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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 purposes.

The payment for and provision of reproductive health services remains of ongoing interest to Congress, which regularly considers bills and enacts laws related to various aspects of reproductive health care. This includes policies 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.

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

After providing an overview of the reproductive health services, 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 entities to provide specific types of reproductive health services.

Contents

Introduction 1
General Questions 1
What Are Reproductive Health Services? 1
What Are Contraceptive and Contraceptive Counseling Services? 2
What Are Abortions and Abortion Counseling Services? 6
Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling? 8
What Are Infertility Services? 9
What Are Maternity Services? 10
What Are Reproductive Health Prevention and Treatment Services? 11
What Are Gender-Affirming Services? 14
Medicaid 17
Does Medicaid Cover Reproductive Services? 19
Comparing Medicaid Traditional Benefit Coverage of Reproductive Health Services to ABPs 22
Where Do Medicaid Enrollees Receive Reproductive Health Care Services? 23
Does Medicaid Cover Contraceptive Services? 24
Does Medicaid Cover Abortions or Abortion Counseling? 28
Does Medicaid Cover Infertility Services? 29
Does Medicaid Cover Maternity Services? 29
Medicaid Eligibility Pathways 29
Benefit Coverage 31
Comparing Medicaid Maternity Coverage Across Coverage Types 32
Does Medicaid Cover Reproductive Health Prevention and Treatment Services? 33
Traditional Benefits 33
ABPs 34
Comparing Medicaid Reproductive Health Prevention Services Across Coverage Types 34
Does Medicaid Cover Gender-Affirming Services? 34
Medicare 36
Does Medicare Cover Reproductive Health Services? 37
Does Medicare Cover Contraceptive Services? 37
Does Medicare Cover Abortions or Abortion Counseling? 38
Does Medicare Cover Infertility Services? 38
Does Medicare Cover Maternity Services? 39
Does Medicare Cover Reproductive Health Prevention and Treatment Services? 39
Does Medicare Cover Gender-Affirming Services? 39
Federal Regulation of Private Health Insurance 40
Does Federal Law Require Private Health Insurance Coverage of Reproductive Health Services? 41
Overview: Coverage of the Essential Health Benefits (EHB) 42
Overview: Coverage of Certain Preventive Services Without Cost Sharing 43
Does Federal Law Require Private Health Insurance Coverage of Contraceptive Services? 44
Does Federal Law Require Private Health Insurance Coverage of Abortions or Abortion Counseling? 47
Does Federal Law Require Private Health Insurance Coverage of Infertility Services? 50

Does Federal Law Require Private Health Insurance Coverage of Maternity Services? 52
Does Federal Law Require Private Health Insurance Coverage of Reproductive Health Prevention and Treatment Services? 54
Does Federal Law Require Private Health Insurance Coverage of Gender-Affirming Services? 56
Federal Employees Health Benefits Program (FEHB) 58
Do FEHB Plans Cover Reproductive Health Services? 59
Do FEHB Plans Cover Contraceptive Services? 59
Do FEHB Plans Cover Abortions or Abortion Counseling? 60
Do FEHB Plans Cover Infertility Services? 61
Do FEHB Plans Cover Maternity Services? 61
Do FEHB Plans Cover Reproductive Health Prevention and Treatment Services? 62
Do FEHB Plans Cover Gender-Affirming Services? 63
Federal Agencies and Departments 63
Bureau of Prisons (BOP) 63
Does BOP Provide Reproductive Health Services? 64
Does BOP Provide Contraceptive Services? 65
Does BOP Provide Abortions or Abortion Counseling? 65
Does BOP Provide Infertility Services? 65
Does BOP Provide Maternity Services? 66
Does BOP Provide Reproductive Health Prevention and Treatment Services? 66
Does BOP Provide Gender-Affirming Services? 67
Department of Defense (DOD) 68
Does DOD Provide Reproductive Health Services? 68
Does DOD Provide Contraceptive Services? 69
Does DOD Provide Abortions or Abortion Counseling? 69
Does DOD Provide Infertility Services? 69
Does DOD Provide Maternity Services? 71
Does DOD Provide Reproductive Health Prevention and Treatment Services? 71
Does DOD Provide Gender-Affirming Services? 71
U.S. Immigration and Customs Enforcement (ICE) Noncitizen Detention 72
Does ICE Provide Reproductive Health Services? 73
Does ICE Provide Contraceptive Services? 73
Does ICE Provide Abortions or Abortion Counseling? 73
Does ICE Provide Infertility Services? 73
Does ICE Provide Maternity Services? 73
Does ICE Provide Reproductive Health Prevention and Treatment Services? 74
Does ICE Provide Gender-Affirming Services? 75
Indian Health Service (IHS) 75
Does IHS Provide Reproductive Health Services? 75
Does IHS Provide Contraceptives? 77
Does IHS Provide Abortions or Abortion Counseling? 78
Does IHS Provide Infertility Services? 79
Does IHS Provide Maternity Services? 79
Does IHS Provide Reproductive Health Prevention and Treatment Services? 79
Does IHS Provide Gender-Affirming Services? 80
Department of Veterans Affairs (VA) 80
Does VA Provide Reproductive Health Services? 81
Does VA Provide Contraceptive Services? 81

Does VA Provide Abortions or Abortion Counseling? 82
Does VA Provide Infertility Services? 82
Does VA Provide Maternity Services? 84
Does VA Provide Reproductive Health Prevention and Treatment Services? 84
Does VA Provide Gender-Affirming Services? 85
Grant Programs Focused on Reproductive Health 85
The Title X Family Planning Program 85
Do Title X Projects Provide Reproductive Health Services? 86
Do Title X Projects Provide Contraceptive Services? 87
Do Title X Projects Provide Abortions or Abortion Counseling? 88
Do Title X Projects Provide Infertility Services? 89
Do Title X Projects Provide Maternity Services? 90
Do Title X Projects Provide Reproductive Health Prevention and Treatment Services? 90
Do Title X Projects Provide Gender-Affirming Services? 92
What Are Adolescent Pregnancy Prevention Programs? 92
Do Adolescent Pregnancy Prevention Programs Provide Reproductive Health Services? 93
Do Adolescent Pregnancy Prevention Programs Provide Contraceptive Services? 94
Do Adolescent Pregnancy Prevention Programs Provide Abortions or Abortion Counseling? 94
Do Adolescent Pregnancy Prevention Programs Provide Infertility Services? 94
Do Adolescent Pregnancy Prevention Programs Provide Maternity Services? 94
Do Adolescent Pregnancy Prevention Programs Provide Reproductive Health Prevention and Treatment Services? 95
Do Adolescent Pregnancy Prevention Programs Provide Gender-Affirming Services? 95
What Federal Grant Programs Address Sexually Transmitted Infections (STIs)? 95
What Centers for Disease Control and Prevention (CDC) Programs Address STIs? 95
What Is the Ryan White HIV/AIDS Program? 96
What Is the National Breast and Cervical Cancer Early Detection Program? 97
Grant Programs That May Be Used to Support Reproductive Health Services 98
How Does the Federal Health Center Program Support Reproductive Health Services? 98
How Does the Title V Maternal Child Health State Block Grant Support Reproductive Health Services? 99
How Does the Social Services Block Grant Program Support Reproductive Health Services? 100
How Does the Healthy Start Program Support Reproductive Health Services? 100
How Does the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Support Reproductive Health Services? 101
How Did the Pregnancy Assistance Fund (PAF) Program Support Reproductive Health Services? 102

Tables

Table 1. Contraceptive Methods: Effectiveness and Descriptions 4

Table 2. Examples of Reproductive Health Prevention and Treatment Services 14
Table 3. IHS Priority Levels: Reproductive & Maternal/Child Health Services (Category C)..... 76
Table 4. Infertility Services Offered by the VA 82

Table A-1. Acronyms Used in This Report..... 104

Appendixes

Appendix A. Acronyms Used in This Report 104
Appendix B. CRS Points of Contact 108

Contacts

Author Information..... 109

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 purposes and requirements under federal law.

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

The report next describes the federal government's role 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 two appendixes: **Appendix A** identifies acronyms used in this report; **Appendix B** lists CRS experts on the various reproductive health topics discussed in this report.

Throughout this report, CRS has taken the primary approach of using terms in the same manner as the terms are used in the statute, rules, regulations, and guidance of specific agencies and grant programs.[3]

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; abortion; maternal health; sexually transmitted infections

[1] Gender-affirming services are medical and surgical interventions designed to help align 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] For example, gendered terms such as "woman," "man," "female," "male," "pregnant women," "individuals who are pregnant" in each section are consistent with terminology used by each federal agency or grant program.

(STIs)/sexually transmitted diseases (STDs);[4] screening and treatment for diseases, including cancers of the reproductive organs and breast tissues; and gender-affirming services.

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.[5]

What Are Contraceptive and Contraceptive Counseling 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.[6] Some contraceptive methods are available without contraceptive counseling or prescription by a health care provider.

A *contraceptive* is a product or method intended to lower the possibility of becoming pregnant.[7] Contraceptive products vary in type and include drugs (e.g., oral contraceptives) and medical 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), an operating division of the Department of Health and Human Services (HHS).

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.[8] For high-risk (class III) contraceptive devices, FDA *approves* those products that demonstrate *reasonable assurance* of safety and effectiveness.[9] For moderate-risk (class II) contraceptive devices, FDA

[4] The federal programs described in this report use the terms sexually transmitted infections (STIs) and sexually transmitted diseases (STDs) 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 clinical difference between the two is that an STI is a "virus, bacteria, fungus, or parasite people can get through sexual contact." An STD develops following an infection with the manifestation of symptoms. 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 and may resolve without any symptoms, 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.

[5] Kathryn M. Curtis et al., Centers for Disease Control and Prevention (CDC), "U.S. Selected Practice Recommendations for Contraceptive Use, 2024," *Morbidity and Mortality Weekly Report Recommendations and Reports*, vol. 73, no. 3 (August 8, 2024). Adoption is not discussed in this report because, although it is included as a family planning service, it is not an explicit health service.

[6] Kathryn M. Curtis et al., Centers for Disease Control and Prevention (CDC), "U.S. Selected Practice Recommendations for Contraceptive Use, 2024," *Morbidity and Mortality Weekly Report Recommendations and Reports*, vol. 73, no. 3 (August 8, 2024).

[7] 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.

[8] 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*.

[9] 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 (continued...)

clears those products that demonstrate substantial equivalence to a device already on the market (a predicate device).[10] Contraceptive methods also include fertility awareness-based methods. These methods monitor symptoms and biological markers to determine periods during the menstrual cycle when the possibility of pregnancy is lowest.[11] FDA has cleared mobile medical applications (apps) for users to track biological markers, such as body temperature, to prevent pregnancy. Fertility-awareness tracking can also be tracked manually, although the FDA has not cleared this method.

Federal funding or payment for contraceptives is generally limited to products that are FDA-approved, cleared, or authorized for marketing and certain medical or surgical procedures.

FDA has approved or cleared a variety of contraceptive methods.[12] Adapted from FDA's *Birth Control Guide*, **Table 1** lists those methods from those most effective at preventing pregnancy to those least effective, and provides a description for each method.[13] 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), up to 28 pregnancies per 100 women per year would be expected under typical use.[14] Long-acting reversible contraceptives (LARCs), which include intrauterine devices (IUDs) and implants, 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 although EC is effective at preventing pregnancy if it is taken soon after unprotected sex or birth control failure, EC "should not be used as a regular form of birth control."[15] FDA-approved contraceptive methods do not cause abortion.[16] These contraceptive products, including EC, are not effective if the patient is already pregnant (*pregnancy* "encompasses the period of time from implantation until delivery").[17]

Some contraceptives need to be prescribed by a health care provider, in the case of some oral contraceptives. Other contraceptives additionally require a health care provider to physically place them, such as contraceptive implants and IUDs. Contraceptives including condoms, ECs, and a recently approved oral contraceptive are available without a prescription at pharmacies,

Bayer in 2018), and the female condom. For IUD regulation, see 21 C.F.R. §884.5360; for tubal occlusion device regulation, see 21 C.F.R. §884.5380.

[10] CRS Report R42130, *FDA Regulation of Medical Devices*. Examples of contraceptive devices that are class II (moderate risk) include the diaphragm and the male condom. 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.

[11] CDC, "Contraception and Birth Control Methods," August 6, 2024, https://www.cdc.gov/contraception/about/. Fertility awareness tracking can also be used to indicate when during someone's menstrual cycle they are most likely to become pregnant.

[12] 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.

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

[14] Ibid.

[15] FDA, "Birth Control," May 10, 2024, https://www.fda.gov/consumers/womens-health-topics/birth-control.

[16] Abortifacient drugs are those for which the main or side effect is a medical abortion. Emergency contraception (EC), for instance, prevents pregnancy by delaying ovulation and will not affect an existing pregnancy. For an example of 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. Plan B One-Step is one of the drugs approved by FDA as EC. For more information on abortions, see the section of this report titled "What Are Abortions and Abortion Counseling Services?"

[17] 45 C.F.R. §46.202(f).

online vendors, or other retailers. In July 2023, FDA approved the first over-the-counter (OTC) birth control pill, Opill (norgestrel).[18] In order for a 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 supervision from a health care professional.[19] In a decisional memorandum, 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 Opill to be available OTC.[20]

Sterilization surgeries, including tubal ligation and vasectomy procedures, are the most effective form of contraception and are considered permanent.[21] Though not listed in FDA's *Birth Control Guide*, other surgeries 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.

Table 1. Contraceptive Methods: Effectiveness and Descriptions

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.

[18] 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.

[19] For more on OTCs, see CRS Report R46985, *FDA Regulation of Over-the-Counter (OTC) Drugs: Overview and Issues for Congress*

[20] 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.

[21] FDA, "Birth Control," May 10, 2024, https://www.fda.gov/consumers/womens-health-topics/birth-control.

[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.harvardhealth.org/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.

Method	Number of Pregnancies Expected (per 100 women over one year)	Description
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.
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.

Method	Number of Pregnancies Expected (per 100 women over one year)	Description
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.
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 birth control failure or 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 if used continuously (sterilization is most effective; spermicide used alone is 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.

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 FDA has approved for pregnant patients within the first 10 weeks of a pregnancy.[24] To terminate a pregnancy with medication, the drugs mifepristone and misoprostol are prescribed in combination.[25] Mifepristone is a progesterone hormone blocker and is the only FDA-approved drug for the termination of pregnancy.[26] Misoprostol is used off-label to induce

[24] FDA, "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation," January 17, 2025, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation. Katherine Kortsmit et al., "Abortion Surveillance—United States, 2021," *Morbidity and Mortality Weekly Report*, vol. 72, no. SS-9 (November 24, 2023), pp. 1-29.

[25] FDA, "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation," January 17, 2025, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation.

[26] Mifepristone is the generic form of Mifeprex, the first form of mifepristone approved by the FDA. 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.

uterine contractions, though its approved use is to prevent stomach ulcers.[27] Using misoprostol alone can be an alternative if mifepristone is unavailable, although it is less effective than the combination mifepristone-misoprostol method.[28] Using medication as an abortion method can include a follow-up appointment with a health care provider to confirm termination of the pregnancy.

Mifepristone was first approved by the FDA in 2000 under specified restrictions on its use. [29] In 2007, the Food and Drug Administration Amendments Act (P.L. 110-85) expanded FDA's authority to require Risk Evaluation and Mitigation Strategies (REMS) for certain drugs under specified conditions.[30] Since 2011, mifepristone has been subject to restricted distribution pursuant to the drug's REMS program. FDA has changed the REMS requirements for mifepristone over time. Among these changes, in 2021, FDA reviewed the mifepristone REMS program and determined that certain elements of the program would be updated. Subsequently, the mifepristone REMS program was changed to remove an in-person dispensing requirement and add a new pharmacy certification process, which enabled retail pharmacies that meet certain qualifications to dispense mifepristone directly to patients who have a prescription from a certified prescriber.[31] These changes allowed mifepristone to be available via telehealth prescribing for the first time. Changes to the REMs have been subject to litigation.[32]

Surgical abortion procedures vary depending on gestational age. These procedures can include aspiration of the uterus, dilation of the cervix, and evacuation procedures.[33]

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 in addition to discussions on parenting and adoption.[34] Clinical guidelines on all-options counselling recommend providers offer nondirective counseling and give patients neutral, factual information.[35] For patients interested in an abortion, counseling may also include

[27] American College of Obstetricians and Gynecologists (ACOG), Practice Bulletin Number 225, Medication Abortion Up to 70 Days of Gestation, October 2020, https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation.

[28] Ibid.

[29] FDA, Center for Drug Evaluation and Research (CDER), *Approval Letter MIFEPREX*, NDA 20-687, September 28, 2000, https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2000/20687appltr.htm. These requirements included providing the medication by or under the supervision of a physician who met certain qualifications, obtaining a patient's and provider's signatures on a Patient Agreement form, reporting any hospitalizations and any other serious events to the drug's sponsor, and recording the medication package serial number in the patient's medical chart.

[30] See CRS Report R44810, *FDA Risk Evaluation and Mitigation Strategies (REMS): Description and Effect on Generic Drug Development*.

[31] FDA, "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation," January 17, 2025, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation.

[32] See CRS Legal Sidebar LSB10919, *FDA Regulation of Medication Abortion: Recent Legal Developments*.

[33] Stephanie Ramer et al., "Abortion Surveillance — United States, 2022," *Morbidity and Mortality Weekly Report Surveillance Series*, vol. 73, no. 7 (November 28, 2024), pp. 1-31.

[34] 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.

[35] Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6 (December 2024).

providing information about their available options based on gestational age and legal restrictions that vary from state to state.[36]

The U.S. Supreme Court's opinion in *Dobbs v. Jackson Women's Health Organization* concluded that the U.S. Constitution does not confer a right to an abortion.[37] In light of this decision and existing state laws, the availability of abortion services vary by state. Abortion services may be affected by state laws limiting abortion based on gestational age, requiring certain information to be shared prior to obtaining an abortion, or other conditions. For a survey of state laws restricting or prohibiting abortion, see CRS Report R47595, *State Laws Restricting or Prohibiting Abortion*. Additionally, litigation related to abortion access under federal and state law remains ongoing.[38]

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 pregnant woman's life. This restriction is the result of statutory and legislative provisions such as the Hyde Amendment (see **text box**), a funding restriction which has been added to the annual appropriations measure for the Departments of Labor, HHS, and Education, and Related Agencies (LHHS) since 1976.[39] LHHS appropriations for FY2026 include the restriction that no funds appropriated in the act shall be used for an abortion, except if the pregnancy was the result of rape or incest or the woman suffers from a physical disorder, injury, or illness arising from the pregnancy that a physician certifies places her in danger of death unless an abortion is performed.[40] Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Treasury, and the Department of Justice (DOJ).[41] 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), and the use of federal subsidies for health insurance plans offered on the health insurance exchanges.[42]

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.[43]

[36] CRS Report R47595, *State Laws Restricting or Prohibiting Abortion*.

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

[38] See KFF, *State and Federal Reproductive Rights and Abortion Litigation Tracker*, August 26, 2026, https://www.kff.org/womens-health-policy/litigation-involving-reproductive-health-and-rights-in-the-federal-courts/.

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

[40] See Division B, Title II, Sections 506 and 507 of P.L. 119-75

[41] 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*.

[42] 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." Regarding the federal subsidies for plans on the exchanges, see "Can Federal Funds Be Used to Pay for Abortion in Private Health Insurance Plans?"

[43] 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.")

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 funds appropriated in the act to pay for abortions. In 1980, the U.S. Supreme Court upheld the validity of the Hyde Amendment, concluding that the funding restriction was constitutional. The original provision stated, "None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term."

Sources: P.L. 94-439, §209, 90 Stat. 1418, 1434 (1976).
Note: For additional discussion of abortion funding restrictions, see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*.

What Are Infertility Services?

Infertility is a reproductive health disorder generally defined as the inability to become pregnant after a certain amount of time attempting to conceive.[44] Infertility affects people of all genders and can be caused by reproductive organ damage, hormone imbalance, genetic disorders, or certain medical treatments.[45] Infertility caused by medical treatments is called *iatrogenic infertility*, such as chemotherapy treatment for cancer.[46]

Treatments for infertility thus may involve surgery, hormone/medication therapy, genetic counseling, or medical procedures such as intrauterine insemination (IUI).[47] Treatment may also involve Assisted Reproductive Technologies (ARTs), which are generally defined as all fertility treatments in which either eggs or embryos are handled outside the body.[48] In vitro fertilization (IVF), the most commonly used ART, is a set of procedures designed to help initiate a pregnancy via transfer of an embryo into a uterus.[49] Other ARTs include gamete and zygote intrafallopian transfer.[50]

IVF consists of several steps and can be referred to as an *ART cycle*. The basic procedures of an ART cycle typically include the following:

[44] Infertility is generally defined as not being able to become pregnant after one year of unprotected sex. For women 35 years and older, they may be evaluated for infertility following a period of six month. CDC, "Infertility: Frequently Asked Questions,' May 15, 2024, https://www.cdc.gov/reproductive-health/infertility-faq/.

[45] Ibid.

[46] American Society for Reproductive Medicine, "Fertility preservation in patients with medical indications: a committee opinion," *Fertility and Sterility*, vol. 125, no. 2 (February 2026), pp. 247-259.

[47] CDC, "Infertility: Frequently Asked Questions,' May 15, 2024, https://www.cdc.gov/reproductive-health/infertility-faq/. Intrauterine insemination (IUI), sometimes called artificial insemination, is an infertility treatment. In this procedure, specially prepared sperm are transferred into the uterus.

[48] See CRS In Focus IF13144, *Assisted Reproductive Technology Regulation and Oversight*. IVF is typically administered in "cycles." In a single cycle, one egg or many eggs are retrieved from an ovary and externally fertilized. The embryo or embryos are transferred into the uterus and monitored for development. More than one cycle may be necessary to achieve pregnancy.

