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Federal Support for Reproductive Health Services: Frequently Asked Questions

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SUMMARY

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Federal Support for Reproductive Health Services: Frequently Asked Questions

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

Congress has considered bills related to various aspects of reproductive health care. This includes bills that expand or restrict the types of reproductive health services available, how they are paid for or delivered, and the restrictions in place on paying for or providing certain types of reproductive health services. The Supreme Court's June 2022 decision regarding *Dobbs v. Jackson Women's Health Organization* may raise questions about access to contraception and abortion services.

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

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

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

- describes 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;
- describes the services that federal payment programs will reimburse when services are provided to enrolled beneficiaries;
- answers questions about federal requirements for private health insurance coverage of reproductive health services; and
- provides short summaries of various federal programs that administer grants to nongovernmental entities to provide specific types of reproductive health services.

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Introduction

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

This report first defines six different types of reproductive health services that may receive federal support, noting restrictions where relevant. The report first discusses services related to fertility, then discusses screening, prevention, and treatment of reproductive health conditions, and concludes with a discussion of gender-affirming services.[1] The six types of reproductive health services are

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

The report next describes the role that federal agencies and programs have in providing domestic reproductive health services directly, paying for services provided to beneficiaries enrolled in federal health insurance programs, and requiring payment for services by certain private health insurance plans. The report then discusses grant programs that may focus on a specific type of reproductive health service (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.

On June 24, 2022, the U.S. Supreme Court issued its opinion in *Dobbs v. Jackson Women's Health Organization*, a case challenging the constitutionality of Mississippi's Gestational Age Act, which generally prohibits an abortion once a fetus's gestational age is greater than 15 weeks. A majority of the Court not only upheld the Mississippi law but also overruled the Court's prior decisions in *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, concluding that the U.S. Constitution does not confer a right to an abortion.[2] The Court's decision in *Dobbs* may raise questions about access to contraception and abortion services.

General Questions

What Are Reproductive Health Services?

Human reproductive health services are preventive, diagnostic, and treatment services related to reproductive systems, functions, and processes. These services include, but are not exclusive to, those related to family planning, sexually transmitted infections (STIs)/sexually transmitted

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

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

diseases (STDs),[3] screening and treatment for cancers of the reproductive organs and breast tissues, and gender-affirming services.[4]

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 contraceptives, infertility treatments, resources about adoptions[5] and abortions, and counseling on healthy sexual behaviors.[6] Individuals may also choose to use Fertility Awareness-Based family planning methods, which involve monitoring the menstrual cycle calendar and other symptoms/markers to determine periods of least and greatest fertility.[7]

What Are Contraceptive Services?

A *contraceptive* is a product or method intended to lower the risk of becoming pregnant.[8] Prior to marketing in the United States, contraceptive products are reviewed by the Food and Drug Administration (FDA) of the U.S. Department of Health and Human Services (HHS). Federal funding or reimbursement for contraception is generally limited to certain medical or surgical procedures and to products that are FDA-approved or cleared for marketing. Such products vary in type, and include drugs, medical devices, or combinations of the two.

[3] Some assert there to be a distinction between sexually transmitted infections (STIs) and sexually transmitted diseases (STDs). Others use the terms interchangeably. The federal programs described in this report use the terms interchangeably. As a result, this report presents either term as it is used in the program being discussed, without suggesting a distinction between the terms. The difference between the two is that STIs "are infections that have not yet developed into diseases". All STDs start out as infections, but not all STIs develop into diseases. For example, a Human Papillomavirus Virus (HPV) infection is classified as an STI, but if it develops into genital warts or cervical cancer, it is then considered an STD. See Tulane University School of Public Health and Tropical Medicine, "STI vs. STD: Key Differences and Resources for College Students," press release, March 16, 2020, https://publichealth.tulane.edu/blog/sti-vs-std/.

[4] World Health Organization (WHO), "Reproductive health," 2022, https://www.who.int/westernpacific/health-topics/reproductive-health.

[5] 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] Centers for Disease Control and Prevention (CDC), "Update: Providing Quality Family Planning Services—Recommendations from CDC and the U.S. Office of Population Affairs, 2015," March 11, 2016, https://www.cdc.gov/mmwr/volumes/65/wr/mm6509a3.htm.

[7] CDC, "Classifications for Fertility Awareness-Based Methods," February 1, 2017, https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixf.html.

[8] 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.

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.[9] For high-risk (class III) contraceptive devices, FDA *approves* those products that demonstrate *reasonable assurance* of safety and effectiveness. For moderate-risk (class II) contraceptive devices, FDA *clears* those products that demonstrate substantial equivalence to a device already on the market (a predicate device).[10] FDA has identified 18 different methods of contraception (see the **text box**, which lists those methods from those most effective at preventing pregnancy to those least effective).[11] For example, for each of the first five methods listed, according to FDA, less than one pregnancy per 100 women per year would be expected, in contrast to the last method listed (spermicide alone), in which 28 pregnancies per 100 women per year would be expected.[12] FDA has approved emergency contraceptives (EC), which may be used if the regular form of birth control fails (e.g., condom breakages, unprotected sex). FDA states that EC "prevents about 55-85% of predicted pregnancies," and "should not to be used as a regular form of birth control."[13] FDA also states that approved contraceptive methods, including EC and intrauterine devices (IUDs), are not abortifacients[14] within the meaning of federal law.[15] These contraceptive products, including EC pills, are not effective if the patient is already pregnant (where "pregnancy" encompasses the period of time from implantation until delivery").[16] **Table 1** displays the FDA's definitions of the 18 contraceptive methods.

Contraceptive Methods Identified by FDA

1. Sterilization surgery for women
2. Sterilization surgery for men
3. Intrauterine device (IUD) copper
4. IUD with progestin
5. Implantable rod
6. Shot/injection
7. Oral contraceptives (combined pill)
8. Oral contraceptives extended/continuous use
9. Oral contraceptives (progestin only)
10. Patch
11. Vaginal contraceptive ring
12. Diaphragm with spermicide
13. Sponge with spermicide
14. Cervical cap with spermicide
15. Male condom
16. Female condom
17. Spermicide alone

Other Contraceptive Methods:

18. Emergency contraception (EC)

Source: FDA, "Birth Control Guide," undated, https://www.fda.gov/media/135111/download.

[9] CRS Report R41983, *How FDA Approves Drugs and Regulates Their Safety and Effectiveness*.

[10] CRS Report R42130, *FDA Regulation of Medical Devices*. Examples of contraceptive devices that are class III (high risk) include intrauterine devices (IUDs), tubal occlusion devices (such as Essure, which was discontinued by Bayer in 2018), and the female condom. Examples of contraceptive devices that are class II (moderate risk) include the diaphragm and the condom. For IUD regulation, see 21 C.F.R. §884.5360; for tubal occlusion device regulation, see 21 C.F.R. §884.5380; for female condom regulation, see female condom 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] FDA, "Birth Control Guide," https://www.fda.gov/media/135111/download.

[12] Ibid.

[13] Ibid.

[14] Abortifacient drugs are those for which the main or side effect is a medical abortion. See, e.g., Liza Gibson, "WHO puts abortifacients on its essential drug list," *BMJ*, vol. 331, no. 7508 (July 9, 2005). For more information on medical abortions, see the section of this report titled "What Are Abortions and Abortion Counseling Services?"

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

[16] 45 C.F.R. §46.202.

Table 1. Contraceptive Methods Definitions

Method	Definition
Sterilization surgery for women	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	Vasectomy; blocking of vas deferens (tubes that carry seminal fluid).
Intrauterine device (IUD) copper	T-shaped copper device inserted into the uterus; prevents sperm from reaching the egg and may prevent the egg from implanting in the uterus. Can be used for a maximum of 10 years.
IUD with progestin	T-shaped device containing the hormone progestin inserted into the uterus; prevents sperm from reaching the egg and prevents egg from implanting in the uterus. Can be used for a maximum of three to five years.
Implantable rod	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 a maximum of three years.
Shot/Injection	Intramuscular or subcutaneous injection of the hormone progestin; one shot is needed every three months.
Oral contraceptive (combined pill)	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)	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	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	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.
Diaphragm with spermicide	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	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	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.
Male condom	Thin film sheath placed over the penis; over-the-counter barrier method that prevents sperm from reaching the egg.
Female condom	Thin lubricated pouch placed inside the vagina; over-the-counter barrier method that prevents sperm from reaching the egg.
Spermicide alone	Sperm cell killing foam, cream, jelly, film, or tablet placed intravaginally; over-the-counter product.

Method	Definition
Emergency contraceptive (EC) (Levonorgestrel 1.5mg [one pill] or Levonorgestrel 0.75mg [two pills])	Progestin hormone pill(s); should be taken within 72 hours of birth control failure or unprotected sex; primarily works to stop ovaries from releasing eggs; may prevent egg from implanting in the uterus. Levonorgestrel 1.5mg (one pill) is available over-the-counter for patients of all ages (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)	Pill that blocks progesterone hormone; should be taken within 120 hours of unprotected sex; stops or delays ovaries from releasing eggs; available by prescription (e.g., Ella).

Source: FDA, "Birth Control," June 18, 2021, https://www.fda.gov/consumers/free-publications-women/birth-control.

Notes: Table language reflects that of the FDA Birth Control resource and chart. It is organized from most to least effective contraceptive (sterilization is most effective; ECs are least effective).

Though not mentioned in the FDA "Birth Control Guide," other forms of sterilization surgery exist and may be used as a primary form of contraception. These procedures include hysterectomy (removal of uterus)[17] and bilateral salpingectomy (removal of fallopian tubes), often with bilateral oophorectomy (removal of both ovaries).[18] These surgeries are also commonly used to treat medical conditions, such as reproductive cancers.

What Are Abortions and Abortion Counseling Services?

An abortion, which is used to terminate a pregnancy, may be medically induced or surgically performed. A medically induced abortion (also called a medical abortion) is a nonsurgical intervention that is effective within the first nine weeks of a pregnancy.[19] To terminate a pregnancy medically, mifepristone (also known as RU-486) and misoprostol are prescribed[20] in combination.[21] Mifepristone is a progesterone hormone blocker and is FDA-approved for the termination of pregnancy,[22] and misoprostol is used off-label to induce uterine contractions,

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

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

[19] CDC, "Reproductive Health: Data and Statistics," November 25, 2020, https://www.cdc.gov/reproductivehealth/data_stats/index.htm.

[20] Mifepristone is subject to restricted distribution pursuant to the drug's FDA-mandated Risk Evaluation and Mitigation Strategies (REMS) program. Formerly, the drug could be prescribed only by certified health care providers and dispensed only in-person at specially certified health care settings, among other requirements. In 2021, FDA reviewed the Mifepristone REMS program and determined that certain elements of the program would be updated. The REMS program was updated to remove the in-person drug-dispensing requirement. Additionally, the update allows for the dispensing of Mifepristone in certified pharmacies subject to manufacturers' proposals. In response to FDA's modifications, Mifepristone manufacturers must now prepare proposals on how the REMS modifications will be implemented to the FDA. See FDA, "Approved Risk Evaluation and Mitigation Strategies (REMS): Mifepristone," December 26, 2021, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

[21] FDA, "Questions and Answers on Mifeprex," December 26, 2021, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifeprex.

