the cost of IVF-related drugs for three cycles annually, and standard fertility preservation procedures for persons facing the possibility of iatrogenic infertility.[310]

In addition, OPM encourages FEHB plans to provide discounted or negotiated rates for noncovered ART procedures.[311]

Do FEHB Plans Cover Maternity Services?

FEHB plans are statutorily required to cover obstetrical benefits.[312] In addition, FEHB plans are required to cover maternity and newborn care, consistent with the EHB requirement, and are required to cover certain preventive prenatal and postpartum services (as recommended) without cost-sharing, consistent with OPM guidance and the preventive services requirement.[313] There are multiple recommended preventive services for pregnant and postpartum individuals, including certain STI screenings, mental health and substance use screening and counseling, gestational diabetes screening and healthy weight counseling, folic acid supplements, and breastfeeding services and supplies.

[308] For example, see Section 613 and 614 in Title VI, Division B, of the Further Consolidated Appropriations Act, 2024 (P.L. 118-47).

[309] See 42 U.S.C. §2000e(k). In addition, statute specifies "That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion." For more information about the Pregnancy Discrimination Act of 1978, see "Does Federal Law Require Private Health Insurance Coverage of Maternity Services?" The federal government is subject to the Pregnancy Discrimination Act of 1978 in its capacity as an employer providing health coverage to its employees. 42 U.S.C. §2000e-16. CRS is unaware of instances where OPM has provided further guidance on the interaction between the Financial Services and General Government Appropriations Act language and the Pregnancy Discrimination Act of 1978.

[310] OPM, "Federal Employees Health Benefits Program Call Letter (2024)," OPM, "Federal Employees Health Benefits Program Call Letter (2023)," and OPM, "Technical Guidance and Instructions for 2025 Benefit Proposals," Letter Number 2024-06, March 7, 2024, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2024/2024-06.pdf.

[311] OPM, "Federal Employees Health Benefits Program Call Letter (2024)."

[312] 5 U.S.C. §8904(a).

[313] For more information about EHB and preventive services coverage requirements related to maternity and newborn care and preventive prenatal and postpartum services, see the "Does Federal Law Require Private Health Insurance Coverage of Maternity Services?" section of this report.

Per the Pregnancy Discrimination Act of 1978 (PDA; P.L. 95-555), FEHB plans must cover "expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions" for federal employees and their spouses.[314] In other words, FEHB coverage of pregnancy-related conditions must not be substantially different than they are for other medical conditions.

Outside of applicable requirements, benefits and cost sharing vary among FEHB plans.

OPM encourages FEHB plans to cover additional maternity services. As examples, OPM encourages FEHB plans to address mental health among pregnant women and in the postpartum year.[315] OPM also encourages FEHB plans to consider expanding coverage and services in support of prenatal and postpartum care, including "childbirth education classes, group prenatal care, home visiting programs, care management for high-risk pregnancies, and self-measured blood pressure monitoring for individuals with hypertension."[316]

Do FEHB Plans Cover Reproductive Health Screening, Prevention, and Treatment Services?

FEHB plans are required to cover specified preventive services and, as such, must cover certain reproductive health screening and preventive services (as recommended) without cost-sharing. This includes, for example, screening and counseling for STIs/STDs; universal HIV screening; PrEP medication for persons at high risk of HIV acquisition; well-woman visits; breast cancer screening, genetic testing, and preventive medications such as Tamoxifen (to lower the risk of developing breast cancer among women with specified risk factors); gynecological exams, Pap smears, and cervical cancer screenings; colorectal cancer screenings; and the HPV vaccine.[317]

Treatments for various reproductive health diagnoses may be covered consistent with FEHB statute, the EHB requirement, and other OPM requirements.

Outside of applicable requirements, benefits and cost sharing vary among FEHB plans.

Does FEHB Cover Gender-Affirming Services?

OPM has established requirements relating to coverage of gender-affirming care under the FEHB program. Outside of applicable requirements, benefits and cost-sharing vary among FEHB plans.

OPM requires FEHB plans to establish benefits, including formulary design, that do not limit or deny services in a discriminatory way.[318] FEHB plans are required to cover procedures and treatments for gender dysphoria when plans cover the same procedures or treatments for other diagnoses. As highlighted in an example provided by OPM, FEHB plans are not allowed to

[314] For more information on the Pregnancy Discrimination Act of 1978, see "Does Federal Law Require Private Health Insurance Coverage of Maternity Services?" The federal government is subject to the Pregnancy Discrimination Act of 1978 in its capacity as an employer providing health coverage to its employees. 42 U.S.C. §2000e-16. Also, see 42 U.S.C. §2000e; 29 C.F.R. §1604 Appendix. Also see "EEOC Enforcement Guidance" and "EEOC Q&A."

[315] OPM, "Technical Guidance and Instructions for 2023 Benefit Proposals," Letter Number 2022-04, March 16, 2022, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2022/2022-04.pdf. Hereinafter, OPM, "Technical Guidance and Instructions for 2023 Benefit Proposals."

[316] OPM, "Federal Employees Health Benefits Program Call Letter (2023)."

[317] See footnote 299.

[318] OPM, "Coverage for Gender Affirming Care and Services," Letter Number 2023-12, May 23, 2023, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2023/2023-12.pdf. Hereinafter, OPM, "Coverage for Gender Affirming Care and Services."

"exclude or otherwise limit or deny coverage for surgery, such as a mammoplasty, for a covered individual whose sex assigned at birth is male while providing coverage for such surgeries for a covered individual whose sex assigned at birth is female."[319]

In addition, OPM directs FEHB plans to have current medical policies so that coverage decisions are consistent with up-to-date standards of care. To incorporate such standards, as appropriate, FEHB plans are to review information from recognized entities (e.g., the World Professional Association of Transgender Health [WPATH], the Endocrine Society, and the Fenway Institute).[320] Consistent with this requirement, FEHB plan coverage should include "primary care (to include preventive services appropriate to the individual's circumstances), gynecologic and urologic care, mental health services (e.g., counseling, psychotherapy), hormonal treatments, pharmacological therapies, and surgical treatments, among others."[321]

OPM also has required FEHB plans to cover standard fertility preservation procedures for persons facing the possibility of iatrogenic infertility, including infertility associated with medical and surgical gender transition treatment.[322]

OPM has prohibited FEHB plans from having a general exclusion of services, drugs, or supplies related to the treatment of gender dysphoria, and prohibited FEHB plans from categorically excluding services related to gender-affirming care (e.g., hormone therapy, genital surgeries, breast surgeries, and facial gender-affirming surgeries).[323]

Federal Agencies and Departments

Several federal agencies provide health services directly to specific service populations. These agencies, the populations they serve, and the reproductive services they provide or pay for are discussed below. Agencies are organized alphabetically by agency name.

Bureau of Prisons (BOP)

The Bureau of Prisons (BOP) within the Department of Justice (DOJ) operates the federal prison system, which includes 122 facilities in 35 states. BOP was established in 1930 to house federal prisoners, professionalize the prison service, and ensure consistent and centralized administration of the federal prison system.[324] BOP must confine any offender convicted and sentenced in a federal court to a term of imprisonment. As of the end of FY2023, there were approximately 158,400 prisoners under BOP's jurisdiction.[325] BOP provides medically necessary health care treatment to all prisoners housed in BOP-operated facilities, including medically necessary

[319] OPM, "Coverage for Gender Affirming Care and Services."

[320] OPM, "Technical Guidance and Instructions for 2022 Benefit Proposals," Letter Number 2021-05, April 7, 2021, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2021/2021-05.pdf; OPM, "Federal Employees Health Benefits Program Call Letter (2023)"; OPM, "Technical Guidance and Instructions for 2023 Benefit Proposals"; OPM, "Federal Employees Health Benefits Program Call Letter (2024)."

[321] OPM, "Federal Employees Health Benefits Program Call Letter (2023)."

[322] Ibid.

[323] OPM, "Covered Benefits for Gender Transition Services," Letter Number 2015-12, June 23, 2015, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2015/2015-12.pdf, and "Coverage for Gender Affirming Care and Services."

[324] U.S. Department of Justice (DOJ), Bureau of Prisons (BOP), *About the Bureau of Prisons*, June 2015, p. 1.

[325] DOJ, BOP, "Statistics," https://www.bop.gov/about/statistics/population_statistics.jsp#old_pops (data on the federal prison population was accessed on May 16, 2024).

reproductive health services.[326] Most of this treatment is provided through health care clinics operated in each BOP facility. Most clinics have examination rooms, treatment rooms, dental clinics, radiology and laboratory areas, a pharmacy, and administrative offices.[327] When BOP cannot provide services at a BOP facility, it transports prisoners to a community health care facility or provider (e.g., a hospital). Generally, each BOP facility maintains its own contract with health care facilities or providers and sets the rate to be paid for providing medical treatment to inmates.[328] For prisoners with acute or chronic long-term care needs that cannot be managed through in-prison clinics, BOP transfers these patients to one of its Federal Medical Centers.[329]

All prisoners serving a period of incarceration are given an intake screening within 24 hours of arriving at the facility. The screening is performed to identify

- urgent medical, oral, or mental health care needs;
- indications of acute drug or alcohol intoxication or signs of withdrawal;
- presence of transmissible skin, respiratory, or gastrointestinal infections;
- pregnancy in female prisoners;
- sensory, cognitive, or physical disabilities requiring further evaluation and potential accommodations; and
- medication needs.[330]

In addition to the intake screening, BOP conducts a comprehensive physical assessment on all new prisoners to assess, diagnose, and treat medical needs.[331] The assessment includes a medical records review. During the assessment, BOP can order diagnostic tests and immunizations, including

- HIV testing;
- hepatitis screening;
- STD testing, if clinically indicated;
- pregnancy testing, if clinically indicated and not conducted during the intake screening;
- a measles, mumps, and rubella vaccine for women of child-bearing age who report never having the vaccine as an adult.[332]

BOP policy requires facilities to make age-appropriate medical screening available to all prisoners.

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[326] DOJ, BOP, *FY 2025 Performance Budget, Congressional Submission, Salaries and Expenses*, p. 25 (hereinafter, "BOP FY2025 S&E budget justification").

[327] U.S. Government Accountability Office (GAO), *Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs*, GAO-17-379, June 2017, p. 8 (hereinafter, "GAO BOP rising inmate health care costs report").

[328] GAO BOP rising inmate health care costs report, p. 11.

[329] Examples of services provided at Federal Medical Centers include dialysis for inmates with chronic renal failure; oncology treatment (i.e., chemotherapy and radiation therapy); inpatient and forensic mental health; surgery (i.e., limited orthopedic and general surgery procedures); prosthetics and orthotics; long-term ventilator-dependent management; dementia care; and end-of-life care. BOP FY2025 S&E budget justification, p. 26.

[330] DOJ, BOP, *Patient Care*, Program Statement 6031.04, p. 35 (hereinafter "*Patient Care*").

[331] *Patient Care*, p. 37.

[332] *Patient Care*, p. 37.

Does BOP Provide Reproductive Health Services?

BOP provides medically necessary health care treatment to all prisoners housed in BOP-operated facilities, including medically necessary reproductive health services.[333]

In addition to the intake medical examination mentioned above, BOP policy requires facilities to provide age-appropriate medical screening, which may include reproductive health screening, to all prisoners.

Does BOP Provide Contraceptive Services?

BOP policy requires medical staff to provide female prisoners with information related to birth control, if requested.[334] Female prisoners have access to birth control while incarcerated, but it is usually limited to hormone replacement therapy.[335] Birth control can be prescribed for other reasons, but only if a clinician believes it is medically appropriate and the prescription is approved by BOP's medical director.[336]

BOP does not provide sterilization to male or female prisoners except for bona fide medical indications (e.g., as the result of surgical treatment for cancer of the reproductive organs).[337]

Does BOP Provide Abortions or Abortion Counseling?

BOP does not directly provide abortions; however, it will permit pregnant prisoners to terminate their pregnancies, with certain conditions.[338] Wardens are required to offer pregnant prisoners medical, religious, and social counseling to help them decide whether to carry a pregnancy to term. If a prisoner chooses to terminate the pregnancy, the prisoner is required to sign a statement to that effect.[339] Upon receipt of the signed statement, the facility's clinical director arranges for an abortion.[340] BOP assumes the cost of the procedure only when the mother's life is endangered by carrying the pregnancy to term or in the case of rape or incest.[341] In all other cases, the prisoner must arrange payment for the procedure.[342] However, in cases where the prisoner pays

[333] BOP FY2025 S&E budget justification, p. 25.

[334] DOJ, BOP, Female Offender Manual, Program Statement 5200.07 CN-1, p. 12 (hereinafter, "*Female Offender Manual*.")

[335] Ibid.

[336] The medical director is a part of the executive staff of BOP's Health Services Division, which is responsible for overseeing the programs, operations, and delivery of health care at all BOP facilities.

[337] *Patient Care*, p. 69.

[338] Traditionally, as a part of the annual Commerce, Justice, Science, and Related Agencies Appropriations Act, Congress places limitations on how BOP can use its funding to provide abortion services to prisoners. For example, the Commerce, Justice, Science, and Related Agencies Appropriations Act, 2024 (Division C of P.L. 118-42), states that "none of the funds appropriated by [Title II of Division C] shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape or incest: Provided, That should this prohibition be declared unconstitutional by a court of competent jurisdiction, this section shall be null and void. None of the funds appropriated under this title shall be used to require any person to perform, or facilitate in any way the performance of, any abortion. Nothing in the preceding section shall remove the obligation of the Director of the Bureau of Prisons to provide escort services necessary for a female inmate to receive such service outside the Federal facility: Provided, that nothing in this section in any way diminishes the effect of section 203 intended to address the philosophical beliefs of individual employees of the Bureau of Prisons."

[339] *Female Offender Manual*, p. 16.

[340] Clinical directors are responsible for clinical care provided at each BOP facility. The clinical director provides clinical oversight of health care services and is responsible for all health care delivered.

[341] *Female Offender Manual*, p. 17.

[342] Ibid.

for the procedure, BOP may use its funds to transport the prisoner to a facility outside of the institution where the procedure will be performed.[343]

Does BOP Provide Infertility Services?

BOP's policies regarding prisoner health care and regarding health care for female prisoners, specifically, do not address infertility services.

Does BOP Provide Maternity Services?

BOP has several programs that provide parenting assistance.[344] With regard to maternity services, the most relevant program is the Mothers and Infants Nurturing Together (MINT) program.

MINT is a community-based residential program where pregnant prisoners are allowed to give birth and spend time bonding with their newborn outside of a secure facility. To be eligible for the MINT program, prisoners must be pregnant when they begin their period of incarceration, must have an expected delivery date prior to their scheduled release date, must have less than five years of incarceration remaining, must be eligible for halfway house placement, and must assume financial responsibility for child care.[345] Prisoners in the MINT program are transferred to a Residential Reentry Center (RRC) (BOP's term for a halfway house) during the last two months of pregnancy, and they are allowed to stay at the RRC for at least three months, though BOP policy recommends a minimum of six months.[346] Once they complete the program, prisoners are returned to their designated facility to serve the remainder of their sentences.

Does BOP Provide Reproductive Health Screening, Prevention, and Treatment Services?

All federal prisoners receive a medical screening upon intake at a BOP facility, which includes ordering appropriate laboratory and diagnostic tests, if medically indicated. Such tests include age-appropriate preventive health examinations. BOP provides medically necessary treatment, including treatment for reproductive health, to all federal prisoners.[347] BOP is responsible for providing medically necessary care in a manner consistent with the standards of care for nonprisoners.[348]

In addition, BOP policy requires facilities to make age-appropriate medical screening available to all prisoners.

In general, BOP tests for STIs when there is a clinical indication that a prisoner has an STI.[349] BOP has special procedures related to testing for HIV. If a prisoner who is sentenced to six months or more has risk factors for HIV, or if there is a clinical indication that the prisoner has

[343] Ibid.

[344] For a description of BOP's national parenting from prisons program, see DOJ, BOP, *First Step Act Approved Programs Guide*, September 2023, p. 35.

[345] DOJ, Office of the Inspector General, *Review of the Federal Bureau of Prisons' Management of Its Female Inmate Population,* Evaluation and Inspections Division 18-05, September 2018, p. 9.

[346] *Female Offender Manual*, p. 18.

[347] The GAO notes, "Multiple U.S. courts over the years have determined that inmates have a constitutional right to adequate medical and mental health care." GAO BOP rising inmate health care costs report, p. 2.

[348] GAO BOP rising inmate health care costs report, p. 8.

[349] DOJ, BOP, *Infectious Disease Management*, Program Statement 6190.04, p. 11 (hereinafter, "*Infectious Disease Management*").

HIV, then HIV testing is mandatory.[350] HIV testing is also mandatory when there is a well-founded belief that a prisoner has transmitted HIV to BOP employees or to other non-BOP employees working in the facility.[351] In addition, BOP conducts HIV testing, as necessary, to collect information on the prevalence of HIV in the prison population (i.e., surveillance testing). BOP provides HIV testing to prisoners upon request; such tests are limited to one per 12-month period, unless BOP determines that additional testing is warranted.[352] BOP provides pre- and post-test counseling to all prisoners who are tested for HIV, regardless of the test results.[353]

Does BOP Provide Gender-Affirming Services?

If a prisoner identifies as transgender, BOP psychologists provide the prisoner with information regarding the range of treatment options available from BOP and their implications.[354] In addition to a referral for medical services, a transgender prisoner may be offered individual psychotherapy.[355] The goals of psychotherapy include

- helping the prisoner to live more comfortably within a gender identity and deal effectively with nongender issues;
- emphasizing the need to set realistic life goals related to daily living, work, and relationships, including family of origin;
- seeking to define and address issues that may have undermined a stable lifestyle, such as substance abuse and/or criminal behavior; and
- addressing any co-occurring mental health issues.

BOP may provide hormone therapy or other medical treatment after an individualized assessment of the requesting prisoner by institution medical staff.[356] BOP policy states that medical staff will request consultation from facility's psychologists regarding the mental health benefits of hormone or other medical treatment.[357]

Prisoners can be considered for gender-affirming surgery only after one year of clear conduct and compliance with mental health, medical, and programming services.[358] When this period is complete, the prisoner may submit a request to the facility's warden requesting surgical consideration. The warden forwards the request to the Transgender Executive Council (TEC).[359] TEC is the sole body who may determine that all milestones and individual goals for surgical consideration have been met. When this occurs, the case is referred to the BOP's medical director for medical consideration. The medical director may review existing records and/or interview the prisoner, facility staff, and members of TEC. After this individualized assessment, the medical

[350] *Infectious Disease Management*, p. 5.

[351] Ibid.

[352] *Infectious Disease Management*, p. 6.

[353] Ibid.