[49] American Society for Reproductive Medicine, *Assisted Reproductive Technology: A Guide for Patients*, 2018, https://www.reproductivefacts.org/globalassets/_rf/news-and-publications/bookletsfact-sheets/english-pdf/art-booklet.pdf.

[50] CDC, "2021 Assisted Reproductive Technology: Fertility and National Summary Report," 2023, https://stacks.cdc.gov/view/cdc/154438. Gamete and zygote intrafallopian transfers are procedures in which gametes (eggs and sperm) or zygotes (fertilized egg before it begins to divide) are transferred into the fallopian tubes rather than the uterus.

- **Ovarian Stimulation.** A female patient is prescribed medications that stimulate her ovaries to prepare to produce multiple oocytes (eggs).
- **Oocyte Retrieval.** The resulting oocytes are removed from the ovaries before ovulation occurs during a surgical procedure at a fertility clinic. These retrieved oocytes might then be frozen for future use.
- **Fertilization of the Oocytes.** The retrieved oocytes are either thawed and combined with sperm or, shortly after retrieval, combined with sperm in an embryology laboratory with the purpose of fertilizing the oocytes to develop into an embryo.
- **Embryo Culture.** The fertilized oocytes are cultured in the laboratory to develop into embryos. Embryos that develop appropriately are then prepared for transfer or frozen for later use.
- **Embryo Transfer.** An embryo, either fresh or frozen, can then be transferred into the uterine cavity. This may result in a pregnancy if the embryo successfully attaches to the uterine lining.[51]

ART cycles can involve other procedures or variations of the procedures briefly summarized above, depending on factors like an infertility diagnosis or whether donated material is being used. Multiple treatment cycles may be needed to achieve a successful pregnancy.

The provision of ART services involves multiple entities, which the federal government regulates in various capacities. These include fertility clinics, embryology and clinical laboratories, and health care professionals providing ART services. These entities are subject to federal oversight and regulations specific to the ART services they provide. For information, see CRS In Focus IF13144, *Assisted Reproductive Technology Regulation and Oversight*.

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).[52] Other maternity services may include support provided by entities such as doulas[53] 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.

[51] CDC, "2021 Assisted Reproductive Technology: Fertility and National Summary Report," 2023, https://stacks.cdc.gov/view/cdc/154438.

[52] 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*, September 26, 2025, https://womenshealth.gov/pregnancy/you-get-pregnant/preconception-health, and ACOG, *Good Health Before Pregnancy: Prepregnancy Care*, October 2025, https://www.acog.org/womens-health/faqs/good-health-before-pregnancy-prepregnancy-care.

[53] A doula is a nonmedical, trained professional who "provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth." See DONA International, "What is a Doula," https://dona.org/what-is-a-doula/.

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.[54] Patient education is provided on a range of topics, including nutrition and the use of prenatal vitamins (e.g., folic acid supplementation[55]), counseling against the use of harmful substances, and referrals to relevant medical or social services.[56] Ultrasonographic technology (i.e., ultrasound) is typically used to confirm pregnancy and assess the overall health and growth of the fetus.[57]

Intrapartum care includes the range of services provided from the onset of labor through the delivery of the newborn.[58] 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).[59]

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.[60]

What Are Reproductive Health Prevention and Treatment Services?

Prevention services in a reproductive health context seek to prevent, detect, or treat infections, diseases, and other disorders or conditions involving the reproductive system. Common reproductive infections include STIs [61] such as chlamydia, gonorrhea, human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), and human papillomavirus (HPV).[62]

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[54] 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. Health Resources and Services Administration (HRSA), "Women's Preventive Services Guidelines," December 2025, https://www.hrsa.gov/womens-guidelines.

[55] U.S. Preventive Services Task Force (USPSTF), "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 in the section "What Are Reproductive Health Prevention and Treatment Services?" below for more information about the USPSTF.

[56] 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.

[57] 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.

[58] 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*.

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

[60] HRSA, "Women's Preventive Services Guidelines," December 2025, https://www.hrsa.gov/womens-guidelines. 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 2025).

[61] 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."

[62] CDC, "About HIV," January 14, 2025, https://www.cdc.gov/hiv/about/index.html. CDC, "About Genital HPV Infection," January 31, 2025, https://www.cdc.gov/sti/about/about-genital-hpv-infection.html. Human
(continued...)

Other reproductive disorders include malignant cancers of the reproductive tract and breast, benign cysts and tumors, and infertility.[63]

In public health and in the provision of health care, prevention occurs along a continuum, depending on the outcomes to be prevented. For example, vaccination can prevent infectious disease, chemotherapy can prevent the progression of cancer, and hospice care can prevent pain and distress. Health programs and payers may categorize these services differently, including as treatment rather than prevention.

Health care services can be generally described as either prevention or treatment, as follows:

- **Preventive services** as health interventions can encompass a large range of activities with the goal of preventing the development or progression of infection, disease, or other adverse health outcome.[64] Prevention interventions can be applied at a community level, such as controlling lead in public drinking water, or directly to individuals, such as immunizations and screenings for disease. Preventive *screenings* aim to identify those without symptoms of a disease but who are at increased risk of developing a disease based on age, sex, health behaviors, or other risk factors. Preventive screenings also aim to identify those who are in the early stages of disease but are asymptomatic For example, cervical cytology, also known as a Pap test, is a screening service used to detect precancerous cervical cells that may develop into cervical cancer if not treated.[65] Prevention services can also include *counseling*, which can include an assessment of a patient by a health care provider and subsequent patient education to avoid or reduce health behaviors that could result in an infection, disease, or other undesirable condition. For example, behavioral counseling for consistent condom use in sexually active adults can lower a person's risk for STIs.[66] *Preventive medications* are another intervention tool, such as contraceptives to prevent unintended pregnancies and improve birth outcomes.[67]
- **Treatment services** are surgical and medical (including pharmaceutical) interventions to control or cure a disease, manage its symptoms, or both. Treatment services are provided to patients who have symptoms or diagnostic findings of an actual illness or condition. *Monitoring*, the use of diagnostic services to track the course or remission of a disease, is considered a form of treatment, thus it is not discussed separately in this report. Some reproductive

immunodeficiency virus (HIV) and human papillomavirus (HPV) infections can cause other diseases and certain cancers.

[63] 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," February 11, 2025, https://www.cdc.gov/prostate-cancer/about/index.html. For more information on infertility services, see the "What Are Infertility Services?" section of this report.

[64] See CRS Infographic IG10083, *Public Health Prevention and the Determinants of Health*, and CRS In Focus IF13100, *The United States Preventive Services Task Force*.

[65] CDC, "Screening for Cervical Cancer," February 26, 2025, https://www.cdc.gov/cervical-cancer/screening/index.html.

[66] U.S. Preventive Services Task Force, "Behavioral Counseling Interventions to Prevent Sexually Transmitted Infections," *JAMA*, vol. 324, no. 7 (August 18, 2020), pp. 674-681.

[67] HRSA, "Women's Preventive Services Guidelines," December 2025, https://www.hrsa.gov/womens-guidelines. Also see the section "What Are Contraceptive and Contraceptive Counseling Services?" in this report.

health treatment services may address symptoms related to reproductive health conditions, such as managing symptoms for women experiencing menopause.[68]

Clinical Preventive Services Recommendations and Guidelines

Certain sets of clinical preventive service recommendations, including the "A" and "B" recommendations from the U.S. Preventive Services Task Force (USPSTF) and the women's preventive services guidelines supported by the HHS Health Resources and Services Administration (HRSA), are referenced in federal law to define certain requirements for coverage of or payment for clinical preventive services. These recommendations also serve as guidance to clinicians in providing some of the reproductive health care services described in this report.

U.S. Preventive Services Task Force (USPSTF) Recommendations

The U.S. Preventive Services Task Force is an independent, volunteer panel of experts in prevention, evidence-based medicine, and primary care that makes recommendations for health care providers 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.

In making its recommendations, USPSTF grades the preventive service based on the certainty of evidence and magnitude of the preventive service's net benefit. USPSTF gives "A" and "B" ratings to those services that it most highly recommends implementing for preventive care. These preventive services have a high or moderate net benefit for a given population (e.g., individuals of a certain demographic or risk group) based on available evidence.

HRSA Women's Preventive Services Guidelines

HRSA supports guidelines on preventive services that address the health needs of adolescent and adult women with strong evidence of their health benefits. To develop these guidelines, HRSA has funded cooperative agreements to the Women's Preventive Services Initiative (WPSI), which is a coalition of health professional organizations representing women's health care clinicians and patient advocates with expertise in women's health. Under cooperative agreements, WPSI has developed, reviewed, and updated the *Women's Preventive Services Guidelines* (Guidelines), which are based on a report initially published in 2011 by the National Academies of Science, Engineering, and Medicine (formerly known as the Institutes of Medicine) to provide evidence-based recommendations on preventive health services for women.

Beginning in 2016, HRSA funded a cooperative agreement with WPSI to review and update existing guidelines and develop new ones. Ultimately, HRSA has determined whether to support and approve the guidelines issued by WPSI in whole or in part. The most recent WPSI cooperative agreement ended in February 2026. In November 2026, HRSA announced a new funding opportunity for the Women's Initiative for Screening and Health (WISH) program to continue reviewing and updating the Guidelines. The Guidelines as supported by HRSA still have statutory requirements for federal health programs as described in this report.

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: CRS In Focus IF13100, *The United States Preventive Services Task Force*. HRSA, "Women's Preventive Services Guidelines," December 2025, https://www.hrsa.gov/womens-guidelines. Institutes of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*, Washington, DC, 2011. HHS, "HHS Opens $1 Million Funding Opportunity to Strengthen Women's Preventive Care," press release, November 6, 2026, https://www.hhs.gov/press-room/hhs-opens-1-million-womens-preventive-care-funding-opportunity.html.

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 non-preventive service when used to diagnose someone with relevant symptoms or to monitor a breast cancer patient's treatment progress or remission. Considering the definitions above, health care services may be

[68] CDC, "Menopause, Women's Health, and Work," November 14, 2024, https://www.cdc.gov/womens-health/features/menopause-womens-health-and-work.html.

considered preventive or treatment services based on their use. These services may be used as a diagnostic service for someone with symptoms or increased risk for a disease. Often, the use or purpose of a service determines how it is financed by the health programs described in this report. **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	**Prevention**	**Screening/Post-Exposure Prophylaxis (PEP)**	**Diagnosis and/or Monitoring**	**Medical/Surgical Treatment**
Breast cancer[a]	None known, although some healthy behaviors may lower incidence	Mammography and other exams,[a] genetic counseling and testing	Mammography and other exams	Mastectomy/lumpectomy, chemotherapy, immunotherapy, radiation
Cervical cancer[b]	Human papillomavirus (HPV) vaccine	Visual exam, cervical cytology (Pap smear), HPV testing	Visual exam, cervical cytology (Pap smear)	Surgery, chemotherapy, radiation
Human immunodeficiency virus (HIV)	Pre-exposure prophylaxis (PrEP),[c] counseling regarding safe sexual practices, bloodborne pathogens protections[d]	HIV testing, Post-exposure prophylaxis (PEP)[e]	Viral load testing, other bloodwork, retesting following exposure	Combination drug therapy, management of HIV-associated conditions
Gonorrhea[f]	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," April 16, 2026, https://www.cdc.gov/breast-cancer/about/index.html.

b. CDC, "Cervical Cancer Basics," December 11, 2024, https://www.cdc.gov/cervical-cancer/about/index.html.

c. CDC, "Preventing HIV with PrEP," September 15, 2026, 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.

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

e. CDC, "Preventing HIV with PEP," December 2, 2024, https://www.cdc.gov/hiv/prevention/pep.html. According to CDC guidance, HIV PEP medications should be started within 72 hours of possible exposure.

f. CDC, "About Gonorrhea," January 31, 2025, https://www.cdc.gov/gonorrhea/about/.

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.[69] 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 these health services are of legislative interest to Congress.

For the purposes of this report, the terms *gender-affirming services* or *gender-affirming care* refer to gender transition-related services unless specified in relevant statute, rules, regulations, and guidance.

Terminology Relevant to Gender-Affirming Care

This report uses the following terms and definitions relevant to the provision of gender-affirming care, unless otherwise defined by the federal health programs included in this report. The terms included here are non-exhaustive, and the usage and acceptability of these terms may change over time.

Gender can refer to gender identity, gender expression, or social gender roles, including social understandings and expectations culturally tied to people based on the sex they were assigned at birth.

Gender affirmation refers to the process of recognizing or affirming people in their gender identity. 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.

Gender diverse (GD) describes people with gender identities or gender expressions that differ from societal and cultural expectations of someone based on their sex assigned at birth.

Gender dysphoria is a feeling of significant discontent with someone's own biological sex and/or birth gender.

Gender identity refers to an individual's deeply felt, internal, intrinsic sense of their own gender.

Sex assigned at birth refers to a person's sex usually being assigned or determined at birth based on the appearance of external genitalia.

Transgender or trans is an umbrella term used to describe people whose gender identities or gender expressions are not what is typically expected for the sex to which they were assigned at birth.

Source: E. Coleman 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.

Use of gender-affirming services may stem from a diagnosis of gender dysphoria. 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 transgender and gender diverse (TGD) individuals experience gender dysphoria or feelings of distress. Health services that are gender-affirming are not synonymous with gender transition-related care. TGD individuals may still seek out or receive gender-affirming care. Gender-affirming care can be 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 services can include primary care, mental health services, hormone therapy, and surgical and postoperative care. Gender-affirming primary care is primary care with specific attention to the 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.[71]

[69] E. Coleman 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.

[70] Ibid.

[71] Ibid., p. S143.

Depending on the scope of the health provider and their knowledge of providing gender-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 with an individual's gender identity. 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 to such care. Roughly half of states have enacted laws restricting the provision of certain gender-affirming care services, including to minors, for the treatment of gender dysphoria.[75] These restrictions generally limit or prohibit the provision of medical interventions (such as puberty-blockers and hormone therapy, and surgical gender-affirming care services to minors).

The Trump Administration has taken actions to limit federal support for gender-affirming care to minors. This has included two executive orders issued in January and February 2025 and subsequent agency guidelines addressing gender identity and gender-affirming care for minors. The January 2025 executive order established the Administration's policy to "recognize two sexes, male and female [which] are not changeable and are grounded in fundamental and incontrovertible reality."[76] The executive order goes on to define the term "sex" as an immutable biological classification as either male or female. A subsequent executive order issued in February 2025 directly addressed gender-affirming care for minors, stating the federal government will "not fund, sponsor, promote, assist, or support the so-called 'transition' of a child from one sex to another, and it will rigorously enforce all laws that prohibit or limit these destructive and life-altering procedures."[77] The executive order further directs the HHS Secretary to issue regulations to "take all appropriate actions to end the chemical and surgical mutilation of children, including regulatory and subregulatory actions." This report provides information on federal policies related to the provision and payment for gender-affirming care services, including changes that align

[72] Kevan Wylie 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] 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, "APA Resolution on Gender Identity Change Efforts," February 2021, https://www.apa.org/about/policy/resolution-gender-identity-change-efforts.pdf.

[75] Lindsey Dawson and Jennifer Kates, *Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions*, KFF, August 14, 2026, https://www.kff.org/lgbtq/gender-affirming-care-policy-tracker/.

[76] Executive Order 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," 90 *Federal Register* 8615-8618, January 20, 2025.

[77] Executive Order 14187, "Protecting Children From Chemical and Surgical Mutilation," 90 *Federal Register* 8771-8773, February 3, 2025.

with the Administration's policies to limit the provision of these services to minors. For an example, see the section "Does Medicaid Cover Gender-Affirming Services?"

Medicaid

Medicaid, authorized in Title XIX of the Social Security Act (SSA), 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.[78] 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. At the federal level, Medicaid is administered by the Centers for Medicare & Medicaid Services (CMS) within HHS. 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 FY2025, Medicaid provided health care services to an estimated 82 million individuals.[79] Federal and state expenditures totaled approximately $949 billion in FY2024.[80]

Medicaid provides a health care safety net for low-income populations, playing a more significant role for certain subpopulations.[81] For example, in 2024 approximately 21% of the U.S. population received Medicaid coverage.[82] 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).[83] For some types of services (including reproductive health services), Medicaid is a significant payer. For instance, Medicaid paid for approximately 40% of all births in the United States in 2024.[84] According to the most recent data available, Medicaid provided 75% of all public expenditures on family planning services in FY2015.[85]

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

[79] 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*, February 2026, at https://www.cbo.gov/system/files/2026-02/51301-2026-02-medicaid.pdf.

[80] CMS, Form CMS-64 data as of April 14, 2025, at https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes.

[81] 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.

[82] 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: 2024*, at https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.

[83] KFF, *Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL), as of 2024*, State Health Facts, accessed June 123, 2026, at https://www.kff.org/state-health-policy-data/state-indicator/health-insurance-coverage-population-0-64-up-to-100-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[84] Joyce A. Martin et al., *Births In the United States, 2024*, NCHS Data Brief, No. 535, July 2025, at https://stacks.cdc.gov/view/cdc/174613.

[85] Michelle J. K. Osterman et al., *Births: Final Data for 2024, National Vital Statistics Reports*, vol 75, no 2, Hyattsville, MD: National Center for Health Statistics, June 9, 2026, at https://stacks.cdc.gov/view/cdc/252440.

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 FY2025, CHIP covered health care services for an estimated 7 million individuals. Federal and state expenditures totaled an estimated $28 billion, with the federal government paying approximately $20 billion of that total.

Participation in CHIP is voluntary, and all states, the District of Columbia (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 (SSA §2105(c)(7)).

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 from conception to birth pathway (formerly known as 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 children from conception to birth as permitted through federal regulation at 42 C.F.F.R. §457.10. 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 for 50 states and DC from Congressional Budget Office (CBO), "CHIP Baseline Projections," February 2026, https://www.cbo.gov/system/files/2026-02/51296-2026-02-chip.pdf. CHIP expenditures estimates from CMS, Form CMS-64 Data and Net CHIP Expenditures, February 18, 2025, https://www.medicaid.gov/medicaid/financial-management/state-budget-expenditure-reporting-for-medicaid-and-chip/expenditure-reports-mbes/cbes. 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, https://healthlaw.org/chip-provides-critical-reproductive-health-care-to-adolescents-and-pregnant-women/. For more information on CHIP eligibility for and coverage of pregnancy services, see *Medicaid and CHIP Coverage for Pregnant Women: Federal Requirements, State Options*, November 2020, https://ccf.georgetown.edu/wp-content/uploads/2020/11/Pregnancy-primary-v6.pdf.

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).[86] 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[87] 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[88] for all categorically needy individuals.[89] In addition, states may provide optional services—that is, services that states can choose whether to provide under their state plans.[90] 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

[86] SSA §1937 [42 U.S.C. §1396u-7].

[87] 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).

[88] MACPAC, Issue Brief, *Mandatory and Optional Enrollees and Services in Medicaid*, March 2026, at https://www.macpac.gov/wp-content/uploads/2026/03/Issue-Brief-Mandatory-and-Optional-Enrollees-and-Services-in-Medicaid.pdf.

[89] *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.

[90] 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.

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.

Within the general Medicaid service categories listed in statute, states define the specific features of each covered benefit within four broad federal guidelines.[91] 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,[92] 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.[93]

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[91] 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.

[92] 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 Guidance, at https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/epsdt-guidance.

[93] 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*
(continued...)

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 Patient Protection and Affordable Care Act (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).[94]

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.[95]

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[96] and family planning services and supplies for individuals of reproductive age.[97] 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 described in ACA Section 1302(b)."[98] 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

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/.

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

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

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

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

[98] 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. SSA §1937(b)(5) [42 U.S.C. §1396u-7(b)(5)] requires Medicaid ABP benefit packages to include the essential health benefits "at least as described in ACA Section 1302(b)," and 42 C.F.R. §440.347 directs ABP packages to include benefits "consistent with the applicable requirements ... in 45 CFR Part 156." Because ACA §1302(b) directs the HHS Secretary to define EHBs, CRS interprets these Medicaid-specific ABP requirements to incorporate ongoing marketplace rules and regulations defining EHBs.

preventive services without beneficiary cost sharing.[99] (Information on Medicaid coverage of specific types of reproductive health services appears below.)

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. [100] 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 or not 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 and Contraceptive Counseling Services?" section of this report), as prescribed, to meet the Medicaid EHB preventive services requirement.[101] (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. Examples of these coverage rule differences are discussed throughout the Medicaid 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,[102] for example, Minnesota[103] covers doulas under Medicaid's traditional mandatory pregnancy-related services category, while Oregon[104] 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

[99] 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, 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/.

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

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

[102] See footnote 53 for additional details.

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

[104] See Oregon CHIP state plan, Transmittal # 22-0019, Attachment 4.19-B, Page 1a.6, at https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/22-0019.pdf.

diagnostic, screening, preventive and rehabilitative services benefit category.[105] In each of these 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.[106] 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.[107]

In general, under Medicaid's "freedom of choice of provider" requirement, states must permit enrollees to receive services from any willing Medicaid-participating provider,[108] and states cannot exclude providers solely on the basis of the range of services they provide.[109] Medicaid managed care enrollees may be restricted to providers in a given managed care plan network,[110] except in the case of family planning services.[111] Medicaid enrollees (regardless of whether they receive services through the

FY2025 Reconciliation Law: Section 71113. Federal Payments to Prohibited Entities

Section 71113 of the 2025 reconciliation law (P.L. 119-21) prohibits federal Medicaid direct spending, as defined therein, for payments for items and services provided by "prohibited entities" for a one-year period beginning on the date of enactment (i.e., July 4, 2025, through July 4, 2026). A prohibited entity is defined as an entity, including its affiliates, subsidiaries, successors, and clinics that (as of October 1, 2025) is a tax-exempt organization as described under Section 501(c)(3) of the Internal Revenue Code; that is an essential community provider, as described in 45 C.F.R. Section 156.235 (as in effect on July 4, 2025), that primarily provides family planning services, reproductive health and related medical care, and abortion services other than those allowable under the Hyde Amendment; and that received federal and state Medicaid reimbursements exceeding $800,000 in FY2023.