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

though its approved use is to prevent stomach ulcers.[23] This intervention typically necessitates a follow-up physician appointment to confirm termination of the pregnancy. Surgical abortion procedures vary depending on which trimester of pregnancy a patient is in. These procedures in general seek to evacuate fetal tissue from the uterus using gynecological tools.[24]

Abortion counseling is, in general, a discussion between a clinician and a patient about abortion as a potential option in pregnancy decision-making. Abortion counseling may also involve a discussion of future fertility decisions.[25]

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, federal funds may only be used to pay for abortions in cases of rape, incest, or endangerment of a mother's life. This restriction is the result of statutory and legislative provisions such as the Hyde Amendment (see text box), which has been added to the annual appropriations measure for HHS since 1976.[26] Similar provisions exist in the appropriations measures for foreign operations, the District of Columbia, the Treasury, and the Department of Justice (DOJ).[27] 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).[28]

These provisions may additionally restrict abortion counseling for federal agencies and grant programs.

Hyde Amendment

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

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

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

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

[24] CDC, "Abortion Surveillance—United States, 2018," November 27, 2020, https://www.cdc.gov/mmwr/volumes/69/ss/ss6907a1.htm?s_cid=ss6907a1_x.

[25] J.D. Asher, "Abortion counseling," *American Journal of Public Health*, vol. 62, no. 5 (May 1972), pp. 686-688.

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

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

[28] 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.")

What Are Infertility Services?

Infertility is a reproductive health disorder generally defined as the inability to conceive pregnancy after at least one year of attempting to conceive.[29] Infertility affects people of all genders and can be caused by reproductive organ damage, hormone imbalance, or genetic disorders. Treatments for infertility thus may involve surgery, hormone/medication therapy, genetic counseling, or medical procedures such as intrauterine (artificial) insemination (IUI).[30] Treatment may also involve Assisted Reproductive Technologies (ARTs), which are generally defined as "all fertility treatments in which either eggs or embryos are handled."[31] In Vitro Fertilization (IVF), the most notable example of an ART, is a procedure designed to help initiate a pregnancy via artificial implantation of fertilized embryo(s) into a uterus. IVF is a last resort pregnancy option for those with clinical infertility issues or those with heritable genetic conditions. Other ARTs include gamete and zygote intrafallopian transfer[32] and elective single embryo transfer.[33]

The three federal agencies that currently regulate the use of ARTs are the Centers for Disease Control and Prevention (CDC),[34] the Centers for Medicare & Medicaid Services (CMS), and the FDA. According the American Society of Reproductive Medicine, the professional organization that represents ART providers and clinics, the agencies' roles are as follows:

> The Centers for Disease Control and Prevention (CDC) collects and publishes data on ART procedures. The Food and Drug Administration (FDA) controls approval and use of drugs, biological products, and medical devices and has jurisdiction over screening and testing of reproductive tissues, such as donor eggs and sperm. The Centers for Medicare and Medicaid Services (CMS) is responsible for implementation of the Clinical Laboratory Improvement Act to ensure the quality of laboratory testing.[35]

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[29] CDC, "Infertility FAQs," March 1, 2022, https://www.cdc.gov/reproductivehealth/infertility/index.htm.

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

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

[32] CDC, "2019 Assisted Reproductive Technology: Fertility and National Summary Report, 2021, https://www.cdc.gov/art/reports/2019/pdf/2019-Report-ART-Fertility-Clinic-National-Summary-h.pdf. Gamete and zygote intrafallopian transfers are procedures in which "gametes or zygotes [are] transferred into the fallopian tubes rather than the uterus.

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

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

[35] American Society for Reproductive Medicine, *Oversight of Assisted Reproductive Technology*, Birmingham, AL, 2010, https://www.asrm.org/globalassets/asrm/asrm-content/about-us/pdfs/oversiteofart.pdf.

What Are Maternity Services?

Maternal health services include a broad range of interventions to support pregnant individuals. These interventions include care during "the intrapartum *hospital* stay, such as practices related to immediate prenatal care, care during labor and birthing, and postpartum care"; *hospital* in this case refers to "hospitals, birthing clinics, and freestanding birth centers."[36] Prenatal care[37] usually takes the form of routine monitoring and support, including administration of prenatal vitamins, medication counseling, drug and alcohol counseling, and management of obstetric conditions that may arise (e.g., ectopic pregnancies, which are nonviable and life-threatening for the mother).[38] Prenatal care may also include care for chronic medical conditions that may make an otherwise normal pregnancy high risk (e.g., diabetes, cardiovascular disease, obesity). Recent Administrations have focused on improving maternal health. Specifically, the Biden Administration released its "Blueprint for Addressing the Maternal Health Crisis" in June 2022. The blueprint includes goals to improve maternal health services, improve birthing services, advance data collection, expand and improve the diversity of the perinatal workforce, and strengthen economic and social supports before, during, and after birth.[39] In 2020, the Trump Administration, through HHS, developed a Maternal Health Action Plan that included similar foci. Specifically, that plan aimed to improve health outcomes for women of reproductive age, achieve healthy pregnancies and births, optimize postpartum health, improve data, and bolster research in this area.[40]

What Are Reproductive Health Prevention and Treatment Services?

Prevention and screening services in reproductive health seek to prevent, detect, or treat infections, cancers, and other disorders of the reproductive organs. Common reproductive infections include STDs [41] such as chlamydia, gonorrhea, human immunodeficiency virus (HIV)/ acquired immune deficiency syndrome (AIDS), and human papillomavirus (HPV).[42] Other

[36] CDC, "The CDC Guide to Breastfeeding Interventions," 2005, https://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf.

[37] CDC, "During Pregnancy," October 1, 2020, https://www.cdc.gov/pregnancy/during.html.

[38] American College of Obstetricians and Gynecologists, "ACOG Practice Bulletin No. 191: Tubal Ectopic Pregnancy," *Obstetrics & Gynecology*, vol. 131, no. 2 (February 2018), pp. 65-77. An ectopic pregnancy is one in which a fertilized egg implants outside the uterus. Ectopic pregnancies most often occur in the fallopian tube, but can also be found in the abdominal cavity, cervix, or ovary. Ruptured ectopic pregnancy was the leading cause of hemorrhage-related mortality in 2011-2013 (excess bleeding to the point of death). This pregnancy is terminated through surgery or use of the medication methotrexate; it is not treated with mifepristone (also known as RU-486).

[39] White House, *White House Blueprint for Addressing the Maternal Health Crisis*, Washington, DC, June 2022, https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf.

[40] HHS, *Health Women, Health Pregnancies, Health Futures: Action Plan to Improve Maternal Health in America*, https://aspe.hhs.gov/sites/default/files/private/aspe-files/264076/healthy-women-healthy-pregnancies-healthy-future-action-plan_0.pdf.

[41] Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), CDC, "Diseases & Related Conditions," December 8, 2021, https://www.cdc.gov/std/general/default.htm. "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. STDs are passed from one person to another through sexual activity including vaginal, oral, and anal sex. They can also be passed from one person to another through intimate physical contact, such as heavy petting, though this is not very common."

[42] CDC, "Sexually Transmitted Diseases," https://www.cdc.gov/std/default.htm. Human immunodeficiency virus (HIV) and human papillomavirus (HPV) infections can cause certain cancers.

reproductive disorders include malignant cancers of the reproductive tract and breast, benign cysts and tumors, and infertility.[43]

In health care, prevention occurs along a continuum, depending on the outcomes to be prevented.[44] For example, vaccinations can prevent infectious diseases, chemotherapy can prevent a cancer-related death, and hospice care can prevent pain and distress. In common usage, health care services are generally described as either prevention or treatment, as follows:

- **Preventive services**, which are furnished in the absence of symptoms, encompass *primary prevention* and *secondary prevention*. Primary prevention includes interventions such as vaccinations that remove a risk factor for illness. Secondary prevention consists of *screening*—diagnostic tests that detect disease early, when treatment may be more likely to achieve remission or cure—and *post-exposure prophylaxis (PEP)*—usually a drug(s) or vaccine given following exposure to an infectious disease to prevent illness.[45] For example, "Well Woman" visits give a patient and provider an opportunity to review risk factors and plan the delivery of prevention and screening services.[46] The United States Preventive Services Task Force (USPSTF; see **text box** below) evaluates evidence and makes recommendation for the effective use of preventive services in primary care settings.
- **Treatment services** are surgical and medical (including pharmaceutical) interventions to control or cure a disease, manage its symptoms, or both. Treatment services are sometimes referred to as *tertiary prevention*. They are furnished to patients who have symptoms or diagnostic findings of actual illness. *Monitoring*, the use of diagnostic services to track the course of a disease or remission, is considered a form of treatment, thus it is not discussed separately in this report.

[43] CDC, "Common Reproductive Health Concerns for Women," April 27, 2018, https://www.cdc.gov/reproductivehealth/womensrh/healthconcerns.html, and "Prostate Cancer," August 18, 2020, https://www.cdc.gov/cancer/prostate/.

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

[45] CDC, *Prevention: Picture of America*, undated, p. 1, https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf.

[46] American College of Obstetricians and Gynecologists' Committee on Gynecologic Practice and Catherine Witkop, MD, MPH, "Well-Woman Visit: Committee Opinion," *Obstetrics and Gynecology*, vol. 132, no. 4 (October 2018), pp. 181-186. A well-woman visit encompasses, among other things, screenings and diagnostics appropriate to age and risk factors, counseling with respect to a reproductive life plan and minimizing health risks, immunizations appropriate to age and risk factors, and comprehensive history-taking.

U.S. Preventive Services Task Force (USPSTF)

The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of experts in prevention, evidence-based medicine, and epidemiology that makes evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. USPSTF recommendations inform clinical practice and are referenced in federal law to define certain requirements for coverage of or payment for clinical preventive services. Depending on available evidence, recommendations are tailored to specific populations, such as age groups. However, evidence is often insufficient to tailor recommendations for specific subpopulations, such as racial and ethnic groups.

The USPSTF defines preventive services as follows: "[USPSTF] recommendations focus on interventions to prevent disease, so they only apply to persons without signs or symptoms of the disease or condition under consideration. USPSTF recommendations address services offered in the primary care setting or services referred by primary care professionals."

The USPSTF assigns grades to preventive services based on evidence of effectiveness balanced against potential harm. A and B grade recommendations are given to those services that the task force most highly recommends implementing for preventive care and that are relevant for implementing certain coverage requirements in the Affordable Care Act. These preventive services have a high or moderate net benefit for patients.

Several services recommended for use by the USPSTF, such as screenings for cancers of the reproductive organs, are discussed as reproductive health preventive services in this report. These services are furnished to individuals in clinical settings and are distinct from public health prevention activities, such as sex education in schools.

The USPSTF does not evaluate the use of vaccines, although they are also clinical preventive services. Rather, the USPSTF defers to another federal advisory group, the Advisory Committee on Immunization Practices (ACIP). Certain vaccines (e.g., those for hepatitis B and human papillomavirus [HPV]) can prevent sexual transmission of these diseases; those vaccines are also discussed as reproductive health preventive services in this report.

Sources: U.S. Preventive Services Task Force (USPSTF), "About the USPSTF," https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf. U.S. Preventive Services Task Force, "Scope of Work," *Procedure Manual,* Section 1.4, pp.1-2, December, 2015, https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/inline-files/procedure-manual-2020_3.pdf. Advisory Committee on Immunization Practices (ACIP), https://www.cdc.gov/vaccines/acip/index.html.

Notes: The task force is supported by the HHS Agency for Healthcare Quality and Research (AHRQ). The ACIP is supported by CDC.

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

Table 2. Examples of Reproductive Health Prevention and Treatment Services

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

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

Source: Prepared by CRS.

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

a. CDC, "Basic Information About Breast Cancer," September 14, 2020, https://www.cdc.gov/cancer/breast/basic_info/index.htm.

b. CDC, "About PrEP," June 3, 2022, https://www.cdc.gov/hiv/basics/prep/about-prep.html. "PrEP (pre-exposure prophylaxis) is medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use." There are currently three medications with FDA approval for use as PrEP: Truvada, Descovy, and Apretude.