[354] DOJ, BOP, *Transgender Offender Manual*, Program Statement 5200.08, p. 9.

[355] Ibid.

[356] Ibid., p. 8.

[357] Ibid.

[358] Ibid., p. 9.

[359] TEC is BOP's official decisionmaking body on all issues affecting the transgender population. It consists of senior leadership of several divisions of BOP's headquarters. TEC meets at least monthly to offer advice and guidance on unique measures related to treatment and management needs of transgender prisoners and/or prisoners with gender dysphoria, including training, designation issues, and reviewing all transfers for approval. Ibid., p. 4.

director determines if the surgery is medically appropriate for referral to a gender-affirming surgeon.

Department of Defense (DOD)

DOD administers a statutory health benefit (under Title 10, Chapter 55, of the *U.S. Code*) through the Military Health System (MHS). The MHS offers health care benefits and services through its TRICARE program to approximately 9.6 million beneficiaries, comprising members and retirees of the uniformed services and their family members.[360] TRICARE offers a range of health care services, including reproductive health services, in military hospitals and clinics (also known as military treatment facilities, or MTFs) and from participating civilian health care providers. With the exception of active duty servicemembers, beneficiaries are subject to certain cost-sharing requirements based on beneficiary category, health plan or benefit program, and the sponsor's initial enlistment or appointment date to military service.[361]

Does DOD Provide Reproductive Health Services?

By law, DOD is required to offer certain *primary and preventive health services* to all active duty servicemembers and retirees.[362] Eligible family members of servicemembers and retirees may also access these services. Primary and preventive health services are generally offered at no cost to beneficiaries; however, some services may be subject to certain cost-sharing requirements.

Does DOD Provide Contraceptive Services?

DOD offers contraceptive services as part of its *family planning* benefit.[363] Counseling and contraception methods are offered in accordance with Section 718 of the National Defense Authorization Act (NDAA) for FY2016 (P.L. 114-92) and CDC's *medical eligibility criteria* and *selected practice recommendations for contraceptive use*.[364] DOD offers or covers only methods of contraception recognized by FDA (see **Table 1** in "What Are Contraceptive Services?") including the following:

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[360] Military Health System (MHS), "Patients by Beneficiary Category," accessed May 24, 2024, at https://www.health.mil/Military-Health-Topics/MHS-Toolkits/Media-Resources/Media-Center/Patient-Population-Statistics/Patients-by-Beneficiary-Category. The term *uniformed services* includes the Armed Forces (Army, Navy, Marine Corps, Air Force, Space Force, and Coast Guard), the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration. For additional information about the MHS, see CRS In Focus IF10530, *Defense Primer: Military Health System*.

[361] For more on TRICARE's cost-sharing features, see CRS Report R45399, *Military Medical Care: Frequently Asked Questions* ("Question 7. What are the Different TRICARE Plans?"). A sponsor refers to a servicemember or military retiree. For more on sponsors and family members, see https://www.tricare.mil/Plans/Eligibility.

[362] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) requires most insurance programs and plans to cover women's preventive health services. Those requirements do not apply to the TRICARE program; however, 10 U.S.C. §1074d requires TRICARE to cover similar preventive health services. For more information on the ACA's requirements, see the "Overview: Coverage of Certain Preventive Services Without Cost Sharing" section of this report.

[363] Ibid. For additional information about Department of Defense (DOD) contraceptive services, see CRS In Focus IF11109, *Defense Health Primer: Selected Contraceptive Services*.

[364] Defense Health Agency (DHA) Procedural Instruction 6200.02, *Comprehensive Contraceptive Counseling and Access to the Full Range of Methods of Contraception*, May 13, 2019, p. 6, at https://www.health.mil/Reference-Center/DHA-Publications/2019/05/13/DHA-PI-6200-02. The FY2016 National Defense Authorization Act (NDAA) requires DOD to establish and disseminate clinical guidelines on contraception and contraception counseling, as well as to make annual and pre- and post-deployment contraceptive counseling available to female members of the Armed Forces.

- Short-Acting Reversible Contraceptives (SARCs): oral contraceptive, patch, vaginal ring, injection.
- Long-Acting Reversible Contraceptives (LARCs): intrauterine device (IUD), implantable rod.
- Barriers: diaphragm, cervical cap, sponge, male/female condom.
- Sterilization: male/female surgical sterilization, permanent implant.
- Emergency Contraceptives (ECs)**:** *Plan B One Step*/*Next Choice One Dose*, *ella*.[365]

Servicemembers may access these services through a TRICARE health care provider or MTF health care provider. Some MTFs offer walk-in contraceptive services on a space-available basis.[366] Deployed servicemembers may also receive prescribed contraceptives (up to 180-day supply) prior to their departure and while in-theater (90-day supply increments) when subscribed to the Deployed Prescription Program (DPP).[367] In-theater military health care providers are authorized to issue new or renewal prescriptions that would be filled through the DPP.

Does DOD Provide Abortions or Abortion Counseling?

Title 10, Section 1093, of the *U.S. Code* prohibits DOD from directly providing or paying for abortion services, 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. An abortion that meets these exceptions is considered a *covered abortion*.[368] DOD may provide medically necessary care and services (including behavioral health care) when related to a covered abortion. Abortion counseling, referral, preparation, and follow-up care for noncovered abortions are not available in MTFs or paid for by TRICARE.[369]

Does DOD Provide Infertility Services?

DOD offers certain counseling and treatment services for infertility, when medically necessary and combined with natural conception, including

- correction of any physical cause of infertility;
- erectile dysfunction resulting from a physical cause; and

[365] Ibid., p. 14. A list of FDA-approved contraceptive methods is available at https://www.fda.gov/media/150299/download.

[366] DHA Administrative Instruction 6025.09, *Walk-in Contraception Services at Military Medical Treatment Facilities*, November 16, 2023, at https://www.health.mil/Reference-Center/DHA-Publications/2023/11/16/DHA-AI-6025-09.

[367] The Deployed Prescription Program (DPP) delivers prescription medications to deployed servicemembers via the military mail system (i.e., Army Post Office, Fleet Post Office). DOD civil service employees and DOD contractors without other health insurance are also eligible for DPP. For more information on the DPP, see https://tricare.mil/dpp.

[368] DOD uses the term *covered abortion* as referring to those that meet one of the exceptions under 10 U.S.C. 1093 and *noncovered abortion* as those that do not meet one of the exceptions allowed under statute. Part §199.4(e)(2) of Title 32, *Code of Federal Regulations*, further specifies that "abortions performed for suspected or confirmed fetal abnormality (e.g., ancephalic) or for mental health reasons (e.g., threatened suicide) do not fall within the exceptions" permitted in statute.

[369] See Chapter 4, Section 18.3 of the TRICARE Policy Manual 6010.60-M, updated March 10, 2017, at https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-01-20/ChangeOnly/tp15/c4s18_3.html.

- diagnostic services (e.g., semen analysis, hormone evaluation, chromosomal studies, immunologic studies, special and sperm function tests, and bacteriologic investigation).[370]

In general, DOD does not offer or cover other types of infertility services or assisted reproductive technologies (ART) under the TRICARE program.[371] Excluded services include artificial intrauterine insemination (IUI), costs related to donors or sperm banks, reversal of tubal ligation or vasectomy (unless medically necessary), erectile dysfunction resulting from psychological causes, and *noncoital* reproductive procedures (e.g., IVF, gamete or zygote intrafallopian transfer, tubal embryo transfer).[372]

In certain instances, DOD may pay for limited ART services for seriously or severely ill or injured active duty servicemembers and their spouses, unmarried partners, or third-party gestational carriers with a qualifying diagnosis (i.e., infertility).[373] Limited ART services include sperm or egg retrieval; IVF; artificial insemination; and egg, sperm, or embryo cryopreservation.[374] Eight DOD hospitals offer these services to eligible servicemembers and their spouses:

- Madigan Army Medical Center (Tacoma, WA);
- Naval Medical Center Portsmouth (Portsmouth, VA);
- Naval Medical Center San Diego (San Diego, CA);
- San Antonio Military Medical Center (San Antonio, TX);
- Tripler Army Medical Center (Honolulu, HI);
- Walter Reed National Military Medical Center (Bethesda, MD);
- Wright Patterson Medical Center/88th Medical Group (Greene County, OH); and
- Womack Army Medical Center (Fayetteville, NC).[375]

Most of these services are provided at no cost to the patient; however, the cost of cryopreservation and storage may be shared between the beneficiary and DOD while the beneficiary remains eligible for the benefit.[376]

[370] See Chapter 4, Sections 15.1 and 17.1 of the TRICARE Policy Manual 6010.60-M, April 1, 2015. For more on DOD infertility services, see CRS In Focus IF11504, *Infertility in the Military.*

[371] For more on assisted reproductive technologies (ART), see https://tricare.mil/CoveredServices/IsItCovered/AssistedReproductiveServices. *Noncoital* refers to sexual or reproductive activities that do not involve heterosexual intercourse.

[372] See Chapter 7, Section 2.3 of the TRICARE Policy Manual 6010.60-M, April 1, 2015.

[373] 10 U.S.C. §1074(c) authorizes DOD to provide extended care benefits to servicemembers who "incur a serious injury or illness on active duty."

[374] Assistant Secretary of Defense Memorandum, *Amended Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members*, March 8, 2024, at https://media.defense.gov/2024/Mar/11/2003410399/-1/-1/0/AMENDED-POLICY-FOR-ASSISTED-REPRODUCTIVE-SERVICES-FOR-THE-BENEFIT-OF-SERIOUSLY-OR-SEVERELY-ILL-INJURED-CATEGORY-II-OR-II-ACTIVE-DUTY-SERVICE-MEMBERS.PDF.

[375] Ibid.; and DOD, "Assisted Reproductive Technology (ART) Services," accessed May 24, 2024, at https://tricare.mil/CoveredServices/IsItCovered/AssistedReproductiveServices.

[376] DOD policy authorizes cost sharing of embryo cryopreservation and storage until the servicemember separates/retires. For more on ART for ill or injured servicemembers, see Assistant Secretary of Defense Memorandum, *Amended Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members*, March 8, 2024.

Does DOD Provide Maternity Services?

DOD offers and pays for medically necessary maternity care, including "care and treatment related to conception, delivery, abortion,[377] including prenatal and postnatal care (generally through the 6th postdelivery week), and also including treatment of the complications of pregnancy."[378] Maternity care for pregnancies resulting from noncoital reproductive procedures or surrogacy are also covered.[379] Labor doula services may also be covered under the TRICARE Childbirth and Breastfeeding Support Demonstration program for TRICARE Prime and TRICARE Select enrollees.[380]

Does DOD Provide Reproductive Health Screening, Prevention, and Treatment Services?

DOD offers a wide-range of clinical preventive services, including certain reproductive health screening and preventive services.[381] These services include, but are not limited to, screening and counseling of breast, cervical, colon, gynecological, testicular, and prostate cancers; family planning; menopause; STIs or STDs; PrEP for HIV prevention; and physical or psychological conditions resulting from an act of violence.[382] DOD also offers medically necessary treatment or therapy options to eligible beneficiaries with a reproductive health issue identified during a clinical screening.[383]

Does DOD Provide Gender-Affirming Services?

DOD offers or pays for "medically necessary" nonsurgical treatment (i.e., hormone therapy, pubertal suppression, or psychotherapy) for gender dysphoria.[384] According to TRICARE coverage policy, beneficiaries with gender dysphoria diagnosed by a mental health provider and who meet certain clinical indications may access these services.[385] With regard to surgical treatment of gender dysphoria (i.e., "gender-affirming surgery" or GAS), Title 10, Section 1079(a)(11), of the *U.S. Code* prohibits DOD from directly providing or paying for surgical treatment of gender dysphoria (i.e., GAS) for nonactive duty beneficiaries.

All active duty servicemembers diagnosed with gender dysphoria may receive nonsurgical treatment, as described above. In addition, DOD may cover "medically necessary" surgical

[377] DOD will pay for abortions only in limited circumstances. For more information, see "Does DOD Provide Abortions or Abortion Counseling?" in this report.

[378] 32 C.F.R. §§199.2 and 199.4.

[379] For more on TRICARE coverage of maternity care, see Chapter 4, Section 18.1 of the TRICARE Policy Manual, April 1, 2015.

[380] For more on this program, see https://www.tricare.mil/CBSD.

[381] For more on DOD's provision of clinical preventive services, see Chapter 7, Sections 2.1 and 2.2 of the TRICARE Policy Manual, April 1, 2015.

[382] 32 C.F.R. §199.4(e)(3) defines DOD's *family planning* benefit as certain "services and supplies related to preventing conception."

[383] For more on DOD administered/sponsored medically necessary treatment or therapy options, see 32 C.F.R. §199.4.

[384] For more on TRICARE coverage of gender dysphoria services, see Chapter 7, Sections 1.2 and 1.3 of the TRICARE Policy Manual, April 1, 2015.

[385] Ibid.

procedures (i.e., GAS) for active duty servicemembers, who may be required to meet certain clinical and administrative requirements prior to receiving approval for treatment.[386]

U.S. Immigration and Customs Enforcement (ICE) Noncitizen Detention

The Department of Homeland Security's (DHS's) Immigration and Customs Enforcement's (ICE) mission "is to protect America from the cross-border crime and illegal immigration that threaten national security and public safety."[387] ICE's Enforcement and Removal Operations (ERO) is responsible for immigration enforcement in the interior of the United States, including managing and overseeing the immigrant detention system.[388]

ICE detention standards were originally developed in 2000 and have been updated several times, resulting in various sets of standards that incorporate different laws and regulations and vary in terms of scope and rigor. Although there are different sets of standards, all facilities housing noncitizen detainees must generally comply with one of the sets of ICE detention standards, including health care standards.[389] Contracts or agreements between ICE and detention facilities specify which set of standards facilities are required to follow.[390]

Two sets of detention standards are applied at facilities that house the majority of the adult detained population: the 2011 Performance-Based National Detention Standards (PBNDS)[391] and the 2000/2019 National Detention Standards (NDS).[392] The 2011 PBNDS and 2019 NDS provide identical guidance on certain standards, including many health care standards. In the frequently asked questions section that follows, the two sets of standards provide the same guidance unless otherwise noted. The following sections present these standards as enumerated in ICE guidance. There are multiple DHS Office of Inspector General (OIG) and GAO reports that identify inadequate compliance with these standards.[393]

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[386] DHA Procedural Instruction 6025.21, *Guidance for Gender-Affirming Health Care of Transgender and Gender-Diverse Active and Reserve Component Service Members*, May 12, 2023, at https://www.health.mil/Reference-Center/DHA-Publications/2023/05/12/DHA-PI-6015-21.

[387] Department of Homeland Security (DHS), *Immigration and Customs Enforcement (ICE)*, at http://www.dhs.gov/topic/immigration-and-customs-enforcement.

[388] The law provides ICE with broad authority to detain noncitizens while awaiting a determination of whether they should be removed from the United States, and mandates that certain categories of noncitizens are subject to mandatory detention (e.g., when the noncitizen is removable on account of certain criminal or terrorist activity). See 8 U.S.C. §§1225, 1226, 1226a, 1231, and 1357.

[389] For more information, see CRS In Focus IF12623, *Medical Care Standards in Immigrant Detention Facilities*.

[390] ICE owns and operates some of its own facilities, and it has arrangements through contracts with private companies that operate immigration detention facilities. In addition, immigrant detention facilities owned by state or local governments or private entities operate through intergovernmental agreements. (GAO, *ICE Should Enhance Its Use of Facility Oversight Data and Management of Detainee Complaints*, 20-596, August 2020, pp. 6-7.)

[391] The 2011 Performance-Based National Detention Standards (PBNDS) was revised in 2016 to meet detention standards consistent with federal legal and regulatory requirements, as well as prior ICE policies and policy statements. The 2011 PBNDS is an updated version of the 2008 PBNDS; some facilities have contracts agreeing to adhere to the 2008 version. (GAO, *ICE Should Enhance Its Use of Facility Oversight Data and Management of Detainee Complaints*, 20-596, August 2020.)

[392] The 2019 National Detention Standards (NDS) is a modified version of the 2000 NDS. The data provided by GAO do not distinguish between the facilities utilizing 2000 and 2019 NDS. (GAO, *ICE Should Enhance Its Use of Facility Oversight Data and Management of Detainee Complaints*, 20-596, August 2020.)

[393] For example, see GAO, *Immigration Detention: ICE Can Improve Oversight and Management*, GAO-23-106350, January 2023; GAO, *Immigrant Detention: ICE Needs to Strengthen Oversight of Informed Consent for Medical Care*, (continued...)

Does ICE Provide Reproductive Health Services?

ICE provides certain reproductive health services to noncitizens in detention. Detained noncitizens are entitled to medical care per Title 42, Section 249, of the *U.S. Code* and Title 42, Section 34.7(a), of the *Code of Federal Regulations*. Medical care standards are outlined in ICE's detention standards; those related to reproductive health services are discussed in the sections below.

Does ICE Provide Contraceptive Services?

According to ICE guidance, detainees are entitled to impartial family planning and contraceptive consultations with medical personnel. Detainees may receive "medically appropriate" medical contraception.[394]

Does ICE Provide Abortions or Abortion Counseling?

ICE provides abortion services in certain circumstances. ICE assumes the cost of terminating the pregnancy "if the life of the mother would be endangered by carrying a fetus to term, or in the case of rape or incest."[395] In all other circumstances, the detainee bears the cost of terminating the pregnancy. In all instances, ICE arranges transportation to the medical appointment at no cost to the detainee and, if requested, to religious or social counseling.

Does ICE Provide Infertility Services?

ICE detention standards are silent on the provision of infertility services. CRS confirmed with ICE that it does not "generally provide infertility services."[396]

Does ICE Provide Maternity Services?

In July 2021, ICE announced a new directive that specifies that immigrants who are pregnant, nursing, or postpartum will not be detained while they wait for immigration court proceedings, unless they are subject to mandatory detention or there are exceptional circumstances.[397]

GAO -23-105196, October 2022; GAO, *Immigrant Detention: ICE Should Enhance Its Use of Facility Oversight Data and Management of Detainee Complaints*, GAO-20-956, August 2020; DHS OIG, *Capping Report: Observations of Unannounced Inspections of ICE Facilities in 2019*, OIG-20-45, July 1, 2020; GAO *Immigrant Detention: Care of Pregnant Women in DHS Facilities*, GAO-20-330, March 2020; DHS OIG, *Concerns about ICE Detainee Treatment and Care at Four Detention Facilities*, OIG-19-57, June 3, 2019; DHS OIG, *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California*, OIG-18-87, September 27, 2018; DHS OIG, *ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements*, OIG-18-67, June 26, 2018; DHS OIG, *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards*, OIG-19-18, January 29, 2018; DHS OIG, *Concerns about ICE Detainee Treatment and Care at Detention Facilities*, OIG-18-32, December 11, 2017; GAO, *Immigrant Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care*, GAO-16-321, February 2016.