Source: CRS analysis of P.L. 119-21.

[105] Anoosha Hasan, *State Medicaid Approaches to Doula Service Benefits*, National Academy for State Health Policy, 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/sites/default/files/2024-03/NY-24-0003.pdf.

[106] 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.

[107] Michelle Long 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/experiences-with-health-care-access-cost-and-coverage-findings-from-the-2022-kff-womens-health-survey/.

[108] 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.

[109] 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 https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6-1-11-Info-Bulletin.pdf. Section 71113 of P.L. 119-21 prohibited federal Medicaid spending for payments for items and services provided by "prohibited entities" (as defined therein) for a one-year period (i.e., through July 4, 2026). For more information, see CRS Report R48633, *Health Provisions in P.L. 119-21, the FY2025 Reconciliation Law*.

[110] 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.

[111] 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.

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.[112]

Does Medicaid Cover Contraceptive Services?

States are required[113] to provide family planning services and supplies to prevent or delay pregnancy under both traditional and ABP benefit coverage for most individuals[114] of reproductive age (including minors) who desire such services and supplies.[115] 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.[116] Family planning services and supplies must be available to Medicaid enrollees without undue burden, coercion, or mental pressure.[117] 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.[118] States may pay for sterilization services only if certain specified conditions are met.[119] In addition, Medicaid beneficiaries must be free to choose the provider of their choice and the method of family planning to be used.[120]

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., for the purpose of preventing or delaying pregnancy, or at the state's

[112] 42 C.F.R. §431.51. Also see HHS, CMCS Informational Bulletin, SUBJECT: Medicaid Family Planning Services and Supplies: Requirements and Best Practices, August 8, 2024, at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/AID/cib08082024_0.pdf.

[113] 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 also SSA §§1937(b)(5) and 1937(b)(7) [42 U.S.C. §§1396u-7(b)(5) and 1396u-7(b)(7)]. (See HHS, CMS, "Re: Medicaid Family Planning Services and Supplies," SHO letter, SHO#16-008, June 14, 2016, at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/sho16008.pdf.)

[114] 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.

[115] SSA §1902(a)(4)(C) [42 U.S.C. 1396d(a)(4)(C)]. 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.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/AID/cib08082024_0.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.

[116] 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); 42 C.F.R. §§447.56(a)(2)(ii) and 438.108.

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

[118] 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/sites/default/files/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/federal-policy-guidance/downloads/faq11117.pdf and CMS, CMCS Informational Bulletin, "Medicaid Family Planning Services and Supplies: Requirements and Best Practices," August 8, 2024, at https://www.medicaid.gov/federal-policy-guidance/downloads/cib08082024.pdf.

[119] 42 C.F.R. §§441.253-441.258.

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

option, for treating infertility) 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.[121] 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 conception, and infertility services, including sterilizations and sterilization reversals),[122] and for related administrative costs.[123] By contrast, family planning-related services are reimbursable at the state's regular FMAP rate.[124] 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.[125] (Family planning-related services are discussed in more detail in the "Does Medicare Cover Reproductive Health Prevention and Treatment 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),[126] 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,[127] 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

[121] For more information on the types of family planning benefits covered under state Medicaid programs, see Usha Ranji 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/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 (p. 2), at https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf; CMS, CMCS Informational Bulletin, "Medicaid Family Planning Services and Supplies: Requirements and Best Practices," August 8, 2024, at https://www.medicaid.gov/federal-policy-guidance/downloads/cib08082024.pdf; and KFF, Women's Health Indicators, Family Planning for 50-state coverage of various Medicaid family planning benefits (e.g., state Medicaid coverage of over the counter contraception without a prescription, and Medicaid coverage of emergency contraception) at https://www.kff.org/state-category/womens-health/.

[122] 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.

[123] 42 C.F.R. §433.15(b)(2).

[124] For FY2027, states' regular FMAP rates range from 50.00% to 77.32%, 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)*.

[125] CMS, "Re: Family Planning Services Option and New Benefit Rules for Benchmark Plans," SHO Letter, SMDL#10-013 ACA# 4, July 2, 2010, at https://www.medicaid.gov/federal-policy-guidance/downloads/smd011901c.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/sites/default/files/federal-policy-guidance/downloads/sho16008.pdf.

[126] For more information on state coverage of emergency contraception (EC) as of July 1, 2021, see Usha Ranji 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/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

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

sponge, EC) and prescription contraceptives (e.g., oral contraceptives, LARCs, patch, diaphragm, injectable, IUDs).[128]

Prescription drugs are considered an optional Medicaid service, but all states cover them.[129] State coverage of various FDA-approved prescription contraceptives under traditional Medicaid is generally established through national drug rebate agreements between drug manufacturers and the HHS Secretary under the Medicaid Drug Rebate program.[130] 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, state utilization control policies cannot interfere with an enrollee's freedom to choose the covered method of family planning, services, or any counseling associated with that choice. 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.[131]

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 and Contraceptive Counseling Services?")[132] and other recommended preventive health services (see the Clinical Preventive Services Recommendations and Guidelines text box in the "What Are Reproductive Health Prevention and Treatment Services?" section).[133]

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

[128] For more on the range of family planning benefits covered by states under traditional Medicaid, see Usha Ranji 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/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

[129] States are also permitted to cover 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.

[130] 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 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*.

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

[132] 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/sites/default/files/federal-policy-guidance/downloads/sho16008.pdf.

[133] HRSA, "Women's Preventive Services Guidelines," December 2025, https://www.hrsa.gov/womens-guidelines. For more on the range of family planning benefits covered by states under Medicaid ABPs, see Usha Ranji 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/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

adults) through special waivers of federal law (i.e., Section 1115 family planning waivers).[134] 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.[135]

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).[136] The ACA family planning eligibility group includes individuals (men and women) (1) who are not pregnant and (2) whose income does not exceed the highest income eligibility level established by the state for pregnant women.[137] Benefits for this eligibility group are limited to family planning services and supplies and related medical diagnosis and treatment services.[138] 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 and Contraceptive Counseling Services?") and relevant preventive services recommended by USPSTF and HRSA.[139] 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

[134] 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 February 2025, 10 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/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[135] Beginning January 1, 2027, Section 71118 of P.L. 119-21 requires the CMS chief actuary to certify that Medicaid Section 1115 demonstration waiver submissions are budget neutral to the federal government. For more information, see CMS, "SMD # 26-003 RE: Budget Neutrality and Certification by the Chief Actuary of CMS for Section 1115 Medicaid Demonstration Projects," June 11, 2026, at https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf.

[136] As of February 2025, 20 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/.

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

[138] "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/sites/default/files/federal-policy-guidance/downloads/sho16008.pdf.

[139] 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 https://www.kff.org/affordable-care-act/medicaid-and-family-planning-background-and-implications-of-the-aca/.

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.[140]

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.[141]

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, 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).[142] Some states rely on state-only funds to pay for abortions that do not meet the Hyde amendment exceptions.

Through program regulations,[143] 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.[144]

Following the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*,[145] coverage of Hyde-permissible abortions under Medicaid has shifted. Among states where abortion remains legal (subject to specified criteria such as gestational age), 22 states and the District of Columbia follow the Hyde amendment restrictions when paying for abortion services

[140] For more information, see Usha Ranji 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/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

[141] 42 C.F.R. §441.207.

[142] 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 Consolidated Appropriations Act, 2026 (P.L. 119-75). See also HHS, Health Care Financing Administration (HCFA), Center for Medicaid and State Operations (CMSO), SMDL, February 12, 1998, at https://www.medicaid.gov/federal-policy-guidance/downloads/smd021298.pdf.

[143] 42 C.F.R. §§441.203, 441.206, and 441.208.

[144] HHS, HCFA, CMSO, SMDL, February 12, 1998, at https://www.medicaid.gov/federal-policy-guidance/downloads/smd021298.pdf.

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

for Medicaid enrollees, and 7 states provide funds for more limited exceptions such as life endangerment (1 state), fetal impairment (4 states), and to prevent long-lasting damage to the pregnant individual's health (4 states). Finally, 21 states use state-only funds to pay for abortions beyond the Hyde Amendment limitations, as of July 16, 2026.[146]

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, IUI, and 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).[147] 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.[148]

Does Medicaid Cover Maternity Services?

Medicaid is a significant payer of maternal health services and births in the United States. According to the Centers for Disease Control and Prevention (CDC), Medicaid paid for approximately 40% of all births in the United States in 2024.[149] In general, Medicaid benefits for pregnant women can differ by eligibility pathway across and within states.[150]

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,[151] and up to 185% of FPL at state option.[152] As of July 2025,[153] the Medicaid upper-income

[146] Guttmacher Institute, *State Insurance Coverage of Abortion Under Medicaid, State Laws and Policies*, as of June 16, 2026, at https://www.guttmacher.org/state-policy/explore/state-insurance-coverage-abortion-under-medicaid.

[147] For more information of state coverage of fertility services by program type, see Usha Ranji 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/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/. Also see KFF, State Health Facts, Women's Health, Family Planning, Mandated Coverage of Infertility Treatment, November 2025, at https://www.kff.org/state-health-policy-data/state-indicator/infertility-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

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

[149] Michelle J. K. Osterman et al., *Births: Final Data for 2024*, National Vital Statistics Reports, vol 75, no 2, Hyattsville, MD: National Center for Health Statistics, at https://stacks.cdc.gov/view/cdc/252440.

[150] For more information on Medicaid's pregnancy coverage, see 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/wp-content/uploads/2020/11/Pregnancy-primary-v6.pdf. See also, MACPAC, Pregnant Women, January 31, 2023, at https://www.macpac.gov/subtopic/pregnant-women/.

[151] 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)].

[152] 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) [42 U.S.C. §1396a(l)(2)].

[153] MACPAC, "Exhibit 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State," July 2025, *MACStats*, February 2026, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-35.-Medicaid-and-CHIP-Income-Eligibility-Levels-as-a-Percentage-of-the-Federal-Poverty-Level-for-Children-and-Pregnant-Women-by-State-2025.pdf.

eligibility threshold for pregnant women ranged from 133% of FPL in three states (Idaho, Louisiana, and South Dakota) to 319% of FPL (in the District of Columbia).[154] Coverage for these women may include full Medicaid benefit coverage, or states may limit services to those related to pregnancy.[155] In either case, coverage under these statutory authorities 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.[156]

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 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).[157]

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.[158]

Section 71109 of the FY2025 reconciliation law (P.L. 119-21) prohibits federal Medicaid funding from being used to provide coverage to individuals who are residents of the United States but do not fall into one of the following categories: (1) citizens or nationals of the United States; (2) aliens lawfully admitted for permanent residence; (3) aliens who have been granted the status of Cuban and Haitian entrants; or (4) aliens lawfully residing in the United States in accordance with

[154] 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 were 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*.

[155] 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, January 1, 2023, at https://www.macpac.gov/subtopic/pregnant-women/.

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

[157] 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.

[158] As of July 15, 2026, all states (except Arkansas) and the District of Columbia 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 KFF, Medicaid Postpartum Coverage Extensions: Approved and Pending State Action as of July 15, 2026, at https://www.kff.org/medicaid/medicaid-postpartum-coverage-extension-tracker/.

the Compacts of Free Association (COFA), beginning October 1, 2026. This provision does not apply to the two groups described below: individuals eligible under emergency Medicaid and those eligible through the Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women state plan option.

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.[159] 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 pregnancy or the delivery.[160]

Many *qualified aliens*, such as Legal Permanent Residents who entered the United States after August 22, 1996,[161] are prohibited from receiving Medicaid for five years (often referred to as the five-year bar).[162] 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).

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 the woman having been pregnant."[163] 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).[164] 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).[165] 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.[166]

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

[160] 42 C.F.R. §440.255(b)(2).

[161] *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.

[162] 8 U.S.C. §1613.

[163] 42 C.F.R. §440.210(a)(2)(i).

[164] For more information on the kinds of pregnancy benefits that states offer under their Medicaid programs, Usha Ranji 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.

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

[166] For examples of state efforts to improve maternal and child health outcomes, see MACPAC, *Report to the*
(continued...)

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 "Does Federal Law Require Private Health Insurance Coverage of Reproductive Health Services?" section of this report).[167] Under the maternity and newborn care EHB category, ABP plans must provide coverage of maternity and newborn care services that is substantially equal to such coverage provided by the state's EHB benchmark plan. Under the preventive and wellness services and chronic disease management EHB coverage category, Medicaid ABPs must cover a variety of prenatal care services at no cost to the enrollee, including but not limited to prenatal visits, folic acid supplements, anxiety and depression screening, screenings and medication for preeclampsia, STI tests, smoking cessation support, and breastfeeding support services and supplies.[168]

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) was less 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]

Congress, Chapter 5: Medicaid's Role in Maternal Health June 2020, at https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaids-Role-in-Maternal-Health.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. The Current Procedural Terminology (CPT) Editorial Panel has approved a significant restructuring of maternity care services codes for the CPT 2027 code set. Effective January 1, 2027, the CPT codes will move from a global code for maternity care to codes that will allow care to be reported at the service level across four phases of maternity care (i.e., antepartum, labor management, delivery, and postpartum). For more information, see American Medical Association, Maternity Care Services at https://www.ama-assn.org/system/files/cpt-maternity-care-codes-guidelines.pdf.

[167] 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.

[168] For more information, see KFF, ACA Preventive Services Tracker, Pregnancy-Related Preventive Services for Adults Covered by the ACA, last updated on June 27, 2025, at https://www.kff.org/affordable-care-act/pregnancy-related-preventive-services-covered-by-the-aca/.

[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 et al., *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey*, Kaiser Family Foundation (KFF), April 27, 2017, at https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-and-Perinatal-Benefits. For more recent survey data tracking Medicaid state coverage of pregnancy-related services, see Usha Ranji et al., *Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey*, KFF, May 19, 2022, at
(continued...)

Does Medicaid Cover Reproductive Health Prevention and Treatment Services?

In general, Medicaid covers a wide array of reproductive health 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]

Breast and Cervical Cancer Treatment Program (BCCTP)

The Breast and Cervical Cancer Treatment Program is a standalone Medicaid coverage pathway that is available at state option. Under BCCTP, states are permitted to extend full Medicaid coverage to uninsured persons under age 65 with annual income up to 250% of the federal poverty level who are screened or diagnosed with breast or cervical cancer with funding from the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) or, more broadly, persons screened under the NBCCEDP program, regardless of the funding source or diagnosis site. Medicaid benefits for these individuals will be available without enrollee cost sharing. According to KFF, all states and the District of Columbia participate as of 2023. See the section "What Is the National Breast and Cervical Cancer Early Detection Program?" in this report.

Sources: SSA Sections 1902(a)(10)(A)(ii)(XVIII) [42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII)]; 1902(a)(10) in subdivision (XIV) in the matter after (G) [42 U.S.C. 1396a(a)(10)) in subdivision (XIV) in the matter after (G)]; 1902(aa) [42 U.S.C. 1396a(aa)]; 1905(b) in the matter at (4) [42 U.S.C. 1396d(b) in the matter at (4)]; 1916A(b)(3)(B)(viii) [42 U.S.C. 1396o-1(b)(3)(B)(viii)]; 1916A(b)(3)(A)(v) [42 U.S.C. 1396o-1(b)(3)(A)(v)]; and SSA Section 1920B [42 U.S.C. 1396r-1b]. See also KFF, State Health Facts, Medicaid Breast and Cervical Cancer Treatment Program Enrollment, as of 2023, at https://www.kff.org/medicaid/state-indicator/medicaid-breast-and-cervical-cancer-treatment-program-enrollment/.

https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-Related-Services-Findings-from-a-2021-State-Survey.pdf. 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* (continued...)

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. Many states go beyond the EHB screening requirements to include coverage for the treatment of conditions identified through these health screenings. Examples of ABP reproductive health screening, preventive services, and treatment for conditions identified under these screenings 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.[171]

Comparing Medicaid Reproductive Health Prevention Services Across Coverage Types

Comparing reproductive health 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.[172]

Does Medicaid Cover Gender-Affirming Services?

Federal law does not expressly specify gender-affirming services as a category of mandatory Medicaid benefits, but Medicaid can cover a broad range of medically necessary physical and mental health care services for transgender, nonbinary, and gender-nonconforming individuals.[173]

Brief, Women's Sexual and Reproductive Health Services: Key Findings from the 2017 Kaiser Women's Health Survey, March 13, 2018, at https://files.kff.org/attachment/Issue-Brief-Womens-Sexual-and-Reproductive-Health-Services-Key-Findings-from-the-2017-Kaiser-Womens-Health-Survey.

[171] For more information, see KFF, ACA Preventive Services for Adults Covered by the ACA, Sexual and Reproductive Health Related Preventive Services for Adults Covered by the ACA, last updated on June 27, 2025, at https://www.kff.org/affordable-care-act/sexual-health-preventive-services-covered-by-the-aca/. See also KFF, ACA Preventive Services for Adults Covered by the ACA, Cancer-Related Preventive Health Services for Adults Covered by the ACA, last updated on March 11, 2026, at https://www.kff.org/affordable-care-act/cancer-related-preventive-services-covered-by-the-aca/.

[172] 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. For more information on 50 state coverage of well women care, cervical and breast cancer services, STIs and HIV, see Usha Ranji et al., Medicaid Coverage of Family Planning Services: Findings from a 2021 State Survey, KFF, February 2022, at https://files.kff.org/attachment/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey.pdf.

[173] There is ongoing litigation on whether Medicaid *must* cover such services under relevant constitutional principles or other statutory provisions such as ACA Section 1557, which prohibits discrimination based on race, color, national origin, sex, disability, and age in federally funded health programs and other specified contexts. See Kadel v. Folwell, 100 4th 122 (4th Cir. 2024), *judgment vacated and remanded by* 145 S. Ct. 2838 (2025).

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.[174] 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.[175] A 2026 study identified 20 states and the District of Columbia as including gender-affirming care under Medicaid, and 18 states expressly exclude such coverage.[176]

As a part of a series of executive branch actions to limit federal funds for gender-affirming care for minors[177] (some of which have been the subject of recent litigation),[178] CMS released two proposed rules in 2025. The first, titled *Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children*, was finalized on August 13, 2026, and is scheduled to take effect on October 13, 2026.[179] The rule prohibits federal Medicaid (and CHIP) funding for "sex-rejecting procedures" as defined therein, for individuals under the age of 18 (under Medicaid) and for individuals under age 19 (under CHIP). The rule defines "sex rejecting procedures" as "any pharmaceutical or surgical intervention that attempts to align a child's physical appearance or body with an asserted identity that differs from the child's sex," as defined. The definition excludes treatments for certain conditions (e.g., "a medically verifiable disorder of sexual development" or to address complications caused by previous procedures). The rule codifies definitions for *male*, *female*, and *sex*. The preamble of the rule also makes it clear that Medicaid and CHIP federal funds would be available for mental health counseling and psychotherapy for gender dysphoria.[180]

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[174] For more information, see Movement Advancement Project, *Health Care Laws and Policies: Medicaid Coverage for Transition-Related Care* at https://mapresearch.org/citation/medicaid-coverage-for-transgender-related-health-care/.

[175] 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 et al., *Update on Medicaid Coverage of Gender-Affirming Health Services*, KFF, October 11, 2022, at https://www.kff.org/womens-health-policy/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://mapresearch.org/equality-map/medicaid-coverage-of-transgender-related-health-care/#medicaid.

[176] Posner, Jacob, Covered USA, Gender-Affirming Care Medicaid Coverage by State (2026), May 15, 2026, at https://coveredusa.org/en/qa/gender-affirming-care-medicaid-by-state.

[177] See for example, Executive Order 14187, "Protecting Children from Chemical and Surgical Mutilation," vol. 90, no. 21 *Federal Register* 8771, January 28, 2025, at https://www.govinfo.gov/content/pkg/FR-2025-02-03/pdf/2025-02194.pdf, and HHS, Declaration of the Secretary of the Department of Health and Human Services, RE: Safety, Effectiveness, and Professional Standards of Care for Sex Rejecting Procedures on Children and Adolescents, December 18, 2025, at https://web.archive.org/web/20260422230725/https://www.hhs.gov/sites/default/files/declaration-pediatric-sex-rejecting-procedures.pdf.

[178] For examples of ongoing litigation on these executive branch actions, see *Washington v. Trump*, 768 F. Supp. 3d 1239, 1282 (W.D. Wash. 2025), *PFLAG, Inc. v. Trump*, 769 F. Supp. 3d 405, 455 (D. Md. 2025), and *State of Oregon v. Kennedy*, 6:25-cv-02409-MTK (D. Or. 2026).

[179] CMS, "Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children," vol. 91, no. 155, *Federal Register* 52406-52474, August 13, 2026, at https://www.govinfo.gov/content/pkg/FR-2026-08-13/pdf/2026-16508.pdf.

[180] 90 C.F.R. §59448. For CMS actions related to this proposed rule, see U.S. General Services Administration, Office of Information and Regulatory Affairs, Office of Management and Budget, Executive Office of the President, "Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Specified Sex-Rejecting Procedures Furnished to Children and Youth (CMS-2451)," RIN: 0938-AV73, Publication ID: 2026, at https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202510&RIN=0938-AV73.

The second proposed rule, titled "Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children," would revise the Medicare and Medicaid conditions of participation requirements for participating hospitals.[181] Specifically, such hospitals would be prohibited from performing "sex rejecting procedures," as defined therein, on any child under the age of 18. As with the previous proposed rule, this proposed rule would exclude treatments for certain conditions (e.g., "a medically verifiable disorder of sexual development" or to address complications caused by previous procedures) and would codify definitions for *male*, *female*, and *sex*, among other definitions.[182]

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. Medicare has four distinct parts. Parts A, B, and D each cover different services, while Part C provides an alternative to Parts A and B administered by private insurers. Together, Parts A and B constitute "original" or "traditional" Medicare.