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

d. CDC, "HIV PEP," October 21, 2020, https://www.cdc.gov/hiv/basics/pep.html. HIV PEP medications should be started within 72 hours of a possible exposure.

e. CDC, "Gonorrhea–CDC Fact Sheet (Detailed Version)," January 19, 2021, https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea-detailed.htm.

On December 17, 2020, HHS released a National Strategic Plan for improving STI education, prevention, and treatment in the United States for 2021-2025.[47] This action plan specifically targets rising rates of chlamydia, gonorrhea, syphilis, and HPV through four main objectives: (1) STI prevention, (2) reduction of adverse outcomes through acceleration of STI research, (3) reduction of STI-related health disparities and inequalities, and (4) integration of existing STI prevention programs.

What Are Gender-Affirming Services?

Gender-affirming services are medical and surgical interventions designed to help match an individuals' primary and secondary sex characteristics with their gender identity.[48] Use of these services may stem from a diagnosis of gender dysphoria (previously known as gender identity disorder [GID]), defined by CMS as an individual's "significant discontent with their biological sex and/or gender assigned at birth."[49]

[47] HHS, "STI National Strategic Plan Overview," press release, December 17, 2020, https://www.hhs.gov/programs/topic-sites/sexually-transmitted-infections/plan-overview/index.html.

[48] Office of Population Affairs, OASH, "Gender Affirming Care and Young People," https://opa.hhs.gov/sites/default/files/2022-03/gender-affirming-care-young-people-march-2022.pdf.

[49] CMS, "Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N)," August 30, 2016,

Medical interventions primarily take the form of hormone therapy but may also involve treatment of behavioral health conditions related to stigma and discrimination, as well as other types of treatment.[50] Surgical interventions, commonly known as sex reassignment surgeries (SRS) or gender reassignment surgeries (GRS), typically involve altering physical features to match an individual's gender identity.[51] Surgeries include, but are not limited to, those that target the face, the chest/breasts, or genitals.

A Note About Gender References in This Report

Throughout this report CRS has taken the primary approach of using gendered terms in the same manner as the terms are used in the statute, rules, regulations, and guidance of specific agencies and grant programs. That is to say, the usage of the terms "women," "man," "female," and "male," in each section have been made consistent with each federal agency's or grant program's official terminology.

Notes: For more information about terminology related to gender and gender identify, see the following resources:

CDC, "HIV and Transgender People: Terminology," April 15, 2021, https://www.cdc.gov/hiv/group/gender/transgender/terminology.html.

WHO, "Gender, equity and human rights: Glossary of terms and tools," 2011, https://www.who.int/gender-equity-rights/knowledge/glossary/en/.

Federal Agencies and Departments

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

Bureau of Prisons (BOP)

The Bureau of Prisons (BOP) within the Department of Justice (DOJ) operates the federal prison system, which includes 122 facilities in 35 states. BOP was established in 1930 to house federal prisoners, professionalize the prison service, and ensure consistent and centralized administration of the federal prison system.[52] BOP must confine any offender convicted and sentenced to a term of imprisonment in a federal court. As of the end of FY2021, there were approximately 156,000 prisoners under BOP's jurisdiction.[53] BOP provides medically necessary health care treatment to all prisoners housed in BOP-operated facilities, including medically necessary reproductive health services.[54] 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

https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282.

[50] CDC, "Patient-Centered Care for Transgender People: Recommended Practices for Health Care Settings," February 18, 2022, https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/affirmative-care.html.

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

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

[53] DOJ, BOP, "Statistics," https://www.bop.gov/about/statistics/population_statistics.jsp#old_pops (data on the federal prison population was accessed on June 29, 2022).

[54] DOJ, BOP, *FY 2023 Performance Budget, Congressional Submission, Salaries and Expenses*, p. 25 (hereinafter, "BOP FY2023 S&E budget justification").

and laboratory areas, a pharmacy, and administrative offices.[55] When services cannot be provided at a BOP facility, it transports prisoners to a community health care facility or provider (e.g., a hospital). Generally, each BOP facility maintains its own contract with health care facilities or providers and sets the rate to be paid for providing medical treatment to inmates.[56] 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.[57]

All prisoners serving a period of incarceration are given an intake medical examination within 14 days of their arrival at their designated facility. This intake includes

- compiling a complete medical, mental health, and substance abuse history and conducting a physical examination;
- conducting a dental examination; and
- ordering appropriate laboratory and diagnostic tests, if medically indicated (e.g., screenings for hepatitis, sickle cell anemia, and STDs).[58]

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.[59]

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

Does BOP Provide Contraceptive Services?

BOP policy requires medical staff to provide female prisoners with information related to birth control, if requested.[60] Female prisoners have access to birth control while incarcerated, but it is usually prescribed only for regulating menstruation and for hormone replacement therapy in postmenopausal women, as clinically indicated.[61] 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.[62]

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[55] 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").

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

[57] 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 FY2023 S&E budget justification, p. 26.

[58] DOJ, BOP, *Patient Care*, Program Statement 6031.04, p. 24 (hereinafter "*Patient Care*").

[59] BOP FY2023 S&E budget justification, p. 25.

[60] *Patient Care*, p. 28.

[61] Ibid.

[62] 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.

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).[63]

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.[64] Wardens are required to offer pregnant prisoners medical, religious, and social counseling to help them decide whether to carry a pregnancy to term. If the prisoner chooses to terminate the pregnancy, the prisoner is required to sign a statement to that effect.[65] Upon receipt of the signed statement, the facility's clinical director arranges for an abortion.[66] 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.[67] In all other cases, the prisoner must arrange payment for the procedure.[68] However, in cases where the prisoner pays for the procedure, BOP may use its funds to transport the prisoner to a facility outside of the institution where the procedure will be performed.[69]

Does BOP Provide Infertility Services?

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

Does BOP Provide Maternity Services?

BOP has several programs that provide parenting assistance.[70] 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

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[63] *Patient Care*, p. 42.

[64] 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, 2022 (Division B of P.L. 117-103), states that "none of the funds appropriated by [Title II of Division B] 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."

[65] DOJ, BOP, *Female Offender Manual*, Program Statement 5200.07, p. 16 (hereinafter, "*Female Offender Manual*").

[66] 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.

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

[68] Ibid.

[69] Ibid.

[70] For a description of BOP's national parenting from prisons program, see DOJ, BOP, *First Step Act Approved Programs Guide*, July 2022, p. 26.

financial responsibility for child care.[71] 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.[72] Once they complete the program, prisoners are returned to their designated facility to serve the remainder of their sentences.

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

All federal prisoners receive a medical screening upon intake at a BOP facility, which includes ordering appropriate laboratory and diagnostic tests, if medically indicated. Such tests include age-appropriate preventive health examinations (e.g., Pap smears). BOP policy also requires medical staff to counsel prisoners regarding any necessary follow-up treatment or testing within a clinically appropriate time frame.[73] BOP provides medically necessary treatment, including treatment for reproductive health, to all federal prisoners.[74] BOP is responsible for providing medically necessary care in a manner consistent with the standards of care for nonprisoners.[75]

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.[76] 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.[77] 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.[78] In addition, BOP conducts HIV testing, as necessary, to collect information on the prevalence of HIV in the prison population (i.e., surveillance testing). BOP provides HIV testing to prisoners upon request; such tests are limited to one per 12-month period, unless BOP determines that additional testing is warranted.[79] BOP provides pre- and post-test counseling to all prisoners who are tested for HIV, regardless of the test results.[80]

Does BOP Provide Gender-Affirming Services?

BOP provides prisoners who have a possible diagnosis of GID with medical and mental health evaluations. The evaluations are administered by staff who have experience with diagnosing recognized sexual disorders and who have participated in BOP's GID training. The evaluation

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[71] 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.

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

[73] *Patient Care*, p. 26.

[74] 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.

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

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

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

[78] Ibid.

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

[80] Ibid.

includes an assessment of the prisoner's treatment and life experiences prior to incarceration, as well as experiences during incarceration (including hormone therapy, completed or in-process surgical interventions, real life experience consistent with the prisoner's gender identity, private expressions that conform to the preferred gender, and counseling).[81]

If a prisoner is diagnosed with GID, BOP develops a treatment plan, which is not solely dependent on services provided or the prisoner's life experiences prior to incarceration. The treatment plan may include elements or services that were, or were not, provided prior to incarceration, including, but not limited to, those elements of the real life experience consistent with the prison environment, hormone therapy, and counseling. Treatment plans are reviewed regularly and updated as necessary.

BOP uses all current, accepted standards of care as a reference for developing treatment plans for prisoners with GID. Each treatment plan or denial of treatment must be reviewed by BOP's medical director or the prison's chief psychiatrist.[82]

Department of Defense (DOD)

DOD administers a statutory health benefit (10 U.S.C. Chapter 55) through the Military Health System (MHS). The MHS offers health care benefits and services through its TRICARE program to approximately 9.6 million beneficiaries, comprising members and retirees of the uniformed services and their family members.[83] 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.[84] 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.[85]

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.[86] 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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[81] *Patient Care*, p. 41.

[82] Each prison has a chief psychiatrist, chosen by the warden with the approval of BOP's medical director. The chief psychiatrist is responsible for supervising the prison's psychiatric program.

[83] Military Health System (MHS), "Beneficiary Population Statistics," accessed November 5, 2020, https://www.health.mil/I-Am-A/Media/Media-Center/Patient-Population-Statistics. The term *uniformed services* includes the Armed Forces (Army, Navy, Air Force, Marine Corps, and Coast Guard), the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration. For additional information about the MHS, see CRS In Focus IF10530, *Defense Primer: Military Health System*.

[84] For more on the MHS, see CRS In Focus IF10530, *Defense Primer: Military Health System*.

[85] For more on TRICARE's cost-sharing features, see CRS Report R45399, *Military Medical Care: Frequently Asked Questions* ("Question 6. 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.

[86] 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 does require TRICARE to include similar preventive health services. For more information on the ACA's requirements, see "Coverage of Certain Preventive Services Without Cost Sharing."

Does DOD Provide Contraceptive Services?

DOD offers contraceptive services as part of its *family planning* benefit.[87] Counseling and contraception methods are offered in accordance with Section 718 of National Defense Authorization Act (NDAA) for FY2016 (P.L. 114-92) and CDC's *medical eligibility criteria* and *selected practice recommendations for contraceptive use*.[88] DOD offers or covers only methods of contraception recognized by FDA (see text box in "What Are Contraceptive Services?") including the following:

- Short-Acting Reversible Contraceptives (SARCs): oral contraceptive, patch, vaginal ring, injection.
- Long-Acting Reversible Contraceptives (LARCs): intrauterine device (IUD), implantable rod.
- Barriers: diaphragm, cervical cap, sponge, male/female condom.
- Sterilization: male/female surgical sterilization, permanent implant.
- Emergency Contraceptives (ECs)**:** *Plan B One Step*/*Next Choice One Dose*, *Ella*.[89]

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).[90] In-theater military health care providers are authorized to issue new or renewal prescriptions that would be filled through the DPP.

Does DOD Provide Abortions or Abortion Counseling?

Title 10, Section 1093, of the *U.S. Code* prohibits the DOD from directly providing or paying for abortion services, except where the life of the mother would be endangered if the fetus were carried to term, or in a case in which the pregnancy is the result of an act of rape or incest.[91] DOD may provide medically necessary care and services (including behavioral health care) when related to a covered abortion. Abortion counseling, referral, preparation, and follow-up care for noncovered abortions are not available in MTFs or paid for by TRICARE.[92]

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

[88] Defense Health Agency (DHA) Procedural Instruction 6200.02, *Comprehensive Contraceptive Counseling and Access to the Full Range of Methods of Contraception*, May 13, 2019, p. 6, https://go.usa.gov/x79gj. The FY2016 National Defense Authorization Act (NDAA) requires DOD to establish and disseminate clinical guidelines on contraception and contraception counseling, as well as to make annual and pre-and postdeployment contraceptive counseling available to female members of the Armed Forces.