[394] 2011 PBDNS, "4.4 Medical Care (Women)" and 2019 NDS "4.3 Medical Care."

[395] ICE, *Performance-Based National Detention Standards 2011* (hereinafter, "2011 PBNDS"), "4.4 Medical Care (Women)"; ICE, *National Detention Standards for Non-Dedicated Facilities*, revised 2019 (hereinafter, "2019 NDS"), "4.3 Medical Care."

[396] CRS communication with ICE on October 21, 2020.

[397] ICE, "Directive: Identification and Monitoring of Pregnant, Postpartum, or Nursing Individuals," at https://www.ice.gov/directive-identification-and-monitoring-pregnant-postpartum-or-nursing-individuals.

For those that are detained, ICE provides maternity services to detainees. ICE considers pregnant detainees one of its vulnerable populations. According to ICE guidance, "pregnant detainees shall have access to prenatal and specialized care, and comprehensive counseling on topics including, but not limited to, nutrition, exercise, complications of pregnancy, prenatal vitamins, labor and delivery, postpartum care, lactation, family planning, abortion services and parenting skills."[398] In addition, ICE accommodates a pregnant individual's special needs, such as an additional pillow or a special diet, as identified by a medical professional. Finally, if a health care practitioner identifies pregnant detainees as being high risk, they "shall be referred to a physician specializing in high-risk pregnancies."[399]

Does ICE Provide Reproductive Health Screening, Prevention, and Treatment Services?

All detainees are to be provided "comprehensive, routine and preventive health care, as medically indicated."[400] The 2011 PBNDS guidance states that "detainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment."[401] Similarly, the 2019 NDS guidance states that "all detainees shall have access to appropriate medical, dental, and mental health care, including emergency services."[402]

For detained women, ICE offers routine preventive screening services, such as pelvic and breast examinations, Pap smears, testing for STIs, and mammograms.

In addition, ICE's initial health assessment for women entering detention collects information regarding

- pregnancy testing for detainees aged 18-56 and documented results;
- if the detainee is currently nursing (breastfeeding);
- use of contraception;
- reproductive history (number of pregnancies, number of live births, number of spontaneous/elective abortions, pregnancy complications, etc.);
- menstrual cycle;
- history of breast and gynecological problems;
- family history of breast and gynecological problems; and
- any history of physical or sexual victimization and when the incident occurred.[403]

Although ICE detention standards are silent on men's reproductive health screening and preventive services specifically, according to correspondence with CRS, "ICE offers routine age- and gender-appropriate preventive health services and examinations for all male and female detainees annually. Testing for STIs is available upon detainee request and as clinically indicated."[404]

[398] 2011 PBDNS, "4.4 Medical Care (Women)" and 2019 NDS "4.3 Medical Care."

[399] Ibid.

[400] 2011 PBDNS, "4.3 Medical Care" and 2019 NDS "4.3 Medical Care."

[401] 2011 PBDNS, "4.3 Medical Care."

[402] 2019 NDS "4.3 Medical Care."

[403] 2011 PBDNS, "4.4 Medical Care (Women)" and 2019 NDS "4.3 Medical Care."

[404] CRS communication with ICE on October 21, 2020.

Does ICE Provide Gender-Affirming Services?

ICE provides gender-affirming services, though unlike the aforementioned services, the 2011 PBNDS and the 2019 NDS differ in terms of their guidance about transgender detainees' health care. (See the "U.S. Immigration and Customs Enforcement (ICE) Noncitizen Detention" section above for a discussion of the different sets of detention standards.)

Per the 2011 PBNDS guidance, transgender detainees have access to the hormone therapy they were receiving prior to being detained. Furthermore, "all transgender detainees shall have access to mental health care, and other transgender-related health care and medication based on medical need."[405] The guidance also states that their "treatment shall follow accepted guidelines regarding medically necessary transition-related care," though it does not reference specific guidelines.

The 2019 NDS guidance states that the detention facility and ICE/ERO should coordinate care "based on [the] medical needs" of self-identified transgender detainees.[406]

Indian Health Service (IHS)

The IHS provides health care directly or provides funds for Indian tribes or tribal organizations to operate health care facilities.[407] It provides services free of charge to approximately 2.8 million eligible American Indians and Alaska Natives in 37 states.[408] IHS does not have a standard medical benefit that includes or excludes certain services.[409] The agency generally focuses on primary and preventive services and does so through a network of more than 600 facilities, which include hospitals (43), health centers (383), and small health stations (101). Other facility types include school health centers, youth regional treatment centers, and Alaska village clinics.[410]

Does IHS Provide Reproductive Health Services?

IHS does not have a standard medical benefit that includes or excludes certain services, but some facilities provide reproductive health services and maternity care services. Among other services, IHS provides specific women's health services, such as mammograms and other preventive services.

Specific reproductive health services may or may not be available at IHS because it has limited funding and some facilities serve small populations. As such, not all facilities offer reproductive health services, and the services available vary. In addition, IHS's ability to pay for services outside of its system is limited. IHS receives annual appropriations for its purchased referred care

[405] 2011 PBDNS, "4.3 Medical Care"

[406] 2019 NDS, "4.3 Medical Care."

[407] The Indian Health Service (IHS) also provides grants to Urban Indian Organizations (UIOs) that operate smaller health facilities in urban areas. These facilities vary in terms of the services available; some provide comprehensive services, while others provide information and referral services. The following discussion does not include UIOs because as grantees they have more flexibility in the services they provide. Outside of the grants they receive, UIOs are generally not eligible to receive funds from the overall IHS budget, with some exceptions. See discussion in CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[408] U.S. Department of Health and Human Services (HHS), IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-2.

[409] CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[410] HHS, IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budget formulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-41-42.

program (PRC),[411] which enables the agency to pay for outside services. PRC funds are limited and may not be available later in any given fiscal year. IHS reports that it denied or deferred 119,938 services in FY2022 because of these funding limitations.[412] Moreover, only a subset of the IHS population is eligible for PRC, as eligibility is restricted to IHS-eligible individuals who live in certain geographic areas. PRC funds are authorized only for services in instances when the PRC-eligible individual does not have an alternate resource (e.g., Medicaid).

PRC will pay for services, to the extent that funds are available, based on medical priorities ranging from priority one (services necessary to save life, limb, or sense, which are almost always paid) to priority five (services considered elective or experimental).[413] Reproductive health services are generally included in levels one and two. Priority level one includes services that are emergency and acute, including maternity services such as delivery and acute prenatal care. Routine prenatal care and screening services, such as mammograms or HIV testing, are included in priority level two, which encompasses preventive care services. IVF and gender-affirming surgery are listed as examples of priority level five—excluded services that are not paid for by PRC. PRC programs are managed locally, and these local programs determine what priority level will be paid and may add or remove services within specific priority levels. In FY2022, 90% of IHS operated PRC programs were able to pay for services beyond priority level two, which represents an increase in services that PRC is able to pay for relative to prior years.[414]

Does IHS Provide Contraceptives?

As mentioned above, IHS does not have a standard medical benefit package, so services provided vary by facility. Most facilities offer pharmaceutical services that include contraception. IHS uses a National Core Formulary, which individual facilities can supplement with additional drugs depending on facility needs. The formulary includes oral contraceptives, IUDs, and implants.[415] IHS also expanded its formulary to include the Opill in 2023.[416] As with other IHS services, pharmaceuticals are provided to eligible American Indians and Alaska Natives free of charge.

IHS provides EC (Plan B One-Step [Levonorgestrel]) through its pharmacies, emergency departments, and health clinics. The June 2013 FDA approval of Plan B One-Step as an over-the-counter drug presented a challenge for IHS, because the agency generally does not dispense drugs without a provider order.[417] This issue was resolved in October 2015, when IHS amended its

[411] HHS, IHS, "Purchased Referred Care," https://www.ihs.gov/prc/. In FY2024, the program received an appropriation of $996,755,000. IHS's FY2024 appropriation was provided in FY2023 appropriations law (P.L. 117-328) as an advance appropriation.

[412] HHS, IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-97.

[413] For more information, see HHS, IHS, "Purchased Referred Care, Requirements: Priorities of Care," https://www.ihs.gov/prc/eligibility/requirements-priorities-of-care/.

[414] HHS, IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-97.

[415] HHS, IHS, "National Core Formulary," https://www.ihs.gov/nptc/formularysearch/.

[416] HHS, IHS, "National Pharmacy and Therapeutics Committee: Formulary Brief: OTC Norgestrel 0.075mg (Opill®)" August 2023, https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC-Formulary-Brief-Opill-FINAL.pdf. See also text box in the "What Are Contraceptive Services?" section in this report.

[417] 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.

internal policies to make EC available without a provider visit or a requirement that patients register with the facility.[418]

IHS does provide sterilization services if requested, but it must follow HHS procedures when doing so.[419] This service permits only tubal ligation or vasectomy and prohibits the use of a hysterectomy for purposes of sterilization. It also prohibits providing these procedures to anyone under the age of 21 or anyone incapable of giving consent.[420]

Does IHS Provide Abortions or Abortion Counseling?

IHS is generally prohibited from using any of its appropriated funds to perform or pay for abortion services.[421] IHS funds may be used in cases where the mother's life is endangered, or if 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 may be paid for; the pregnancy criteria described must be met to merit this circumstance.[422] In addition, IHS will provide health services necessary to terminate an ectopic pregnancy[423]—a pregnancy that occurs outside the womb (uterus)—which is life-threatening to the mother.[424]

IHS policies do not discuss abortion counseling, thus it is unclear whether the agency will provide such services. It is also unclear which of the tiered IHS PRC medical priority groups abortion counseling would fit into if it were to be offered.

Does IHS Provide Infertility Services?

IHS provides some limited infertility services when obstetrician/gynecologist (OB/GYN) specialists are available at an IHS facility. In addition, each IHS area or specific facility may develop its own specific protocols. According to IHS's program manual (the agency's document governing its care),

> the basic elements should be provided to women and men when requested and indicated, including history and exam, basal temperature charting, semen analysis and post coital testing, and serum progesterone assay. Endometrial biopsy, hysterosaipingography [sic] and diagnostic laparoscopy should be made available in those facilities with OB/GYN specialists on-site. Specific clinical protocols can be developed by consultation with gynecological consultants within each Area/Program.[425]

[418] HHS, IHS, "Indian Health Manual: Part 1- General, Chapter 15-Emergency Contraception," https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p1c15.

[419] 42 C.F.R. 50.205(b).

[420] HHS, IHS, "Indian Health Manual: Part 1- General, Chapter 13-Maternal and Child Health" https://www.ihs.gov/IHM/pc/part-3/p3c13/#3-13.12F5.

[421] 25 U.S.C. §1676.

[422] HHS, 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 and HHS, IHS, Indian Health Circular No. 22-15, "Use of Indian Health Service Funds for Abortions," https://www.ihs.gov/ihm/circulars/2022/use-of-indian-health-service-funds-for-abortions/.

[423] HHS, 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.

[424] National Institutes of Health, National Library of Medicine, MedlinePlus Medical Encyclopedia, Ectopic pregnancy: MedlinePlus Medical Encyclopedia.

[425] HHS, IHS, "Indian Health Manual: Part 1- General, Chapter 13-Maternal and Child Health" https://www.ihs.gov/ihm/pc/part-3/p3c13/#3-13.12F4. A hysterosalpingography is a contrast X-ray of the uterus and fallopian tubes.

IHS is limited in terms of payments for infertility services under PRC. As noted, IHS specifically includes IVF under priority group five, which is an excluded service.[426]

Does IHS Provide Maternity Services?

IHS does not have a standard medical benefit that includes or excludes certain services, but some facilities provide reproductive health services and maternity care services. The IHS system includes 43 hospitals that offer inpatient care;[427] however, specific data on the number of hospitals performing deliveries are not available. IHS has funded maternal health initiatives and proposes to focus on improving maternal health in the FY2025 budget request to continue efforts to address high levels of maternal mortality among its service population.[428]

IHS facilities that have access to obstetric services provide more comprehensive maternity services. In instances where these services are not available at the facility, PRC will pay for deliveries and acute prenatal care as a priority level one (emergency) service. Routine prenatal care is considered a priority level two service. Such care is generally paid for, but it may be subject to available funding.[429]

Does IHS Provide Reproductive Health Screening, Prevention, and Treatment Services?

As noted above, the services available at IHS facilities vary, but some facilities may provide reproductive screening, preventive services, and treatment for conditions identified within the facility. Preventive screenings, such as mammography, may be paid for under PRC and are considered to be priority level two (preventive services); however, treatment for an acute or emergent condition (which may be identified during a screening) would be considered priority level one.[430] IHS also funds or operates programs to screen individuals at risk of HIV/AIDS and to provide treatment services as necessary.[431] These activities are coordinated through IHS's National HIV/AIDS Program, which coordinates the HIV/AIDS specific medical care delivered throughout the IHS system and undertakes public health activities related to prevention and testing.[432] In 2019, President Trump announced the Ending the HIV Epidemic initiative for FY2020.[433] This initiative has continued since that time and IHS noted that in FY2024 it added new staff to carry out this initiative.[434] IHS also requested funds to continue work on this

[426] For more information, see HHS, IHS, "Purchased Referred Care, Requirements: Priorities of Care," https://www.ihs.gov/prc/eligibility/requirements-priorities-of-care/.

[427] HHS, IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-41-42.

[428] Ibid., p. CJ-51.

[429] For more information, see HHS, IHS, "Purchased Referred Care, Requirements: Priorities of Care," https://www.ihs.gov/prc/eligibility/requirements-priorities-of-care/.

[430] Ibid.

[431] HHS, IHS, "HIV/AIDS," https://www.ihs.gov/hivaids/.

[432] Ibid.

[433] HHS, *Ending the HIV Epidemic: A Plan for America*, Washington, DC, February 5, 2019, https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview, and Anthony S. Fauci et al., "Ending the HIV Epidemic: A Plan for the United States," *JAMA*, vol. 321, no. 9 (February 7, 2019), pp. 844-845.

[434] HHS, IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-47.

initiative in FY2025.[435] IHS was included as part of the initiative because, between 2012 and 2016, rates of HIV diagnosis increased by 34% among the American Indian/Alaska Native population.[436] As part of this initiative, IHS added PrEP (i.e., Truvada) to its formulary and is focusing on increasing HIV testing and linkages to care. IHS continues to work with its pharmacies to ensure access to PrEP.[437] IHS also noted that the agency received funding from the HHS Minority HIV/AIDS Fund to expand its HIV prevention work and support Native led projects including projects using telehealth to provide access to PrEP.[438]

Does IHS Provide Gender-Affirming Services?

In 2022, IHS approved adding gender-affirming medications to its core formulary.[439] In the notice doing so, it stated that, the criteria

> for the use of hormone therapy for gender-affirmation in transgender people include: persistent, well-documented gender dysphoria, capacity (legal and otherwise) to provide informed consent, and medical and mental health concerns otherwise present must be reasonably well-controlled prior to starting hormone treatment. Provider responsibilities in initiating hormone therapy include evaluation and diagnosis and providing informed consent with discussion of the benefits and risks of gender-affirming medications—with particular attention to fertility risk and fertility preservation options.[440]

PRC will not pay for gender-affirming surgery. Specifically, IHS lists gender-affirming surgery as an example of priority level five—excluded services not paid for by PRC. It is not clear whether IHS offers or will pay for other types of gender-affirming services, either through PRC or within its system.

The U.S. Coast Guard (USCG)

The U.S. Coast Guard (USCG) delivers certain health benefits under Title 14, Chapter 5, and Title 10, Chapter 55, of the *U.S. Code* to members of the uniformed services, retirees, and their families.[441] USCG delivers a limited range of outpatient medical and dental care in fixed outpatient health care facilities, ships, and certain deployed environments. Typical health care services offered include primary care; occupational health; flight medicine; optometry; mental health; physical therapy; dentistry; and basic laboratory, radiology, and pharmacy services. Patients with medical needs exceeding a USCG clinic's capabilities may be referred or medically

[435] HHS, IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-4.

[436] NCHHSTP, CDC, "Health Disparities in American Indian or Alaska Native People," April 22, 2024, https://www.cdc.gov/health-disparities-hiv-std-tb-hepatitis/populations/american-indian-alaska-native.html, and IHS, "HIV in Indian Country," https://www.ihs.gov/newsroom/factsheets/hiv-in-indian-country/.

[437] HHS, IHS, *Fiscal Year 2023 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf, p. 45.

[438] HHS, IHS, *Fiscal Year 2025 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY-2025-IHS-CJ030824.pdf, pp. CJ-45-46.

[439] IHS, "National Pharmacy and Therapeutics Committee: Formulary Brief: Gender-Affirming Medications," February 2022, https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC-Formulary-Brief-Gender-Affirming-Medications.pdf.

[440] Ibid.

[441] The term *uniformed services* includes the Armed Forces (Army, Navy, Marine Corps, Air Force, Space Force, and Coast Guard), the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration.

evacuated to a DOD military treatment facility (MTF) or civilian medical facility participating in TRICARE.[442] USCG clinics typically offer limited outpatient medical and dental care.

Does USCG Provide Reproductive Health Services?

USCG clinics offer limited reproductive health services, often provided by primary care providers.[443] USCG clinics may refer beneficiaries to DOD MTFs (preferable option) or to a TRICARE provider (secondary option) for comprehensive reproductive health services.[444]

Does USCG Provide Contraceptive Services?

USCG clinics offer limited contraceptive services, including family planning counseling and contraception prescriptions.[445] Contraceptive services not available in USCG clinics may be accessed through the TRICARE program. Services available through USCG or through TRICARE include the following:

- Short-Acting Reversible Contraceptives (SARCs): oral contraceptive, patch, vaginal ring, injection.
- Long-Acting Reversible Contraceptives (LARCs): IUD, implantable rod.
- Barriers: diaphragm, cervical cap, sponge, male/female condom.
- Sterilization: male/female surgical sterilization, permanent implant.
- Emergency Contraceptives (ECs): *Plan B One Step*/*Next Choice One Dose*, *Ella*.[446]

Section 718 of the FY2016 NDAA (P.L. 114-92) requires the Secretary of Defense to make annual (as well as pre- and intra-deployment) contraceptive counseling available to female members of the Armed Forces (including USCG) through the TRICARE program. DOD policy also requires USCG to offer contraceptive counseling during the annual periodic health assessment and during accession training (i.e., boot camp or officer candidate school).[447]

Deployed servicemembers may also receive prescribed contraceptives (up to 180-day supply) prior to their departure and while in-theater (90-day supply increments) when subscribed to the Deployment Prescription Program (DPP).[448] In-theater military health care providers are authorized to issue new or renewal prescriptions that would be filled through the DPP.