- Part A (Hospital Insurance, or HI) covers primarily inpatient hospital services and certain post-acute care services.
- Part B (Supplementary Medical Insurance, or SMI) covers a range of medical services and supplies, including physician, outpatient hospital, and preventive services.
- Part C (Medicare Advantage, or MA) is an alternative to Parts A and B. Beneficiaries may choose to receive essentially all covered benefits through a private insurer under contract with Medicare. Additionally, MA plans may offer supplemental benefits not covered under Parts A, B, or D.
- Part D is an optional outpatient prescription drug benefit offered through private organizations, either as a stand-alone benefit (PDP) or integrated with an MA plan (MA-PD). [183]

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.[184] As such, covered items and services depend on different factors, such as age, disease status, and other characteristics.

[181] CMS, "Medicare and Medicaid Programs; Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children," Vol. 90, No. 242 *Federal Register* 59463 -59478, December 19, 2025, at https://www.govinfo.gov/content/pkg/FR-2025-12-19/pdf/2025-23465.pdf.

[182] The U.S. General Services Administration's Unified Agenda set the action date for this proposed rule as December 19, 2028, which has led some to speculate that the rule may not be finalized. For example, see NPR, *Trump's HHS Shelves Threat to Withhold Medicare and Medicaid Funding Over Trans Care*, heard on *All Things Considered*, July 14, 2026, at https://www.npr.org/2026/07/13/nx-s1-5888586/transgender-gender-affirming-care-medicare-medicaid-hhs. For CMS actions related to this proposed rule, see U.S. General Services Administration, Office of Information and Regulatory Affairs, Office of Management and Budget, Executive Office of the President, "Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children (CMS-3481)," RIN: 0938-AV87, Publication ID: 2026, at https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202510&RIN=0938-AV87.

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

[184] CRS In Focus IF13031, *Medicare Coverage: Background and Resources*.

The majority of Medicare beneficiaries are 65 years old or older. However, in 2025, approximately 7.1 million beneficiaries under age 65 were enrolled in Medicare due to disability, including an unspecified number of people of reproductive age.[185]

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 the purpose of pregnancy prevention. However, certain contraceptive services or supplies may be covered to treat a medical condition. For example, under Medicare Part B, IUDs may be covered to treat endometrial hyperplasia, a medical condition of the uterus.[186] 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.[187]

Women Medicare beneficiaries may have access to contraceptive services in the form of hormonal contraception under their Medicare Part D prescription drug coverage. Hormonal contraception, such as IUDs, oral contraceptives, contraceptive patches, and implants, are considered covered Part D drugs.[188] There is no statutory requirement that Part D plans cover

[185] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 9, 2026, at https://www.cms.gov/data-research/statistics-trends-and-reports/trustees-report-trust-funds.

[186] Additional coverage criteria apply. Noridian Healthcare Solutions, LLC, *Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999*, A55061, September 25, 2025, https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55061&ver=11&keyword=IUD&keywordType=starts&areaId=all&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1.

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

[188] Covered Part D drugs are defined in SSA Section 1860D–2(e)(1) as (1) outpatient prescription drugs approved by the FDA and used for a medically accepted indication; (2) biological products that may be dispensed only upon a prescription and that are licensed under the Public Health Service (PHS) Act and produced at a licensed establishment; (3) insulin (including medical supplies associated with the injection of insulin); and (4) vaccines licensed under the Public Health Service Act. Contraception that meets the criteria of a covered Part D drug are listed in the Medicare Part D Formulary Reference File, which is available at https://www.cms.gov/medicare/coverage/prescription-drug-coverage/formulary-guidance. In 2024, HHS updated its clinical review process to include additional birth control types, such as the implant and additional IUDs. For more information, see HHS, "HHS Secretary Xavier Becerra Announces New Actions to Increase Contraceptive Care Coverage on 51st Anniversary of Roe v. Wade," press release, (continued...)

contraception, but Part D plan sponsors are generally required to cover at least two drugs in every class and category under their chosen drug classification system. Part D plan sponsors may choose to use any drug classification system, subject to CMS approval.[189] The minimum number and type of contraceptives that a Part D plan is required to cover may vary based on their chosen classification system.[190]

Medicare Advantage plans are explicitly prohibited from offering contraceptives, such as spermicides and prophylactics, as part of an over-the-counter supplemental benefit.[191]

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.[192]

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.[193] 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

January 22, 2024, https://us.pagefreezer.com/en-US/wa/browse/0a7f82bb-be6e-448a-ae11-373d22c37842?find-by-timestamp=2025-01-02T05:49:59Z&url=https:%2F%2Fwww.hhs.gov%2Fabout%2Fnews%2F2024%2F01%2F22%2Fhhs-secretary-xavier-becerra-announces-new-actions-increase-contraceptive-care-coverage-51st-anniversary-roe-v-wade.html&timestamp=2025-01-02T07:03:02Z.

[189] CMS, *Medicare Part D Manual*, Ch. 6 – Part D Drugs and Formulary Requirements, Section 30.2-Provision of an Adequate Formulary, https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf.

[190] Plans that choose to use the United States Pharmacopeial Convention Medicare Model Guidelines (USP MMG) are automatically approved by CMS. While there are drug classes such as "Antidepressants" and "Anti-addiction/Substance Abuse Treatment Agents," there is no USP MMG drug class for contraceptive agents. Hormonal contraception is instead in the drug class "Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)" and under the category of the same name. In contrast, the USP Drug Classification System (USP DC), which is a separate and broader classification produced by the USP, has contraceptives as a distinct class of drugs and then separate categories of contraception within that class.

[191] CMS, *Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections*, April 22, 2016, p. 52, https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf.

[192] 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/.

[193] 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.

expected to be fertile to seek medical consultation and treatment."[194] 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. Under Medicare Part D, therapies used to promote fertility are excluded from coverage, such as drugs used during IVF treatment.[195] A Part D sponsor may elect to include one or more of these drugs in an enhanced Part D plan; however, no federal subsidy is available for the associated costs.

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.[196] 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 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 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, prostate cancer screening, and HIV pre-exposure PrEP.[197] 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."[198] 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.[199] In 2016, CMS announced that it would not issue a national coverage determination

[194] CMS, *Medicare Benefit Policy Manual*, Ch. 15 – Covered Medical and Other Health Services, May 8, 2026, p. 9, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.

[195] Section 1860D-2(e)(2)(A) of the SSA. CMS annually publishes a list of excluded drugs in their Excluded Drug Reference File.

[196] Ibid., p. 8.

[197] CMS, "Medicare Preventive Services," interactive chart, June 2026, https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html.

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

[199] Department of Health and Human Services, Department Appeals Board, Appellate Division, *NCD 140.3,* (continued...)

(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.[200]

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.[201] Certain services that may be considered gender-affirming are not covered under Medicare if they are primarily cosmetic.[202]

Federal Regulation of Private Health Insurance

Private health insurance is the predominant source of health insurance coverage in the United States. Approximately 192.6 million individuals, or 56.5% of the U.S. population at the time, had private health insurance as of December 2024.[203]

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*,[204] and fully insured plans may be purchased in the *large-group* or *small-group markets*.[205] The nongroup and small-group markets include plans both on and off the *health insurance exchanges*.[206]

Federal requirements on private health insurance plans generally apply to some or all of the plan types noted above (i.e., nongroup plans, fully insured small- and large-group plans, and self-

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.

[200] 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/view/ncacal-decision-memo.aspx?proposed=N&ncaid=282.

[201] Michael T. Solotke 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.

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

[203] CRS analysis of National Supplemental Health Care Exhibit (SHCE) and California Department of Managed Health Care (DMHC) data, accessed July 2026. SHCE data accessed from Mark Farrah Associates, "Health Coverage Portal" (CRS subscription), https://www.markfarrah.com/. DMHC data accessed from California Health Care Foundation, "California Health Insurers, Enrollment Almanac – December 2025 Edition," December 16, 2025, https://www.chcf.org/resource/california-health-insurers-enrollment-almanac/. U.S. population as of December 2024 accessed from U.S. Census, "U.S. and World Population Clock," https://www.census.gov/popclock/.

[204] When group plan sponsors (e.g., employers or unions) 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.

[205] 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.

[206] 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 must meet all the requirements applicable to the nongroup and small-group markets, respectively. Additional requirements apply only to exchange plans. See CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates* for more information on these federally and state-run marketplaces, and the private health insurance plans (qualified health plans) sold in them.

insured group plans).[207] 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.[208] While the focus of this report is federal requirements, some examples of relevant state requirements on private health insurance plans 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.[209] 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.

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 EHBs and coverage of certain preventive services without cost sharing—are applicable to multiple types of reproductive health services.[210] Overviews of these provisions are provided below. These provisions are further discussed in the rest of this section as applicable to different types of reproductive health services, along with other federal requirements relevant to the different types of services.

Where there is a benefit coverage requirement, one or more details may be specified in statute or regulations. 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.[211] Coverage requirements may

[207] 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*.

[208] 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.

[209] 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* (last updated in 2019).

[210] 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*.

[211] 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."

depend on how or where the service or item is furnished (e.g., by an *in-network* versus *out-of-network* provider).[212] Coverage requirements may also specify whether plans are allowed to impose medical management requirements, such as prior authorization requirements.[213] To the extent that a reproductive health benefit coverage requirement specifies one or more of these details, they are discussed below.

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).[214] As implemented, states, rather than the federal government, generally specify the benefit coverage requirements within those categories. To date, EHB regulations allow 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.[215]

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.[216]

Cost-sharing and medical management requirements are possible for most categories of EHB, subject to applicable federal and state requirements. Federal requirements limit overall cost sharing on the EHB.[217] 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.

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[212] 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."

[213] 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."

[214] 42 U.S.C. §300gg-6 and 42 U.S.C. §18022.

[215] 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," https://www.cms.gov/cciio/resources/data-resources/ehb.

[216] 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.

[217] 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).

Overview: Coverage of Certain Preventive Services Without Cost Sharing

The ACA, via Section 2713 of the PHSA, requires most plans to cover specified preventive services and items without cost sharing, "such as a copayment, coinsurance, or a deductible."[218] Per statute and regulations, this includes at least the preventive services and items in the following four categories:

- Evidence-based items or services recommended with an "A" or "B" rating by the USPSTF.[219]
- Immunizations with a recommendation in effect by the Advisory Committee on Immunization Practices (ACIP) for routine use for a given individual.[220]
- Evidence-informed preventive care and screenings for infants, children, and adolescents as provided in guidelines supported by HRSA.[221]
- Additional preventive care and screenings for women as provided in guidelines supported by HRSA. [222]

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 preventive prenatal care services; and (7) contraception.[223] These services are further discussed under the relevant questions in this section.

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."[224] See the questions in this section on contraceptive coverage and reproductive health prevention and treatment services for examples of this.[225] Different rules apply with regard to cost-sharing for office visit charges.[226]

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[218] 42 U.S.C. §300gg-13; 45 C.F.R. §147.130. For more information, see CRS In Focus IF13010, *The ACA Preventive Services Coverage Requirement*.

[219] USPSTF, "A & B Recommendations," https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

[220] Advisory Committee on Immunization Practices (ACIP), "ACIP Vaccine Recommendations and Guidelines: Vaccine-Specific Recommendations," https://www.cdc.gov/acip-recs/hcp/vaccine-specific/. Also see CDC, "Healthcare Professionals: Immunization Schedules," 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 "in effect" if it is adopted by the CDC Director, and it is considered to be recommended "for routine use" if it is listed on the CDC Immunization Schedules.

[221] HRSA, "Bright Futures," https://mchb.hrsa.gov/programs-impact/bright-futures. See linked "Periodicity Schedule."

[222] HRSA, "Women's Preventive Services Guidelines," https://www.hrsa.gov/womens-guidelines. See the "Clinical Preventive Service Recommendations and Guidelines" text box earlier in this report for additional information about these guidelines.

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

[224] Departments of Labor, HHS, and the Treasury, "FAQs about Affordable Care Act and Women's Health and Cancer Rights Act Implementation Part 68," October 21, 2024, https://www.cms.gov/files/document/faqs-implementation-part-68.pdf (hereinafter referred to as "ACA FAQ 68, October 2024"). See page 2, including footnote 8.

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

[226] 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.

As specified in regulations and guidelines, plans can 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 or guideline.[227] 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.[228] 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.

If there are new or updated 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 one year after the change.[229] If an existing recommendation or guideline is removed, plans must generally still provide coverage of the preventive service or item through the end of their plan year, unless, as specified, it is determined to pose a safety risk.[230]

The requirement to cover specified preventive services without cost sharing is incorporated into the EHB category "preventive and wellness services and chronic disease management."[231] 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.[232]

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.[233] Since 2011, these Women's Preventive Services Guidelines (Guidelines) have included contraception.[234]

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

The current Guidelines on contraception, updated in December 2021 and adopted by HRSA in January 2022, recommend that "adolescent and adult women have access to the full range of

[227] 45 C.F.R. §147.130(a)(4).

[228] 45 C.F.R. §147.130(a)(3).

[229] 45 C.F.R. §147.130(b).

[230] Ibid.

[231] 45 C.F.R. §156.115(a)(4), referencing 45 C.F.R. §147.130.

[232] 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.

[233] 42 U.S.C. §300gg-13(a)(4). See the "Overview: Coverage of Certain Preventive Services Without Cost Sharing" section of this report.

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

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.[235] 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."[236] This is specified to include 17 of the "methods" (i.e., categories) of contraception as 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."[237]

Although the FDA Birth Control Guide also includes male sterilization, this service is excluded from the Women's Preventive Services Guidelines on contraception because the HRSA Guidelines (and the related coverage requirement) are specific to women's preventive health. However, per agency guidance on the preventive services coverage requirements, the Guidelines on contraception for women include male condoms, in addition to female condoms.[238]

Preventive Services Requirement: Contraceptive Coverage

Through rulemaking and guidance, the Departments of Labor, HHS, and the Treasury have addressed the private health insurance contraceptive coverage requirements that are based on the Women's Preventive Services Guidelines. Applicable nonexempt[239] 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 products as they are approved, cleared, or granted by the FDA, whether or not such

[235] HRSA, "Women's Preventive Services Guidelines," page last reviewed December 2025, https://www.hrsa.gov/womens-guidelines. Also see HRSA, "Update to the Women's Preventive Services Guidelines," 87 *Federal Register* 1763, January 12, 2022, https://www.federalregister.gov/documents/2022/01/12/2022-00465/update-to-the-womens-preventive-services-guidelines.

[236] Ibid.

[237] Ibid. Per the current Women's Preventive Services Guidelines on contraception, "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." The Guidelines reference the FDA Birth Control Guide posted as of December 22, 2021. For more information on the FDA Birth Control Guide, see the "What Are Contraceptive and Contraceptive Counseling Services?" section in this report.

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

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

> products are identified in the categories listed in the current HRSA-supported Guidelines.[240]

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."[241]

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 as well as anesthesia for tubal ligation.[242]

Per additional guidance on contraceptive coverage, applicable plans are *required* to provide coverage without cost-sharing of emergency contraception that is available 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.[243] Applicable plans are encouraged to cover a 12-month supply of contraceptives, such as oral contraceptives, if dispensed at once.[244]

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.[245] According to analyses by two policy research and stakeholder groups, as of April 2026, at least 31 states and DC require private health insurance coverage of FDA-approved prescription contraceptives if the plan otherwise covers prescription drugs, and at least 19 of those 32 prohibit cost sharing on some or all of the required contraceptive coverage. Most of the 32 have one or more additional requirements, such as coverage of certain OTC contraceptives (although insurers may still require prescriptions), coverage of an extended supply of contraception when dispensed at once, or coverage of male sterilization. At least 20 of the 32 provide contraceptive coverage exemptions for certain employers and insurers.[246]

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[240] Departments of Labor, HHS, and the Treasury, "FAQs about Affordable Care Act Implementation Part 64," January 22, 2024, https://www.cms.gov/files/document/faqs-part-64.pdf (hereinafter referred to as "ACA FAQ 64, January 2024"). See page 4. This FAQ also summarizes prior rulemaking and guidance on contraceptive coverage.

[241] 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 "therapeutic equivalence" approach to contraceptive coverage that plans may choose to adopt.

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

[243] 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."

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

[245] 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.

[246] Guttmacher Institute, "Insurance Coverage of Contraceptives," April 17, 2026, 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," updated July 17, 2026, 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).[247] Litigation and court rulings prompted a series of revised rules expanding upon these exemptions.[248] The latest iteration of these rules from November 2018 made exemptions available to most types of nonprofit and for-profit entities with sincerely held religious or moral beliefs against contraception.[249] As of the date of this report, the November 2018 rules are not in effect as a result of a federal district court decision that is on appeal.[250]

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.[251]

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.[252] For example, the ACA specifies that none of its provisions "shall be construed" to require a QHP to cover abortion.[253]

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

[247] 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, https://www.federalregister.gov/d/2011-19684.

[248] 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).

[249] 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, https://www.federalregister.gov/d/2018-24512. 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, https://www.federalregister.gov/d/2018-24514. 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/affordable-care-act/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/.

[250] See Pennsylvania v. Trump, 795 F. Supp. 3d 607 (E.D. Pa. 2025), *appeals filed*, Nos. 25-2575, 25-2662 (3d Cir. 2026). Questions from congressional clients regarding legal issues addressed in this section may be directed to Victoria L. Killion, CRS Legislative Attorney.

[251] 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?"

[252] For more information on the exchanges and qualified health plans (QHPs), see CRS Report R44065, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates*. QHPs may also be offered outside the exchanges, but this report's references to QHPs are generally regarding QHPs offered on the exchanges.

[253] 42 U.S.C. §18023(b).

plan that covers abortion services, applicable plans are not *federally* required to cover abortion in order to meet EHB standards.[254]

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.[255] The ACA also specifies that states are allowed to prohibit abortion coverage by QHPs offered in their exchange.[256] 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."[257] 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.

A July 2026 KFF analysis of state requirements on state-regulated private health insurance plans found the following:[258]

- Ten states prohibit private health insurance plans, including QHPs, from covering abortion. Another 15 states prohibit coverage of abortion by QHPs but not other plans. Some states allow for certain exceptions, such as coverage if the abortion is necessary to save the woman's life. Some states allow insurers to sell a "rider" (a separate policy) for abortion coverage, although it is not clear how many insurers offer such riders.
- Thirteen states require private health insurance plans, including QHPs, to include abortion coverage. See below for further discussion of federal requirements related to financing of QHPs' coverage of abortion.
- The remaining 12 states and DC do not require or limit private health insurance abortion coverage by private health insurance plans, including QHPs. Per KFF review of QHP benefit materials in these states' exchanges, there are no QHPs covering abortion in six of these states. No information was provided on abortion coverage outside of the exchanges in the states that neither require nor prohibit it.

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

[254] 42 U.S.C. §18023(b)(1)(A) and 45 C.F.R. §156.280(c) for QHPs; 45 C.F.R. §156.115(c) for all plans subject to EHB requirements. Also see the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report.

[255] 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.

[256] 42 U.S.C. §18023(a).

[257] 42 U.S.C. §18023(c).

[258] KFF, "Abortion Coverage Limitations in Medicaid and Private Insurance Plans," updated July 24, 2026, https://www.kff.org/womens-health-policy/abortion-coverage-limitations-in-medicaid-and-private-insurance-plans/.

to lack of information about coverage for abortion in plan documents unless abortion is explicitly excluded."[259]

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

As discussed earlier in this report, there are annual restrictions on HHS appropriations known as the Hyde Amendment, generally providing that HHS funds may not finance abortion except in cases of rape, incest, or endangerment of a mother's life (sometimes referred to as Hyde "excepted" abortions).[260] In other words, HHS funding is prohibited for abortion in other cases, referred to here as "non-excepted" abortions.

The ACA also includes restrictions related to the financing of abortion coverage, for QHPs that provide such coverage. These restrictions apply to the exchange financial subsidies that consumers may be eligible for, as well as the premiums that consumers pay themselves.

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. The PTCs are tax expenditures financed through a permanent appropriation; they are not part of HHS appropriations.[261] Such consumers may also be eligible for cost-sharing reductions (CSRs) that effectively reduce their out-of-pocket costs. The CSRs are not currently federally financed, but insurers must provide these subsidies to eligible consumers.[262]

The ACA's restrictions related to abortion coverage in QHPs reference the Hyde Amendment and its distinctions on abortion for which HHS funding is prohibited or allowed.[263] Under the ACA, individuals who receive a PTC and/or CSR are permitted to select a QHP that includes coverage for non-excepted abortions, to the extent that such coverage is allowed and offered in their state's exchange. However, the health insurer providing the QHP cannot use any funds attributable to the PTC or CSR to pay for non-excepted abortions.[264] Per regulations, insurers are required to exclude the value of such services when they calculate the premium rate on which any PTCs will be based.[265] This effectively means that if a QHP covers non-excepted abortions, the PTC will not reflect the value of such coverage.

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[259] KFF, "Coverage of Abortion in Large Employer-Sponsored Plans in 2023," February 29, 2024, https://www.kff.org/womens-health-policy/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, https://www.kff.org/report-section/ehbs-2023-survey-design-and-methods/. More recent data on employment-based coverage of abortion was not found, including in the KFF Employer Health Benefits Survey (October 2025).

[260] 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*.

[261] 31 U.S.C. §1324(b)(2).

[262] For more information, see CRS Insight IN12562, *Financing Cost-Sharing Reduction Reimbursements to Private Health Plans*.

[263] 42 U.S.C. §18023(b)(1)(B). Specifically, this ACA provision distinguishes between abortion for which the expenditure of HHS appropriations is prohibited or allowed, "based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved."

[264] 42 U.S.C. §18023(b)(2)(A) and 45 C.F.R. §156.280(e)(1).

[265] 45 C.F.R. §156.470(a)(1).