[89] Ibid., p. 14. A list of FDA-approved contraceptive methods is available at https://www.fda.gov/consumers/free-publications-women/birth-control-chart.

[90] 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.

[91] 32 C.F.R. §199.4(e)(2) 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.

[92] See Chapter 4, Section 18.3 of the TRICARE Policy Manual 6010.60-M, April 1, 2015, https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-01-20/ChangeOnly/tp15/c4s18_3.html.

Does DOD Provide Infertility Services?

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

- correction of any physical cause of infertility;
- erectile dysfunction resulting from a physical cause; and
- diagnostic services (e.g., semen analysis, hormone evaluation, chromosomal studies, immunologic studies, special and sperm function tests, and bacteriologic investigation).[93]

In general, DOD does not offer or cover other types of infertility services or ART.[94] Excluded services include artificial intrauterine insemination (IUI), costs related to donors or sperm banks, reversal of tubal ligation or vasectomy (unless medically necessary), erectile dysfunction resulting from psychological causes, or *noncoital* reproductive procedures (e.g., IVF, gamete or zygote intrafallopian transfer, tubal embryo transfer).[95]

DOD also offers limited ART services to seriously or severely ill or injured active duty servicemembers and their spouses with qualifying diagnosis (i.e., infertility).[96] Limited ART services include sperm or egg retrieval; IVF; artificial insemination; and egg, sperm, or embryo cryopreservation.[97] Six DOD hospitals offer these services to eligible servicemembers and their spouses:

- Madigan Army Medical Center (Tacoma, WA);
- Naval Medical Center San Diego (San Diego, CA);
- San Antonio Military Medical Center (San Antonio, TX);
- Tripler Army Medical Center (Honolulu, HI);
- Walter Reed National Military Medical Center (Bethesda, MD); and
- Womack Army Medical Center (Fayetteville, NC).[98]

Most of these services are provided at no cost to the patient; however, the cost of cryopreservation and storage up to three years is shared between the patient and DOD.[99]

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

[94] 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.

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

[96] 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."

[97] DOD, *Report to Congress: Efforts to Treat Infertility of Military Families*, December 2015, pp. 7-8, https://go.usa.gov/x79Ww.

[98] Ibid., p. 7.

[99] DOD policy authorizes cost sharing of embryo cryopreservation and storage for no more than three years or when the servicemember separates/retires, whichever comes first. For more on ART for ill or injured servicemembers, see Assistant Secretary of Defense for Health Affairs Memorandum, "Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members," April 3, 2012.

Does DOD Provide Maternity Services?

DOD offers and pays for medically necessary maternity care, including "care and treatment related to conception, delivery, abortion,[100] including prenatal and postnatal care (generally through the 6th postdelivery week), and also including treatment of the complications of pregnancy."[101] Maternity care for pregnancies resulting from noncoital reproductive procedures or surrogacy are also covered.[102]

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

DOD offers a wide-range of clinical preventive services, including certain reproductive health screening and preventive services.[103] These services include, but are not limited to, screening and counseling of breast, cervical, colon, gynecological, testicular, and prostate cancers; family planning; menopause; STIs or STDs; PrEP for HIV; and physical or psychological conditions resulting from an act of violence.[104] DOD also offers medically necessary treatment or therapy options to eligible beneficiaries with a reproductive health issue identified during a clinical screening.[105]

Does DOD Provide Gender-Affirming Services?

DOD offers or pays for medically necessary nonsurgical treatment (i.e., hormone therapy, pubertal suppression, or psychotherapy) for gender dysphoria.[106] According to TRICARE coverage policy, beneficiaries with gender dysphoria diagnosed by a mental health provider and who meet certain clinical indications may access these services.[107] With regard to surgical treatment of gender dysphoria (i.e., SRS), Title 10, Section 1079(a)(11), of the *U.S. Code* prohibits DOD from directly providing or paying for surgical treatment of gender dysphoria (i.e., SRS) for nonactive duty beneficiaries.

All active duty servicemembers diagnosed with gender dysphoria may receive nonsurgical treatment, as described above. In addition, DOD may cover surgical treatment options for servicemembers who entered military service prior to April 12, 2019, and who were either (1) "medically qualified" in their preferred gender at the time of accession or (2) diagnosed with gender dysphoria by a military medical provider.[108] DOD refers to these individuals as *exempt*

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

[101] 32 C.F.R. §199.2 and §199.4.

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

[103] For more on DOD's provision of clinical preventive services, see Chapter 7, Sections 2.1 and 2.22 of the TRICARE Policy Manual, April 1, 2015.

[104] 32 C.F.R. §199.4(e)(3) defines DOD's *family planning* benefit as certain "services and supplies related to preventing contraception."

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

[106] For more on TRICARE coverage of gender dysphoria services, see Chapter 7, Section 1.2 of the TRICARE Policy Manual, April 1, 2015.

[107] Ibid.

[108] DOD Instruction 1300.28, *Military Service By Transgender Persons and Persons with Gender Dysphoria*, September 4, 2020, p. 11, https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/130028p.pdf? ver=2020-09-04-115910-477.

servicememembers.[109] DOD policies require exempt servicemembers to meet certain clinical and administrative requirements prior to receiving approval for surgical treatment.[110]

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

The Department of Homeland Security's (DHS's) Immigration and Customs Enforcement's (ICE's) mission "is to protect America from the cross-border crime and illegal immigration that threaten national security and public safety."[111] 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.[112]

ICE detention standards were originally developed in 2000 and have been updated several times, resulting in various sets of standards that incorporate different laws and regulations and vary in terms of scope and rigor. Although there are different sets of standards, all facilities housing noncitizen detainees must generally comply with one of the sets of ICE detention standards, including health care standards. Contracts or agreements between ICE and detention facilities specify which set of standards facilities are required to follow.[113]

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)[114] and the 2000/2019 National Detention Standards (NDS).[115] The 2011 PBNDS and 2019 NDS provide

[109] Ibid. *Medically qualified* refers to being capable of "satisfactorily completing required training and initial period of contracted service" and "performing duties without aggravating existing physical defects or medical conditions." For more information, see DOD Instruction 6130.03, *Medical Standards For Appointment, Enlistment, or Induction into the Military Services*, May 6, 2018, pp. 4-5, https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/613003p.pdf.

[110] Clinical and administrative requirements include a period of patient stability during cross-sex hormone therapy; full-time, continuous real life experience in the preferred gender; gender marker change in DOD's personnel database (i.e., Defense Enrollment Eligibility Reporting System); unit commander endorsement; and a DHA waiver to authorize payment for surgical care by a designated civilian health care provider. For more on these requirements and approval process, see Assistant Secretary of Defense for Health Affairs Memorandum, *Guidance for Treatment of Gender Dysphoria for Active and Reserve Component Service Members*, July 29, 2016, https://go.usa.gov/x7X3f, and DHA Memorandum, *Interim Defense Health Agency Procedures for Reviewing Requests for Waivers to Allow Supplemental Health Care Program Coverage of Sex Reassignment Surgical Procedures*, November 13, 2017, https://go.usa.gov/x7Xc3.

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

[112] 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.

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

[114] 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.)

[115] The 2019 National Detention Standards (NDS) is a modified version of the 2000 NDS. The data provided by GAO do not distinguish between the facilities utilizing 2000 and 2019 NDS. (GAO, *ICE Should Enhance Its Use of Facility*

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 indicate inadequate compliance with these standards.[116]

Does ICE Provide Reproductive Health Services?

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

Does ICE Provide Contraceptive Services?

According to ICE guidance, detainees are entitled to impartial family planning and contraceptive consultations with medical personnel. Detainees may receive "medically appropriate" medical contraception.[117]

Does ICE Provide Abortions or Abortion Counseling?

ICE provides abortion services in certain circumstances. ICE assumes the cost of terminating the pregnancy "if the life of the mother would be endangered by carrying a fetus to term, or in the case of rape or incest."[118] In all other circumstances, the detainee bears the cost of terminating the pregnancy. In all instances, ICE arranges transportation to the medical appointment at no cost to the detainee and, if requested, to religious or social counseling.

Does ICE Provide Infertility Services?

ICE detention standards are silent on the provision of infertility services. CRS confirmed with ICE that it does not "generally provide infertility services."[119]

Oversight Data and Management of Detainee Complaints, 20-596, August 2020.)

[116] For example, see DHS OIG, *Concerns about ICE Detainee Treatment and Care at Detention Facilities*, OIG-18-32, December 11, 2017; 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, *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California*, OIG-18-87, September 27, 2018; DHS OIG, *Concerns about ICE Detainee Treatment and Care at Four Detention Facilities*, OIG-19-57, June 3, 2019; DHS OIG, *Capping Report: Observations of Unannounced Inspections of ICE Facilities in 2019*, OIG-20-45, July 1, 2020; U.S. GAO, *Immigrant Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care*, GAO-16-321, February 2016; GAO *Immigrant Detention: Care of Pregnant Women in DHS Facilities*, GAO-20-330, March 2020; GAO, *Immigrant Detention: ICE Should Enhance Its Use of Facility Oversight Data and Management of Detainee Complaints*, GAO-20-956, August 2020.

[117] 2011 PBDNS, "4.4 Medical Care (Women)" and 2019 NDS "4.3 Medical Care."

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

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

Does ICE Provide Maternity Services?

ICE provides maternity services to detainees. ICE considers pregnant detainees one of its vulnerable populations. According to ICE guidance, "pregnant detainees shall have access to prenatal and specialized care, and comprehensive counseling on topics including, but not limited to, nutrition, exercise, complications of pregnancy, prenatal vitamins, labor and delivery, postpartum care, lactation, family planning, abortion services and parenting skills."[120] In addition, ICE accommodates a pregnant individual's special needs, such as an additional pillow or a special diet, as identified by a medical professional. Finally, if a health care practitioner identifies pregnant detainees as being high risk, they "shall be referred to a physician specializing in high risk pregnancies."[121]

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

All detainees are to be provided "comprehensive, routine and preventive health care, as medically indicated."[122] 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."[123] Similarly, the 2019 NDS guidance states that "all detainees shall have access to appropriate medical, dental, and mental health care, including emergency services."[124]

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

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

- "pregnancy testing for detainees aged 18-56 and documented results;
- if the detainee is currently nursing (breastfeeding);
- use of contraception;
- reproductive history (number of pregnancies, number of live births, number of spontaneous/elective abortions, pregnancy complications, etc.);
- menstrual cycle;
- history of breast and gynecological problems;
- family history of breast and gynecological problems; and
- any history of physical or sexual victimization and when the incident occurred."[125]

Although ICE detention standards are silent on men's reproductive health screening and preventive services specifically, according to correspondence with CRS, "ICE offers routine age- and gender-appropriate preventive health services and examinations for all male and female

[120] 2011 PBDNS, "4.4 Medical Care (Women)" and 2019 NDS "4.3 Medical Care."

[121] Ibid.

[122] 2011 PBDNS, "4.3 Medical Care" and 2019 NDS "4.3 Medical Care."

[123] 2011 PBDNS, "4.3 Medical Care."

[124] 2019 NDS "4.3 Medical Care."

[125] 2011 PBDNS, "4.4 Medical Care (Women)" and 2019 NDS "4.3 Medical Care."

detainees annually. Testing for STIs is available upon detainee request and as clinically indicated."[126]

Does ICE Provide Gender-Affirming Services?