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[442] For additional information about the TRICARE program, see the "Department of Defense (DOD)" section of this report.

[443] Email communication with U.S. Coast Guard (USCG) officials, April 2019.

[444] Commandant Instruction M6000.1F, *Coast Guard Medical Manual*, June 2018, p. 110, at https://media.defense.gov/2018/Jul/05/2001939216/-1/-1/0/CIM_6000_1F.PDF. For more information on DOD reproductive health services, see the "Does DOD Provide Reproductive Health Services?" section of this report.

[445] Email communication with USCG officials, April 2019.

[446] DOD offers counseling and contraception methods in accordance with Section 718 of NDAA for FY2016 (P.L. 114-92) and CDC's *medical eligibility criteria* and *selected practice recommendations for contraceptive use*. For more on DOD's contraception benefit, see DHA Procedural Instruction 6200.02, *Comprehensive Contraceptive Counseling and Access to the Full Range of Methods of Contraception*, May 13, 2019.

[447] Ibid., p. 1. According to DOD policy, this requirement is applicable to USCG "by agreement" with DHS. The *periodic health assessment* is an annual evaluation of a servicemember's physical and mental health used to determine deployability and military readiness status.

[448] The DPP delivers prescription medications to deployed servicemembers via the military mail system (i.e., Army Post Office, Fleet Post Office). DOD civil service employees and DOD contractors without other health insurance are also eligible for DPP. For more information on the DPP, see https://tricare.mil/dpp.

Does USCG Provide Abortions or Abortion Counseling?

USCG policy prohibits the use of government funds to provide or pay for abortion services, except where the life of the mother would be endangered if the pregnancy were carried to term, or a case in which the pregnancy is the result of an act of rape or incest.[449] USCG clinics are authorized to provide counseling related to covered abortions.[450]

Similarly, Title 10, Section 1093, of the *U.S. Code* prohibits TRICARE from directly providing or paying for abortion services, except where the life of the mother would be endangered if the pregnancy were carried to term, or a case in which the pregnancy is the result of an act of rape or incest. TRICARE may offer or pay only for health care services related to a covered abortion. Abortion counseling, referral, preparation, or follow-up care for noncovered abortions is not available in MTFs or paid for by TRICARE.[451]

Does USCG Provide Infertility Services?

Certain USCG clinics offer initial infertility evaluations only.[452] Other infertility services, such as ART for certain servicemembers, are available at DOD MTFs or from civilian health care providers participating in TRICARE.[453]

Does USCG Provide Maternity Services?

Certain USCG clinics offer outpatient maternity services, including prenatal care and maternal-fetal medicine.[454] Other maternity services are available at DOD MTFs or from civilian health care providers participating in TRICARE.[455]

Does USCG Provide Reproductive Health Screening, Prevention, and Treatment Services?

USCG clinics offer limited reproductive health screening and preventive services, including well-woman exams, as well as counseling and testing for STIs and cancer of the breast, cervix, testicles, or prostate.[456] Comprehensive reproductive health services and related treatment are available at DOD MTFs or from civilian health care providers participating in TRICARE.[457]

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[449] USCG, Commandant Instruction 1000.9, "Pregnancy in the Coast Guard," September 29, 2011, https://media.defense.gov/2017/Mar/06/2001707433/-1/-1/0/CI_1000_9.PDF; and email communication with USCG officials, April 2019.

[450] Email communication with USCG officials, April 2019.

[451] See Chapter 4, Section 18.3 of the TRICARE Policy Manual 6010.60-M, updated July 14, 2021.

[452] Email communication with USCG officials, April 2019.

[453] For more information on DOD infertility services, see the "Does DOD Provide Infertility Services?" section of this report.

[454] Ibid. *Maternal-fetal medicine* refers to the obstetric subspecialty focusing on high-risk pregnancy and related medical complications.

[455] For more on DOD maternity services, see the "Does DOD Provide Maternity Services?" section of this report.

[456] Commandant Instruction M6000.1F, *Coast Guard Medical Manual*, June 2018, pp. 110 and 145; and email communication with USCG officials, April 2019.

[457] For more on DOD reproductive health services, see the "Does DOD Provide Reproductive Health Screening, Prevention, and Treatment Services?" section of this report.

Does USCG Provide Gender-Affirming Services?

Certain USCG clinics offer "medically necessary" nonsurgical treatment (i.e., hormone therapy, pubertal suppression, or psychotherapy) for gender dysphoria.[458] USCG servicemembers diagnosed with gender dysphoria may access surgical treatment based on DOD and TRICARE policies and processes for considering and approving gender-affirming surgery.[459]

Department of Veterans Affairs (VA)

VA provides health care services through the Veterans Health Administration (VHA) for approximately 9.1 million enrolled veterans[460] at over 1,300 VA sites of care.[461] VHA is primarily a direct provider of care; it owns the facilities and employs the clinicians. However, under certain circumstances, VA will pay for a veteran to receive care in the community.[462]

Not all veterans qualify for enrollment in the VA health care system. Enrollment is based primarily on veteran status (i.e., previous military service), service-connected disability, and income.[463] All enrolled veterans are eligible for a standard medical package, which includes a full range of health care, gender-specific medical services, prescription drugs, long-term care, and social support services.[464]

Does the VA Provide Reproductive Health Services?

The VA standard medical benefits package includes reproductive health services, such as routine physical exams, cervical and prostate cancer screening, evaluation and treatment of vaginal infections, pelvic pain and abnormal uterine bleeding, treatment of erectile dysfunction, reproductive mental health, and STI screening, among other services, to eligible veterans who are enrolled in the VA's health care system.[465]

Does the VA Provide Contraceptive Services?

VA provides both contraception counseling and contraceptives as part of the standard medical benefits package. VA uses a national formulary for medications.[466] The formulary includes oral contraceptives, IUDs, and implants.[467] VA health care maintains a tiered structure for copayments

[458] Email communication with USCG officials, April 2019.

[459] For additional information about DOD policies and processes for gender-affirming care, see the "Department of Defense (DOD)" section of this report.

[460] Department of Veterans Affairs, *FY2025 Congressional Submission*, Medical Programs, vol. 2 of 5, March 2024, p. VHA-41.

[461] Ibid., p. VHA-17.

[462] Under certain circumstances, the VA is authorized to pay for primary and specialty care under the Veterans Community Care Program (38 U.S.C. §1703 and 38 C.F.R. §17.4000), for emergent care (38 U.S.C. §1725 and §1728), for urgent care (38 U.S.C. §1725A), and health care abroad (38 U.S.C. §1724), among others.

[463] For more information on veterans health care eligibility and enrollment, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

[464] 38 C.F.R. §17.38.

[465] VA, Veterans Health Administration (VHA), Women's Health Services, *State of Reproductive Health In Women Veterans-VA Reproductive Health Diagnoses and Organization of Care*, February 2014, p. 30.

[466] VA, VHA, *VHA Formulary Management Process*, VHA Directive 1108.08, July 2022.

[467] VA, "Pharmacy Benefits Management Services, VA Formulary Search," https://www.pbmhttps://www.pbm.va.gov/apps/VANationalFormulary/.

for medication, which is dependent on each veteran's enrollment status. Some veterans are subject to copayments for medication, whereas some receive medication free of charge.[468]

VA provides EC (e.g., Plan B One Step [Levonorgestrel]). VA policy requires that EC be made available to patients on the same day as their appointment, even in cases where the provider requested to opt out from providing EC due to right-of-conscience claims.[469]

VA provides sterilization services (e.g., salpingectomy, tubal occlusion procedures, and vasectomy) as part of the medical benefits package. All surgeons performing sterilization procedures must ensure that the patient is aware of the risks and benefits of the procedure, including the potential for regret, the chances of failure, the permanence of the sterilization procedure, and the availability of reversible, highly effective contraceptives (e.g., IUD and subcutaneous contraceptive implants).[470]

Does the VA Provide Abortions or Abortion Counseling?

Under current regulations, VA abortions are allowed under certain circumstance. Abortions are prohibited except when

- the life or the health of the pregnant veteran would be endangered if the pregnancy were carried to term; or
- the pregnancy is the result of an act of rape or incest.[471]

Determination of whether an abortion is covered under either of these circumstances is made on a case-by-case basis by the appropriate health care professional.[472] In addition, self-reporting rape or incest is considered sufficient evidence that an act of rape or incest occurred.[473]

Does the VA Provide Infertility Services?

VA does provide certain infertility services to veterans. Covered infertility services for both female and male veterans are listed in **Table 3**. These covered services are provided to all enrolled veterans without exception.

Table 3. Infertility Services Offered by the VA

Diagnosis and Treatment for Female Veterans	Diagnosis and Treatment for Male Veterans
Diagnostic Tests: • Laboratory blood testing: follicle stimulating hormone (FSH); thyroid stimulating hormone (TSH) • Genetic counseling and testing • Pelvic and/or transvaginal ultrasound • Hysterosalpingogram • Saline-infused sonohysterogram	Diagnostic Tests: • Laboratory blood testing: serum testosterone, FSH, luteinizing hormone (LH), estradiol • Semen analysis • Genetic counseling and testing • Transrectal and/or scrotal ultrasonography • Postejaculatory urinalysis

[468] For more information on copayments for medication, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

[469] VA, VHA, *Healthcare Services for Women Veterans*, VHA Handbook 1330.01(7), February 2017.

[470] VA, VHA, *Fertility Management*, VHA Directive 1332, May 2024.

[471] 38 C.F.R. §17.38(c)(1).

[472] VA, VHA, *Health Care Services for Women Veterans*, VHA Directive 1330.01(7), May 2023, p. 24.

[473] Ibid.

Diagnosis and Treatment for Female Veterans	Diagnosis and Treatment for Male Veterans
Treatments: • Surgical correction of structural pathology • Reversal of tubal ligation • Intrauterine insemination (IUI) • Medication for ovulation induction (e.g., clomiphene) • Injectable gonadotropin medications • Hormonal therapies (e.g., controlled ovarian hyperstimulation) • Additional hormonal therapies as approved by VA Pharmacy Benefits Management • Oocyte cryopreservation for medically indicated conditions up to 5 years.	Treatments: • Evaluation and treatment of erectile dysfunction • Surgical correction of structural pathology • Vasectomy reversal • Hormonal therapies (e.g., clomiphene citrate, human chorionic gonadotropin, phosphodiesterase type 5 medications, testosterone) • Sperm retrieval techniques • Sperm cryopreservation for medically indicated conditions • Ejaculation techniques (e.g., electroejaculation, vibratory stimulation)

Source: Prepared by CRS based on U.S. Department of Veterans Affairs, Veterans Health Administration, *In Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses*, VHA Directive 1334(1), April 4, 2024.

Notes: This table, including terminology, is adapted directly from VHA Directive 1334(1). The use of gender-specific terminology to refer to available infertility services corresponds to how the services are represented in the directive.

VA is not authorized to provide or cover the cost of IVF or other ART. A narrow exception to this policy allows VA to provide IVF services to veterans and their spouses if a service-connected disability results in the inability of the veteran to procreate without the treatment.[474] This exception is authorized on an annual basis through appropriations acts.[475] Such services and benefits may be provided in a manner similar to those described in a memorandum issued by the Assistant Secretary of Defense for Health Affairs,[476] along with guidance issued by DOD. VA is exempt from DOD requirements applicable to the duration of embryo cryopreservation and storage.[477] Namely, VA may provide cryopreservation and storage for an unlimited amount of time.[478]

Under this exception, VA allows the use of donor eggs, sperms and embryos. In addition, eligible veterans are not required to be married to access the benefit under this authority. However, a veteran's partner must be legally married to the veteran to receive evaluation or treatment.[479] VA is not authorized to cover gestational surrogacy treatment under any circumstances.[480] This policy can affect any eligible veteran regardless of gender or sexual orientation. For example, a male

[474] 38 C.F.R. §17.380.

[475] This policy has been authorized in appropriations acts since FY2017. Most recently, Section 234 of Division J of the Consolidated Appropriations Act, 2024 (P.L. 118-42), continued allowing the use of FY2024 appropriations and FY2025 advance appropriations for this purpose.

[476] DOD, Office of the Assistant Secretary of Defense for Health Affairs, "Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members," dated April 3, 2012.

[477] VA, "Final Rule-Fertility Counseling and Treatment for Certain Veterans and Spouses," 84 *Federal Register* 8254-8257, March 7, 2019.

[478] 38 C.F.R. §17.380(b).

[479] VA, "Instructions for Determining Eligibility for In Vitro Fertilization (IVF) Benefit," 89 *Federal Register* 23518, March 28, 2024.

[480] The authorization for VA's IVF benefit limits these services specifically to a covered veteran and the spouse of a covered veteran. Due to this limitation, despite the DOD memo allowing gestational surrogacy, VA cannot provide IVF services to an individual who is not a covered veteran or a spouse of a covered veteran.

veteran in a same-sex relationship could use this benefit to create a fertilized embryo with donor eggs, but VA will not pay for transfer of the embryo into a gestational carrier.[481]

Does the VA Provide Maternity Services?

VA currently provides and pays for maternity and newborn health care services to eligible veterans and their family members.[482] Veterans can access maternity care as soon as their pregnancies are confirmed. However, VA medical facilities do not operate full-service birthing centers with medical units such as maternity wards, newborn nurseries, and neonatal intensive care units. VA does not have specialized health care providers or functioning birth-related medical units in VA medical facilities to deliver babies on a continual basis.[483] VA does not provide these services in its facilities since there is an insufficient population at each VA medical facility to ensure that clinicians can maintain their accreditation. As a result, VA furnishes maternity care through arrangements with community providers to ensure that pregnant veterans and veterans who wish to become pregnant have options near their homes. VA may perform emergency childbirth deliveries.

VA is authorized to provide certain health care services to a newborn child of a veteran receiving maternity care furnished by the VA. Health care for the newborn is authorized for a maximum of seven days after the birth of the child if the veteran delivered the child in a VA facility or in another facility pursuant to a VA contract for maternity services.[484]

Does the VA Provide Reproductive Health Screening, Prevention, and Treatment Services?

VA provides reproductive health screening and preventive services as part of the standard medical benefits package. Preventive screenings, such as mammography, are offered as part of routine health care. VA also operates a national HIV program with policies for screening, prevention, and treatment.[485] It is VA policy that all veterans receiving care through the VA are tested for HIV at least once as part of their routine care. More frequent testing is available for veterans who are at higher risk of contracting HIV. VA follows CDC guidance regarding the use of PrEP, and it is a covered benefit for veterans enrolled in the VA health care system. All FDA-approved medications for PrEP must be readily available at all VA medical facilities, and such medications must be offered routinely as part of a comprehensive risk-reduction program for veterans who are considered to be at an increased risk for HIV infection.

In addition, VA provides medically necessary reproductive health treatment services as part of the standard medical benefits package. With limited exceptions (e.g., abortions and certain IVF discussed in previous sections), VA will provide care to individuals if the appropriate health care

[481] VA, VHA, *Vitro Fertilization Counseling and Services Available to Certain Eligible Veterans and Their Spouses*, VHA Directive 1334(1), April 4, 2024. VA Office of Women's Health, *FAQs: Expansion of In Vitro Fertilization at VA*, March 11, 2024, https://www.womenshealth.va.gov/WOMENSHEALTH/docs/final_FAQs_for_Expansion_of_VA_Fertility_Benefits_3_11_24.pdf.

[482] VA, VHA, *Maternity Health Care and Coordination*, VHA Handbook 1330.03, November 2020.

[483] VA, VHA, Women's Health Services, *State of Reproductive Health In Women Veterans-VA Reproductive Health Diagnoses and Organization of Care*, February 2014, p. 39.

[484] 38 U.S.C. §1786. The William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (P.L. 116-283) created an exception to the seven-day maximum coverage allowance to authorize VA, pursuant to regulations prescribed by the Secretary of VA, to cover newborns for longer periods if medically necessary. However, VA has not promulgated regulations to implement this provision.

[485] VA, VHA, *National Human Immunodeficiency Virus Program*, VHA Directive 1304, August 2019.

professionals determine that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.[486]

Does the VA Provide Gender-Affirming Services?

Under current regulations, VA is prohibited from providing gender-confirming/affirming surgeries.[487] VA provides other gender-affirming services as part of the standard medical benefits package, such as hormonal therapy, mental health care, and preoperative evaluation. In addition, VA provides medically necessary postoperative and long-term care following gender-confirming surgeries if an appropriate health care professional determines that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.[488]

Grant Programs Focused on Reproductive Health

The following sections discuss federal programs that focus on one or more specific reproductive health topics. The first two programs—family planning and adolescent pregnancy prevention programs—discuss each of the reproductive health service categories included in this report. The final three questions for these programs focus on programs that provide specific reproductive health services; these questions discuss information about program missions and the specific services provided.

The Title X Family Planning Program

The Title X Family Planning Program (Title X) was enacted in 1970 as Title X of the PHSA.[489] Title X provides grants to public and nonprofit agencies for family planning services, research, and training. The Office of Population Affairs (OPA) within HHS administers Title X, which is the only domestic federal program devoted solely to family planning and related preventive health services.[490]

In 2019, HHS promulgated a rule that prohibited Title X projects from referring clients for abortion as a method of family planning. It also required physical and financial separation between Title X projects and certain abortion-related activities. The 2019 rule took effect in all states except Maryland, where it was enjoined.[491]

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[486] 38 C.F.R. §17.38(b).

[487] 38 C.F.R. §17.38(c)(4). On May 9, 2016, the VA received a petition for rulemaking to remove the exclusion for gender alterations. The VA sought comments regarding such removal in 2018. No action has been taken since. VA, "Exclusion of Gender Alterations From the Medical Benefits Package," 83 *Federal Register* 31711, July 9, 2018.

[488] VA, VHA, *Providing Health Care for Transgender and Intersex Veterans*, VHA Directive 1341(2), February 2018.

[489] Title X was enacted by P.L. 91-572 , Family Planning Services and Population Research Act of 1970. It is codified as amended at 42 U.S.C. §§300 through 300a-6.

[490] HHS, *Fiscal Year 2025 Health Resources and Services Administration Justification of Estimates for Appropriations Committees*, https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2025.pdf, p. 373. See also Axelle Clochard, Phil Killewald, Addison Larson, et al., *Family Planning Annual Report: 2022 National Summary*, HHS, OPA, October 2023, https://opa.hhs.gov/sites/default/files/2023-10/2022-FPAR-National-Summary.pdf, p. 17.

[491] Office of the Assistant Secretary for Health (OASH), Office of the Secretary, HHS, "Compliance With Statutory Program Integrity Requirements," 84 *Federal Register* 7714, March 4, 2019, https://www.federalregister.gov/d/2019-03461; CRS In Focus IF11142, *Title X Family Planning Program: 2019 Final Rule*. The rule required, for example, separate facilities (including exam and waiting rooms, entrances and exits, and websites), separate staff, separate accounting and medical records, and separate workstations.