Insurers offering QHPs that cover non-excepted abortions are also subject to ACA requirements and implementing regulations regarding the premiums that each enrollee pays for such a plan. The insurer is required to collect two separate payments from each enrollee (regardless of whether an enrollee receives a PTC, and regardless of an enrollee's "age, sex, or family status"): one payment that reflects an amount equal to the portion of the premium for coverage of health services other than non-excepted abortions, and another payment that reflects an amount equal to the actuarial value of the coverage for non-excepted abortions.[266] The latter must be no less than $1 per enrollee, per month.[267] The insurer 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.[268]

State health insurance commissioners must ensure compliance with the 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.[269] Also, within regulations generally addressing oversight of QHPs by the exchanges and HHS, the exchanges are required to review QHP insurers' valuation of their premiums for PTC purposes (which must exclude any coverage of non-excepted abortions), and exchanges must submit information as specified to HHS, for purpose of HHS oversight of the subsidies.[270]

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

No federal law specifically requires 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.[271] 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.[272] Per an analysis by a fertility treatment stakeholder group, at least 25 states and DC have enacted requirements on

[266] 42 U.S.C. §18023(b)(2)(B)(i) and 45 C.F.R. §156.280(e)(2)(i) and (ii). 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.

[267] 42 U.S.C. §18023(b)(2)(D) and 45 C.F.R. §156.280(e)(4).

[268] 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). For further guidance on the segregated accounts, including allowable uses of the segregated funds after the end of a plan year, see CMS, "Frequently Asked Questions (FAQs) on Usage of Funds in Section 1303 Segregated Accounts by Qualified Health Plan (QHP) Issuers in the Individual Market," December 9, 2025, https://www.cms.gov/files/document/2025-faqs-1303-segregated-funds.pdf.

[269] 42 U.S.C. §18023(b)(2)(E)(i) and 45 C.F.R. §156.280(e)(5).

[270] 45 C.F.R. §155.1030(b).

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

[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.

private health insurance coverage of infertility services, as of late 2025.[273] 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.[274] According to its 2025 report, 71% of employers with 500 or more employees covered some type of fertility benefits. This includes, for example, 66% of employers with more than 500 employees that provide coverage of fertility evaluation services, 50% that provide coverage of IVF, and 22% that 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, "About two-thirds of employers [with 500 or more employees] that offer fertility benefits (66 percent) say that the benefits are intended to be inclusive—in other words, eligibility is not limited to women who meet the clinical definition of infertile." Coverage of fertility benefits generally varies by employer size: In 2025, 46% of employers with 50 or more employees, and 89% of employers with 20,000 or more employees, covered some type of fertility benefits.

Per CRS analysis of 2026 QHP benefit coverage, there are QHPs providing infertility coverage in 17 of the 30 states that use the federal exchange platform Healthcare.gov. This includes six states in which fewer than half of QHPs provide such coverage, two states in which more than half of QHPs provide such coverage, and nine states in which all QHPs provide such coverage.[275] 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.[276]

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[273] Resolve, "Insurance Coverage by State," accessed June 2, 2026, https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/. Also see Resolve, "About Insurance Coverage," https://resolve.org/learn/financial-resources/insurance-coverage/.

[274] Information in this paragraph is from Mercer, "National Survey of Employer-Sponsored Health Plans: 2025 Survey Report" and accompanying Survey Tables, March 2026, available for purchase at https://shop.mercer.com/catalog/national-survey-of-employer-sponsored-health-plans.html (hereinafter referred to as "Mercer 2025 Survey Report, March 2026"). 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 156 million full- and part-time employees." In some cases, the data are specified as applicable to employers with a certain number of employees, such as 50 or 500 or more.

[275] CRS analysis of the CMS 2026 Exchange Public Use File (PUF) Datasets, "Benefits and Cost Sharing PUF" and "Plan Attributes PUF," updated April 28, 2026, 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 30 states that utilize the federal platform Healthcare.gov in plan year 2026. The files do not include the 21 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, *Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates*.

[276] 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 search further for other state requirements that may be applicable.

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."[277] 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 earlier in this section includes the requirement for applicable plans to cover, without cost sharing, certain prenatal and postpartum services, as recommended.[278] 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.[279] 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 screening and healthy weight counseling, folic acid supplements, and breastfeeding services and supplies.[280]

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.[281] If the group plan offers coverage to employees' spouses and other dependents, the requirement to cover pregnancy-related services also applies to employees' spouses, but not necessarily to other dependents, enrolled in the plan.[282]

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

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

[279] HRSA, "Women's Preventive Services Guidelines," accessed June 2026, https://www.hrsa.gov/womens-guidelines.

[280] A number of USPSTF preventive services recommendations and HRSA Women's Preventive Services Guidelines are relevant to pregnant and postpartum individuals. Certain HRSA/Bright Futures guidelines and ACIP recommendations are also relevant to pregnant and postpartum individuals. See footnotes footnote 219 through footnote 222 in this report for links to each resource.

[281] 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, 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, https://www.eeoc.gov/laws/guidance/questions-and-answers-about-eeocs-enforcement-guidance-pregnancy-discrimination-and (hereinafter, "EEOC Enforcement Guidance" and "EEOC Q&A," respectively).

[282] See 29 C.F.R. §1604 Appendix, questions 21-23 regarding coverage of pregnancy-related conditions for spouses and other dependents. Also note that other federal requirements are relevant to employers' offer of coverage for (continued...)

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.[283]

Coverage of Minimum Hospital Stay After Childbirth

The Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204, as amended) prohibits most plans (if they otherwise cover maternity-related hospital stays) 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.[284] 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.

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.[285] 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 coverage of and cost-sharing for maternity care benefits, coverage of maternity care furnished by certain types of providers, and other topics.[286] For example, searches in their "Health Costs, Coverage, and

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 and 45 C.F.R. §147.120). 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 EHB and preventive services coverage requirements apply with respect 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, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca_implementation_faqs26.pdf (hereinafter referred to as "ACA FAQ XXVI, May 2015").

[283] EEOC Q&A.

[284] 42 U.S.C. §300gg-25; 45 C.F.R. §146.130.

[285] 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.

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

Delivery State Legislation" database for keywords including "maternity," "birth," "postpartum," and "doula," filtered for "market," return various results.

Does Federal Law Require Private Health Insurance Coverage of Reproductive Health 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: 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 for women, men, and/or adolescents.[287] This includes, for example,

- screening and counseling for STIs/STDs, universal HIV screening, and PrEP medication for persons at high risk of HIV acquisition (oral and injectable formulations);
- 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;
- patient navigation for breast and cervical cancer screening services; and
- colorectal cancer screenings, screening for urinary incontinence, and the HPV vaccine.[288]

It also includes at least one well-woman preventive visit per year, or a series of visits as needed, for women to obtain all recommended preventive services.

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. 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.[289] Recent updates to HRSA Guidelines on breast cancer and cervical cancer screening have also specified that additional imaging, testing, or pathological evaluation may be needed to complete a screening process.[290]

Plans are required to provide coverage of the recommended *preventive* services and items, *as specified* in relevant recommendations and guidelines. For example, the USPSTF and HRSA both

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

[288] A number of USPSTF preventive services recommendations and HRSA Women's Preventive Services Guidelines are relevant to reproductive health screening and prevention services. Certain HRSA/Bright Futures guidelines and ACIP recommendations are also relevant to such services. See footnotes 219 through 222 in this report for links to each resource. Regarding coverage of specified oral and injectable forms of PrEP, also see ACA FAQ 68, October 2024.

[289] Departments of Labor, HHS, and the Treasury, "FAQs About Affordable Care Act Implementation Part 47," July 19, 2021, 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.

[290] See "Screening for Cervical Cancer" (updated December 2025) and "Breast Cancer Screening for Women at Average Risk" (updated December 2024) at HRSA, "Women's Preventive Services Guidelines," accessed June 2026, https://www.hrsa.gov/womens-guidelines.

recommend cervical cancer screening for average risk or asymptomatic women aged 21-65, using different methodologies and at different intervals depending on age.[291] 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."[292]

If someone needs a *diagnostic* test (e.g., for breast cancer) based on the presence of relevant symptoms—or otherwise seeks a test outside of the relevant recommendations—the preventive services coverage requirements generally do not apply. The plan may still 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.[293]

Coverage of Reconstruction after Mastectomy

The Women's Health and Cancer Rights Act of 1998 (WHCRA; P.L. 105-277, as amended) requires that if plans provide coverage for mastectomies, they must also cover breast reconstruction services "in a manner determined in consultation with the attending physician and the patient."[294] The coverage must include all stages of reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction on the other breast for a symmetrical appearance, and prostheses and other specified supplies. Agency guidance has also clarified the applicability of WHCRA coverage requirements to nipple and areola reconstruction and chest wall reconstruction with aesthetic flat closure.[295] Guidance also 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.[296]

Cost sharing is allowed if consistent with cost sharing for other covered medical/surgical benefits. The law does not specify whether its requirements apply out-of-network.

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 prevention (and treatment) services coverage requirements on the plans they regulate.[297] For example, at one of the NCSL state legislation databases cited earlier, a

[291] Ibid., regarding HRSA guideline on cervical cancer screening. Also see USPSTF, "Cervical Cancer: Screening," August 21, 2018, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening.

[292] 45 C.F.R. §147.130(a)(4).

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

[294] 29 U.S.C. §1185b, 42 U.S.C. §300gg-27, and 42 U.S.C. §300gg-52.

[295] 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, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf, question 12. Also see ACA FAQ 68, October 2024, question 7.

[296] See Employee Benefits Security Administration, "Compliance Assistance Guide: Health Benefits Coverage Under Federal Law," September 2014, https://www.dol.gov/general/topic/health-plans/womens.

[297] 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.

search for keywords "breast" or "mammog" returns numerous recently enacted state laws, and a search for "sexually transmitted" returns several such state laws.[298]

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

No federal law specifically requires or prohibits private health insurance coverage of gender-affirming services. However, regulations and guidance have addressed other federal benefit coverage requirements, with respect to such services.

Regulatory Prohibition on Coverage of Specified Sex-Trait Modification Procedures as an Essential Health Benefit

As discussed earlier, federal regulations on essential health benefit requirements generally allow states to specify their EHB package by selecting a benchmark plan, and applicable plans in the state must provide coverage that is "substantially equal."[299] Per statute, the EHB must be equal to the scope of benefits provided under a "typical employer plan," but beyond the 10 required categories of EHB, statute does not require or prohibit the coverage of any particular benefits as EHB.[300] Regulations since 2013 have specified that certain benefits may not be covered *as EHB* (e.g., long-term/custodial nursing home care benefits; nonmedically necessary orthodontia).[301]

For the benefits that may not be covered as EHB, plans may still provide such coverage as *non-EHB*, either voluntarily or subject to state requirements other than as related to the EHB. However, if a benefit is not considered EHB, it is not subject to certain other federal requirements that apply only to the EHB (such as a maximum annual limit on cost sharing). In addition, for consumers eligible for subsidized coverage on the health insurance exchanges, the calculation of the subsidies may include only the value of the EHB.[302]

In June 2025, HHS issued a "Marketplace Integrity" final rule that, among other things, prohibited plans from covering "specified sex-trait modification procedures" as EHB.[303] This was defined as "any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex," as specified.[304] The definition excluded treatments for certain conditions (e.g., "a medically verifiable disorder of sexual development"), such that these treatments could still be covered as EHB. In the preamble to the final rule, HHS indicated that

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[298] 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 June 4, 2026, with a filter on "market."

[299] See the "Overview: Coverage of the Essential Health Benefits (EHB)" section of this report. EHB regulations include requirements on states in their selection of benchmark plans (e.g., 45 C.F.R. §156.110-111) and requirements on applicable plans in their coverage of the EHB (e.g., 45 C.F.R. §156.115).

[300] 42 U.S.C. §18022(b)(2).

[301] 45 C.F.R. §156.115(d) as added by rulemaking in 2013. The 2013 rule also prohibited the coverage of routine non-pediatric eye exams and routine non-pediatric dental services as EHB. A 2024 rule allowed coverage of routine non-pediatric dental as EHB, but a 2026 rule prohibited such coverage again. See 45 C.F.R. §156.115 for rulemaking citations.

[302] 45 C.F.R. §156.470.

[303] Department of HHS, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 *Federal Register* 27074, June 25, 2025, https://www.federalregister.gov/d/2025-11606. Hereinafter referred to as the "2025 Marketplace Integrity final rule."

[304] This definition was added at 45 C.F.R. §156.400 and referenced at 45 C.F.R. §156.115(d).

mental health and substance use disorder services as related to gender dysphoria treatment could still be covered as EHB.[305]

This provision of the final rule was applicable as of plan years beginning January 2026, but as part of a legal challenge, in August 2026, a U.S. district court vacated the provision.[306]

In the preamble to the final rule, HHS reported that five states have EHB benchmark plans that specifically include "coverage of some sex-trait modification," six states have benchmark plans that neither include nor exclude such coverage, and 40 states have EHB benchmark plans that exclude such coverage.[307] The final rule did not require states to change their benchmark plans; it modified the EHB requirements on plans.[308]

Guidance on Coverage of Sex-Specified Recommended Preventive Services

Federal guidance on the preventive services coverage requirement[309] 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."[310]

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.[311] According to a stakeholder group tracking such laws, as of 2026, 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.[312]

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[305] 2025 Marketplace Integrity final rule, page 27159, https://www.federalregister.gov/d/2025-11606/p-943. Within this section of the preamble, HHS also discussed that its use of the term "specified sex-trait modification procedure" was intended to have a narrower scope than the term "gender affirming care," per stakeholder comments that the latter "generally encompasses a broader set of medical services, such as mental health services."

[306] *California v. Kennedy*, No. 25-12019, 2026 U.S. Dist. LEXIS 182153, at *24 (D. Mass. Aug. 14, 2026).

[307] 2025 Marketplace Integrity final rule, page 27154, rule footnote 196. These numbers in the final rule are similar to those in an analysis submitted to CMS by an LGBT health policy research organization in January 2023: Whitman Walker Institute, Comment Letter to the Centers for Medicare & Medicaid Services, "RE: Request for Information on the Essential Health Benefits (87 *Federal Register* 74097, Dec. 2, 2022)," January 31, 2023, https://www.regulations.gov/comment/CMS-2022-0186-0663.

[308] Although the 2025 Marketplace Integrity final rule did not require states to change their EHB benchmark plans with respect to the specified sex-trait modification procedures, it did discuss implications for states that have relevant benefits in their benchmark plan, and/or otherwise have state mandates on such coverage. See the final rule for discussions of existing requirements on state defrayal of certain costs of required benefits, at 45 C.F.R. §155.170.

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

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

[311] 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.

[312] Movement Advancement Project (MAP), "Equality Maps: Healthcare Laws and Policies: Private Insurance," accessed July 21, 2026, https://mapresearch.org/equality-map/healthcare-laws-and-policies/#private-insurance. MAP is a policy research organization focused on "equality and opportunity for all."

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 2025 survey report on U.S. employer-sponsored health benefits, 23% of all employers with 50 or more employees provide coverage for "gender affirmation surgery," and such coverage is more likely as employer size increases (18% of employers with 50-499 employees, 54% of employers with 500 or more employees, and 78% of employers with 20,000 or more employees). Mercer found that among employers covering the surgery, most also cover some associated services. For example, among employers with 500 or more employees that do cover the surgical services, 77% also cover nonsurgical gender affirmation treatment/hormone therapy while fewer cover reconstructive procedures (49%) or puberty suppression (25%).[313]

Per CRS analysis of 2026 QHP benefit coverage, there are QHPs providing coverage of gender-affirming care services in 22 of the 30 states that use the federal exchange platform Healthcare.gov. This includes 18 states in which fewer than half of QHPs provide such coverage, three states in which more than half of QHPs provide such coverage, and one state in which all QHPs provide such coverage.[314]

Federal Employees Health Benefits Program (FEHB)

The Federal Employees Health Benefits (FEHB) Program, which includes the Postal Service Health Benefits Program (PSHB), provides health insurance to most federal employees, retirees, and their dependents, as well as certain Tribal employees and their families.[315] As of the end of 2025, FEHB covered more than 8 million people.[316]

The FEHB Program is administered by the Office of Personnel Management (OPM) in accordance with statute and its implementing regulations.[317] 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,

[313] Mercer 2025 Survey Report, March 2026. See footnote 274 for additional details.

[314] CRS analysis of the CMS 2026 Exchange Public Use File (PUF) Datasets, "Benefits and Cost Sharing PUF" and "Plan Attributes PUF," updated April 28, 2026, 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 30 states that utilize the federal platform Healthcare.gov in plan year 2026. The files do not include the 21 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" or "gender affirming treatment," but additional analysis would be necessary to identify variations in coverage details.

[315] 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. Since 2025, USPS employees, retirees, and their dependents have received health benefits through Postal Service Health Benefits (PSHB) Program. In this report, references to FEHB are inclusive of the PSHB unless explicitly stated otherwise. For more information on these issues, 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 generally, see CRS Report R43922, *Federal Employees Health Benefits (FEHB) Program: An Overview*.

[316] U.S. Office of Personnel Management, *Federal Benefits Open Season Highlights 2026 Plan Year*, 2025, p. 1, https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/reference/federal-benefits-open-season-highlights-for-plan-year-2026.pdf.

[317] 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*.

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.[318] 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, and obstetrical benefits.[319] 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.[320]

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.[321]

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

Do FEHB Plans Cover Contraceptive Services?

Appropriations language generally requires FEHB plans to include "a provision for contraceptive coverage."[322] In addition, FEHB plans are required to cover services and items recommended in HRSA-supported guidelines on women's preventive health care services.[323] Under this requirement, FEHB plans must cover, without cost sharing, at least one form of contraception in

[318] 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.

[319] 5 U.S.C. §8904.

[320] 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).

[321] The preventive services requirement for FEHB plans is similar to the requirement applicable to most 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 private health insurance 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/2013/2013-09.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.

[322] For example, see Section 726 in Title VII, Division E, of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

[323] 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.

each of the categories listed in the HRSA-supported Women's Preventive Services Guidelines.[324] 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.[325] 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.[326] 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."[327] 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.[328] 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.[329]

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.[330]

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."[331]

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[324] HRSA, *Women's Preventive Services Guidelines*, page last reviewed December 2025, https://www.hrsa.gov/womens-guidelines, and OPM, "Consolidated Pharmacy Benefits Guidance for the FEHB Program," Letter Number 2025-07, April 25, 2025, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2025/2025-07.pdf.

[325] 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").

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

[327] 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."

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

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

[330] For example, see Section 613 and 614 in Title VI, Division E, of the Consolidated Appropriations Act, 2026 (P.L. 119-75).

[331] 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 (continued...)

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 for infertility services 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.[332] In addition, FEHB health maintenance organizations (HMOs) generally must satisfy any state IVF coverage requirements.[333]

OPM strongly encourages FEHB plans to continue and expand coverage of fertility benefits, including IVF, and to provide discounted or negotiated rates for noncovered ART procedures.[334]

In 2026, over 25 FEHB plans are offering coverage of IVF services, which is the greatest number of plans to date.[335]

Do FEHB Plans Cover Maternity Services?

FEHB plans are statutorily required to cover obstetrical benefits.[336] 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.[337] 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.

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.

[332] 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. OPM, "Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter," Letter Number 2025-01, January 15, 2025, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2025/2025-01.pdf (hereinafter, OPM, "Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter (2026)").

[333] OPM may allow federal preemption of state level IVF requirements, and such preemption would be negotiated annually. OPM, "Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter (2026)."

[334] OPM, "Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter (2026)," and OPM, "Federal Employees Health Benefits Program Call Letter (2024)."

[335] Kevin Moss, "FEHB Costs are Climbing in 2026. Here's What that Means for Feds," *Government Executive*, November 4, 2025, at https://www.govexec.com/pay-benefits/2025/11/fehb-costs-are-climbing-2026-heres-what-means-feds/409286/.

[336] 5 U.S.C. §8904(a).

[337] 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.[338] 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, including coverage of services provided by midwives.

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.[339] 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 (SMBP) for individuals with hypertension."[340] For plan year 2027, OPM is encouraging FEHB plans to incentivize the use of preconception screening bundles and outreach programs for individuals interested in becoming pregnant within the next year, and plans are to ensure access to treatments for conditions adversely affecting fertility.[341]

Do FEHB Plans Cover Reproductive Health 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 and related monitoring 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.[342]

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.

[338] 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."

[339] 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").

[340] OPM, "Technical Guidance and Instructions for 2023 Benefit Proposals."

[341] Such screening bundles and outreach programs are to follow American College of Obstetricians and Gynecologists (ACOG) pre-pregnancy recommendations and USPSTF recommendations rated "A" or "B." OPM, "Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter," Letter Number 2026-07, March 31, 2026, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2026/2026-07.pdf (hereinafter, OPM, "Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter (2027)").

[342] See footnote 321.

Do FEHB Plans Cover Gender-Affirming Services?

As a result of new OPM requirements for the 2026 plan year, FEHB plans generally are no longer allowed to cover gender-affirming services but must provide a case-by-case exception process for coverage of such services for individuals who are undergoing surgical and/or hormonal treatment for diagnosed gender dysphoria.[343] OPM will require FEHB plans to remove the exception process starting in the 2027 plan year.[344]

OPM requires FEHB plans to cover counseling services for individuals with possible or diagnosed gender dysphoria.

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 118 facilities across the country.[345] BOP was established in 1930 to house federal prisoners, professionalize the prison service, and ensure consistent and centralized administration of the federal prison system.[346] BOP must confine any offender convicted and sentenced in a federal court to a term of imprisonment. As of the end of FY2025, there were approximately 155,300 prisoners under BOP's jurisdiction.[347] BOP provides medically necessary health care treatment to all prisoners housed in BOP-operated facilities, including medically necessary reproductive health services.[348] 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.[349] 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

[343] The prohibition on covering hormone treatments applies only with respect to gender-affirming services. Hormone treatments may still be covered in other instances. OPM, "Chemical and Surgical Sex-Trait Modification Services for Plan Year 2026 Proposals," Letter Number 2025-01b, August 15, 2025, at https://www.opm.gov/healthcare-insurance/carriers/fehb/2025/2025-01b.pdf.