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

Per the 2011 PBNDS guidance, transgender detainees have access to the hormone therapy they were receiving prior to being detained. Furthermore, "all transgender detainees shall have access to mental health care, and other transgender-related health care and medication based on medical need."[127] The guidance also states that their "treatment shall follow accepted guidelines regarding medically necessary transition-related care," though it does not reference specific guidelines.

The 2019 NDS guidance states that the detention facility and ICE/ERO should coordinate care "based on [the] medical needs" of self-identified transgender detainees.[128]

Indian Health Service (IHS)

IHS provides health care directly or provides funds for Indian tribes or tribal organizations to operate health care facilities.[129] It provides services free of charge to approximately 2.7 million eligible American Indians and Alaska Natives in 37 states.[130] IHS does not have a standard medical benefit that includes or excludes certain services.[131] The agency generally focuses on primary and preventive services and does so through a network of more than 600 facilities, which include hospitals (46), health centers (370), and small health stations (104). Other facility types include school health centers, youth regional treatment centers, and Alaska village clinics.[132]

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,

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

[127] 2011 PBDNS, "4.3 Medical Care"

[128] 2019 NDS, "4.3 Medical Care."

[129] 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*.

[130] U.S. Department of Health and Human Services (HHS), IHS, *Fiscal Year 2023 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf.

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

[132] U.S. Department of Health and Human Services (HHS), IHS, *Fiscal Year 2023 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf, p. 275.

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 program (PRC),[133] which enables the agency to pay for outside services. PRC funds are limited and may not be available later in any given fiscal year. IHS reports that it denied or deferred 169,953 services in FY2021 because of these funding limitations.[134] Moreover, only a subset of the IHS population is eligible for PRC, as eligibility is restricted to IHS-eligible individuals who live in certain geographic areas. PRC funds are authorized only for services in instances when the PRC-eligible individual does not have an alternate resource (e.g., Medicaid).

PRC will pay for services, to the extent that funds are available, based on medical priorities ranging from priority one (services necessary to save life, limb, or sense, which are almost always paid) to priority five (services considered elective or experimental).[135] Reproductive health services are generally included in levels one and two. Priority level one includes services that are emergency and acute, including maternity services such as delivery and acute prenatal care. Routine prenatal care and screening services, such as mammograms or HIV testing, are included in priority level two, which encompasses preventive care services. IVF and gender-affirming surgery are listed as examples of priority level five—excluded services that are not paid for by PRC. PRC programs are managed locally, and these local programs determine what priority level will be paid and may add or remove services within specific priority levels. In FY2021, IHS-operated PRC programs were able to pay for priority level one and 94% of priority level two services.[136]

Does IHS Provide Contraceptives?

As mentioned, 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.[137] 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.[138] This issue was resolved in October 2015, when IHS amended its

[133] HHS, IHS, "Purchased Referred Care," https://www.ihs.gov/prc/. In FY2022, the program received an appropriation of $984.8 million in P.L. 117-103.

[134] HHS, IHS, *Fiscal Year 2023 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf, p. 127.

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

[136] HHS, IHS, *Fiscal Year 2023 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf, pp. 127- 128.

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

[138] See, for example, Mary Annette Pember, "Emergency Contraception Finally Available Through All IHS Facilities," *Indian Country*, October 19, 2015, http://indiancountrytodaymedianetwork.com/2015/10/19/emergency-contraception-

internal policies to make EC available without a provider visit or a requirement that patients register with the facility.[139]

IHS does provide sterilization services if requested, but it must follow HHS procedures when doing so.[140] 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.[141]

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.[142] 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.[143] In addition, IHS will provide health services necessary to terminate an ectopic pregnancy[144]—a pregnancy that occurs outside the womb (uterus)—which is life-threatening to the mother.[145]

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

Does IHS Provide Infertility Services?

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

> [t]he 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.[146]

finally-available-through-all-ihs-facilities-162134.

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

[140] 42 C.F.R. 50. 205 (b).

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

[142] 25 U.S.C. §1676.

[143] HHS, IHS, Indian Health Manual: Part 1- General, Chapter 13-Maternal and Child Health" https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p3c13#3-13.14.

[144] Ibid.

[145] National Institutes of Health, National Library of Medicine, MedlinePlus Medical Encyclopedia, http://www.nlm.nih.gov/medlineplus/encyclopedia.html.

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

IHS is limited in terms of payments for infertility services under PRC. As noted, IHS specifically includes IVF under priority group five, which is an excluded service.[147]

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 46 hospitals that offer inpatient care;[148] 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 FY2023 budget request to attempt to address high levels of maternal mortality among its service population.[149]

IHS facilities that have access to obstetric services provide more comprehensive maternity services. In instances where these services are not available at the facility, PRC will pay for deliveries and acute prenatal care as a priority level one (emergency) service. Routine prenatal care is considered a priority level two service. Such care is generally paid for, but it may be subject to available funding.[150]

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

As noted above, the services available at IHS facilities vary, but some facilities may provide reproductive screening, preventive services, and treatment for conditions identified within the facility. Preventive screenings, such as mammography, may be paid for under PRC and are considered to be priority level two (preventive services); however, treatment for an acute or emergent condition (which may be identified during a screening) would be considered priority level one.[151] IHS also funds or operates programs to screen individuals at risk of HIV/AIDS and to provide treatment services as necessary.[152] 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.[153] In 2019, President Trump announced the Ending the HIV Epidemic initiative for FY2020.[154] IHS requested funds to continue work on this initiative in FY2023.[155] IHS was included as part of the initiative because, between 2011 and 2016, rates of HIV diagnosis

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

[148] HHS, IHS, *Fiscal Year 2023 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf, p. 275.

[149] Ibid., p. 272.

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

[151] Ibid.

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

[153] Ibid.

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

[155] HHS, IHS, *Fiscal Year 2023 Indian Health Service Justification of Estimates*, https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023BudgetJustificaton.pdf, p. 38.

increased by 38% among the American Indian/Alaska Native population.[156] As part of this initiative, IHS added PrEP (i.e., Truvada) to its formulary and is focusing on increasing HIV testing and linkages to care. IHS continues to work with its pharmacies to ensure access to PrEP.[157]

Does IHS Provide Gender-Affirming Services?

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

The U.S. Coast Guard (USCG)

The U.S. Coast Guard (USCG) delivers certain health benefits under Title 14, Chapter 5, and Title 10, Chapter 55, of the *U.S. Code* to members of the uniformed services, retirees, and their families.[158] USCG delivers a limited range of outpatient medical and dental care in fixed outpatient health care facilities, ships, and certain deployed environments. Typical health care services offered include primary care; occupational health; flight medicine; optometry; mental health; physical therapy; dentistry; and basic laboratory, radiology, and pharmacy services. Patients with medical needs exceeding a USCG clinic's capabilities may be referred or medically evacuated to a DOD MTF or civilian medical facility participating in TRICARE.[159] USCG clinics typically offer limited outpatient medical and dental care only.

Does USCG Provide Reproductive Health Services?

USCG clinics offer limited reproductive health services, often provided by primary care providers.[160] USCG clinics may refer beneficiaries to DOD MTFs (preferable option) or to a TRICARE provider (secondary option) for comprehensive reproductive health services.[161]

Does USCG Provide Contraceptive Services?

USCG clinics offer limited contraceptive services, including family planning counseling and contraception prescriptions.[162] Contraceptive services not available in USCG clinics may be

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[156] NCHHSTP, CDC, *HIV and American Indians and Alaska Natives*, Atlanta, GA, March 2018, https://www.cdc.gov/hiv/pdf/group/racialethnic/aian/cdc-hiv-natives.pdf, and IHS, "HIV in Indian Country," https://www.ihs.gov/newsroom/factsheets/hiv-in-indian-country/.

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

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

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

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

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

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

accessed through the TRICARE program. Services available through USCG or through TRICARE include the following:

- Short-Acting Reversible Contraceptives (SARCs): oral contraceptive, patch, vaginal ring, injection.
- Long-Acting Reversible Contraceptives (LARCs): IUD, implantable rod.
- Barriers: diaphragm, cervical cap, sponge, male/female condom.
- Sterilization: male/female surgical sterilization, permanent implant.
- Emergency Contraceptives (ECs): *Plan B One Step*/ *Next Choice One Dose*, *Ella*.[163]

Section 718 of the FY2016 NDAA (P.L. 114-92) requires the Secretary of Defense to make annual (as well as pre- and intra-deployment) contraceptive counseling available to female members of the Armed Forces (including USCG) through the TRICARE program. DOD policy also requires USCG to offer contraceptive counseling during the annual periodic health assessment and during accession training (i.e., boot camp or officer candidate school).[164]

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 DPP.[165] In-theater military health care providers are authorized to issue new or renewal prescriptions that would be filled through the DPP.

Does USCG Provide Abortions or Abortion Counseling?

USCG policy prohibits the use of government funds to provide or pay for abortion services, except where the life of the mother would be endangered if the pregnancy were carried to term, or in a case in which the pregnancy is the result of an act of rape or incest.[166] USCG clinics are authorized to provide counseling related to covered abortions.[167]

Similarly, Title 10, Section 1093, of the *U.S. Code* prohibits TRICARE from directly providing or paying for abortion services, except where the life of the mother would be endangered if the pregnancy were carried to term, or in a case in which the pregnancy is the result of an act of rape or incest. TRICARE may offer or pay only for health care services related to a covered abortion. Abortion counseling, referral, preparation, or follow-up care for noncovered abortions is not available in MTFs or paid for by TRICARE.[168]

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

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

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

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

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

[168] See Chapter 4, Section 18.3 of the TRICARE Policy Manual 6010.60-M, April 1, 2015.

Does USCG Provide Infertility Services?

Certain USCG clinics offer initial infertility evaluations only.[169] Other infertility services, such as ART for certain servicemembers, are available at DOD MTFs or from civilian health care providers participating in TRICARE.[170]

Does USCG Provide Maternity Services?

Certain USCG clinics offer outpatient maternity services, including prenatal care and maternal-fetal medicine.[171] Other maternity services are available at DOD MTFs or from civilian health care providers participating in TRICARE.[172]

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

USCG clinics offer limited reproductive health screening and preventive services, including well-woman exams, as well as counseling and testing for STIs and cancer of the breast, cervix, testicles, or prostate.[173] Comprehensive reproductive health services and related treatment are available at DOD MTFs or from civilian health care providers participating in TRICARE.[174]

Does USCG Provide Gender-Affirming Services?

Certain USCG clinics offer medically necessary nonsurgical treatment (i.e., hormone therapy, pubertal suppression, or psychotherapy) for gender dysphoria.[175] USCG servicemembers diagnosed with gender dysphoria may access surgical treatment based on DOD policies and processes for considering and approving SRS.

Department of Veterans Affairs (VA)

The VA provides health care services through the Veterans Health Administration (VHA) for approximately 9.3 million enrolled veterans[176] at 1,456 VA sites of care.[177] The VHA is primarily

[169] Ibid.

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

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

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

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

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

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

[176] Department of Veterans Affairs (VA), *FY2021 Congressional Submission, Medical Programs and Information Technology Programs*, vol. 2 of 4, February 2020, p. VHA-19.

[177] VA, *FY2021 Congressional Submission, Budget in Brief*, February 2020, p. BiB-11. Sites of care used in this calculation are VA hospitals, community living centers, health care centers, community-based outpatient clinics (CBOCs), other outpatient service sites, and dialysis centers.

a direct provider of care; it owns the facilities and employs the clinicians. However, under certain circumstances, the VA will pay for a veteran to receive care in the community.[178]

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.[179] 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.[180]

Does the VA Provide Reproductive Health Services?