In 2021, HHS promulgated a new rule that, among other things, revokes the 2019 rule in its entirety. The 2021 rule requires Title X projects to offer pregnant clients the opportunity to be provided information and nondirective counseling on pregnancy options, including on abortion. Projects are required by the rule to provide an abortion referral if requested by the client. The 2021 rule also removes the physical and financial separation requirement between Title X projects and abortion activities as long as "it is possible to distinguish between the Title X supported activities and non-Title X abortion activities."[492] The 2021 rule has been in effect since November 8, 2021 for all grantees except those in Ohio where the rule was preliminarily enjoined by the U.S. Court of Appeals for the Sixth Circuit on June, 11, 2024.[493] This report describes the Title X program under the 2021 rule that is currently in effect, which has been the subject of recent litigation among other program guidance.[494]

Title X grantees can provide family planning services directly or they can subaward Title X monies to other entities to provide services. In 2022, the most recent year for which client data are available, Title X projects served 2.60 million clients through 4,126 service sites operated by 91 grantees or their 1,132 subrecipients (also known as subgrantees or subawardees).[495]

In 2022, HHS described the activities of Title X grantees and OPA:

> HHS's Title X grantees provide contraceptive education and counseling; breast and cervical cancer screening; testing for sexually transmitted infections and HIV, referral, and prevention education; and pregnancy diagnosis and counseling, using a combination of funding sources to cover the costs for eligible clients. Under the 2021 Title X final rule, Title X funds are awarded to provide high-quality, affordable, and confidential voluntary family planning and related preventive health services to either help achieve or prevent pregnancy. HHS's Office of Population Affairs requires all family planning services to be delivered consistent with nationally recognized standards of care, including nondirective pregnancy options counseling and referral. Moreover, Title X-funded sites not offering a broad range of methods on-site must provide a prescription to the client for their method of choice or referrals, as requested.[496]

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.[497] For unemancipated minors who request confidential services, eligibility

[492] Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services (HHS), "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 *Federal Register* 56144-56180, October 7, 2021, https://www.federalregister.gov/d/2021-21542; CRS In Focus IF11986, *Title X Family Planning Program: 2021 Final Rule*.

[493] State of Ohio v. Becerra, No. 1:21-cv-675 (S.D. Ohio June 11, 2024).

[494] For an example of recent litigation, see CRS Legal Sidebar LSB10916, *Title X Parental Consent for Contraceptive Services Litigation: Overview and Initial Observations (Part 1 of 2)*, and CRS Legal Sidebar LSB10917, *Title X Parental Consent for Contraceptive Services Litigation: Overview and Initial Observations (Part 2 of 2)*.

[495] Axelle Clochard, Phil Killewald, Addison Larson, et al., *Family Planning Annual Report: 2022 National Summary*, HHS, OPA, October 2023, https://opa.hhs.gov/sites/default/files/2023-10/2022-FPAR-National-Summary.pdf. Current and past directories of Title X grantees, subawardees, and service sites are at HHS, OPA, *Current Title X Service Grantees*, https://opa.hhs.gov/grant-programs/title-x-service-grants/current-title-x-service-grantees. For 2022, OPA transitioned from collecting aggregate level data to a data system where grantees submit encounter-level data on the demographic and social characteristics of Title X users and the use of family planning and related preventive health services, staffing, and revenue.

[496] Email from the HHS Office of the Assistant Secretary for Legislation, July 1, 2022.

[497] Individuals earning over 250% of the federal poverty level can still receive care at Title X facilities, but they must pay for the full cost of service. All individuals may utilize their health insurance coverage to potentially cover costs associated with care provision.

for discounts is based on the minor's own income.[498] If a third-party is authorized or legally obligated to pay for services, such as an insurer or government agency, Title X programs must make all reasonable efforts to obtain third-party payment without application of discounts.[499]

Do Title X Projects Provide Reproductive Health Services?

Title X regulations define *family planning services* to include certain reproductive health services, such as

> a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services.[500]

The program's guidelines for providing care to clients include reproductive health services, such as breast and cervical cancer screening and prevention; STI and HIV prevention education, counseling, testing, treatment, and referral; preconception health services; basic infertility services; and counseling on establishing a reproductive life plan.[501]

Do Title X Projects Provide Contraceptive Services?

As noted above, program regulations define *family planning services* to include FDA-approved contraceptive products and natural family planning methods.[502] Program regulations require that each Title X project must provide

> a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods).... If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of acceptable and effective medically approved family planning methods and services. Title X service sites that are unable to provide clients with access to a broad range of acceptable and effective medically approved family planning methods and services, must be able to provide a prescription to the client for their method of choice or referrals to another provider, as requested.[503]

Program regulations also require projects to provide services related to family planning (including consultation by a clinician, examination, prescription and continuing supervision, laboratory examination, contraceptive supplies), in-person or via telehealth, and any referral needed to other health care when indicated, and provide for the effective usage of contraceptive devices and

[498] 42 C.F.R. §59.2 (defining *low-income family*); 42 C.F.R. §59.5(a)(7)-(8).

[499] 42 C.F.R. §59.5(a)(10).

[500] 42 C.F.R. §59.2 (defining *family planning services*).

[501] 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), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; and HHS, OPA, *Quality Family Planning*, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning. See also HHS, OPA, *Key Resources for Title X Grantees*, https://opa.hhs.gov/grant-programs/title-x-service-grants/key-resources-title-x-grantee-recipients.

[502] 42 C.F.R. §59.2; see text box in "What Are Contraceptive Services?".

[503] 42 C.F.R. §59.5(a)(1).

practices.[504] The regulations permit the HHS Secretary to omit this requirement, with an established good cause.[505]

Providing Quality Family Planning Services – Recommendations from CDC and the U.S. Office of Population Affairs (QFP) serve as the clinical guidelines for Title X projects. The document, published in 2014, advises 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" (see **Table 1** in "What Are Contraceptive Services?").[506]

OPA's Title X *Family Planning Annual Report* presents the following 2022 data on female Title X clients' primary contraceptive methods:[507]

- 21% relied on the "most effective" methods (including vasectomy, female sterilization, implants, and IUDs);
- 36% relied on "moderately effective" methods (including injectable contraception, vaginal ring, contraceptive patch, and pills);
- 18% relied on "less effective" methods (including male condoms, female condoms, contraceptive sponge, diaphragm or cervical cap, withdrawal, fertility awareness-based methods [FAM] and lactational amenorrhea methods [LAM], spermicides used alone, and non-spermicidal gel used alone);
- 5% relied on abstinence;
- 15% used no contraceptive methods because, for example, they were pregnant or seeking to become pregnant; and
- for 6%, the primary contraceptive method was unknown.

The *Family Planning Annual Report* presents the following 2022 data on male Title X clients' primary contraceptive methods:[508]

- 63% relied on any method of contraception, including relying on their partner to use any method of contraception;

[504] 42 C.F.R. §59.5(b)(1).

[505] 42 C.F.R. §59.5(b).

[506] Title X clinical guidelines are laid out in HHS, OPA, *Quality Family Planning,* https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning and HHS, OPA, *Title X Program Handbook,* "Nationally Recognized Standards of Care," July 2022, pp. 10-11, https://opa.hhs.gov/sites/default/files/2022-08/title-x-program-handbook-july-2022-508-updated.pdf. See also HHS, OPA, *Key Issues for Title X Grantees,* https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning. FDA-approved contraceptive methods are listed 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," Figure 3, "The typical effectiveness of Food and Drug Administration–approved contraceptive methods," p. 10; and FDA, *Birth Control,* https://www.fda.gov/consumers/womens-health-topics/birth-control.

[507] Axelle Clochard, Phil Killewald, Addison Larson, et al., HHS, OPA, *Family Planning Annual Report: 2022 National Summary*, October 2023, pp. 47-57, https://opa.hhs.gov/sites/default/files/2023-10/2022-FPAR-National-Summary.pdf. Percentages may not sum to 100% due to rounding. Illustrations of contraceptive methods and their effectiveness are in Kathryn M. Curtis, Naomi K. Tepper, Tara C. Jatlaoui, et al., "U.S. Medical Eligibility Criteria for Contraceptive Use, 2016," *Morbidity and Mortality Weekly Report, Recommendations and Reports*, July 29, 2016, "Figure: Effectiveness of Family Planning Methods," https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm#F-1-1_down.

[508] Ibid.

- 12% relied on abstinence;
- 14% reported not using any method; and
- for 12% of male clients, primary contraception was unknown.

Do Title X Projects Provide Abortions or Abortion Counseling?

By law, Title X funds may not be used for abortions.[509] Under program guidance, the prohibition on abortion does not apply to all the activities of a Title X grantee; it applies only to activities that are within the Title X project.[510] The grantee's abortion activities have to be "separate and distinct" from the Title X project activities.[511] The guidance notes that "a Title X project may not provide services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion, promoting or advocating abortion within Title X program activities, or failing to preserve sufficient separation between Title X program activities and abortion-related activities."[512]

Program regulations require Title X projects to offer pregnant clients information and counseling on each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination.[513] If the client requests such information and counseling, the project has to 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 client indicates they do not wish to receive such information and counseling."[514]

Do Title X Projects Provide Infertility Services?

Title X regulations require projects to provide "basic infertility services" that involve services for both partners of an infertile couple.[515] Basic infertility services include understanding the client's

[509] 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 stated that Title X funds "shall not be expended for abortions." (In FY2024, this provision appeared in Further Consolidated Appropriations Act, 2024 [P.L. 118-47], Division D, Title II.)

[510] HHS, OPA, "Title X Guidance: Frequently Asked Questions, Guidance for Nondirective Pregnancy Counseling and Care for Pregnant Clients," https://opa.hhs.gov/grant-programs/archive/title-x-program-archive/compliance-statutory-program-integrity-5.

[511] HHS, OPA, "Provision of Abortion-Related Services in Family Planning Services Projects," 65 *Federal Register* 41281-41282, July 3, 2000, https://federalregister.gov/a/00-16759. Program guidance states that a grantee's abortion-related activities and its Title X project activities can share the same facility, staff, waiting room, and records system, "so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities," for example, through allocating and prorating costs. Specifically, a Title X project's non-Title X abortion-related activities have to be distinguishable from the project's Title X activities. The 2000 guidance is cited in the 2021 rule's preamble at 86 *Federal Register* 56150: "In readopting the 2000 rule, the program is also reinstating interpretations and policies under section 1008 of the statute that were in place for much of the program's history and published in the Federal Register in 2000. 65 FR 41281 (July 3, 2000)."

[512] 65 *Federal Register* 41281.

[513] 42 C.F.R. §59.5(a)(5)(i).

[514] 42 C.F.R. §59.5(a)(5)(ii). The Title X program funds the Reproductive Health National Training Center (RHNTC), which offers training to Title X providers; RHNTC training resources on nondirective counseling include *Exploring All Options: Pregnancy Counseling Without Bias Video*, https://rhntc.org/resources/exploring-all-options-pregnancy-counseling-without-bias-video.

[515] 42 C.F.R. §59.5(a)(1). Program regulations also define family planning services as including "basic infertility services" (42 C.F.R. §59.2).

reproductive life plan, difficulty achieving pregnancy by taking a medical history, and sexual health assessments and physical exams consistent with QFP recommendations. Clinical guidelines state that "infertility visits to a family planning provider are focused on determining potential causes of the inability to achieve pregnancy and making any needed referrals to specialist care."[516]

A 2019 survey of publicly funded family planning clinics found that 66% of Title X clinics provided basic infertility services, such as infertility counseling and testing, to women and 42% provided basic infertility services to men, while 11% offered infertility treatment.[517] Another study examining directory data of Title X and ART clinics found no ART clinics received Title X funding.[518]

Do Title X Projects Provide Maternity Services?

Program regulations require Title X projects to provide a broad range of family planning services, including pregnancy testing and counseling to clients who are pregnant.[519] In 2022, seven percent of female clients reported using no method of contraception because they were pregnant or seeking to become pregnant.[520] With respect to pregnancy counseling, program regulations require Title X projects to offer pregnant clients information and counseling on each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination.[521] If the client requests such information and counseling, the project has to 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 client indicates they do not wish to receive such information and counseling."[522]

With respect to referrals, program regulations generally require Title X projects to provide for "coordination and use of referrals and linkages with primary healthcare providers, other providers of healthcare services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, who are in close physical proximity to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care."[523]

In 2022, HHS identified a range of pregnancy-related services provided by the Title X grantees:

> Title X grantees provide a broad range of family planning and preventive services related to achieving pregnancy, preventing pregnancy, and assisting women, men, and couples

[516] 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), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; and HHS, OPA, Quality Family Planning, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning.

[517] Ana Carolina Loyola Briceno, Katherine A. Ahrens, Marie E. Thomas, et al., "Availability of Services Related to Achieving Pregnancy in U.S. Publicly Funded Family Planning Clinics," *Women's Health Issues*, vol. 29, no. 6 (November-December 2019).

[518] Junying Zhao, Aaron Zahn, Samuel C. Pang, et al., "Early national trends in non-abortion reproductive care access after Roe," *Frontiers in Public Health*, vol. 12, no. 1309068 (March 2024), p. 2.

[519] 42 C.F.R. §59.5(a)(1). Program regulations also define family planning services as including "pregnancy testing and counseling" (42 C.F.R. §59.2).

[520] Axelle Clochard, Phil Killewald, Addison Larson, et al., HHS, OPA, *Family Planning Annual Report: 2022 National Summary*, October 2023, pp. 50-51, https://opa.hhs.gov/sites/default/files/2023-10/2022-FPAR-National-Summary.pdf.

[521] 42 C.F.R. §59.5(a)(5)(i).

[522] 42 C.F.R. §59.5(a)(5)(ii).

[523] 42 C.F.R. §59.5(b)(8).

with achieving their desired number and spacing of children. Services centered around preconception health and achieving pregnancy, include:

- Basic infertility services;
- Sexually transmitted infection (STI) prevention education, screening, and treatment;
- HIV testing and referral for treatment when appropriate; and
- Screening for substance use disorders and referral when appropriate to help reduce adverse pregnancy-related outcomes and improve individuals' reproductive health generally.
- Services to manage pregnancy (e.g., prenatal and delivery care) are out of the scope of Title X funding.[524]

Do Title X Projects Provide Reproductive Health Screening, Prevention, and Treatment Services?

Title X clinical guidelines recommend that providers offer STI services in accordance with the CDC's STI treatment and HIV testing guidelines, and cervical and breast cancer screening in accordance with professional recommendations such as USPSTF recommendations.[525] Title X clinical guidelines also recommend certain other "related preventive health services," such as taking a medical history. The Title X clinical guidelines emphasize family planning service sites may be the only source of health care for people of reproductive age, so both the provision of preventive health services and referral to other health care providers are an important component to providing care at Title X service sites.[526] A 2019 survey of publicly funded family planning clinics found Title X clinics reported having the following percentage of services available on site:

- 76% provided reproductive life plan assessment for all clients,
- 85% provided body mass index screening for women and 73% for men,
- 94% provided chlamydia screening for women and 89% for men,
- 93% provided gonorrhea screening for women and 89% for men,
- 88% provided syphilis screening for women and 85% for men, and
- 92% provided HIV screening for women and 89% for men.[527]

[524] Email from the HHS Office of the Assistant Secretary for Legislation, July 1, 2022.

[525] 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), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; and HHS, OPA, Quality Family Planning, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning. See text box "U.S. Preventive Services Task Force (USPSTF)" in the "What Are Reproductive Health Prevention and Treatment Services?" HHS, OPA, *Title X Program Handbook*, "Nationally Recognized Standards of Care," July 2022, https://opa.hhs.gov/sites/default/files/2022-08/title-x-program-handbook-july-2022-508-updated.pdf, pp. 10-11.

[526] Ibid. See for example "Related preventive health services" (p. 20), Table 2, Checklist of family planning and related preventive health services for women (p. 22), and Table 3, Checklist of family planning and related preventive health services for men (p. 23).

[527] Ana Carolina Loyola Briceno, Katherine A. Ahrens, Marie E. Thomas, et al., "Availability of Services Related to Achieving Pregnancy in U.S. Publicly Funded Family Planning Clinics," *Women's Health Issues*, vol. 29, no. 6 (September 2019), p. 451.

In March 2019, HHS stated that "currently, nearly 90 percent of Title X sites provide HIV testing and approximately one-third of sites offer PrEP."[528]

In general, Title X services focus on family planning and related *preventive* health services, but treatment services are more limited. Title X clinical guidelines recommend that providers offer STI services in accordance with the CDC's STI treatment guidelines.[529]

With regard to HIV/AIDS and cancers of reproductive organs, Title X clinical guidelines recommend various services related to prevention and screening, but do not explicitly address treatment.[530] Title X regulations require projects more generally to "provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, that are in close physical proximity to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care."[531]

In 2022, HHS described the availability of HIV/AIDS treatment services under Title X:

> Regarding HIV/AIDS treatment services, Title X projects provide screening and prevention, through the distribution of PrEP, for instance, however Title X funds are not used for treatment. Title X program funding is limited to services necessary to help individuals prevent or achieve pregnancy, and to help individuals determine the number and spacing of children. Thus, Title X funds are not used for treatment.
>
> Similarly, screening for cancers of reproductive organs (e.g., breast cancer, cervical cancer) is eligible for Title X funding, but treatment is not eligible.[532]

Do Title X Projects Provide Gender-Affirming Services?

In 2022, HHS discussed the availability of Title X funds for gender-affirming care:

> Gender affirming procedures and/or medication are not eligible for Title X funding, however [a] gender affirming approach to all clients is expected to be incorporated into quality family planning services. As mentioned previously, because Title X program funding is limited to services necessary to prevent or achieve pregnancy, and to help individuals determine the number and spacing of children, gender affirming procedures and/or medications would be outside the scope of the Title X program.[533]

Although gender-affirming procedures and medications are not services covered by Title X funds, the Title X clinical guidelines "encourage taking a client-centered approach" by, among other things, delivering services in "a culturally competent manner so as to meet the needs of all clients,

[528] Diane Foley, Deputy Assistant Secretary, OPA, HHS, *Increasing the Availability of PrEP Services in Title-X Funded Family Planning Service Sites: Development of a Decision Tool*, March 8, 2019, https://www.hiv.gov/blog/increasing-availability-prep-services-title-x-funded-family-planning-services-sites-development/.

[529] 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), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; and HHS, OPA, Quality Family Planning, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning.

[530] Ibid.

[531] 42 C.F.R. §59.5(b)(8).

[532] Emails from the HHS Office of the Assistant Secretary for Legislation, February 3, 2020, December 1, 2020, and July 1, 2022.