[344] OPM, "Federal Employees Health Benefits and Postal Service Health Benefits Programs Call Letter (2027)."

[345] U.S. Department of Justice (DOJ), Bureau of Prisons (BOP), *About Our Facilities*, https://www.bop.gov/about/facilities/federal_prisons.jsp.

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

[347] DOJ, BOP, "Statistics," https://www.bop.gov/about/statistics/population_statistics.jsp#old_pops (data on the federal prison population was accessed on May 5, 2026).

[348] DOJ, BOP, *FY 2027 Performance Budget, Congressional Submission, Salaries and Expenses*, p. 22 (hereinafter, "BOP FY2027 S&E budget justification").

[349] 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").

inmates.[350] 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.[351]

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.[352]

In addition to the intake screening, BOP conducts a comprehensive physical assessment on all new prisoners to assess, diagnose, and treat medical needs.[353] 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.[354]

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

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.[355]

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.

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

[351] 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 FY2027 S&E budget justification, p. 23.

[352] DOJ, BOP, *Patient Care*, Program Statement 6031.05, p. 35 (hereinafter "*Patient Care*").

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

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

[355] BOP FY2027 S&E budget justification, p. 22.

Does BOP Provide Contraceptive Services?

BOP policy requires medical staff to provide female prisoners with information related to birth control, if requested.[356] Female prisoners have access to birth control while incarcerated, but it is usually limited to hormone replacement therapy.[357] 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.[358]

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).[359]

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.[360] 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.[361] Upon receipt of the signed statement, the facility's clinical director arranges for an abortion.[362] 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.[363] In all other cases, the prisoner must arrange payment for the procedure.[364] All expenses related to the procedure, including transportation and escort costs, must be covered by the prisoner, the prisoner's family, or from other "appropriate non-federal government funded sources approved by the Warden."[365]

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.

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[356] DOJ, BOP, Female Offender Manual, Program Statement 5200.09 CN-1, p. 13 (hereinafter, "*Female Offender Manual.*")

[357] Ibid.

[358] 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.

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

[360] 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, 2026 (Division A of P.L. 119-74), states that "none of the funds appropriated by [Title II of Division A] 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."

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

[362] 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.

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

[364] Ibid.

[365] Ibid.

Does BOP Provide Maternity Services?

BOP has several programs that provide parenting assistance.[366] 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.[367] 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.[368] Once they complete the program, prisoners are returned to their designated facility to serve the remainder of their sentences.

Does BOP Provide Reproductive Health 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.[369] BOP is responsible for providing medically necessary care in a manner consistent with the standards of care for nonprisoners.[370]

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.[371] 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 HIV, then HIV testing is mandatory.[372] 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.[373] 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

[366] For a description of BOP's national parenting from prisons program, see DOJ, BOP, *First Step Act Approved Programs Guide*, March 2026, p. 22.

[367] 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.

[368] *Female Offender Manual*, p. 20.

[369] 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.

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

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

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

[373] Ibid.

period, unless BOP determines that additional testing is warranted.[374] BOP provides pre- and post-test counseling to all prisoners who are tested for HIV, regardless of the test results.[375]

Does BOP Provide Gender-Affirming Services?

In response to the Trump Administration's EO 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," BOP rescinded its policy to provide gender-affirming care treatment to transgender prisoners in February 2025.[376] BOP then issued several new policies related to the treatment of prisoners with gender dysphoria (GD),[377] including a new policy regarding treatments for prisoners with GD in February 2026.[378] A group of inmates filed a lawsuit in the U.S. District Court for the District of Columbia to challenge the BOP policies banning gender-affirming care. At the time of publication of this report, BOP's policies have been temporarily paused from going into effect, including the February 2026 policy, as a result of that litigation, which remains ongoing.[379]

BOP's February 2026 policy states that EO 14168 prohibits BOP from using appropriated funds to provide any medical procedure, treatment, or drug for the purpose of conforming a prisoner's appearance to that of the opposite sex to the extent consistent with applicable law.[380] The policy states that BOP will comply with the EO's mandate unless prohibited by a court injunction or order.[381] While BOP will not provide sex trait modification surgery to prisoners who have been diagnosed with GD, BOP will provide necessary medical care to prisoners who had sex trait modification surgery prior to incarceration to address any complications or resulting conditions.[382]

BOP's policy states that prisoners who have not started hormone therapy for GD will not be prescribed hormones to address GD. For prisoners who were on hormone therapy before incarceration, prison medical staff are required to develop plans to taper most prisoners off hormone therapy. The policy notes that "for inmates who (1) are post sex trait modification surgery or (2) have been receiving hormones to address GD for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering, it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones. But tapering plans should be reevaluated regularly with respect to cessation of hormones, including during the inmate's chronic care clinic appointments."[383]

The February 2026 policy requires prison clinicians to develop individualized treatment plans for prisoners who have been diagnosed with GD. The treatment plans developed for prisoners with a GD diagnosis are required to focus on treating medical and psychological comorbidities before treatment for GD proceeds.[384] The policy directs BOP clinicians to treat comorbidities through

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

[375] Ibid.

[376] DOJ, BOP, *Transgender Offender Manual*, Program Statement 5200.08.

[377] See text box in "What Are Gender-Affirming Services?" section of this report for terms and definitions related to gender-affirming care.

[378] DOJ, BOP, *Management of Inmates with Gender Dysphoria*, Program Statement 5260.01.

[379] *Kingdom v. Trump,* No. 25-691, 2026 WL 2690647 (D.D.C. Aug. 26, 2026); *appeal filed*, Kingdom v. Trump, No. 26-5310 (D.C. Cir. Aug. 31, 2026).

[380] Ibid., pp. 5-6.

[381] Ibid., p. 6.

[382] Ibid., p. 7.

[383] Ibid., p. 8.

[384] Ibid., p. 6.

psychotherapy, psychotropic medication, or other appropriate medically accepted interventions, with a priority on psychotherapy.[385] Treatment specifically for GD can proceed after comorbidities are resolved and ruled out as potential causes of the GD diagnosis.[386] Treatment for GD is required to focus on "managing the psychological distress/dysphoria, assisting with adjustment to incarceration, community re-entry, and strengthening resilience."[387]

Department of Defense (DOD)

DOD (which is "using a secondary Department of War designation," under Executive Order 14347, dated September 5, 2025) administers a statutory health benefit (under Title 10, Chapter 55, of the *U.S. Code*) through the Military Health System (MHS).[388] The MHS offers health care benefits and services through its TRICARE program to approximately 9.5 million beneficiaries, comprising members and retirees of the uniformed services and their family members.[389] 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.[390]

The United States Coast Guard (USCG) is a uniformed service that operates primarily under the authority of the Department of Homeland Security. The Coast Guard delivers a limited range of outpatient medical and dental care in its own facilities. Patients with medical needs exceeding a USCG clinic's capabilities may be referred or medically evacuated to a DOD MTF or civilian medical facility participating in TRICARE.[391]

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.[392] 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.

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[385] Ibid.

[386] Ibid.

[387] Ibid.

[388] See CRS In Focus IF10530, *Defense Primer: Military Health System*, by Bryce H. P. Mendez.

[389] Defense Health Agency, *About the Military Health System*, https://www.health.mil/About-MHS. 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. CRS In Focus IF10530, *Defense Primer: Military Health System*.

[390] 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.

[391] U.S. Government Accountability Office, *Coast Guard Health Care: Additional Actions Could Help Ensure Beneficiaries' Access*, GAO-23-105574, April 2023, pp. 7-10. For additional information about the TRICARE program, see the "Department of Defense (DOD)" section of this report.

[392] 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.

Does DOD Provide Contraceptive Services?

DOD offers contraceptive services, including the following:

- "Medical contraceptives," including "injections, placement, and removal of intrauterine devices, implantable rods, and diaphragm measurements and fittings" as part of "Well Woman Examinations."[393]
- Prescription contraceptives, including diaphragms, and emergency contraceptives.[394]
- Surgical sterilization.[395]

DOD does not cover

- condoms,
- spermicides, or
- reversal of surgical sterilization, unless medically necessary.[396]

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).[397] In-theater military health care providers may 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* states, "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."[398] Abortion counseling, referral, preparation, and follow-up care are covered for covered abortions, but not for noncovered abortions.[399]

Does DOD Provide Infertility Services?[400]

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

[393] See Chapter 7, Section 2.1, paragraph 1.1.4, of the TRICARE Policy Manual 6010.63-M, updated June 4, 2026, https://manuals.dha.mil/View-Publication/TPT5/FileName/C7S2_1.

[394] See Chapter 7, Section 2.3, paragraph 1.2.1 of the TRICARE Policy Manual 6010.63-M, updated March 17, 2026, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C7S2_3.

[395] See Chapter 7, Section 2.3, paragraph 1.1 of the TRICARE Policy Manual 6010.63-M, updated March 17, 2026, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C7S2_3.

[396] See Chapter 7, Section 2.3 of the TRICARE Policy Manual 6010.63-M, updated March 17, 2026, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C7S2_3.

[397] 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.

[398] 10 U.S.C. §1093. 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.

[399] See Chapter 4, Section 18.3 of the TRICARE Policy Manual 6010.63-M, updated July 14, 2021, at https://manuals.dha.mil/View-Publication/TPT5/FileName/C4S18_3.

[400] See CRS In Focus IF11504, *Infertility in the Military*, coordinated by Michael J. Vassalotti.

- correction of physical causes of infertility;[401]
- erectile dysfunction if it has a physical cause;[402] and
- diagnostic services (e.g., semen analysis, hormone evaluation, chromosomal studies, immunologic studies, special and sperm function tests, and bacteriologic investigation).[403]

In general, DOD does not offer or cover other types of infertility or ART services under the TRICARE program.[404] Excluded services include artificial insemination, including 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).[405]

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.[406] Limited ART services include sperm or egg retrieval; IVF; and artificial insemination.[407] Eight DOD hospitals offer ART services to eligible servicemembers and their spouses:

- Madigan Army Medical Center (Joint Base Lewis-McChord, WA);
- Naval Medical Center Portsmouth (Portsmouth, VA);
- Naval Medical Center San Diego (San Diego, CA);
- Brooke Army Medical Center (Fort Sam Houston, 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).[408]

Per the Defense Health Agency, these services "are available on a first-come, first-served basis at a greatly reduced cost."[409]

[401] See Chapter 4, Section 15.1 paragraph 4.7, and Section 17.1 paragraph 3.1, of the TRICARE Policy Manual 6010.63-M, updated March 28, 2025 at https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C4TOC.

[402] See Chapter 4, Section 15.1 paragraphs 4.1 – 4.6.5. of the TRICARE Policy Manual 6010.63-M, updated March 28, 2025, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C4TOC.

[403] See Chapter 4, Section 15.1 paragraph 4.7, and Section 17.1 paragraph 3.1, of the of the TRICARE Policy Manual 6010.63-M, updated March 28, 2025, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C4TOC. For more on DOD infertility services, see CRS In Focus IF11504, *Infertility in the Military.*

[404] 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.

[405] See Chapter 4, Sections 15.1 and 17.1, and Chapter 7, Section 2.3, of the TRICARE Policy Manual 6010.63-M, updated March 17, 2026, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C4TOC.

[406] 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."

[407] Defense Health Agency, *Assisted Reproductive Technology Services*, https://tricare.mil/CoveredServices/IsItCovered/AssistedReproductiveServices.

[408] Defense Health Agency, *Assisted Reproductive Technology Services.*

[409] Defense Health Agency, *Assisted Reproductive Technology Services.*

Does DOD Provide Maternity Services?

DOD offers and pays for medically necessary maternity care, including "care and treatment related to conception, delivery, abortion,[410] including prenatal and postnatal care (generally through the sixth post-delivery week), and also including treatment of the complications of pregnancy."[411] Maternity care for pregnancies resulting from noncoital reproductive procedures or surrogacy is also offered.[412] Labor doula services may also be covered under the TRICARE Childbirth and Breastfeeding Support Demonstration (CBSD) program for TRICARE Prime, TRICARE Prime Remote and TRICARE Select enrollees. The CBSD program operates until December 31, 2026. It expanded overseas on January 1, 2025.[413]

Does DOD Provide Reproductive Health Prevention and Treatment Services?

DOD offers a range of clinical preventive services, including certain reproductive health screening and preventive services.[414] These services include, but are not limited to, screening and counseling for breast, cervical, colon, testicular, and prostate cancers; STIs or STDs; HIV screening; and physical or psychological conditions resulting from an act of violence.[415] DOD also offers medically necessary treatment or therapy options to eligible beneficiaries with a reproductive health issue identified during a clinical screening.[416]

Does DOD Provide Gender-Affirming Services?

DOD may offer or pay for beneficiaries aged 19 or older to receive mental health care and counseling related to gender dysphoria. Apart from diagnostic consultations and mental health counseling, other gender dysphoria care (such as cross-sex hormone therapy) is to be referred to the private sector. Gender-affirming surgeries (also called sex reassignment surgeries) are excluded from TRICARE private sector coverage. Military treatment facility staff may not make referrals for noncovered care. Military Departments may request case-by-case exceptions from the Assistant Secretary of Defense for Health Affairs for nonsurgical treatment if required to protect the health of a service member.[417]

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

[411] 32 C.F.R. §§199.2 and 199.4(e)(16).

[412] For more on TRICARE coverage of maternity care, see Chapter 4, Section 18.1 of the TRICARE Policy Manual 6010.63-M, April 2021, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C4TOC.

[413] For more on this program, see Defense Health Agency, *TRICARE Childbirth and Breastfeeding Support Demonstration*, https://tricare.mil/Plans/SpecialPrograms/CBSD.

[414] For more on DOD's provision of clinical preventive services, see Chapter 7, Sections 2.1 and 2.2, of the TRICARE Policy Manual 6010.63-M, updated July 31, 2025, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C7TOC.

[415] Chapter 7, Sections 2.1 and 2.2, of the TRICARE Policy Manual 6010.63-M, updated July 31, 2025, https://manuals.dha.mil/View-Publication/TPT5/Revision/58/FileName/C7TOC.

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

[417] Department of Defense, *Additional Guidance on Treatment for Gender Dysphoria*, May 9, 2025, https://health.mil/Reference-Center/Policies/2025/05/09/Additional-Guidance-on-Treatment-of-Gender-Dysphoria.

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

The Department of Homeland Security's (DHS's) Immigration and Customs Enforcement's (ICE) stated mission "is to protect America from the cross-border crime and illegal immigration that threaten national security and public safety."[418] 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.[419]

ICE detention standards were originally developed in 2000 and have been updated several times, resulting in various sets of standards that 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.[420] Contracts or agreements between ICE and detention facilities specify which set of standards facilities are required to follow.[421]

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)[422] and the 2026 National Detention Standards (NDS).[423] The 2011 PBNDS and 2026 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.[424]

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

[419] 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. For more information, see CRS In Focus IF11343, *The Law of Immigration Detention: A Brief Introduction*.

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

[421] ICE owns and operates a relatively small number of its own facilities, and it has arrangements through contracts with private companies that operate the majority of 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.)

[422] 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.)

[423] There have been multiple versions of the NDS over the years: 2026, 2025, 2019, and 2000. In the 2025 revision, ICE explained that "references to gender have been replaced with sex throughout the standards" to align with the January 2025 Executive Order 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to The Federal Government" (ICE, "National Detention Standards," revised 2026," at https://www.ice.gov/doclib/detention-standards/2026/nds2026.pdf (hereinafter, "2026 NDS").

[424] For example, see GAO, *Immigration Detention: DHS Should Define Goals and Measures to Assess Facility Inspection Programs*, GAO-25-107580, May 2025; 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*, 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; (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 all of 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 be prescribed contraception.[425]

Does ICE Provide Abortions or Abortion Counseling?

According to ICE detention standards, 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."[426] 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. In October 2020, CRS confirmed with ICE that it "does not generally provide infertility services."[427]

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.[428] As of

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.

[425] ICE, *Performance-Based National Detention Standards 2011* (hereinafter, "2011 PBNDS"); "4.4 Medical Care (Women)"; 2026 NDS, "4.3 Medical Care."

[426] 2011 PBDNS, "4.4 Medical Care (Women)" and 2026 NDS, "4.3 Medical Care."

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

[428] ICE, "Directive: Identification and Monitoring of Pregnant, Postpartum, or Nursing Individuals," https://www.ice.gov/directive-identification-and-monitoring-pregnant-postpartum-or-nursing-individuals, updated July 9, 2021.

February 2026, according to news reports, "the administration has given the courts conflicting, unclear answers about whether it is following" this policy or whether it has been rescinded.[429]

For those who are detained, ICE detention standards outline maternity services that are to be provided 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."[430] In addition, ICE standards state that 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, ICE standards state that those detainees "shall be referred to a physician specializing in high-risk pregnancies."[431]

Does ICE Provide Reproductive Health Prevention and Treatment Services?

According to ICE detention standards, all detainees are to be provided "comprehensive, routine and preventive health care, as medically indicated."[432] 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."[433] Similarly, the 2025 NDS guidance states that "all detainees shall have access to appropriate medical, dental, and mental health care, including emergency services."[434]

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

In addition, according to ICE standards, the initial health assessment for women entering immigration 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.[435]

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-

[429] Kyle Cheney, "Judges decry treatment of nursing and pregnant detainees in ICE custody," *Politico,* February 18, 2026.

[430] 2011 PBDNS, "4.4 Medical Care (Women)" and 2026 NDS "4.3 Medical Care."

[431] Ibid.

[432] 2011 PBDNS, "4.3 Medical Care" and 2026 NDS "4.3 Medical Care."

[433] 2011 PBDNS, "4.3 Medical Care."

[434] 2026 NDS "4.3 Medical Care."

[435] 2011 PBDNS, "4.4 Medical Care (Women)" and 2019 NDS "4.3 Medical Care."

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."[436]

Does ICE Provide Gender-Affirming Services?

ICE might provide gender-affirming services, depending on which set of standards the facility follows.[437] The 2011 PBNDS, the 2019 NDS, and the 2026 NDS differ in terms of their guidance about transgender detainees' health care.

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."[438] 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 had stated that the detention facility and ICE/ERO should coordinate care "based on [the] medical needs" of self-identified transgender detainees.[439] The 2026 NDS guidance does not include any references to transgender detainees.

Indian Health Service (IHS)

IHS provides health care directly or provides funds for Indian tribes or tribal organizations to operate health care facilities.[440] It provides services free of charge to approximately 2.8 million eligible American Indians and Alaska Natives in 37 states.[441] IHS does not have a standard medical benefit that includes or excludes certain services.[442] The agency generally focuses on primary and preventive services and does so through a network of more than 600 facilities, which include hospitals (44), health centers, (391), and small health stations (102). Other facility types include school health centers (19), youth regional treatment centers (13), and Alaska village clinics (147).[443]

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,

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

[437] See the section "U.S. Immigration and Customs Enforcement (ICE) Noncitizen Detention" for a discussion of the different sets of detention standards.

[438] 2011 PBDNS, "4.3 Medical Care"

[439] 2019 NDS, "4.3 Medical Care."

[440] 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*.

[441] HHS, IHS, *Fiscal Year 2027 Indian Health Service Justification of Estimates for Appropriations Committees,* https://www.ihs.gov/sites/ofa/themes/responsive2017/display_objects/documents/IHS%20Draft%20CJ%20FY%202027.pdf, pp. CJ-1; IHS FY2027 Budget Justification.

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

[443] IHS FY2027 Budget Justification, pp. CJ-25-26 and CJ-166.

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 (PRC) program,[444] 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-operated facilities are required to report information on care deferred or denied. In FY2025, these facilities reported that they denied or deferred close to 65,000 services for eligible American Indians and Alaska Natives in FY2025 because of these funding limitations.[445] 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 pays for services, to the extent that funds are available, based on medical priorities. In 2025, IHS revised these priorities to reflect a care continuum, placing its priorities into four categories (this replaced an earlier five-priority level system). One of the new specified priority level categories is "Category C: Reproductive and Maternal/Child Health Services." Within each of these categories, there are services that are "deemed core, intermediate, and elective representing priority 1, priority 2, and priority 3 respectively."[446] The fourth priority level is excluded services; these are excluded because they are experimental or cosmetic. PRC funds cannot be used to pay for these services.[447]

Table 3 details the IHS priority levels for Reproductive & Maternal/Child Health Services. The new guidelines categorize infertility services as elective/justifiable. IHS describes this priority level as "clinically justifiable services intended to enhance health and well-being."[448] Prior guidance has considered these services to be experimental and had excluded them.[449]

Table 3. IHS Priority Levels: Reproductive & Maternal/Child Health Services (Category C)

(2025)

Priority Level	Service
Core (Priority 1): Essential	Prenatal Care; Labor and Delivery; Postpartum and Newborn Care; Sexual Assault Evaluation; Obstetric/Gynecologic Medical/Surgical Consultation, Acute Colposcopy

[444] HHS, IHS, "Purchased Referred Care," https://www.ihs.gov/prc/. In FY2026, the program received an appropriation of $996,755,000. IHS's FY2026 appropriation was provided in FY2025 appropriations law (P.L. 119-4) as an advance appropriation.

[445] IHS FY2027 Budget Justification, pp. CJ-78.

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

[447] HHS, IHS, "Indian Health Service Medical Priority Levels," February 6, 2025, https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC_Medical_Priorities.pdf, pp. 2-3.

[448] HHS, IHS, "Indian Health Service Medical Priority Levels," February 6, 2025, https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC_Medical_Priorities.pdf.

[449] Information on IHS's prior priority levels is available at https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/IHSMedicalPrioritiesRolesAndResponsibilities.docx.