The VA standard medical benefits package includes reproductive health services, such as routine physical exams, cervical and prostate cancer screening, evaluation and treatment of vaginal infections, pelvic pain and abnormal uterine bleeding, treatment of erectile dysfunction, reproductive mental health, and STI screening, among other services, to eligible veterans who are enrolled in the VA's health care system.[181]

Does the VA Provide Contraceptive Services?

The VA provides both contraception counseling and contraceptives as part of the standard medical benefits package. The VA uses a national formulary for medications.[182] The formulary includes oral contraceptives, IUDs, and implants.[183] 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.[184]

The 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.[185]

The 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

[178] 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.

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

[180] 38 C.F.R. §17.38.

[181] VA, Veterans Health Administration (VHA), Women's Health Services, *State of Reproductive Health In Women Veterans-VA Reproductive Health Diagnoses and Organization of Care*, February 2014, p. 30.

[182] VA, VHA, *VHA Formulary Management Process*, VHA Directive 1108.08(1), November 2016.

[183] VA, "Pharmacy Benefits Management Services, VA Formulary Search," https://www.pbm.va.gov/apps/VANationalFormulary/.

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

[185] VA, VHA, *Healthcare Services for Women Veterans*, VHA Handbook 1330.01(3), February 2017.

procedure, and the availability of reversible, highly effective contraceptives (e.g., IUD and subcutaneous contraceptive implants).[186]

Does the VA Provide Abortions or Abortion Counseling?

Under current regulations, the VA does not provide abortions, abortion counseling, or medication to induce an abortion (e.g., mifepristone, also known as RU-486).[187]

Does the VA Provide Infertility Services?

The VA does provide certain infertility services to veterans. Covered infertility services for both female and male veterans are listed in **Table 3**. These covered services are provided to all enrolled veterans without exception. The VA is not authorized to provide or cover the cost of IVF or other ART. A narrow exception to this policy allows the 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.[188] This exception is authorized on an annual basis through appropriations acts.[189] 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,[190] along with guidance issued by DOD. The VA is exempt from DOD requirements applicable to the duration of embryo cryopreservation and storage.[191] Namely, the VA may provide cryopreservation and storage for an unlimited amount of time.[192] The VA is not authorized to cover gestational surrogacy treatment or costs associated with sperm or oocyte donation.[193]

Table 3. Infertility Services Offered by the VA

Diagnosis and Treatment for Female Veterans	Diagnosis and Treatment for Male Veterans
Diagnostic Tests:	Diagnostic Tests:

[186] VA, VHA, *Infertility Evaluation and Treatment*, VHA Directive 1332, June 2017.

[187] 38 C.F.R. §17.38; and VA, VHA, *Health Care Services for Women Veterans*, VHA Directive 1330.01(2), February 15, 2017. Medically necessary procedures for the management of a miscarriage are provided under the medical benefits package.

[188] 38 C.F.R. §17.380.

[189] This policy has been authorized in appropriations acts since FY2017. Section 260 of the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and the Zika Response and Preparedness Act (P.L. 114-223) permitted the VA to use funds from the Medical Services account for this purpose for FY2017. Section 236 of Division J of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018 (P.L. 115-141) continued this policy for FY2018 and FY2019. Section 235 of the Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations Act, 2019 (P.L. 115-244) continued this policy for FY2019 and FY2020. Section 235 of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2020 (Division F of the Further Consolidated Appropriations Act, 2020; P.L. 116-94) allows the VHA to use FY2020 appropriations and FY2021 advance appropriations to continue providing IVF services to certain veterans and their spouses; Section 234 of Division J of the Consolidated Appropriations Act, 2021 (P.L. 116-260) continued allowing the use of FY2021 appropriations and FY2022 advance appropriations for this purpose. Section 234 of Division J of the Consolidated Appropriations Act, 2022 (P.L. 117-103), continued allowing the use of FY2022 appropriations and FY2023 advance appropriations for this purpose.

[190] 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.

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

[192] 38 C.F.R. §17.380(b).

[193] VA, VHA, *Infertility Evaluation and Treatment*, VHA Directive 1332(2), June 2017.

Diagnosis and Treatment for Female Veterans	Diagnosis and Treatment for Male Veterans
• Laboratory blood testing: follicle stimulating hormone (FSH); thyroid stimulating hormone (TSH) • Genetic counseling and testing • Pelvic and/or transvaginal ultrasound • Hysterosalpingogram • Saline-infused sonohysterogram	• Laboratory blood testing: serum testosterone, FSH, luteinizing hormone (LH), estradiol • Semen analysis • Genetic counseling and testing • Transrectal and/or scrotal ultrasonography • Postejaculatory urinalysis
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	Treatments: • Evaluation and treatment of erectile dysfunction • Surgical correction of structural pathology • Vasectomy reversal • Hormonal therapies (e.g., clomiphene citrate, human chorionic gonadotropin, phosphodiesterase type 5 medications, testosterone) • Sperm retrieval techniques • Sperm cryopreservation for medically indicated conditions • Ejaculation techniques (e.g., electroejaculation, vibratory stimulation)

Source: Prepared by CRS based on U.S. Department of Veterans Affairs, Veterans Health Administration, *Infertility Evaluation and Treatment*, VHA Directive 1332(2), June 2017.

Notes: This table, including terminology, is adapted directly from VHA Directive 1332(2). The use of gender-specific terminology to refer to available infertility services corresponds to how the services are represented in the directive.

Does the VA Provide Maternity Services?

The VA currently provides and pays for a limited number of maternity and newborn health care services to eligible veterans and their family members.[194] Veterans can access maternity care as soon as their pregnancies are confirmed. However, VA medical facilities do not operate full-service birthing centers with medical units such as maternity wards, newborn nurseries, and neonatal intensive care units. The VA does not have specialized health care providers or functioning birth-related medical units in VA medical facilities to deliver babies on a continual basis.[195] Veterans must therefore deliver babies at non-VA medical facilities, such as DOD medical facilities and community hospitals. The VA may perform emergency childbirth deliveries.

The 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.[196]

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

[195] VA, VHA, Women's Health Services, *State of Reproductive Health In Women Veterans-VA Reproductive Health Diagnoses and Organization of Care*, February 2014, p. 39.

[196] 38 U.S.C. §1786.

Does the VA Provide Reproductive Health Screening, Prevention, and Treatment Services?

The VA provides reproductive health screening and preventive services as part of the standard medical benefits package. Preventive screenings, such as mammography, are offered as part of routine health care. The VA also operates a national HIV program with policies for screening, prevention, and treatment.[197] 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. The 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, the 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), the 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.[198]

Does the VA Provide Gender-Affirming Services?

Under current regulations, the VA is prohibited from providing gender-confirming/affirming surgeries.[199] The VA provides other gender-affirming services as part of the standard medical benefits package, such as hormonal therapy, mental health care, and preoperative evaluation. In addition, the VA provides medically necessary postoperative and long-term care following gender-confirming surgeries if an appropriate health care professional determines that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.[200]

Federal Health Insurance Programs

The Social Security Act (SSA) defines a federal health care program as any plan or program that provides health benefits—whether directly, through insurance, or otherwise—and is funded directly, in whole, or in part by the U.S. government (with the exception of the Federal Employees Health Benefits Program) or one of four specified state health care programs.[201] Medicaid, the federal-state program for certain low-income individuals, and Medicare, the national health insurance program that pays for covered services furnished to beneficiaries (generally the elderly and disabled) are among the key federal health programs. The questions

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

[198] 38 C.F.R. §17.38(b).

[199] 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.

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

[201] Social Security Act (SSA) §1128B(f) [42 U.S.C. §1320a–7b]. The four state health care programs are Medicaid (SSA title XIX), Maternal and Child Health Services Block Grand (SSA title V), Block Grants and Programs for Social Services (SSA title XX).

below discuss how these federal health care programs provide, establish coverage, and pay for reproductive health services for their beneficiaries.

Medicaid

Medicaid, authorized in SSA Title XIX, is a federal-state program that jointly finances primary and acute medical services, as well as long-term services and supports (LTSS) to a diverse low-income population, including eligible children, pregnant women, adults, individuals with disabilities, and people aged 65 and older.[202] Participation in Medicaid is voluntary for states; all states, the District of Columbia, and U.S. territories choose to participate.

Medicaid is jointly financed by states and the federal government. States must follow federal rules to receive federal matching funds, but states have the flexibility to design their own versions of Medicaid within the federal statute's framework. This flexibility results in variability across state Medicaid programs in terms of eligibility and covered benefits, among other criteria. In FY2019, Medicaid provided health care services to an estimated 75 million individuals[203] at a total cost of $627 billion (including federal and state expenditures).[204]

Medicaid provides a health care safety net for low-income populations, playing a more significant role for certain subpopulations.[205] For example, in 2019 approximately 20% of the U.S. population received Medicaid coverage.[206] In that same year, Medicaid provided health coverage for 58% of all nonelderly individuals with incomes below 100% of the federal poverty level (FPL).[207]

For some types of services (including reproductive health services), Medicaid is a significant payer. For instance, Medicaid paid for 42% of all births in the United States in 2019[208] and provided 75% of all public expenditures on family planning services in FY2015.[209]

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

[203] This enrollment figure is measured according to person-year equivalents, which represent the average program enrollment over the course of a year and differ from ever-enrolled counts, which measure the number of people covered by Medicaid for any period of time during the year. (Christopher J. Truffer, Kathryn E. Rennie, Lindsey Wilson, et al., *2018 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, Centers for Medicare & Medicaid Services [CMS], HHS, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport.)

[204] CMS, Form CMS-64 data as of September 15, 2020, at https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

[205] 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.

[206] U.S. Census Bureau, American Community Survey Tables for Health Insurance Coverage, Table HI-05, *Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2019*, at https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.

[207] Henry J. Kaiser Family Foundation, *Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL), as of 2019*, State Health Facts, accessed November 4, 2020, at https://www.officeforado.org/other/state-indicator/nonelderly-up-to-100-fpl/.

[208] Joyce A. Martin, Brady E. Hamilton, Michelle Osterman, et al., *Births: Final Data for 2019*, National Center for Health Statistics (NCHS), National Vital Statistics Reports, vol. 70, no. 2, Hyattsville, MD, March 23, 2021, at https://dx.doi.org/10.15620/cdc:100472.

[209] 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.

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).[210] 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 woman who are entitled to limited pregnancy-related services, and women needing treatment for breast or cervical cancer). In addition, states can use waiver authority[211] 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[212] for all categorically needy individuals.[213] In addition, states may provide optional services—that is, services that states can choose whether to provide under their state plans.[214] Examples of *mandatory service categories* likely to include reproductive health services are inpatient hospital services; physician services; family planning services; and early and periodic screening, diagnosis, and treatment (EPSDT) for persons under age 21 (this benefit is described in more detail below). Examples of *optional service categories* likely to encompass reproductive health services include clinic services; prescription drugs; and other diagnostic, screening, preventive, and rehabilitative services.

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

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[210] SSA §1937 [42 U.S.C. §1396u-7].

[211] 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).

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

[213] *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.

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

Within the general Medicaid service categories listed in statute, states define the specific features of each covered benefit within four broad federal guidelines.[215] 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,
- breast feeding 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,[216] 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.[217]

[215] 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.

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

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

Alternative Benefit Plans (ABPs)

As an alternative to providing the mandatory and selected optional benefits 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).[218]

Under ABPs, states must provide comprehensive benefit coverage that is based on one of three commercial insurance products: (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; (3) the health benefits plan offered to state employees). A fourth, "Secretary-approved," coverage option is available instead of a list of discrete items and services, as required under traditional Medicaid.[219]

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[220] and family planning services and supplies for individuals of childbearing age.[221] Finally, states are generally permitted to offer additional benefits beyond those required by law.