[533] Emails from the HHS Office of the Assistant Secretary for Legislation, February 3, 2020, December 1, 2020, February 9, 2021, and July 1, 2022.

including … those who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ)."[534]

The guidelines state: "in addition, professional recommendations for how to address the needs of diverse clients, such as LGBTQ persons or persons with disabilities, should be consulted and integrated into procedures, as appropriate. For example, as noted before, providers should avoid making assumptions about a client's gender identity, sexual orientation, race, or ethnicity; all requests for services should be treated without regard to these characteristics."[535] In addition, Title X is subject to nondiscrimination law and projects must be administered "in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy)."[536]

The Title X program funds the Reproductive Health National Training Center, which offers training to Title X providers.[537] The center's website lists resources related to gender-affirming services, including *The Need for Accepting and Affirming Care in Title X Settings Video,*[538] *Support LGBTQ+ Clients with Affirming Language Job Aid,*[539] and *Innovative Models for PrEP Programs in Family Planning Sites Webinar*, which discusses "services integrating PrEP and gender-affirming care."[540]

What Are Adolescent Pregnancy Prevention Programs?

Given the consequences associated with adolescent births for both the adolescent parents and their children, federal law authorizes programs designed to delay sexual activity and prevent pregnancy and the spread of STIs among children and adolescents.[541] Four HHS programs focus exclusively on providing adolescent pregnancy prevention education: the (1) Teen Pregnancy Prevention (TPP) program, (2) the Personal Responsibility Education Program (PREP), (3) the Title V Sexual Risk Avoidance Education program, and (4) the General Departmental Management (GDM) Sexual Risk Avoidance Education program.[542] These programs generally

[534] 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), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; and HHS, OPA, Quality Family Planning, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning.

[535] Ibid.

[536] HHS, OPA, *Title X Program Handbook,* July 2022, https://opa.hhs.gov/sites/default/files/2022-08/title-x-program-handbook-july-2022-508-updated.pdf, p. 69. See also the text box in the section "What Are Gender-Affirming Services?" in this report.

[537] Title X training grants are authorized under Title X of the PHSA, Section 1003, codified in the *U.S. Code* at 42 U.S.C. §300a-1. The Reproductive Health National Training Center's Services Resources are listed at https://rhntc.org/resources and include resources on LGBTQ+ services.

[538] Reproductive Health National Training Center, *The Need for Accepting and Affirming Care in Title X Settings Video*, https://rhntc.org/resources/need-accepting-and-affirming-care-title-x-settings-video.

[539] Reproductive Health National Training Center, *Support LGBTQ+ Clients with Affirming Language Job Aid*, https://rhntc.org/resources/support-lgbtq-clients-affirming-language-job-aid.

[540] Reproductive Health National Training Center, *Innovative Models for PrEP Programs in Family Planning Sites Webinar*, https://rhntc.org/resources/innovative-models-prep-programs-family-planning-sites-webinar. PrEP refers to preexposure prophylaxis for HIV prevention.

[541] For further information about adolescent birth rates and consequences of adolescent pregnancy, see CRS Report R45184, *Teen Birth Trends: In Brief*.

[542] Despite their similar names and purposes, the latter two programs have different authorizing laws and funding mechanisms. For FY2024, the Teen Pregnancy Prevention (TPP) program was funded at $101 million; the Personal (continued...)

serve children and youth, with a focus on those with risk factors for adolescent pregnancy. HHS awards program funding both competitively and by formula to grantees that may include states, community-based organizations, and selected other entities. The programs provide education and social supports in schools, afterschool programs, community centers, and other settings. The activities carried out under these programs vary, but they generally seek to support youth in making healthy choices about preventing pregnancy and STIs and reducing sexual risk behaviors.

Do Adolescent Pregnancy Prevention Programs Provide Reproductive Health Services?

Adolescent pregnancy prevention programs are intended to prevent pregnancy, STIs, and associated sexual risk behaviors for children and youths through preventive education. The programs vary in their approaches and specific activities.[543]

Grantees that use a *sexual risk avoidance* approach emphasize refraining from nonmarital sexual activity. Such programs may also address *sexual risk cessation*, or discontinuing consensual sexual activity after having engaged in it.[544] Both approaches may provide information about preventing STDs and HIV, the benefits of practicing sexual abstinence, the risks that can be associated with sexual activity outside of marriage, and strategies and tactics to practice abstaining from sex and building relationships without having sex.[545] Grantees that implement broader sexual health education programs may focus on increasing participants' knowledge about STDs and HIV, reducing risk behaviors, and building skills in problem solving and negotiation related to relationships and sexual activity. Some programs may encourage abstinence, negotiating skills around abstaining from sex, improving contraceptive use, and using condoms correctly, among other topics.[546]The Title V Sexual Risk Avoidance Education and the GDM Sexual Risk Avoidance Education programs focus exclusively on abstaining from premarital sex. The PREP program requires most grantees to place "substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections."[547] Under the TPP program, either or both approaches may be used.

Grantees that receive funding under these four programs use education models that have been developed by research organizations and other entities, with curriculum that is generally carried out by trained facilitators. Some of these programs are identified in HHS's Teen Pregnancy Prevention Evidence Review as being effective in improving behaviors related to (1) sexual

Responsibility Education Program (PREP) and Title V Sexual Risk Avoidance Education programs were each funded at $75 million (prior to sequestration); and the General Departmental Management (GDM) Sexual Risk Avoidance Education program was funded at $35 million. For information about historical funding for these programs, see CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

[543] CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs.*

[544] Mathematica, *Factors Influencing Youth Sexual Activity: Conceptual Models for Sexual Risk Avoidance and Cessation* for HHS, OASH and ACF, Office of Planning, Research, and Evaluation (OPRE), January 2021.

[545] See for example, Youth.gov, HHS Teen Pregnancy Prevention Review, "Adult Identity Mentoring (Project AIM) Program Overview" and "Heritage Keepers Abstinence Education Program Overview." These are examples of abstinence education approaches and are included for illustrative purposes only.

[546] See for example, Youth.gov, *HHS Teen Pregnancy Prevention Review*, "¡Cuídate! Program Overview" and "Be Proud! Be Responsible Program Overview." These are examples of broader sexual health education approaches and are included for illustrative purposes only.

[547] Section 513(b)(2)(A)(i) of the SSA.

activity, (2) the number of sexual partners, (3) contraceptive use, (4) STIs or HIV, and/or (5) pregnancies.[548]

Do Adolescent Pregnancy Prevention Programs Provide Contraceptive Services?

As noted, grantees that use a broader approach to providing sexual health education may use program models that provide information about contraceptives, including education on the proper use of contraceptives. Some grantees may potentially provide contraceptives such as condoms given there is no identified prohibition on distributing them in statute or program guidance.

Do Adolescent Pregnancy Prevention Programs Provide Abortions or Abortion Counseling?

As discussed above, the Hyde Amendment has routinely been added to the annual appropriations measure for HHS to restrict federal funds to pay for abortions, except in cases of rape, incest, or endangerment of a mother's life.[549] Two of the four adolescent pregnancy prevention programs, the GDM Sexual Risk Avoidance Education program and the TPP program, are funded via annual appropriations measures for HHS; therefore, the Hyde Amendment applies to these programs.

The other two programs, Title V Sexual Risk Avoidance Education program and PREP, are funded via mandatory appropriations through their authorizing statutes under SSA Title V. These authorizing provisions do not address abortion. However, in a 2024 funding announcement for the Title V Sexual Risk Avoidance Education program, HHS specified that "Referrals cannot be made to family planning organizations that provide abortions." HHS further specified that "referral resources should include, but not be limited to, substance use and abuse and mental health services."[550] The PREP grant announcements do not appear to address abortion.[551] In the absence of program guidance on the topic, general HHS guidance on prohibiting funding for abortions applies.[552]

Do Adolescent Pregnancy Prevention Programs Provide Infertility Services?

The adolescent pregnancy prevention programs do not provide infertility services.

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[548] The Teen Pregnancy Prevention Evidence Review is managed by the Assistant Secretary for Planning and Evaluation (ASPE) in collaboration with the Administration for Children and Families' (ACF's) Family and Youth Services Bureau (FYSB), and the former Office of Adolescent Health (OAH) within OASH. HHS contracts with Mathematica Policy Research, Inc., a social policy research organization, to review studies of teen pregnancy prevention programs. Note that the review was active from 2010 to 2019, and subsequently reestablished as part of FY2022 appropriations. The website for these models and studies is at Youth.gov, HHS Teen Pregnancy Prevention Evidence Review, https://tppevidencereview.youth.gov/EvidencePrograms.aspx.

[549] For more information about the Hyde Amendment, see "Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?" in this report.

[550] See, HHS, ACF, Administration on Children, Youth, and Families (ACYF), FYSB, *Standing Announcement for Title V State Sexual Risk Avoidance Education*, HHS-2024-ACF-ACYF-SRAE-0044, 2024. The funding announcement for the Title V Competitive Sexual Risk Avoidance Education program (HHS-2024-ACF-ACYF-TS-0040, 2024) does not appear to address abortion.

[551] See, for example, HHS, ACF, FYSB, *Competitive Personal Responsibility Education Program (PREP)*, HHS-2024-ACF-ACYF-AK-0032, 2024.

[552] HHS, Office of the Assistant Secretary for Resources and Technology, Office of Grants, *HHS Grants Policy Statement*, January 1, 2007.

Do Adolescent Pregnancy Prevention Programs Provide Maternity Services?

The adolescent pregnancy prevention programs do not provide maternity services.

Do Adolescent Pregnancy Prevention Programs Provide Reproductive Health Screening, Prevention, and Treatment Services?

The adolescent pregnancy prevention programs do not provide reproductive health screening or treatment services. The programs do address preventive services to prevent pregnancy, STDs, and related sexual risk outcomes.

Do Adolescent Pregnancy Prevention Programs Provide Gender-Affirming Services?

The adolescent pregnancy prevention programs do not provide gender-affirming services.

What Federal Grant Programs Address Sexually Transmitted Infections (STIs)?

Both CDC and HRSA provide funding to address STIs. CDC's program focuses on multiple STIs, while HRSA's targets HIV/AIDS specifically.

What Centers for Disease Control and Prevention (CDC) Programs Address STIs?

A number of programs administered by CDC address STIs, including several grant programs administered by the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).[553] For example

- **HIV Prevention and Control:** CDC provides technical and funding assistance to community-based organizations and state/local health departments on many aspects of planning, implementing, and evaluation of HIV prevention programs.[554] This includes grant programs funded as part of the Ending the HIV Epidemic in the U.S. (EHE) initiative to reduce new HIV infections through scaling up prevention and treatment strategies in implementing jurisdictions.[555]
- **STI Prevention and Control:** CDC funds cooperative agreements (a type of grant program) for STI prevention and control programs to health departments in the 50 U.S. states; the District of Columbia; Puerto Rico; the U.S. Virgin Islands; Baltimore, MD; Chicago, IL; Los Angeles, CA; Philadelphia, PA; New York

[553] CDC, NCHHSTP, "NCHHSTP Partners and Programs," February 24, 2024, https://www.cdc.gov/nchhstp/partners-programs/index.html.

[554] CDC, "HIV Program Resources," https://www.cdc.gov/hiv/programresources/index.html; and CDC, HIV Funding and Budget, https://www.cdc.gov/hiv/funding/index.html.

[555] CDC, NCHHSTP, "HIV Prevention Priorities," https://www.cdc.gov/nchhstp/priorities/hiv-prevention.html. See also HHS, Office of Infectious Disease and HIV/AIDS Policy, "EHE Priority Jurisdictions," December 20, 2023, https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/jurisdictions/phase-one.

City, NY; and San Francisco, CA.[556] The current program targets three major STIs: chlamydia, gonorrhea, and syphilis.[557]

These are long-standing assistance programs, although award structures, goals, and amounts often change from one year to the next. Current programs support a number of activities, for example, referrals for screening and treatment, contact tracing and partner notification, and provider education and training. Additional CDC assistance programs may address HIV and STI prevention in part. These include programs for adolescents and young adults, LGBTQ+ populations, pregnant people, and epidemiology and laboratory capacity; among others.[558]

What Is the Ryan White HIV/AIDS Program?

The Ryan White HIV/AIDS program ("Ryan White") is the main federal program that targets HIV/AIDS prevention and treatment, administered by HRSA. Most of the program funding is distributed to eligible entities based on formulas that take into account the number of people living with HIV/AIDS, and funding is divided among the individual grant programs (Parts A, B, C, D, and F).[559] These grants to metropolitan areas and states provide funding to HIV primary medical care, medication, and other HIV-related services to low-income people with HIV.[560] The Ryan White program is considered to be a residual payer as its funds are not used to provide services to individuals with another source of coverage (e.g., private health insurance) and instead are a payer of last resort.[561]

Ryan White Part A provides grants to eligible metropolitan and transition areas with high numbers of people living with HIV to provide core medical services and support services to people with HIV.[562] Part B provides funding to states and jurisdictions for the AIDS Drug Assistance Program (ADAP), which is used to pay for HIV/AIDS medications for individuals who do not have another source of payment. Part C provides grants to health centers, family planning clinics, and community-based organizations, among others, to support outpatient HIV early intervention services to the safety net population. Part D provides grants to public and private nonprofit entities for family-centered care for women, infants, children, and youth with HIV/AIDS. The Ryan White program is required to serve people with HIV/AIDS and, as such, does not provide PrEP; it does, however, through the Part C-Early Intervention Service program, provide testing and counseling for individuals at risk of acquiring HIV.[563] Part F authorizes demonstration and

[556] Cooperative agreements are a form of financial assistance used when there will be substantial federal programmatic involvement. Substantial involvement means that the awarding office program staff will collaborate or participate in project or program activities. See Grants.gov, "Grant Terminology," https://www.grants.gov/learn-grants/grant-terminology.

[557] CDC, Strengthening STD Prevention and Control for Health Departments (STD PCHD), July 22, 2024, https://www.cdc.gov/sti/php/projects/pchd.html.

[558] Ibid.

[559] Ryan White has five parts each with multiple components; for further information, see the Appendix in CRS Report R44282, *The Ryan White HIV/AIDS Program: Overview and Impact of the Affordable Care Act*.

[560] 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*, and HRSA, "HIV/AIDS Programs," http://hab.hrsa.gov/

[561] According to the Ryan White statute (PHSA §2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i)), the program is the payer of last resort. Program guidance clarifies that this includes Medicaid among other federal programs. See HHS, HRSA, HIV/AIDS Bureau, "Ryan White HIV/AIDS Program: Part A Manual," revised 2023, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.

[562] HRSA, Ryan White HIV/AIDS Program, *Program Parts & Initiatives*, https://ryanwhite.hrsa.gov/about/parts-and-initiatives.

[563] HRSA, HAB, *Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds*, Policy (continued...)

training efforts, including provider training, special projects of regional and national significance, and the Minority AIDS Initiative (MAI). MAI provides additional funds to Ryan White-funded entities to support education and outreach to increase minority access to Ryan White services. The program has also received funding through the Ending the HIV Epidemic (EHE) in the United States initiative. In 2023, the program received additional funding for jurisdictions with the highest levels of HIV transmission to link people with HIV to essential care, support, and treatment, and provide workforce training and technical assistance.[564] Additional funding for this initiative was provided in 2022, 2021, and 2020.[565]

What Is the National Breast and Cervical Cancer Early Detection Program?

In 1990, Congress established the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) within CDC. Congress authorized CDC to fund American Indian and Alaska Native tribes and tribal organizations through NBCCEDP in 1993.[566] This program provides low-income, uninsured, and underserved women access to screening and diagnostic services to detect breast and cervical cancer.[567] Currently, the program funds 71 grantees: all 50 states, the District of Columbia, five U.S. territories, two freely associated nations, and 13 American Indian/Alaska Native tribes or tribal organizations.[568]

Despite various coverage requirements for these services (as described in this report; see the sections on Medicare and Medicaid programs and certain private health insurance coverage), CDC reports that many women remain eligible for the NBCCEDP services due to lack of an alternate payment source. The NBCCEDP is funded through annual discretionary appropriations,[569] which historically have not been sufficient to meet the needs of all eligible women. According to CDC:

> During 2015-2017, about 5.7% of U.S. women were eligible for NBCCEDP cervical cancer screening services, and the program served 6.8% of those eligible women. During 2016-2017, about 5.3% of U.S. women were eligible for NBCCEDP breast cancer screening services, and the program served 15.0% of those eligible women.[570]

Clarification Notice (PCN) #16-02, October 2022, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/service-category-pcn-16-02-final.pdf.

[564] HHS Press Office, "HHS Awards $147 Million to Support Ending the HIV Epidemic in the United States," press release, April 27, 2023, https://www.hhs.gov/about/news/2023/04/27/hhs-awards-147-million-support-ending-hiv-epidemic-united-states.html.

[565] HHS Press Office, "HHS Awards $115 Million to Support Ending the HIV Epidemic in the United States," June 16, 2022, https://www.hhs.gov/about/news/2022/06/16/hhs-awards-115-million-to-support-ending-hiv-epidemic-in-united-states.html, and HHS, HRSA, "HRSA Awards $99 Million to End the HIV Epidemic in the United States," March 4, 2021, https://www.hrsa.gov/about/news/press-releases/hrsa-awards-99-million-to-end-hiv-epidemic, and HHS Press Office, "HHS Awards $117 Million to End the HIV Epidemic in the United States," February 26, 2020, https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2020/02/26/hhs-awards-117-million-to-end-hiv-epidemic-in-the-united-states.html.

[566] See P.L. 103-183.

[567] CDC, National Breast and Cervical Cancer Early Detection Program, "About National Breast and Cervical Cancer Early Detection Program," https://www.cdc.gov/breast-cervical-cancer-screening/about/index.html.

[568] Ibid.

[569] CDC, *Justification of Estimates for Appropriation Committees, FY2025*, p. 133, https://www.cdc.gov/budget/documents/fy2025/FY-2025-CDC-congressional-justification.pdf.

[570] CDC, National Breast and Cervical Cancer Early Detection Program, "About National Breast and Cervical Cancer Early Detection Program" https://www.cdc.gov/breast-cervical-cancer-screening/about/. See also Florence Tangka et al., "The Eligibility and Reach of the National Breast and Cervical Cancer Early Detection Program after (continued...)

CDC states that cervical cancer screenings provided under this program are targeted toward women who have never or rarely been screened for cervical cancer, with a focus on reducing disparities and reaching women who may have delayed screening or services during the COVID-19 pandemic.[571] Individuals who screen positive in CDC's discretionary-funded Breast and Cervical Cancer Early Detection Program are given presumptive Medicaid eligibility for services including, but not limited to, treatment of the cancer.