Priority Level	Service
Intermediate (Priority 2): Necessary	Breastfeeding Equipment/Counseling; Obstetric/Gynecologic Medical/Surgical Consultation, Chronic; Reproductive/Family Planning Services; Long-Acting Reversible Contraception; Bilateral Tubal Ligation; Vasectomy
Elective (Priority 3): Justifiable	Infertility Services

Source: CRS adaptation of IHS, "Indian Health Service Priority Levels, February 6, 2025, https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC_Medical_Priorities.pdf, p. 6.

Notes: This table includes services that are discussed in this report and not the universe of reproductive and maternal/child health services. Screening, such as routine mammograms, are included under the "Preventive and Rehabilitative Services" category and are considered to be essential services. This category also includes child health services, which are not included in this table because they are beyond the scope of this report.

Reproductive health services are generally included within Priorities 1 and 2 of Category A. Priority Level 1 includes services that are essential, including maternity services such as delivery and prenatal care. Family planning services are included as Priority 2—necessary. Some reproductive health services—such as screening mammography and services to prevent and treat STIs—are included in either the "Category A: Preventive and Rehabilitative Services" or as "Category B: Medical, Dental, Vision and Surgical Services" PRC categories. Category A includes "services designated to maintain health, prevent disease or the complications of disease, as well as those services intended to return or maintain a higher level of physical functioning." Category B includes "services provided by medical, dental, vision, or surgical specialists, as well as diagnostic tests, equipment, and supplies, whose purpose is the diagnosis and treatment of disease."[450] In general, reproductive health care, such as those to screen and treat an STI, would be considered to be Priority 2—necessary services, those that are necessary for the diagnosis and treatment of chronic and non-emergent conditions.

IHS's 2025 document does not mention gender-affirming care. IHS does have a website that discusses "Two-Spirit/LGBTQI+ Health." The website includes a notice at the top stating that HHS was required to restore the website (as of February 14, 2025) because of a court order. It further states that the information on this page promoting gender ideology is extremely inaccurate and Trump Administration rejects gender ideology."[451] Prior PRC guidance had excluded GAC for that reason. The current guidance is silent on how GAC is treated for PRC purposes.

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 FY2025, 88% of IHS operated PRC programs were able to pay for services beyond Priority Level 2.[452]

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.[453]

[450] HHS, IHS, "Indian Health Service Medical Priority Levels," February 6, 2025, https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC_Medical_Priorities.pdf, p. 1.

[451] HHS, IHS, "Two-Spirit/.LGBTQI+ Health," https://www.ihs.gov/lgbt/.

[452] IHS FY2027 Budget Justification, pp. CJ-78.

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

IHS also expanded its formulary to include the Opill in 2023.[454] 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.[455] This issue was resolved in October 2015, when IHS amended its internal policies to make EC available without a provider visit or a requirement that patients register with the facility.[456] When services are not available at an IHS facility, PRC will pay for reproductive planning services, including LARCs, as a necessary (Priority 2) service (see **Table 3** above).

IHS does provide sterilization services if requested, but it must follow HHS procedures when doing so.[457] 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.[458]

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.[459] 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.[460] In addition, IHS will provide health services necessary to terminate an ectopic pregnancy[461]—a pregnancy that occurs outside the womb (uterus)—which can be life-threatening.[462]

IHS policies do not discuss abortion counseling, thus it is unclear whether the agency provides 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.

[454] 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.

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

[456] HHS, IHS, "Indian Health Manual: Part 1- General, Chapter 15-Emergency Contraception," https://www.ihs.gov/ihm/pc/part-1/p1c15/.

[457] 42 C.F.R. 50.205(b).

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

[459] 25 U.S.C. §1676.

[460] HHS, IHS, "Indian Health Manual: Part 3 – Professional Services, Chapter 13-Maternal and Child Health" https://www.ihs.gov/IHM/pc/part-3/p3c13/ 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/.

[461] HHS, IHS, "Indian Health Manual: Part 3 – Professional Services, Chapter 13-Maternal and Child Health" https://www.ihs.gov/IHM/pc/part-3/p3c13/.

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

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.[463]

IHS is limited in terms of payments for infertility services under PRC—it is included within Category C as Priority Level 3—justifiable (see **Table 3**).

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 44 hospitals that offer inpatient care;[464] 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 FY2027 budget request. Specifically, it is focused on obstetric preparedness in emergency departments. The agency stated that clinicians have completed Advanced Life Support in Obstetrics training and that these courses are offered regularly at IHS and tribal sites.[465]

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 pays for deliveries and prenatal care as a Category C, Priority Level 1 (essential) services (see **Table 3**).

Does IHS Provide Reproductive Health Prevention and Treatment Services?

As noted above, the services available at IHS facilities vary, but some facilities may provide reproductive preventive services and treatment for conditions identified within the facility. Preventive screenings, such as routine mammograms, are included under the "Category A: Preventive and Rehabilitative Services" category and are considered to be essential services. [466] IHS also funds or operates programs to screen individuals at risk of HIV/AIDS and to provide treatment services as necessary.[467] 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.[468] IHS provides access to both PrEP and PEP. As part of an attempt to reduce rates of HIV

[463] HHS, IHS, "Indian Health Manual: Part 3 – Professional Services, 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.

[464] IHS FY2027 Budget Justification pp. CJ-25 and CJ27.

[465] IHS FY2027 Budget Justification p. CJ-51.

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

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

[468] Ibid.

in the Native population, IHS simplified PrEP and PEP policies and created guides for providers to facilitate offering PrEP to eligible individuals.[469]

Does IHS Provide Gender-Affirming Services?

In 2022, IHS approved adding gender-affirming medications to its core formulary.[470] 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.[471]

With this exception, IHS policies do not mention "gender-affirming" services. As noted above, IHS's website for "Two-Spirit/LGBTQI+ Health" includes a notice at the top stating that HHS was required to restore the website (as of February 14, 2025) because of a court order. It further states that "the information on this page promoting gender ideology is extremely inaccurate and Trump Administration rejects gender ideology."[472] IHS current PRC policies are silent on GAC. Prior IHS PRC policies had included GAC at an excluded service because it was considered to be experimental or cosmetic.[473] It is not clear whether IHS offers or will pay for other types of gender-affirming services (see the section "What Are Gender-Affirming Services?" in this report), either through PRC or within its system.

Department of Veterans Affairs (VA)

The Department of Veterans Affairs (VA) provides health care services through the Veterans Health Administration (VHA) for approximately 9.3 million enrolled veterans[474] at over 1,700 VA sites of care.[475] VHA is primarily a direct provider of care; it owns the facilities and employs the

[469] IHS, "PrEP and PEP," https://www.ihs.gov/hivaids/clinicalinfo/prepandpep/.

[470] 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.

[471] 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. A 2026 search of the National Core Formulary did not include testosterone, which was included in the 2022 formulary brief. It did include estradiol, with notes that this was for menopause treatment, with links to a 2025 document on Menopause Treatment Guidelines. For National Core Formulary, see https://www.ihs.gov/nptc/formularysearch/. For Menopause treatment guidelines, see IHS, "National Pharmacy and Therapeutics Committee: Formulary Brief: Menopause Treatment Guidelines," January 2025, https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC%2DFormulary%2DBrief%2DMenopause%2DTreatment.pdf.

[472] HHS, IHS, "Two-Spirit/.LGBTQI+ Health," https://www.ihs.gov/lgbt/.

[473] Information on IHS's prior priority levels is available at https://web.archive.org/web/20241122213406/https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/IHSMedicalPrioritiesRolesAndResponsibilities.docx.

[474] Department of Veterans Affairs, *FY2027 Congressional Submission, Medical Programs*, vol. 2 of 5, April 2026, p. VHA-37.

[475] *FY2027 Congressional Submission, Budget in Brief*, April 2026, p. BiB-22.

clinicians. However, under certain circumstances, VA will pay for a veteran to receive care in the community.[476]

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.[477] 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.[478]

Does 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.[479]

Does 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.[480] The formulary includes oral contraceptives, IUDs, and implants, among others.[481] VA health care maintains a tiered structure for copayments 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.[482]

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.[483]

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

[476] 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.

[477] For more information on veterans health care eligibility and enrollment, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

[478] 38 C.F.R. §17.38.

[479] VA, Veterans Health Administration (VHA), Women's Health Services, *State of Reproductive Health In Women Veterans-VA Reproductive Health Diagnoses and Organization of Care*, January 2023, pp. 36-38.

[480] VA, VHA, *VHA Formulary Management Process*, VHA Directive 1108.08, July 2022.

[481] VA, "Pharmacy Benefits Management Services, VA Formulary Advisor, https://www.va.gov/formularyadvisor/. For a list of VA National Formulary Hormonal Contraceptives, see https://www.va.gov/formularyadvisor/DOC_PDF/CRE_Contraceptive_Agents_Hormonal_on_VA_National_Formulary_Rev_Aug_2026.pdf.

[482] For more information on copayments for medication, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

[483] VA, VHA, *Healthcare Services for Women Veterans*, VHA Handbook 1330.01(7), February 2017.

procedure, and the availability of reversible, highly effective contraceptives (e.g., IUD and subcutaneous contraceptive implants).[484]

Does VA Provide Abortions or Abortion Counseling?

Under current regulations, VA is prohibited from providing abortions or abortion counseling.[485] Medically necessary procedures for the management of a miscarriage are covered under the medical benefits package.[486] In addition, VA provides care under the medical benefits package for ectopic pregnancies (i.e., pregnancy occurring outside the uterine cavity).[487]

Does 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 4**. These covered services are provided to all enrolled veterans without exception.

Table 4. 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

[484] VA, VHA, *Fertility Management*, VHA Directive 1332, May 2024.

[485] 38 C.F.R. §17.38(c)(1).

[486] A miscarriage, or pregnancy loss, is also called a spontaneous abortion, which is "the unexpected loss of a fetus before the 20th week of pregnancy, or gestation." (Source: https://www.nlm.nih.gov/medlineplus/miscarriage.html.) For clinical purposes, "spontaneous abortion often is subdivided into threatened abortion, inevitable abortion, incomplete abortion, missed abortion, septic abortion, recurrent spontaneous abortion, and complete abortion." (Source: Craig P. Griebel et al., "Management of Spontaneous Abortion," *American Family Physician*, vol. 72, no. 7, October 1, 2005, pp. 1243-1250.) In some cases, the procedures used for management of a miscarriage are the same as those used for an abortion (i.e., dilation and curettage). *Health Care Services for Women Veterans*, VHA Directive 1330.01(2), February 15, 2017.

[487] VA, VHA, Maternity Health Care and Coordination, VHA Directive 1330.03, November 3, 2020, p. 2. VA directives do not describe the type of care provided for ectopic pregnancy.

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 (VA), Veterans Health Administration (VHA), *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.[488] This exception is authorized on an annual basis through appropriations acts.[489] 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,[490] along with guidance issued by DOD. VA is exempt from DOD requirements applicable to the duration of embryo cryopreservation and storage.[491] Namely, VA may provide cryopreservation and storage for an unlimited amount of time.[492]

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.[493] VA is not authorized to cover gestational surrogacy treatment under any circumstances.[494] This policy can affect any eligible veteran regardless of gender or sexual orientation. For example, a male

[488] 38 C.F.R. §17.380.

[489] This policy has been authorized in appropriations acts since FY2017. Most recently, Section 234 of Division D of the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026 (P.L. 119-37), continued allowing the use of FY2026 appropriations and FY2027 advance appropriations for this purpose.

[490] 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.

[491] VA, "Final Rule-Fertility Counseling and Treatment for Certain Veterans and Spouses," 84 *Federal Register* 8254-8257, March 7, 2019.

[492] 38 C.F.R. §17.380(b).

[493] VA, "Instructions for Determining Eligibility for In Vitro Fertilization (IVF) Benefit," 89 *Federal Register* 23518, March 28, 2024.

[494] 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.[495]

Does VA Provide Maternity Services?

VA currently provides and pays for maternity and newborn health care services to eligible veterans and their family members.[496] Veterans can access maternity care as soon as their pregnancies are confirmed. However, VA medical facilities do not provide onsite obstetrics services.[497] 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.[498]

Does VA Provide Reproductive Health Prevention and Treatment Services?

VA provides reproductive health 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.[499] 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 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.[500]

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[495] 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.

[496] VA, VHA, *Maternity Health Care and Coordination*, VHA Handbook 1330.03, November 2020.

[497] VA, VHA, Women's Health Services, *State of Reproductive Health In Women Veterans-VA Reproductive Health Diagnoses and Organization of Care*, January 2023, p. 31.

[498] 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.

[499] VA, VHA, *National Human Immunodeficiency Virus Program*, VHA Directive 1304, August 2019.

[500] 38 C.F.R. §17.38(b).

Does VA Provide Gender-Affirming Services?

Under current regulations, VA is prohibited from providing gender-confirming/affirming surgeries.[501] As of March 2025, VA no longer provides medical treatment for gender dysphoria. This includes services such as hormone therapy, voice and communication trainings, and gender-affirming prosthetics, among others.[502]

Prior to March 2025, VA provided some services as part of the standard medical benefits package, such as hormonal therapy, mental health care, and preoperative evaluation. In addition, VA provided medically necessary postoperative and long-term care following gender-confirming surgeries if an appropriate health care professional determined 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.[503] Veterans who were already receiving such care from either VA or DOD prior to March 2025 will continue to receive it.[504]

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.[505] Title X provides grants to public and nonprofit agencies for family planning services, research, and training. The Office of Population Affairs (OPA) within HHS's Office of the Assistant Secretary for Health administers Title X, which is the only domestic federal program devoted solely to family planning and related preventive health services.[506]

Title X of the PHSA authorizes the Secretary of HHS to award grants for projects to provide family planning services to any person desiring such services, with priority given to individuals with low incomes.[507] Furthermore, services must be provided at no cost for individuals under

[501] 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.

[502] VA, "VA to phase out treatment for gender dysphoria," press release, March 17, 2025, https://news.va.gov/press-room/va-to-phase-out-treatment-for-gender-dysphoria/.

[503] VA, VHA, *Providing Health Care for Transgender and Intersex Veterans*, VHA Directive 1341(2), February 2018 (rescinded).

[504] VA, "VA to phase out treatment for gender dysphoria," press release, March 17, 2025, https://news.va.gov/press-room/va-to-phase-out-treatment-for-gender-dysphoria/.

[505] 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.

[506] Phil Killewald et al., *Family Planning Annual Report: 2023 Summary*, HHS, Office of Population Affairs (OPA), September 2024, https://opa.hhs.gov/sites/default/files/2025-08/2023-FPAR-national-summary.pdf. For more on the Title X program, see CRS In Focus IF10051, *Title X Family Planning Program*

[507] 42 U.S.C. 300a-4(c)(1). Federal regulations 42 C.F.R. §59.2 further define *low-income* as a family whose income (continued...)

100% of the federal poverty level and to provide sliding scale fees for individuals between 100% and 250% of the federal poverty level.[508] For unemancipated minors who request confidential services, eligibility for discounts is based on the minor's own income.[509] 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.[510] The authorization of appropriations for the Title X program expired in FY1985, but Congress has continued to provide annual appropriations to carry out the program. For FY2026 Congress appropriated $286,479,000.[511]

Title X is implemented through competitively awarded grants generally for a period of five years, subject to available annual appropriations for the program. Title X grantees can provide family planning services to clients directly or they can subaward Title X monies to other entities to provide services. In 2023, the most recent year for which client data are available, Title X projects served 2.80 million clients through 3,853 service sites operated by 95 grantees and their 1,614 subrecipients (also known as subgrantees or subawardees).[512]

Do Title X Projects Provide Reproductive Health Services?

Title X projects are required to provide a "broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents)."[513] 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.[514]

Current regulations further specify that Title X projects must provide services in a manner that "ensures equitable and quality service delivery consistent with nationally recognized standards of care."[515] The program's policies for providing such care to clients points to guidance outlined in *Providing Quality Family Planning Services in the United States: Recommendations of the U.S.*

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does not exceed 100% of the most recently issued Poverty Guidelines. In CY2026, a family of two with a combined income of $21,640 is considered 100% of the federal poverty level in all states except Alaska and Hawaii. See HHS, "Annual Update of the HHS Poverty," 91 *Federal Register* 10, January 15, 2026.

[508] Individuals with a household income 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. 42 C.F.R. §59.5(a)(7)-(8).

[509] 42 C.F.R. §59.2 (defining *low-income family*).

[510] 42 C.F.R. §59.5(a)(10).

[511] See Consolidated Appropriations Act, 2026 [P.L. 119-75], Division B, Title II.

[512] Phil Killewald et al., *Family Planning Annual Report: 2023 Summary*, HHS, Office of Population Affairs (OPA), September 2024, p. 42, https://opa.hhs.gov/sites/default/files/2025-08/2023-FPAR-national-summary.pdf. Current and past directories of Title X grantees, subawardees, and service sites are at HHS, OPA, Current Title X Service Grant Recipients, https://opa.hhs.gov/grant-programs/title-x-service-grants/current-title-x-service-grant-recipients. For the 2022 project year, 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.

[513] 42 U.S.C. §300(a).

[514] 42 C.F.R. §59.2 (defining *family planning services*).

[515] 42 C.F.R. §59.5(a)(3).

Office of Population Affairs (Revised 2024) (QFP).[516] QFP provides guidance for relevant Title X 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.[517]

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.[518] 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…"[519]

Program regulations also require projects to provide contraceptive 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 practices.[520] The regulations permit the HHS Secretary to omit this requirement, with an established good cause.[521]

The QFP, last updated in 2024, advises providers that contraceptive services should include (1) establishing and maintaining client rapport; (2) asking about a client's contraceptive preferences; (3) determining with the client which contraceptive method (if any) aligns with the client's preferences; (4) conducting exams related to contraceptive use, if indicated; and (5) providing or referring for the chosen method, including giving instructions about correct and consistent use.[522] Regulations require that Title X service sites unable to provide clients with access to a broad range of acceptable and effective medically approved contraceptives must be able to provide a prescription to the client for their method of choice, or referrals to another provider, as requested.[523] See **Table 1** in "What Are Contraceptive and Contraceptive Counseling Services?" for a list of FDA-approved contraceptive methods.[524]

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[516] HHS, OPA, *OPA Program Policy Notice 2024-02—Implementing Quality Family Planning Services Recommendations within Title X Projects*, OPA Program Policy Notice: 2024 – 02, November 19, 2024, https://opa.hhs.gov/node/4173. Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6, Supplement (December 2024), pp. S41-S86.

[517] Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6, Supplement (December 2024), pp. S41-S86. HHS, OPA, "Title X Program Expectations," December 2024, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/title-x-program-expectations.

[518] 42 C.F.R. §59.2; see **Table 1** in "What Are Contraceptive and Contraceptive Counseling Services?".

[519] 42 C.F.R. §59.5(a)(1).

[520] 42 C.F.R. §59.5(b)(1).

[521] 42 C.F.R. §59.5(b).

[522] Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6, Supplement (December 2024), pp. S41-S86.

[523] 42 C.F.R. §59.5(a)(1).

[524] Title X clinical guidelines are laid out in HHS, OPA, *OPA Program Policy Notice 2024-02—Implementing Quality Family Planning Services Recommendations within Title X Projects*, OPA Program Policy Notice: 2024 – 02, November 19, 2024, https://opa.hhs.gov/node/4173. See also HHS, OPA, *Title X Program Handbook*, December 2024, https://opa.hhs.gov/sites/default/files/2025-03/title-x-program-handbook-dec-2024.pdf.

OPA's Title X *Family Planning Annual Report* presents the following 2023 data on female Title X clients' primary contraceptive methods:[525]

- 21% relied on the "most effective" methods (including vasectomy, female sterilization, implants, and IUDs);
- 33% relied on "moderately effective" methods (including injectable contraception, vaginal ring, contraceptive patch, and pills);
- 20% 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 7%, the primary contraceptive method was unknown.

The *Family Planning Annual Report* presents the following 2023 data on male Title X clients' primary contraceptive methods:[526]

- 59% relied on any method of contraception, including relying on their partner to use any method of contraception;
- 11% 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.[527] 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" and "that all pregnancy counseling shall be nondirective."[528] 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.[529] If the grantee provides abortion services, its abortion activities have to be "separate and distinct" from the Title X project activities.[530] The guidance notes that "a

[525] Phil Killewald et al., *Family Planning Annual Report: 2023 Summary*, HHS, Office of Population Affairs (OPA), September 2024, p. 67, https://opa.hhs.gov/sites/default/files/2025-08/2023-FPAR-national-summary.pdf. Percentages may not sum to 100% due to rounding. Contraceptive methods and their effectiveness are listed in **Table 1**.

[526] Phil Killewald et al., *Family Planning Annual Report: 2023 Summary*, HHS, Office of Population Affairs (OPA), September 2024, p. 72, https://opa.hhs.gov/sites/default/files/2025-08/2023-FPAR-national-summary.pdf. Percentages may not sum to 100% due to rounding. Contraceptive methods and their effectiveness are listed in **Table 1**.

[527] 42 U.S.C. §300a-6.

[528] Consolidated Appropriations Act, 2026 [P.L. 119-75], Division B, Title II.

[529] HHS, OPA, *Title X Program Handbook*, December 2024, p. 27, https://opa.hhs.gov/sites/default/files/2025-03/title-x-program-handbook-dec-2024.pdf.

[530] 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-
(continued...)

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."[531]

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.[532] 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."[533]

Do Title X Projects Provide Infertility Services?

Title X authorizing statute and program regulations require projects to provide infertility services that involve services for both partners of an infertile couple.[534] Basic infertility services include understanding the client's reproductive life plan, their difficulty achieving pregnancy by taking a medical history, and providing sexual health assessments and physical exams consistent with QFP recommendations.[535] Clinical guidelines recommend screening all persons attempting to achieve pregnancy for infertility, providing counseling and resources to clients, and referring clients promptly for specialty care for clients who want to pursue medically assisted reproduction.[536] Medically assisted reproductive services, such as IVF or other ART, are generally provided by other providers. A 2024 study examining directory data of Title X and ART clinics found no ART clinics received Title X funding.[537]

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)."