Unlike traditional Medicaid benefit coverage, ABPs must cover at least the 10 categories of health care services—known as the essential health benefits (EHBs)—as defined in ACA Section 1302(b).[222] However, as with traditional Medicaid, states generally specify the amount, duration, and scope of benefit coverage within these broad categories in the Medicaid state plan.

Certain EHB categories are particularly relevant to coverage of reproductive health services. For example, under the "maternity and newborn care" category, states are required to cover prenatal care, labor and delivery, and postpartum care services. Under the "preventive and wellness services and chronic disease management" EHB category, states are required to cover specified preventive services without beneficiary cost sharing.[223] (Information on Medicaid coverage of specific types of reproductive health services appears below.)

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

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

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

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

[222] 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 Insurance Coverage of 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.

[223] 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,

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.[224] States can even design different ABPs for different beneficiary subgroups.

Comparing Medicaid Traditional Benefit Coverage of Reproductive Health Services to ABPs

It is difficult to compare the ways in which coverage of reproductive health under traditional Medicaid benefits are similar to and different from ABP benefits. Although both coverage types offer many of the same benefits, the scope of coverage under each type may vary from state to state. This variability largely reflects the choices permitted by federal law in defining the amount, duration, and scope of benefits offered under the state plan. (The sections below, where possible, highlight key differences in the federal requirements regarding the scope of traditional Medicaid benefits and ABP benefits.) For example, while both coverage types require states to cover family planning services, under traditional Medicaid, states generally have the discretion to identify the specific services they will cover. By contrast, under ABPs, states are required to provide all of the FDA-approved contraceptive methods (see text box in "What Are Contraceptive Services?"), as prescribed, to meet the EHB preventive services requirement.[225] (For more information, see the "Does Medicaid Cover Contraceptive Services?" section of this report.)

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

In addition, states are permitted to rely on different statutory authorities to direct federal Medicaid funds to pay for certain services. In the case of doula services, for example, Minnesota covers doulas under Medicaid's traditional mandatory pregnancy-related services category, while Oregon covers them under Medicaid's traditional optional preventive services category.[226] Nebraska, by contrast, covers doula services for certain enrollees as a value-added service (i.e., services that are not a plan benefit but are included as a part of a benefit package as an incentive

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Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule," *Federal Register* 901, 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/preventive-care-benefits/.

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

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

[226] A doula is a trained nonmedical professional whose job it is to provide physical, emotional and informational support to a mother before, during and after childbirth. See DONA International, "What is a Doula," https://www.dona.org/what-is-a-doula/.

for enrollment in the managed-care plan)[227] under one of the state's managed-care contracts.[228] 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.[229] Medicaid beneficiaries access reproductive health services in various types of facilities, including freestanding birth centers, federally qualified health centers, family planning clinics, health departments, certain school-based health centers, and other clinics.[230]

In general, under Medicaid's "freedom of choice of provider" requirement, states must permit enrollees to receive services from any willing Medicaid-participating provider,[231] and states cannot exclude providers solely on the basis of the range of services they provide.[232] However, this federal requirement is currently being challenged in the courts.[233] Medicaid managed-care enrollees may be restricted to providers in a given managed-care plan network,[234] except in the case of family planning services.[235] Medicaid enrollees (regardless of whether they receive services through the managed care delivery system or not) may obtain family planning services

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[227] Taylor Platt and Neva Kaye, *Four State Strategies to Employ Doulas to Improve Maternal Health and Birth Outcomes in Medicaid*, National Academy for State Health Policy (NASHP), July 30, 2020, at https://www.nashp.org/four-state-strategies-to-employ-doulas-to-improve-maternal-health-and-birth-outcomes-in-medicaid/#toggle-id-1.

[228] Under managed care, Medicaid enrollees get most or all of their services through a managed-care organization under contract with the state.

[229] 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.

[230] A 2013 survey found that, among Medicaid-enrolled women aged 15-44 who had their most recent gynecological exam in the past three years, 57% received the service in a private physician's office or health maintenance organization setting; 13%, in a community health center or public clinic; 5%, in a family planning or Planned Parenthood clinic; and 5%, in a school or college-based or urgent care/walk-in facility. The rest received the gynecological exam in other places or did not answer the question. See Alina Salganicoff, Usha Ranji, Adara Beamesderfer, et al., *Women and Health Care in the Early Years of the ACA: Key Findings from the 2013 Kaiser Women's Health Survey*, Kaiser Family Foundation, Washington, DC, May 2014, at https://www.kff.org/wp-content/uploads/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf. See also Kaiser Family Foundation, *Women's Sexual and Reproductive Health Services: Key Findings from the 2017 Kaiser Women's Health Survey*, March 2018, at https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2017-kaiser-womens-health-survey/.

[231] 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.

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

[233] SCOTUSblog, Pending Petition in *Kerr v. Planned Parenthood South Atlantic*, at https://www.scotusblog.com/case-files/cases/kerr-v-planned-parenthood-south-atlantic.

[234] 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.

[235] 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.

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.[236]

Does Medicaid Cover Contraceptive Services?

States are required[237] to provide family planning services and supplies to prevent or delay pregnancy under both traditional and ABP benefit coverage for most individuals[238] of childbearing age (including minors) who desire such services and supplies.[239] 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.[240] Family planning services and supplies must be available to Medicaid enrollees without undue burden, coercion, or mental pressure.[241] 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.[242] States may pay for sterilization services only if certain specified conditions are met.[243] In addition, Medicaid beneficiaries must be free to choose the provider of their choice and the method of family planning to be used.[244]

Although the term "family planning services" is not defined in Medicaid statute or program regulations, the Medicaid program distinguishes between items and procedures for *family planning purposes* (i.e., contraceptive care) and *family planning-related services* (i.e., services provided in a family planning setting as part of or as follow-up to a family planning visit) to determine the federal reimbursement rate (i.e., the federal medical assistance percentage [FMAP] rate) available to states for these services.[245] Specifically, states may receive a 90% FMAP rate for

[236] 42 C.F.R. §431.51.

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

[238] 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.

[239] 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.

[240] 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).

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

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

[243] 42 C.F.R. §§441.253-441.256.

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

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

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),[246] and for related administrative costs.[247] By contrast, family planning-related services are reimbursable at the state's regular FMAP rate.[248] 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.[249] (Family planning-related services are discussed in more detail in the "Does Medicaid Cover Reproductive Health Screening and Preventive Services?" section of this report.)

The specific benefits that states offer under the family planning service category vary. For Medicaid enrollees who receive traditional state plan coverage, states may identify the specific services and supplies they cover (including EC),[250] 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,[251] and beneficiaries are permitted to choose which family planning method to use). States generally cover a broad range of medically approved methods, procedures (e.g., sterilization), and devices to prevent conception under traditional Medicaid, including over-the-counter contraceptive methods (e.g., male/female condoms, spermicide, the sponge, EC) and prescription contraceptives (e.g., oral contraceptives, LARCs, patch, diaphragm, injectable, IUDs).[252]

Prescription drugs are considered an optional Medicaid service, but all states cover them. 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.[253] States are permitted to rely on

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[246] 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.

[247] 42 C.F.R. §433.15(b)(2).

[248] For FY2022, states' regular FMAP rates range from 50.00% to 78.31%, depending on the state's per capita income. 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)*.

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

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

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

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

[253] Drug manufacturers enter into national rebate agreements with the HHS Secretary under the Medicaid Drug Rebate Program. The program requires a drug manufacturer to enter into, and have in effect, a national rebate agreement with the HHS Secretary to rebate a portion of the Medicaid payment for the drug to the states based on a statutory formula. States then share the rebate they receive from pharmaceutical manufacturers with the federal government as a way to

utilization controls, such as preferred drug lists and prior authorization, to encourage providers to prescribe certain drugs over others. However, in general, Medicaid covers most FDA-approved drugs produced by manufacturers that enter into rebate agreements with HHS, which results in enrollee access to a wide range of prescription drugs.[254]

For Medicaid enrollees who receive ABP coverage, states must cover family planning services and supplies that meet 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 text box in "What Are Contraceptive Services?"),[255] and all of the services recommended by the USPSTF (e.g., counseling on STIs and HIV and screening for breast and cervical cancers). (See the USPSTF text box in the "What Are Reproductive Health Prevention and Treatment Services?" section)[256] In addition, states may provide targeted family planning services under Medicaid for populations who are not otherwise eligible for traditional Medicaid (e.g., nonpregnant, nondisabled childless adults) through special waivers of federal law (i.e., Section 1115 family planning waivers).[257] States have discretion to determine the populations and benefits covered under Section 1115 family planning waivers. However, such coverage is time-limited and must be budget-neutral to the federal government, whereby the estimated federal spending under the waiver cannot exceed the estimated federal cost of the state's Medicaid program without the waiver.

The ACA established an optional Medicaid eligibility group for family planning services so that states no longer have to rely on time-limited waiver authority to extend limited benefit coverage for family planning services and supplies to targeted eligibility groups (including groups who were not traditionally eligible for Medicaid).[258] 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.[259]

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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*.

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

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

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

[257] 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 September 1, 2020, nine states have CMS approval for Medicaid Section 1115 family planning waivers. For more information, see, Kaiser Family Foundation, 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/.

[258] As of September 1, 2021, 17 states have CMS approval for Medicaid family planning state plan amendments. For more information, see Kaiser Family Foundation, 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/.

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

Benefits for this eligibility group are limited to family planning services and supplies and related medical diagnosis and treatment services.[260] 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 EHB preventive service requirements that establish a federal coverage floor of FDA-approved contraceptives (see (see text box in "What Are Contraceptive Services?") and the USPSTF services.[261] Under the other coverage types, states have more discretion when defining covered benefits. The multiple eligibility pathways and related service coverage options make it difficult to assess the relative richness of the benefit coverage within and across states. However, findings from a 2021 50-state survey of Medicaid fee-for-service (FFS) coverage of select family planning services highlight the mandatory nature of various types of contraceptive coverage under ABPs, as well as state choices in offering different types of contraception under the other coverage types. The survey also captures differences across coverage types in terms of utilization controls (e.g., whether prescription required, brand/type restrictions, quantity or frequency limits, medical necessity requirements), which states use to control costs or otherwise influence how beneficiaries use the benefit.[262]

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.)[263] The Hyde Amendment does not

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

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

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

[263] In FY2016, states claimed federal financial participation (FFP) for 69 abortions: 34 were due to endangerment to the life of the mother, 33 were due to rape, and 2 were due to incest. HHS, Office of the Assistant Secretary for Financial Resources, *FY 2018 Moyer Material*, June 21, 2017, Addendum: Abortion-Related Reporting. GAO has since noted problems with the accuracy of the above-mentioned HHS report (i.e., *FY 2018 Moyer Material*). According to GAO, some states reported their Medicaid abortions inaccurately and the HHS report lacked data on abortions paid through managed care organizations. GAO conducted its own survey of state Medicaid officials and identified nearly 5,000 abortions for which states claimed federal funding from FY2013 through FY2016. GAO noted that its own count was also incomplete because some states were unable to provide complete, or any, information on Medicaid abortions eligible for federal funding. For more state-reported information on Medicaid coverage of abortions, see GAO, *Medicaid: CMS Action Needed to Ensure Compliance with Abortion Coverage Requirement*, GAO-19-159, January

restrict federal funding for the cost of treating a physical disorder, injury, or illness, including a physician-certified, life-endangering condition that is caused by or arises from pregnancy. Moreover, Medicaid program regulations permit federal reimbursement for the termination of ectopic pregnancies, which are nonviable and endanger the life of the mother.[264] As of June 1, 2022, 16 state Medicaid programs fund all or most "medically necessary" abortions. Seven states do so voluntarily, and nine states do so pursuant to a court order.[265] It remains to be seen what effects the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*[266] will have on coverage of abortions under the Medicaid program, especially in jurisdictions where state laws are in effect that may prohibit Medicaid beneficiaries from obtaining an abortion in cases that would otherwise be permissible for Medicaid to cover.