Grant Programs That May Be Used to Support Reproductive Health Services

The following questions discuss federal programs that have broad purposes but may provide some types of reproductive health services. General descriptions of these programs, and brief explanations of the extent of their focus on reproductive health, appear below. The Pregnancy Assistance Fund is no longer an active program and is included for historical reference.

How Does the Federal Health Center Program Support Reproductive Health Services?

The Federal Health Center Program, administered by HHS's HRSA,[572] awards grants to nonprofit, tribal, or state and local government facilities to provide outpatient health services to populations located in underserved areas. These facilities are required to be Medicaid providers and to provide services to all individuals regardless of their ability to pay.[573] Health centers focus on providing primary care services and are required to provide voluntary family planning services. Health center data from 2023 reports that more than 2.9 million visits were for contraceptive management, provided to nearly 1.7 million patients.[574] While specific health services may vary by facility, health centers generally provide preventive health services, including reproductive health screenings. In 2023, health centers provided more than 1.9 million mammograms, according to health center data. Health centers also provide STI testing and treatments. In particular, from 2020 to 2022, health centers received supplemental funding as part of the Ending the HIV Epidemic: A Plan for America initiative to identify individuals who may be at risk for contracting the virus, provide preventive services, test for HIV, and prescribe PrEP when appropriate.[575] Health centers must provide access to pharmaceutical services either onsite

Implementation of the Affordable Care Act," *Cancer Causes & Control*, vol. 31, pp. 473-489, March 10, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7895499/pdf/nihms-1578514.pdf.

[571] CDC, *Justification of Estimates for Appropriation Committees, FY2023*, p. 167, https://www.cdc.gov/budget/documents/fy2023/FY-2023-CDC-congressional-justification.pdf. Individuals who screen positive in CDC's discretionary-funded Breast and Cervical Cancer Early Detection Program are given presumptive Medicaid eligibility for services including, but not limited to, treatment of the cancer.

[572] These facilities are also called federally qualified health centers (FQHCs) or community health centers.

[573] CRS Report R43937, *Federal Health Centers: An Overview*. See 42 C.F.R. §51c.102(h).

[574] HHS, HRSA, "Uniform Data System National Report 2023, Table 6A: Selected Diagnoses and Services Rendered," https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6A&year=2023.

[575] HHS, HRSA, "HHS Awards $117 Million to End the HIV Epidemic in the United States," February 26, 2020, https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https:/www.hhs.gov/about/news/2020/02/26/hhs-awards-117-million-to-end-hiv-epidemic-in-the-united-states.html. HHS, HRSA, "HHS Awards Over $48 Million to Health Centers for Ending the HIV Epidemic in the U.S. Initiative," https://www.hhs.gov/about/news/2021/09/16/hhs-awards-48-million-to-health-centers-to-end-the-hiv-epidemic.html; and "HHS Secretary Becerra Announces More than $20 Million in Funding to End HIV Epidemic," August 23, 2022, https://www.hhs.gov/about/news/2022/08/23/hhs-secretary-becerra-announces-more-than-20-million-in-funding-end-hiv-epidemic.html. FY2023 funds for HRSA were (continued...)

or through contracts. Health centers may receive Title X grants and must comply with program requirements if they do. Health centers continued to provide these services in 2023, with 4.0 million HIV tests provided and 216,000 visits for PrEP.[576] Health centers are prohibited from using federal funds to provide abortions.[577] No information is available about whether health centers provide infertility services.

How Does the Title V Maternal Child Health State Block Grant Support Reproductive Health Services?

The Title V State Maternal and Child Health (MCH) Block Grant program, administered by HRSA's Maternal and Child Health Bureau (MCHB), is permanently authorized under Title V of the SSA.[578] This federal-state partnership program provides formula-based block grants to all 50 states and nine jurisdictions (collectively discussed hereinafter as states), which are required to match $3 for every $4 in federal funds allocated to the state. Often referred to in short as "Title V," this program aims to provide states the flexibility to address the unique needs of its population of pregnant women, mothers, infants, and children, including children and youth with special health care needs (CYSHCN),[579] with a focus on MCH populations with low-income or limited access to health services.[580]

Federal law requires states to use 30% of federal funds for preventive and primary care services for children and 30% of federal funds for services specific to CYSHCN. Aside from these requirements, states have the discretion to determine which populations and MCH services to prioritize. MCHB categories these services as (1) direct health care services (e.g., primary or preventive care services); (2) enabling services (e.g., care coordination services that improve health access and outcomes); and (3) public health services and systems (e.g., health education campaigns). In FY2022, the most recent year for which data are available, states collectively spent 28.1% of program funds on direct services, 40.7% on enabling services, and 31.2% on public health services and systems. Children aged 1-21 and CYSHCN collectively accounted for the largest proportion of expenditures (65.9%), followed by pregnant women (13.7%), infants (13.1%), and others (7.3%).[581]

The extent to which states use Title V State MCH Block Grant funds toward reproductive health services and the degree to which certain services are included or excluded can vary by state. Each state is required to coordinate with other federal, state, and local entities, including Medicaid and the Title X program, to prevent duplicated efforts. The program is intended to serve as a gap-

used to support HRSA's HIV/AIDS Bureau and not the health center program. No information is available about FY2024 funding as of the date of this report's publication.

[576] HHS, HRSA, "Uniform Data System National Report 2023, Table 6A: Selected Diagnoses and Services Rendered," https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6A&year=2023.

[577] Health centers receive funding both under discretionary appropriations, which are subject to the Hyde Amendment, and from the Community Health Center Fund (see CRS Report R43911, *The Community Health Center Fund: In Brief*). Recent appropriations for the Community Health Center Fund have applied Hyde language in appropriations to these funds. See Section 101(d), Division G, Title I, Subtitle A of P.L. 118-42.

[578] SSA §501(a)(1).

[579] Children who "have or are at risk of having chronic physical, development, behavioral, or emotional conditions" and who generally require more intensive types or an increased volume of services than other children are considered as children or youth with special health care needs (CYSHCN), according to HRSA. See HRSA, Glossary, https://mchb.tvisdata.hrsa.gov/Glossary/Glossary.

[580] For more information, see CRS Report R48088, *Maternal and Child Health Services Block Grant: Overview and Issues for Congress*, and CRS In Focus IF12685, *Title V State Maternal and Child Health (MCH) Block Grants*.

[581] Ibid.

filling resource and payor-of-last resort; that is, the Title V State MCH Block Grant program cannot be used to provide services covered by other federal programs. Each state submits a combined Application/Annual Report that describes the state's MCH priorities, budget and expenditure plans, coordination efforts, and performance metrics related to the MCH priority areas. For example, performance measurement data from FY2022 reported that 47 states selected "well-woman visit" and 13 states selected "risk-appropriate perinatal care" as programmatic focus areas; details on the specific services or strategies measured under these indicators, such as reproductive health screenings or maternity services, are provided in individual state reports.[582]

The grant receives funding from discretionary appropriations provided in the annual appropriations measure for LHHS. As such, these funds are subject to the LHHS bill's abortion restrictions (commonly referred to as the Hyde Amendment).[583]

How Does the Social Services Block Grant Program Support Reproductive Health Services?

The Social Services Block Grant Program (SSBG), administered by the HHS Administration for Children and Families (ACF), provides flexible funding to states and territories to support a wide range of social services.[584] Federal regulations issued in 1993 established uniform definitions for 28 main SSBG service categories, including *family planning services, pregnancy and parenting,* and *health related and home health services*.[585] States are not required to spend SSBG funds in any particular service category and may support other services as well. In FY2020, the most recent year for which complete data are available, roughly 0.3% of all SSBG expenditures were spent on family planning services, 0.2% were spent on pregnancy and parenting, and roughly 0.9% were spent on health-related services.[586] The SSBG is an annually appropriated capped entitlement. Mandatory appropriations for the SSBG are provided each year in the LHHS Appropriations Act and, as such, are subject to the LHHS bill's abortion-related restrictions (commonly referred to as the Hyde amendment).[587]

[582] For more information, including links to individual state reports, aggregated budget and expenditure data, and the FY2022 National Summary, see HRSA's Title V Information System, available at https://mchb.tvisdata.hrsa.gov/. Note that TVIS data are estimates/projections that are collected once each year at the time of application and are not meant to be the final fiscal record of note. For example, FY2022 data were reported in July 2023 and may not reflect final expenditures.

[583] For more information, see the "Restrictions Related to Certain Controversial Issues" section in CRS Report R46492, *Labor, Health and Human Services, and Education: FY2020 Appropriations*. For more information about the Hyde Amendment, see "Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?" in this report. Also see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*.

[584] CRS In Focus IF10115, *Social Services Block Grant*, and CRS Report 94-953, *Social Services Block Grant: Background and Funding*.

[585] These regulations were codified at 45 C.F.R. §96, Appendix A.

[586] For more information, see HHS, ACF, Office of Community Services, *Social Services Block Grant Program Annual Report 2022*, https://www.acf.hhs.gov/ocs/report/ssbg-annual-report-fy-2022. These percentages were calculated based on spending from state Social Services Block Grant (SSBG) allotments as well as, where applicable, state transfers to SSBG from the Temporary Assistance for Needy Families (TANF) block grant.

[587] For more information, see the "Restrictions Related to Certain Controversial Issues" section in CRS Report R47936, *Labor, Health and Human Services, and Education: FY2024 Appropriations*. For more information about the Hyde Amendment, see "Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?" in this report. Also see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*.

How Does the Healthy Start Program Support Reproductive Health Services?

The Healthy Start program, administered by HRSA's MCHB, aims to improve infant and maternal health outcomes before, during, and after pregnancy and to reduce persistent racial and ethnic disparities in infant deaths and adverse perinatal health outcomes.[588] The program awards competitive grants to local entities that serve communities with high infant mortality rates and/or poor perinatal health outcomes. In FY2024, Healthy Start provided over $105 million across 113 grantees.[589]

Healthy Start grantees support local community participants with a range of services that may include health education and promotion activities (e.g., group prenatal, childbirth, and parenting education), case management and informational services (e.g., health insurance and social services enrollment, screening and referrals, peer support groups), and community action networks (i.e., local partnerships and collaborations to improve MCH). In FY2019, the Healthy Start program also began hiring clinical service providers within existing program sites. Healthy Start-funded clinicians may provide a range of well-woman care (e.g., contraceptive counseling, reproductive health screenings), maternity services (e.g., prenatal and postpartum care), and behavioral health services (e.g., screening for depression or substance use disorders). In FY2021 and FY2022, the Healthy Start program awarded supplemental grants to train, certify, and pay for community-based doula services.[590] Overall, the extent to which Healthy Start programs provide reproductive health-related services can vary, as grantees aim to tailor activities to their local communities' needs.

The program is authorized through FY2025 and receives funding from discretionary appropriations provided in the annual appropriations measure for LHHS. As such, these funds are subject to the LHHS bill's abortion restrictions (commonly referred to as the Hyde Amendment).[591]

How Does the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Support Reproductive Health Services?

The federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program supports home visiting services for pregnant women and families with young children who reside in communities that have concentrations of poor child health and other indicators of risk.[592] Home visiting services involve assessing family needs, educating and supporting parents, and providing referrals and coordinating services. While the focus of the MIECHV program is not on reproductive health services, the program provides information and resources about related topics such as health during pregnancy, postpartum care, and birth spacing. In the absence of MIECHV

[588] Section 330H of the Public Health Service Act, as amended by P.L. 116-36.

[589] Health Resources and Services Administration, *Justification of Estimates for Appropriations Committees*, Fiscal Year 2025, p. 222, https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2025.pdf.

[590] A doula is a trained nonmedical professional who can provide physical, emotional, and informational support to a birthing person and their family before, during, and after childbirth. See DONA International, "What is a Doula," https://www.dona.org/what-is-a-doula-2/.

[591] For more information, see the "Restrictions Related to Certain Controversial Issues" section in CRS Report R46492, *Labor, Health and Human Services, and Education: FY2020 Appropriations*. For more information about the Hyde Amendment, see "Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?" in this report. Also see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*.

[592] CRS In Focus IF10595, *Maternal, Infant, and Early Childhood Home Visiting Program*.

statutory language or other guidance specific to the program, the general HHS guidance on prohibiting funding for abortions applies.[593]

At the federal level, the MIECHV program is jointly administered by HRSA and ACF at HHS. The ACA, and amendments to the act, have directly appropriated mandatory funding for the program. Most recently, the Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022 (§6101 of the Consolidated Appropriations Act, 2023, P.L. 117-328) reauthorized the program and provided funding for FY2023 through FY2027.

The MIECHV program predominantly provides funding for the 50 states, District of Columbia, five territories, and tribal entities. Generally, a jurisdiction's public health or social services department is the lead agency that administers the funds, and this entity determines which home visiting model(s) to implement in the jurisdiction. However, entities must use a majority of MIECHV funding to implement evidence-based home visiting models and no more than 25% of funding to implement and evaluate models that have shown promise of effectiveness, all according to criteria established by HHS as required under current law. Depending on the model, home visits may be conducted by nurses, mental health clinicians, social workers, educators, or paraprofessionals with specialized training. Generally, they visit the homes of eligible families on a regular basis (e.g., weekly or monthly) over an extended period (e.g., six months or longer) to provide support to caregivers and children, such as providing information about birth spacing, breastfeeding, and nutrition. In FY2023, the MIECHV Program served all 50 states, the District of Columbia, and five U.S. territories. Among the 56 awardees, states and jurisdictions served over 139,000 parents and children in approximately 70,000 families and provided over 919,000 home visits.[594]

How Did the Pregnancy Assistance Fund (PAF) Program Support Reproductive Health Services?

The Pregnancy Assistance Fund (PAF) was active from FY2010-FY2019 and sought to improve the educational, health, and social outcomes for vulnerable individuals during pregnancy and the postnatal period.[595] This group included expectant and parenting teens, women, men, and their families, as well as women of any age who were survivors of domestic violence, sexual violence, sexual assault, and stalking. PAF was administered by OPA in HHS's Office of the Assistant Secretary for Health (OASH). The ACA established the program and authorized funding of $25 million annually from FY2010 through FY2019.[596] (No new grants were issued after FY2019, effectively terminating the program; however, the ACA provisions that apply to the program have not been repealed.)

HHS distributed PAF funding on a competitive basis to states, the District of Columbia, U.S. territories, and tribal entities. These grantees could decide how to use funding under four purpose areas. Three of the purpose areas focused on providing services to the eligible expectant and parenting population through subgrants and partnerships.[597] In general, grantees provided subgrants to school districts, community service organizations, and institutions of higher

[593] HHS, Office of the Assistant Secretary for Resources and Technology, Office of Grants, *HHS Grants Policy Statement*, January 1, 2007.

[594] HHS, ACF, and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program*, Program Brief, June 2024, p. 2, https://mchb.hrsa.gov/sites/default/files/mchb/about-us/program-brief.pdf.

[595] For further information, see CRS Report R45426, *The Pregnancy Assistance Fund: An Overview*.

[596] 42 U.S.C. §18201-18204.

[597] The fourth category focuses on public awareness about such services; however, HHS advises that grantees may not use funding solely for public awareness activities.

education (IHE) that directly served the expectant and parenting population.[598] For the most recent year of available data (2017-2018), the most common services provided to expectant and recent parents were parenting supports, concrete supports (e.g., transportation), and health care services.[599] Health care services included health insurance supports and enrollment assistance, reproductive health care, primary health care, and breastfeeding skills and resources. (These health-related terms are not further defined.)

The PAF authorizing statute addresses reproductive health care in selected contexts. Subgrantees that are IHEs must annually assess how well they are meeting the needs of pregnant and parenting college students, including whether the IHE offers maternity coverage and availability of riders for additional family members in student health coverage.[600] Separately, grantees that provide training and technical assistance—related to domestic violence, sexual violence, sexual assault, and stalking against pregnant women or women who were pregnant within the past year—must address certain issues, including evaluating the impact of the violence or stalking on the pregnant woman's health.[601]

HHS advised in past PAF funding announcements that public awareness and education activities should not include abortion services. Further, the announcements stated that "abortion referrals are not within the scope of permissible referral services under this grant and, therefore, grant funds may not be used for this purpose."[602]

[598] CRS Report R45426, *The Pregnancy Assistance Fund: An Overview*.

[599] HHS, OASH, OAH (now known as the Office of Population Affairs [OPA]), *Performance Measures Snapshot The Pregnancy Assistance Fund (PAF) Program: 2017-2018*, May 2019. See also Amy Margolis et al., "Meeting the Multifaceted Needs of Expectant and Parenting Young Families Through the Pregnancy Assistance Fund," *Maternal and Child Health Journal*, vol. 24 (May 8, 2020).

[600] 42 U.S.C. §18203(b)(4).

[601] 42 U.S.C. §18203(d)(3).

[602] See, for example, HHS, OASH, OAH, *Announcement of Anticipated Availability of Funds for Support for Expectant and Parenting Teens, Women, Fathers, and Their Families*, AH-SP1-18-001, 2018.

Appendix A. Federal Requirements on Private Health Insurance Coverage of Reproductive Health Services

The following table summarizes federal requirements applicable to private health insurance coverage of various reproductive health services. The table includes a brief description and citations for each requirement, and it identifies the types of private health insurance plans subject to the requirement. To the extent that a reproductive health benefit coverage requirement includes provisions related to cost-sharing, medical management requirements, or out-of-network providers, this is also summarized in the table below.

For further discussion of these federal requirements and brief background on private health insurance plans, see the "Federal Regulation of Private Health Insurance" section in this report.