[531] 65 *Federal Register* 41281.

[532] 42 C.F.R. §59.5(a)(5)(i).

[533] 42 C.F.R. §59.5(a)(5)(ii). In May 2025, HHS wrote to the Tennessee Title X grantee, "Tennessee is one of only two states to have lost funding for failure to comply with the Title X 2021 regulations requiring counseling and referral for abortion, 42 CFR § 59.5(a)(5). The Department is declining to enforce this provision against the state, and you may rely on this letter to that effect."

[534] 42 U.S.C. §300(a). 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).

[535] HHS, OPA, *Title X Program Handbook*, December 2024, p. 17, https://opa.hhs.gov/sites/default/files/2025-03/title-x-program-handbook-dec-2024.pdf.

[536] Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6, Supplement (December 2024), pp. S41-S86. See section "What Are Infertility Services?" for a description of infertility and ART services.

[537] Junying Zhao 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.

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.[538] In 2023, 6% of female clients reported using no method of contraception because they were pregnant or seeking to become pregnant.[539] 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.[540] 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."[541]

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."[542]

Do Title X Projects Provide Reproductive Health Prevention and Treatment Services?

Federal regulations require Title X projects to provide clients with "sexually transmitted infection (STI) services, and other preconception health services."[543] 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.[544] Title X clinical guidelines emphasize that clinics offering sexual and reproductive health services 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.[545]

The *Family Planning Annual Report* presents the following 2023 data on reproductive prevention and treatment services provided to clients:

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[538] 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).

[539] Phil Killewald et al., *Family Planning Annual Report: 2023 Summary*, HHS, Office of Population Affairs (OPA), September 2024, p. 67, https://opa.hhs.gov/sites/default/files/2025-08/2023-FPAR-national-summary.pdf.

[540] 42 C.F.R. §59.5(a)(5)(i).

[541] 42 C.F.R. §59.5(a)(5)(ii).

[542] 42 C.F.R. §59.5(b)(8).

[543] 42 C.F.R. §59.2 defining *family planning services*.

[544] Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6, Supplement (December 2024), pp. S41-S86. See text box "Standards of Care" in the HHS, OPA, *Title X Program Handbook*, December 2024, p. 11, https://opa.hhs.gov/sites/default/files/2025-03/title-x-program-handbook-dec-2024.pdf.42 C.F.R. § 59.5(a)(1); and 42 C.F.R. § 59.2 defining *family planning services*.

[545] Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6, Supplement (December 2024), pp. S41-S86.

- 433,844 female clients screened for cervical cancer, 18% of all female clients;
- 1,106,746 female clients tested for chlamydia, 47% of all female clients;
- 236,657 male clients tested for chlamydia, 56% of all male clients;
- 1,325,638 gonorrhea tests for female clients;[546]
- 241,477 gonorrhea tests for male clients;
- 544,429 syphilis tests for female clients;
- 190, 450 syphilis tests for male clients;
- 729,637 HIV tests for female clients;
- 254,738 HIV tests for male clients.[547]

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.[548]

With regard to HIV/AIDS and cancers of reproductive organs, Title X clinical guidelines recommend various services related to prevention and screening, such as supplemental testing and prompt referral. Title X projects focus on prevention and may not have the capacity to treat such conditions.[549] Title X regulations require projects more generally to "provide for coordination and use of referrals and linkages with primary health care 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."[550]

In 2022, HHS described the availability of 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.[551]

[546] The percentage of clients who receive gonorrhea, syphilis, and HIV tests are not included in the *Family Planning Annual Report*.

[547] Phil Killewald et al., *Family Planning Annual Report: 2023 Summary*, HHS, Office of Population Affairs (OPA), September 2024, pp. 74, 76-78, https://opa.hhs.gov/sites/default/files/2025-08/2023-FPAR-national-summary.pdf.

[548] Sarah E. Romer et al., "Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)," *American Journal of Preventive Medicine*, vol. 67, no. 6, Supplement (December 2024), pp. S41-S86; and Kimberly A. Workowski, Laura H. Bachmann, and Philip A. Chan, "Sexually Transmitted Infections Treatment," *Morbidity and Mortality Weekly Report, Recommendations and Reports*, vol. 70, no. 4 (July 23, 2021).

[549] HHS, OPA, *Title X Program Handbook*, December 2024, p. 17, https://opa.hhs.gov/sites/default/files/2025-03/title-x-program-handbook-dec-2024.pdf.

[550] 42 C.F.R. §59.5(b)(8).

[551] Emails from the HHS Office of the Assistant Secretary for Legislation, February 3, 2020, December 1, 2020, and July 1, 2022.

Do Title X Projects Provide Gender-Affirming Services?

Title X program funding is limited to services necessary to prevent or achieve pregnancy, and help individuals determine whether to have children and, if so, how to space pregnancies. Therefore, gender-affirming medications and procedures outside of family planning services are outside the scope of Title X projects.[552]

Although gender-affirming medications and procedures are not services covered by Title X funds, current federal regulations require Title X projects to "provide services in a manner that does not discriminate against any client based on religion, race, color, national origin, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, or marital status."[553] Title X program regulations also encourage taking a client-centered approach by, among other things, delivering services in a culturally appropriate and inclusive manner so as to meet the needs of all clients, including those who are lesbian, gay, bisexual, transgender, or queer (LGBTQ+). [554]

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)."[555]

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.[556] 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.[557] These programs generally 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

[552] Emails from the HHS Office of the Assistant Secretary for Legislation, February 3, 2020, December 1, 2020, and July 1, 2022.

[553] 42 C.F.R. §59.5(a)(4).

[554] 42 C.F.R. §59.5(a)(3) and 42 C.F.R. § 59.2 define *client-centered*, *culturally and linguistically appropriate services*, and *inclusive*. OASH policy priorities currently include ending diversity, equity, and inclusion policies and practices across its programs. See OASH, "Priorities of Office of the Assistant Secretary for Health," https://health.gov/priorities.

[555] HHS, OPA, *Title X Program Handbook*, December 2024, p. 30, https://opa.hhs.gov/sites/default/files/2025-03/title-x-program-handbook-dec-2024.pdf.

[556] For further information about adolescent birth rates and consequences of adolescent pregnancy, see CRS Report R45184, *Teen Births in the United States: Overview and Recent Trends*.

[557] Despite their similar names and purposes, the latter two programs have different authorizing laws and funding mechanisms. For FY2026, the Teen Pregnancy Prevention (TPP) program was funded at $101 million; the Personal 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, *Adolescent Pregnancy: Federal Prevention Programs*.

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.[558]

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.[559] 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.[560] 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.[561] 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."[562] 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 activity, (2) the number of sexual partners, (3) contraceptive use, (4) STIs or HIV, and/or (5) pregnancies.[563]

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[558] CRS Report R45183, *Adolescent Pregnancy: Federal Prevention Programs*.

[559] 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.

[560] See for example, *HHS Teen Pregnancy Prevention Review*, "Adult Identity Mentoring (Project AIM) Program Overview" and "Heritage Keepers Abstinence Education Program Overview," available through https://youth.gov/evidence-innovation/tpper/compare-programs. These are examples of abstinence education approaches and are included for illustrative purposes only.

[561] See for example, *HHS Teen Pregnancy Prevention Review*, "¡Cuídate! Program Overview" and "Be Proud! Be Responsible Program Overview," available through https://youth.gov/evidence-innovation/tpper/compare-programs. These are examples of broader sexual health education approaches and are included for illustrative purposes only.

[562] Section 513(b)(2)(A)(i) of the SSA.

[563] The Teen Pregnancy Prevention Evidence Review was 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 has contracted 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; it was discontinued by HHS in 2025 and reestablished by HHS in 2026. The website for these models and studies is at Youth.gov, HHS Teen Pregnancy Prevention Evidence Review, https://tppevidencereview.youth.gov/EvidencePrograms.aspx.

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.[564] 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."[565] The PREP grant announcements do not appear to address abortion.[566] In the absence of program guidance on the topic, general HHS guidance on prohibiting funding for abortions applies.[567]

Do Adolescent Pregnancy Prevention Programs Provide Infertility Services?

The adolescent pregnancy prevention programs do not provide infertility services.

Do Adolescent Pregnancy Prevention Programs Provide Maternity Services?

The adolescent pregnancy prevention programs do not provide maternity services.

[564] For more information about the Hyde Amendment, see "Can Federal Funds Be Used to Pay for Abortions or Abortion Counseling?" in this report.

[565] 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.

[566] See, for example, HHS, ACF, FYSB, *Competitive Personal Responsibility Education Program (PREP)*, HHS-2026-ACF-ACYF-AK-0014, 2026.

[567] 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 Reproductive Health 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 programs seek to prevent and control multiple STIs, while HRSA programs focus on 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, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).[568] 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. 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.[569]
- **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 City, NY; and San Francisco, CA.[570] The current program targets three major STIs: chlamydia, gonorrhea, and syphilis.[571]

[568] CDC, NCHHSTP, "NCHHSTP Partners and Programs," June 13, 2026, https://www.cdc.gov/nchhstp/partners-programs/index.html. CDC, "CDC's HIV, Viral Hepatitis, STD, and Tuberculosis Prevention Budget," June 22, 2026, https://www.cdc.gov/nchhstp/budget-funding/index.html.

[569] 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," January 25, 2024, https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/jurisdictions.

[570] 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.

[571] CDC, "Strengthening STD Prevention and Control for Health Departments (STD PCHD)," January 31, 2025, https://www.cdc.gov/sti/php/projects/pchd.html.

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.[572] 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.

What Is the Ryan White HIV/AIDS Program?

The Ryan White HIV/AIDS program (Ryan White), the main federal program that addresses HIV/AIDS care and treatment, is administered by HRSA.[573] 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 in their jurisdictions.[574] The program provides grants to metropolitan areas and states to provide funding to HIV primary medical care, medication, and other HIV-related services to low-income people with HIV.[575]

According to HRSA, the Ryan White program served more than 50% of all people in the United States with diagnosed HIV in 2024.[576] More than 600,000 clients were served by the Ryan White program in 2024, which was the most clients served in one year in the program's history. Of Ryan White clients receiving medical care that year, 91.4% were virally suppressed.[577]

The 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.[578] However, Ryan White can pay for recipients' health insurance premiums, deductibles, and co-payments.[579]

Ryan White funding is divided among the individual grant programs, Parts A, B, C, D, and F.[580]

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[572] Ibid.

[573] Ryan White is required to serve people with HIV/AIDS and, as such, the program primarily focuses on care and treatment. However, Ryan White does engage in some prevention strategies as allowed by program policies.

[574] Beginning in FY2026, HRSA updated its funding methodology used to calculate Ryan White program funding for Parts A and B from number of living HIV/AIDS cases residence at time of diagnosis to a person's most recent address.

[575] HRSA, "HIV/AIDS Programs," http://hab.hrsa.gov/.

[576] HRSA, HIV/AIDS Bureau, *Implementing Interventions, Expanding Partnerships, and Engaging Communities to End the HIV Epidemic 2026 Ryan White HIV/AIDS Program Highlights*, 2026, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/data/HRSA-2026-Biennial-Report.pdf

[577] Viral suppression of HIV, possible through consistent use of antiretroviral therapy (ART) medications, stops HIV from replicating itself and both improves the health of the person with HIV and can prevent transmission from that person to someone without an HIV infection.

[578] 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://web.archive.org/web/20250202202435/https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/manual-part.pdf.

[579] HRSA, RWHAP, *Clarifications Regarding the use of Ryan White HIV/AIDS Program Funds for Health Care Coverage Premium and Cost Sharing Assistance*, Policy Notice 18-01, 2018, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/18-01-use-rwhap-funds-premium-cost-sharing-assistance.pdf.

[580] As authorized by Title XXVI of the PHSA. Part E of Title XXVI of the PHSA contains general provisions for Ryan White.

- Part A provides grants to cities and counties with high numbers of people living with HIV for core medical and support services for people with HIV.[581] Eligible areas include metropolitan areas (EMAs), areas with more than 2,000 reported AIDS cases over the past five years, and transitional grant areas (TGAs), areas with 1,000–1,999 reported AIDS cases over the past five years.[582] Both EMAs and TGAs must have a population of at least 50,000 to receive Part A grants. Two-thirds of funds are distributed by formula based on an area's share of living HIV (non-AIDS and AIDS) cases; the rest are distributed via competitive grants based on demonstrated need.
- Part B provides funding to states and jurisdictions for core medical services such as drug treatments, home and community-based health care, and support services or health insurance coverage for low-income persons.[583] Within Part B, Congress provides a specific appropriation 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. The remaining funds (non-ADAP) are used for Part B base grants and a supplemental grant program.
- Part C provides grants to health centers, family planning clinics, and community-based organizations, among others, to support outpatient HIV early intervention services (EIS) to the safety net population.[584]
- Part D provides grants to public and private nonprofit entities for family-centered care for women, infants, children, and youth with HIV/AIDS.
- Part F authorizes demonstration and training efforts, including provider training, special projects of regional and national significance, and the Minority AIDS Initiative (MAI). MAI provides additional funds to RWHAP-funded entities to support education and outreach to increase minority access to RWHAP services.

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.[585] This program provides low-income, uninsured, and underserved women access to screening and diagnostic services to detect breast and cervical cancer.[586] Currently, the program funds 71 grantees: all 50 states, DC, five U.S. territories, two freely associated nations, and 13 American Indian/Alaska Native tribes or tribal organizations.[587]

[581] HRSA, "Program Parts & Initiatives," December 2025, https://ryanwhite.hrsa.gov/about/parts-and-initiatives.

[582] HRSA, "Ryan White HIV/AIDS Program: Part A Manual," January 2024, pp. 9-10, https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/part-a-program-manual.pdf.

[583] HRSA, "Part B: Grants to States and Territories," February 2026, https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-b-grants-states-territories.

[584] HRSA, "Part C: Early Intervention Services (EIS) and Capacity Development Grants," February 2026, https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-c-early-intervention.

[585] See P.L. 103-183.

[586] CDC, National Breast and Cervical Cancer Early Detection Program, "About National Breast and Cervical Cancer Early Detection Program," September 18, 2026, https://www.cdc.gov/breast-cervical-cancer-screening/about/index.html.

[587] Ibid.

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, which historically have not been sufficient to meet the needs of all eligible women. According to CDC:

> During 2020 to 2021, more than 2.6 million U.S. women were eligible for NBCCEDP breast cancer screening services, and the program served 13.5% of eligible women. During 2019 to 2021, more than 5.3 million U.S. women were eligible for NBCCEDP cervical cancer screening services, and the program served 6.0% of eligible women.[588]

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.[589] Individuals who screen positive 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,[590] 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.[591] Health centers focus on providing primary care services and are required to provide voluntary family planning services. While specific health services may vary by facility, health centers generally provide preventive health services, including reproductive health screenings.

Health center data from 2024 reports that nearly 3.0 million visits were for contraceptive management, provided to more than 1.7 million patients, and that more than 2.1 million

[588] 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 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.

[589] 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.

[590] These facilities are also called federally qualified health centers (FQHCs) or community health centers.

[591] CRS Report R43937, *Federal Health Centers: An Overview*. See 42 C.F.R. §51c.102(h).

mammograms were provided by health centers.[592] Health centers also provide STI testing and treatments. Health centers must provide access to pharmaceutical services either onsite or through contracts. For example, health centers reported providing PrEP during more than 190,000 visits in 2024.[593] Health centers are prohibited from using federal funds to provide abortions.[594] 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.[595] 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),[596] with a focus on MCH populations with low-income or limited access to health services.[597]

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 categorizes 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 FY2024, the most recent year for which data are available, states collectively spent 23.8% of program funds on direct services, 40.4% on enabling services, and 35.9% on public health services and systems. Children and CYSHCN collectively accounted for the largest proportion of expenditures (67.9%), followed by infants (younger than one year) and pregnant women (both 12.9%) and others (6.3%).[598]

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-

[592] HHS, HRSA, "Uniform Data System National Report 2024, Table 6A: Selected Diagnoses and Services Rendered," https://data.hrsa.gov/topics/healthcenters/uds/overview/national/table?tableName=6A&year=2024.

[593] Ibid.

[594] 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 6401(d) Division J, Title IV, Subtitle J of P.L. 119-75.

[595] SSA §501(a)(1).

[596] 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.

[597] For more information about this program, 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*.

[598] HRSA, *Title V Information System (TVIS)*, Financial, https://mchb.tvisdata.hrsa.gov/.

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 FY2024 reported that 59 states selected "postpartum 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.[599]

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).[600]

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.[601] Federal regulations issued in 1993 established uniform definitions for 28 main SSBG service categories, including *family planning services* and *pregnancy and parenting*.[602] States are not required to spend SSBG funds in any particular service category and may support other services as well. In FY2022, the most recent year for which complete data are available, roughly 0.3% of all SSBG expenditures were spent on family planning services and 0.2% were spent on pregnancy and parenting.[603] The SSBG is an annually appropriated capped entitlement. Mandatory appropriations for the SSBG are provided each year in the LHHS Appropriations Act and are subject to the LHHS bill's abortion-related restrictions (commonly referred to as the Hyde amendment).[604]

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

[599] For more information, including links to individual state reports, aggregated budget and expenditure data, and the FY2024 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, FY2024 data were reported in July 2025 and may not reflect final expenditures.

[600] 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*.

[601] CRS In Focus IF10115, *Social Services Block Grant*, and CRS Report 94-953, *Social Services Block Grant: Background and Funding*.

[602] 45 C.F.R. §96, Appendix A.

[603] 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.

[604] For more information, see the "Restrictions Related to Certain Controversial Issues" section inCRS Report R48970, *Labor, Health and Human Services, and Education: FY2026 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*.

ethnic disparities in infant deaths and adverse perinatal health outcomes.[605] The program awards competitive grants to local entities that serve communities with high infant mortality rates and/or poor perinatal health outcomes. In FY2026, Healthy Start provided over $145 million across 114 grantees.[606]

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). 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 Healthy Start program has also awarded supplemental grants, such as those to train, certify, and pay for community-based doula services, and implemented pilot programs to provide blood pressure cuff kits to communities served by Healthy Start.[607]

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).[608]

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.[609] 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

[605] Section 330H of the Public Health Service Act, as amended by P.L. 116-36.

[606] HRSA, *Operating Plan for FY2026*, https://www.hrsa.gov/sites/default/files/hrsa/about/budget/fy2026-hrsa-operating-plan.pdf. Email from HRSA's Maternal and Child Health Bureau (MCHB), May 13, 2026.

[607] A doula is a nonmedical, trained professional who "provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth." See DONA International, "What is a Doula," https://www.dona.org/what-is-a-doula-2/. For more information on the blood pressure cuff pilot program, see Healthy Start TA & Support Center, *What is the Cuff Kit Pilot Project?*, https://healthystart-tasc.org/initiatives/past-initiatives/cuff-kit-pilot-project/.

[608] 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*.

[609] 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.[610]

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 FY2025, MIECHV state and jurisdictional grantees served over 158,000 parents and children and provided over 1 million home visits.[611]

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.[612] 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.[613] (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, DC, 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.[614] In general, grantees provided subgrants to school districts, community service organizations, and institutions of higher education (IHE) that directly served the expectant and parenting population.[615] For the most recent year of available data (2017-2018),

[610] HHS, Office of the Assistant Secretary for Resources and Technology, Office of Grants, *HHS Grants Policy Statement*, January 1, 2007.

[611] HHS, Administration for a Healthy America, FY2027 Justification of Estimates for Appropriations Committees, April 2026, p. 203, https://www.hhs.gov/sites/default/files/fy-2027-aha-cj.pdf.

[612] For further information, see CRS Report R45426, *The Pregnancy Assistance Fund: An Overview*.

[613] 42 U.S.C. §18201-18204.

[614] The fourth category focuses on public awareness about such services; however, HHS advises that grantees may not use funding solely for public awareness activities.

[615] CRS Report R45426, *The Pregnancy Assistance Fund: An Overview*.

the most common services provided to expectant and recent parents were parenting supports, concrete supports (e.g., transportation), and health care services.[616] 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.[617] 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.[618]

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."[619]

[616] 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).

[617] 42 U.S.C. §18203(b)(4).

[618] 42 U.S.C. §18203(d)(3).

[619] 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. Acronyms Used in This Report

Table A-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
BCCTP	Breast and Cervical Cancer Treatment Program
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
COFA	Compacts of Free Association
CRS	Congressional Research Service
CSR	Cost-Sharing Reductions
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

Acronym	Definition
EEOC	Equal Employment Opportunity Commission
EHB	Essential Health Benefits
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
FSGG	Financial Services and General Government appropriations bill
FSH	Follicle Stimulating Hormone
FY	Fiscal Year
FYSB	Family and Youth Services Bureau
GAO	Government Accountability Office
GD	Gender dysphoria
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

Acronym	Definition
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
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
OPM	Office of Personnel Management
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
PSHB	Postal Service Health Benefits Program
PRC	Purchased Referred Care Program

Acronym	Definition
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
SHO	State Health Official
SHOP	Small Business Health Options Program
SMDL	State Medicaid Directors Letter
SMI	Supplementary Medical Insurance
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*
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 B. CRS Points of Contact

Topic	Contact
Reproductive Health Services (General)	Alexa C. DeBoth
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Medicare Drug Coverage	Laura A. Wreschnig
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Private Health Insurance (Legal Issues)	Jennifer A. Staman
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Bureau of Prisons (BOP)	Nathan James
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U.S. Immigration and Customs Enforcement (ICE)	Abigail F. Kolker; Audrey Singer
Indian Health Service	Elayne J. Heisler
Department of Veterans Affairs	Jared S. Sussman
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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
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Social Services Block Grant Program (SSBG)	Karen E. Lynch
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Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program	Patrick A. Landers
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