Table A-1. Federal Requirements on Private Health Insurance Coverage of Reproductive Health Services

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[c]	Applies Out-of-Network?[d]	Group[a]			
					Fully Insured[b]			
					Large Group[e]	Small Group[e]	Self-Insured[f]	Nongroup[g]
Requirements applicable to coverage of various reproductive health services[h]								
42 U.S.C. §300gg-6, 42 U.S.C. §18022 45 C.F.R. §156.100-155, 45 C.F.R. §147.150	Coverage of the Essential Health Benefits (EHB)	Applicable plans are required to cover 10 categories of health care services.[i] EHB requirements apply to coverage of certain reproductive health services, in some cases subject to state and plan variation. Cost sharing is possible and may vary by plan. There are provisions limiting cost sharing on the EHB.[j]	Allowed; may vary by state and by plan	No	N.A.[j]	✓	N.A.[j]	✓
42 U.S.C. §300gg-13, 45 C.F.R. §147.130-133	Coverage of Certain Preventive Services Without Cost Sharing	Specified items and services (including various reproductive health services) must be covered without cost sharing if recommended by the ACIP or USPSTF, or if listed in HRSA guidelines for women's or pediatric preventive services.[k]	Allowed; may vary by plan	Not generally	✓	✓	✓	✓
Contraceptive services								
42 U.S.C. §300gg-13, 45 C.F.R. §147.130-133	*Applicability of preventive services requirement*	Applicable plans are required to cover, without cost-sharing, contraceptives and contraceptive care as recommended in the Women's Preventive Services Guidelines supported by HRSA.[l] An exemption is available to most types of nonprofit and for-profit entities with sincerely held religious or moral beliefs against contraception.	Allowed; may vary by plan	Not generally	✓	✓	✓	✓

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[c]	Applies Out-of-Network?[d]	Group[a]			
					Fully Insured[b]			
					Large Group[e]	Small Group[e]	Self-Insured[f]	Nongroup[g]
Abortion services and counseling[m]								
42 U.S.C. §18023, 45 C.F.R. §156.115(c) and 45 C.F.R. §156.122(b), each referencing 45 C.F.R. §156.280	*Applicability of EHB requirement*	Even if a state selects an EHB benchmark plan that provides abortion coverage, plans in the state that are otherwise subject to EHB requirements are not federally required to provide abortion coverage.	N.A.	N.A.	N.A.	✓	N.A.	✓
42 U.S.C. §18023, 45 C.F.R. §156.280	*Provisions affecting QHPs sold in exchanges*[n]	A state may prohibit abortion coverage by QHPs offered in its exchange. Insurers offering QHPs that cover nontherapeutic abortions may not use federal funds (attributable to eligible individuals' PTCs) to pay for such services. There are related rules about segregation of plan payments for nontherapeutic abortion services versus other covered services.	N.A.	N.A.	N.A.	QHPs in SHOPs	N.A.	QHPs in exchanges
42 U.S.C. §18023, 45 C.F.R. §156.280	*Federal non-preemption of state laws*	Federal provisions do not preempt state abortion laws. States may prohibit, require, and otherwise regulate abortion coverage by the plans they regulate.	N.A.	N.A.	✓	✓	N.A.	✓

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[c]	Applies Out-of-Network?[d]	Group[a]			
					Fully Insured[b]			
					Large Group[e]	Small Group[e]	Self-Insured[f]	Nongroup[g]
42 U.S.C. §2000e(k), 29 C.F.R. §1604.10(b)	*Applicability of pregnancy-related conditions requirement*	This provision does not require coverage of abortion, "except where the life of the mother would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion," while "nothing herein, however, precludes an employer from providing abortion benefits or otherwise affects bargaining agreements in regard to abortion."	See "Coverage of Pregnancy-Related Conditions" in this table.		✓	✓ (groups over 15)	✓ (groups over 15)	N.A.
Infertility services[m]								
42 U.S.C. §300gg-6, 42 U.S.C. §18022, 45 C.F.R. §156.115	*Applicability of EHB requirement*	If a state selects a benchmark plan that includes infertility treatments in one or more EHB categories, applicable plans in that state would be required to offer substantially equal coverage.	Allowed; may vary by state and by plan	No	N.A.[j]	✓	N.A.[j]	✓
Maternity services								
42 U.S.C. §300gg-6, 42 U.S.C. §18022, 45 C.F.R. §156.110, 45 C.F.R. §156.115	*Applicability of EHB requirement*	One of the 10 EHB categories is "maternity and newborn care." Applicable plans must provide substantially equal coverage in this category, and other categories as relevant, as the state's EHB benchmark plan.	Allowed; may vary by state and by plan	No	N.A.[j]	✓	N.A.[j]	✓
42 U.S.C. §300gg-13, 45 C.F.R. §147.130	*Applicability of preventive services requirement*	This provision includes the requirement for applicable plans to cover certain prenatal and post-natal services without cost sharing.[k]	Allowed; may vary by plan	Not generally	✓	✓	✓	✓

					Group[a]			
					Fully Insured[b]			
Authority	**Provision**	**Coverage and Cost-Sharing Requirements**	**Medical Management Approaches Allowed?[c]**	**Applies Out-of-Network?[d]**	**Large Group[e]**	**Small Group[e]**	**Self-Insured[f]**	**Nongroup[g]**
42 U.S.C. §2000e, 29 C.F.R. §1604.10, 29 C.F.R. §1604 Appendix[o]	Coverage of Pregnancy-Related Conditions[p]	Applicable employers offering health insurance must cover "expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions" for employees enrolled in the group health plan. Plan features (e.g., any cost-sharing or medical management requirements, out-of-network coverage) as related to pregnancy-related conditions must not be substantially different than they are for other covered medical conditions. If the plan offers coverage to employees' spouses and dependents, this coverage also applies to employees' spouses, but not necessarily to other dependents, enrolled in the plan.			✓	✓ (groups over 15)	✓ (groups over 15)	N.A.
42 U.S.C. §300gg-25, 45 C.F.R. §146.130, 45 C.F.R. §148.170	Coverage of Minimum Hospital Stay After Childbirth[q]	Plans that cover maternity hospital stays are prohibited from restricting the length of a hospital stay for childbirth for either the mother or newborn child to less than 48 hours following vaginal deliveries and to less than 96 hours following caesarian deliveries. Cost sharing is allowed, as specified.[r]	Prior authorization requirements for these stays, and incentives offered for shorter stays, are prohibited.[r]	Not specified	✓ (GF)[s]	✓ (GF)[s]	✓ (GF)[s]	✓ (GF)[s]
Reproductive health screening, prevention, and treatment services								
42 U.S.C. §300gg-13, 45 C.F.R. §147.130	*Applicability of preventive services requirement*	This provision includes the requirement that specified reproductive health screening and preventive services must be covered without cost sharing.[k]	Allowed; may vary by plan	Not generally	✓	✓	✓	✓

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[c]	Applies Out-of-Network?[d]	Group[a]			
					Fully Insured[b]			
					Large Group[e]	Small Group[e]	Self-Insured[f]	Nongroup[g]
42 U.S.C. §300gg-27	Coverage of Reconstruction After Mastectomy[t]	Plans that provide coverage for mastectomies must also cover breast reconstruction services and prostheses. This applies for women and men, and it need not be connected to a cancer diagnosis. Cost sharing is allowed, if consistent with cost sharing for other covered medical/surgical benefits.[u]	Not specified	Not specified	✓ (GF)[s]	✓ (GF)[s]	✓ (GF)[s]	✓ (GF)[s]
Gender-affirming services[m]								
42 U.S.C. §300gg-6, 42 U.S.C. §18022, 45 C.F.R. §156.115	*Applicability of EHB requirement*	If a state selects a benchmark plan that includes gender-affirming services in one or more EHB categories, applicable plans in that state would be required to offer substantially equal coverage.	Allowed; may vary by state and by plan	No	N.A.[j]	✓	N.A.[j]	✓
42 U.S.C. §300gg-13, 45 C.F.R. §147.130	*Applicability of preventive services requirement*	Plans must cover without cost-sharing a sex-specific recommended preventive service if determined medically appropriate for a particular individual" by an individual's attending provider, and as otherwise specified.[v]	Allowed; may vary by plan	Not generally	✓	✓	✓	✓

Source: CRS analysis of relevant legislation, statute, regulation, and guidance.

Notes: *Checkmark* (✓) indicates that the requirement is applicable to that type of health plan. The variation *(✓+GF)* indicates that the requirement is also applicable to grandfathered plans; see table note "r". *N.A.* indicates that the requirement is not applicable to that type of health plan.

EHB = essential health benefits. USPSTF = United States Preventive Services Task Force. ACIP = Advisory Committee on Immunization Practices. HRSA = U.S. Health Resources and Services Administration. FDA = U.S. Food and Drug Administration. QHP = Qualified health plan. SHOP = Small Business Health Options Program.

The requirements listed in the table are not a comprehensive list of all federal requirements and standards that apply to all health plans that may be related to reproductive health. Listed requirements are provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended), unless otherwise specified.

a. Health insurance may be provided to a group of people who are drawn together by an employer or other organization, such as a trade union. Such groups generally are formed for purposes other than obtaining insurance, such as employment. When insurance is provided to a group, it is referred to as *group coverage* or *group insurance*. In the group market, the entity that purchases health insurance on behalf of a group is referred to as the *plan sponsor*.

b. A *fully insured* health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurer; the insurer assumes the risk of paying the medical claims of the sponsor's enrollees.

c. In general, medical management requirements include different types of standards or processes (e.g., prior authorization requirements) through which plans aim to ensure appropriate use of covered benefits and to control costs.

d. All requirements apply to services or items furnished in-network. Under private insurance, benefit coverage and consumer cost sharing are often contingent upon whether a service or item is furnished by a provider that the insurer has contracted with (i.e., whether that provider is *in network* for a given plan). In instances where a contract between an insurer and provider does not exist, the provider is considered *out of network.*

e. In general, for purposes of health insurance requirements, *small groups* are those with 50 or fewer individuals (e.g., employees). States can also define small groups as having 100 or fewer individuals. The definition of *large group* is 51 or more individuals, or 101 or more individuals, depending on the definition of small group.

f. *Self-insured plans* refer to health coverage that is provided directly by the organization sponsoring coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering medical claims. In general, the size of a self-insured employer does not affect the applicability of federal requirements.

g. Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurer in the nongroup health insurance market.

h. This table does not reflect judicial orders enjoining enforcement of certain coverage requirements against specific entities. See "Overview: Coverage of the Essential Health Benefits (EHB)" in this report for examples of such orders.

i. The 10 categories of essential health benefits (EHB) are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

j. See CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, regarding several federal requirements relevant to consumer cost sharing on the EHB (e.g., maximum annual limitation on cost-sharing, prohibition on lifetime and annual coverage limits, and minimum actuarial value requirements). Large group plans and self-insured plans must also comply with the first two of those requirements even though such plans are not required to cover the EHB. HHS has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirement.

k. The preventive services and items that must be covered are listed in their entirety at Healthcare.gov, "Preventive health services," https://www.healthcare.gov/preventive-care-benefits/. See "Overview: Coverage of Certain Preventive Services Without Cost Sharing" in this report for further information on coverage and cost-sharing requirements.

l. HRSA, "Women's Preventive Services Guidelines," page last reviewed March 2024, at https://www.hrsa.gov/womens-guidelines. Also see Women's Preventive Services Initiative (WPSI), "Contraception," at https://www.womenspreventivehealth.org/recommendations/contraception/, and its linked "Evidence Review: Contraception," December 2021.

m. No federal law specifically requires or prohibits private health insurance coverage of abortion services and counseling, infertility services, or gender-affirming services.

n. The individual exchanges and small-business health options program (SHOP) exchanges are virtual marketplaces in which consumers and small businesses, respectively, can shop for and purchase private health insurance coverage. Qualified health plans (QHPs) are private health insurance plans certified to be sold in the individual and SHOP exchanges, and they must meet all requirements applicable to the individual and small-group markets, respectively, plus certain additional requirements. For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

o. Title 29 of the *Code of Federal Regulations*, Appendix to Part 1604—Questions and Answers on the Pregnancy Discrimination Act, P.L. 95-555, 92 Stat. 2076 (1978).

p. This provision is from the Pregnancy Discrimination Act of 1978 (PDA, P.L. 95-555, as amended).

q. This provision is from the Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204, as amended).

r. See the "Overview: Coverage of Certain Preventive Services Without Cost Sharing" section of this report for additional details.

s. *Grandfathered plans* are nongroup or group plans in which at least one individual was enrolled as of enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and which continue to meet certain criteria. Plans that maintain their grandfathered status are exempt from some federal requirements.

t. This provision is from the Women's Health and Cancer Rights Act of 1998 (P.L. 105-277, as amended).

u. See Employee Benefits Security Administration, "Compliance Assistance Guide: Health Benefits Coverage Under Federal Law…", September 2014, at https://www.dol.gov/general/topic/health-plans/womens. See Departments of Labor, Health and Human Services (HHS), and the Treasury, "FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation," April 20, 2016, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf, for additional detail.

v. This may include, for example, "a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix – and the individual otherwise satisfies the criteria in the relevant recommendation or guideline as well as all other applicable coverage requirements." See question 5, Departments of Labor, HHS, and the Treasury, "FAQs About Affordable Care Act Implementation (Part XXVI)," May 11, 2015, at https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf.

Appendix B. Acronyms Used in This Report

Table B-1. Acronyms Used in This Report

Acronym	Definition
AAP	American Academy of Pediatrics
ABP	Alternative Benefit Plan
ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
ACF	Administration for Children and Families
ACIP	Advisory Committee on Immunization Practices
ACYF	Administration for Children, Youth, and Families
ADAP	AIDS Drug Assistance Program
AFDC	Aid to Families with Dependent Children
AIDS	Acquired Immunodeficiency Syndrome
ARPA	The American Rescue Plan Act of 2021 (P.L. 117-2)
ART	Assisted Reproductive Technology
ASPE	Assistant Secretary for Planning and Evaluation
BBA 2018	Bipartisan Budget Act of 2018 (P.L. 115-72)
BOP	Bureau of Prisons
CBO	Congressional Budget Office
CBOC	Community-Based Outpatient Clinic
CCIIO	Center for Consumer Information and Insurance Oversight
CDC	Centers for Disease Control and Prevention
CFR	*Code of Federal Regulations*
CHIP	State Children's Health Insurance Program
CMCS	Center for Medicaid, CHIP and Survey & Certification
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
CRS	Congressional Research Service
CYSHCN	Children and Youth with Special Health Care Needs
DHA	Defense Health Agency
DHS	Department of Homeland Security
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DPP	Deployed Prescription Program
EC	Emergency Contraceptive
EEOC	Equal Employment Opportunity Commission
EHB	Essential Health Benefits

Acronym	Definition
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERO	Enforcement and Removal Operations
FAM	Fertility Awareness-Based Method
FDA	Food and Drug Administration
FEHB	Federal Employee Health Benefits
FFP	Federal Financial Participation
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSH	Follicle Stimulating Hormone
FY	Fiscal Year
FYSB	Family and Youth Services Bureau
GAO	Government Accountability Office
GDM	General Departmental Management (Sexual Risk Avoidance Education Program)
GID	Gender Identity Disorder
GRS	Gender Reassignment Surgery
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
ICE	Immigration and Customs Enforcement
IHE	Institute of Higher Education
IHS	Indian Health Service
IUD	Intrauterine Device
IUI	Intrauterine Insemination
IVF	In Vitro Fertilization
LAM	Lactational Amenorrhea Method
LARC	Long-Acting Reversible Contraceptive
LGBTQ	Lesbian, Gay, Bisexual, Transgender, or Questioning Their Sexual Identity
LH	Luteinizing Hormone
LHHS	Appropriation bill that provides funding for the Departments of Labor, HHS, and Education, and Related Agencies
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MAC	Medicare Administrative Contractor

Acronym	Definition
MACPAC	Medicaid and CHIP Payment and Access Commission
MAGI	Modified Adjusted Gross Income
MAI	Minority AIDS Initiative
MCH	Maternal Child Health
MHS	Military Health System
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MINT	Mothers and Infants Nurturing Together Program
MTF	Military Treatment Facility
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCD	National Coverage Determination
NCHHSTP	CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCHS	National Center for Health Statistics
NCSL	National Conference of State Legislatures
NDAA	National Defense Authorization Act
NDS	National Detention Standards
OAH	Office of Adolescent Health
OASH	Office of the Assistant Secretary for Health
OB/GYN	Obstetrician/Gynecologist
OCR	Office for Civil Rights (HHS)
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPA	Office of Population Affairs
OPRE	Office of Planning, Research, and Evaluation
OTC	Over-the-counter
PAF	Pregnancy Assistance Fund
PBNDS	Performance-Based National Detention Standards
PDA	Pregnancy Discrimination Act of 1978 (P.L. 95-555)
PEP	Post-Exposure Prophylaxis
PHSA	Public Health Service Act
PRC	Purchased Referred Care Program
PrEP	Pre-exposure Prophylaxis
PREP	Personal Responsibility Education Program
PTC	Premium Tax Credit
QFP	Quality Family Planning
QHP	Qualified Health Plan
RRC	Residential Reentry Center
SARC	Short-Acting Reversible Contraceptive

Acronym	Definition
SHO	State Health Official
SHOP	Small Business Health Options Program
SMDL	State Medicaid Directors Letter
SRS	Sex Reassignment Surgery
SSA	Social Security Act
SSBG	Social Services Block Grant Program
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TANF	Temporary Assistance for Needy Families
TGD	Transgender and Gender Diverse
TPP	Teen Pregnancy Prevention Program
TSH	Thyroid Stimulating Hormone
UIO	Urban Indian Organization
USC	*U.S. Code*
USCG	U.S. Coast Guard
USPS	United States Postal Service
USPSTF	United States Preventive Services Task Force
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
WPATH	World Professional Association of Transgender Health
WPSI	Women's Preventive Services Institute

Appendix C. Policy Experts and Other Points of Contacts Table

Topic	Contact
Reproductive Health Services (General)	Alexa C. DeBoth
Abortion (Services)	Alexa C. DeBoth
Abortion (Legal Issues)	Jon Shimabukuro
Regulation of Contraceptives	Amanda K. Sarata, Hassan Z. Sheikh
Maternal Child Health	Alexandria K. Mickler
Gender-affirming Care (Services)	Alexa C. DeBoth
Gender-affirming Care (Legal Issues)	Abigail A. Graber, Hannah-Alise Rogers
Medicaid	Evelyne P. Baumrucker
State Children's Health Insurance Program (CHIP)	Evelyne P. Baumrucker
Medicare	Paulette C. Morgan
Private Health Insurance	Vanessa C. Forsberg
Private Health Insurance (Legal Issues)	Jennifer A. Staman
Federal Contraceptive Coverage Requirement (Legal Issues)	Victoria L. Killion
Federal Employee Health Benefits (FEHB)	Ryan J. Rosso
Bureau of Prisons (BOP)	Nathan James
Department of Defense (DOD)	Bryce H.P. Mendez
U.S. Immigration and Customs Enforcement (ICE)	Abigail F. Kolker; Audrey Singer
Indian Health Service	Elayne J. Heisler
The U.S. Coast Guard	Bryce H.P. Mendez
Department of Veterans Affairs	Jared S. Sussman
Title X Program	Alexa C. DeBoth, Angela Napili
Adolescent Pregnancy Prevention Programs	Jessica Tollestrup
Sexually Transmitted Infections (STI) Prevention Grants	Alexa C. DeBoth
The Ryan White HIV/AIDS Program	Alexa C. DeBoth
National Breast and Cervical Cancer Early Detection Program	Alexa C. DeBoth
Federal Health Center Program	Elayne J. Heisler
Title V Maternal and Child Health Services Block Grant	Alexandria K. Mickler
Social Services Block Grant Program (SSBG)	Karen E. Lynch
Healthy Start Program	Alexandria. K. Mickler

Topic	Contact
Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program	Patrick A. Landers
Pregnancy Assistance Fund (PAF)	Jessica Tollestrup; Alexandria K. Mickler

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