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).[267] Some states rely on state-only funds to pay for abortions that do not meet the Hyde amendment exceptions.[268]

Through program regulations,[269] 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.[270]

Does Medicaid Cover Infertility Services?

States are permitted to cover fertility diagnosis services (e.g., lab tests, semen analysis, and imaging studies) and infertility treatment services (e.g., medications, surgeries, ARTs such as IUI or IVF) at state option under all coverage types (i.e., traditional Medicaid, ABPs, Section 1115 Medicaid family planning waivers, and the optional ACA family planning eligibility group).[271]

2019, at https://www.gao.gov/assets/700/696338.pdf.

[264] 42 C.F.R. §441.207.

[265] For more information, see Guttmacher Institute, State Laws and Policies, State Funding of Abortion Under Medicaid, at https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid.

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

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

[268] Although FFP is forbidden for most abortions, 16 state Medicaid programs fund all or most "medically necessary" abortions. Seven states do so voluntarily, and nine states do so pursuant to a court order. For more information, see Guttmacher Institute, State Laws and Policies, *State Funding of Abortion Under Medicaid*, as of December 1, 2020, at https://www.guttmacher.org/state-policy/explore/state-funding-abortion-under-medicaid.

[269] 42 C.F.R. §§441.203, 441.206 and 441.208.

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

[271] For more information of state coverage of fertility services by program type, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey*, The Henry J.

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.[272]

Some states cover treatments for conditions that may affect fertility (e.g., treatment of gynecological abnormalities, thyroid medications); five states (California, Illinois, Maryland, New York, and Wisconsin) cover fertility medications for women (e.g., human menopausal gonadotropin); two states (Illinois and Maryland) cover IUI and IVF; and one state (Illinois) covers egg freezing, as of July 1, 2021.[273]

Does Medicaid Cover Maternity Services?

Medicaid is a significant payer of maternal health services and births in the United States. According to CDC, Medicaid paid for 42% of all births in the United States in 2020.[274] In general, Medicaid benefits for pregnant women can differ by eligibility pathway across and within states.[275]

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,[276] and up to 185% of FPL at state option.[277]As of July 2021, [278] the Medicaid upper-income eligibility threshold for pregnant women ranged from 133% of FPL in four states (Idaho, Louisiana, Oklahoma, and South Dakota) to 375% of FPL (in Iowa).[279] Coverage for these

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Kaiser Family Foundation, February 17, 2022, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey/.

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

[273] For more on the range of benefits covered by states, see Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., *Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey*, The Henry J. Kaiser Family Foundation, May 2022, at https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-Related-Services-Findings-from-a-2021-State-Survey.pdf.

[274] Michelle J.K. Osterman, Brady E. Hamilton, Joyce A. Martin, et al., *Births: Final Data for 2020*, National Center for Health Statistics (NCHS), National Vital Statistics Report, vol. 70, no. 17, Hyattsville, MD, February 7, 2022, at https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-17.pdf.

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

[276] 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)].

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

[278] MACPAC, *MACStats*, EXHIBIT 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State, July 2021, at https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-35.-Medicaid-and-CHIP-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Children-and-Pregnant-Women-by-State-July-2021.pdf.

[279] 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

women may include full Medicaid benefit coverage, or states may limit services to those related to pregnancy.[280] According to the Medicaid and CHIP Payment and Access Commission (MACPAC), as of January 2019, five states (Arkansas, Idaho, New Mexico, North Carolina, and South Dakota) provided only pregnancy-related services.[281] In either case, coverage generally begins at the time of application and ends after 60 days postpartum. While states may impose cost sharing in the form of program participation fees (e.g., premiums) for pregnant women with incomes above 150% FPL, pregnant women are exempt from point-of-service cost sharing (e.g., copays, coinsurance) for pregnancy-related services, including tobacco cessation counseling.[282]

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).[283]

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. This state plan option is in effect for a five-year period that begins April 1, 2022.[284]

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

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

[281] MACPAC, *MACPAC Report to the Congress*, Chapter 5: Medicaid's Role in Maternal Health June 2020, at https://www.macpac.gov/wp-content/uploads/2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

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

[283] 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.

[284] As of May 25, 2022, 11 states (California, Florida, Illinois, Kentucky, Louisiana, Michigan, New Jersey, Oregon, South Carolina, Tennessee, and Virginia) have CMS approval to extend Medicaid and CHIP coverage from 60 days to 12 months postpartum under this temporary state plan option. For more information, see CMS Pres Release, *HHS Applauds 12-Month Postpartum Expansion in California, Florida, Kentucky, and Oregon*, May 25, 2022, at https://www.hhs.gov/about/news/2022/05/25/hhs-applauds-12-month-postpartum-expansion-in-california-florida-kentucky-and-oregon.html#:~:text=California%2C%20Florida%2C%20Kentucky%2C%20and%20Oregon%20join%20South%20Carolina%2C,days%20t

Many *qualified aliens*, such as Legal Permanent Residents who entered the United States after August 22, 1996,[285] are prohibited from receiving Medicaid for five years (often referred to as the five-year bar).[286] States are permitted to provide Medicaid coverage to certain lawfully residing pregnant women within the five-year waiting period when certain conditions are met (e.g., the state offers coverage to all such individuals who meet the definition of lawfully residing, or applicants meet state residency requirements).

For nonpregnant women who would be eligible for Medicaid but for their citizenship status, states are required to pay for services to treat an emergency medical condition under emergency Medicaid.[287] For pregnant women, emergency Medicaid includes services covered under the state plan, including routine prenatal care, labor and delivery, and routine postpartum care. States may provide additional services to treat conditions that may complicate the pregnancy or the delivery.[288]

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."[289] 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, breast feeding support and supplies, case management, postpartum home visits).[290] 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).[291] 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.[292]

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o%2012%20months%20postpartum.

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

[286] 8 U.S.C. §1613.

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

[288] 42 C.F.R. §440.255(b)(2).

[289] 42 C.F.R. §440.210(a)(2)(i).

[290] For more information on the kinds of pregnancy benefits that states offer under their Medicaid programs, Usha Ranji, Ivette Gomez, Alina Salganicoff, et al., Medicaid Coverage of Pregnancy-Related Services: Findings from a 2021 State Survey, The Henry J. Kaiser Family Foundation, May 2022, at https://files.kff.org/attachment/Report-Medicaid-Coverage-of-Pregnancy-Related-Services-Findings-from-a-2021-State-Survey.pdf. See also Becky Normile, Karen VanLandeghem, and Alex King, *Medicaid Financing of Home Visiting Services for Women, Children and Their Families*, NASHP, August 2017, at https://nashp.org/wp-content/uploads/2017/09/Home-Visiting-Brief.pdf.

[291] For more information, see CMS, *1115 Substance Use Disorder Demonstrations*, at https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/program-areas/substance-use-disorders/1115-substance-use-disorder-demonstrations/index.html.

[292] For examples of state efforts to improve maternal and child health outcomes, see MACPAC, *MACPAC Report to the Congress*, Chapter 5: Medicaid's Role in Maternal Health June 2020, at https://www.macpac.gov/wp-content/uploads/

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.)[293] Under the maternity and newborn care and preventive services EHB coverage categories, Medicaid ABPs must cover several services related to maternity care at no cost to the enrollee, including but not limited to prenatal visits, folic acid supplements, and breastfeeding support services.

Comparing Medicaid Maternity Coverage Across Coverage Types

Coverage of Medicaid maternity services can and does vary within and across states based on enrollees' eligibility pathways. According to a 2015 survey of Medicaid FFS pregnancy and perinatal benefits by coverage type (i.e., traditional Medicaid, ABP coverage, and pregnancy-only Medicaid), most states cover basic prenatal services such as ultrasounds, prenatal vitamins, prenatal genetic testing, and postpartum visits. However, coverage of maternity-related services after delivery (e.g., parenting classes, breastfeeding and lactation support services) is less 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).[294]

Does Medicaid Cover Reproductive Health Screening and Preventive Services?

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

Traditional Benefits

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

2020/06/June-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

[293] 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.

[294] For more information on Medicaid state coverage of routine prenatal services, counseling and support services, delivery and postpartum care, and breastfeeding supports by coverage type, see Kathy Gifford, Jenna Walls, Usha Ranji, et al., *Medicaid Coverage of Pregnancy and Perinatal Benefits: Results from a State Survey*, Kaiser Family Foundation, April 27, 2017, at https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/.

For 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.[295]

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 under Public Health Service Act (PHSA) Section 2713 without beneficiary cost sharing. (The EHB categories are described in the following sections of this report: "Coverage of the Essential Health Benefits (EHB)," and "Coverage of Certain Preventive Services Without Cost Sharing.") These EHB coverage requirements represent a floor for all ABP benefit coverage. Examples of ABP reproductive health screening, preventive services, and treatment for conditions identified under these screenings under this EHB coverage category include screening, counseling and treatment for STIs, universal HIV screening and treatment, breast and cervical cancer screenings and follow-up treatment, gynecological exams and Pap smears, well-woman visits, vaccines (e.g., HPV), and domestic and interpersonal violence screenings and related treatment.

Comparing Medicaid Reproductive Health Screenings and Preventive Services Across Coverage Types

Comparing reproductive health screenings and preventive services coverage across the various types of Medicaid benefit coverage (i.e., traditional Medicaid, ABP coverage, Section 1115 family planning waivers, or the optional ACA family planning eligibility group) reveals a key difference: under ABPs, states must comply with the EHB requirement for states to cover all required 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.[296]

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

[296] Key findings from a 2015 50-state survey of Medicaid FFS coverage of cervical and breast cancer screening and

Does Medicaid Cover Gender-Affirming Services?

Medicaid covers a broad range of medically necessary physical and mental health care services for transgender, nonbinary, and gender-nonconforming individuals. Like other Medicaid benefits, coverage of such services may vary state by state and within states across eligibility pathways, benefit categories, and by coverage type.[297] Examples of Medicaid-covered services for such individuals include surgical interventions, speech and language interventions, behavioral health services, hormone therapy, and hair removal. According to a recent study, 19 states and the District of Columbia require Medicaid coverage of gender-affirming care, and 2 states (Iowa and Wisconsin) have been directed by court order to cover medically necessary gender-affirming care under their Medicaid programs. The study also identified nine states as having policies in place that explicitly exclude Medicaid coverage of certain gender-affirming services.[298] Another recent study identified 18 states and the District of Columbia as including (or in the process of extending coverage) gender-affirming care.[299]

Medicare

Medicare is a federal program that pays for covered health care services for qualified beneficiaries, namely individuals 65 and older and permanently disabled individuals under the age of 65. It consists of four parts (A through D), which cover hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, and hospice care, among other services and supplies.[300]

The majority of Medicare beneficiaries are 65 years old or older. However, in 2021, approximately 8.3 million beneficiaries under age 65 were enrolled in Medicare Part A and/or B as a result of disability, including an unspecified number of women of childbearing age.[301]

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preventive services offer a limited view of state coverage under this broad coverage category; however, the survey does highlight the mandatory nature of breast and cervical screenings under ABPs, and state choices in offering this type of benefit coverage under the other coverage types. For more information, see Jenna Walls, Kathy Gifford, Usha Ranji, et al., *Medicaid Coverage of Family Planning Benefits: Results from a State Survey*, Kaiser Family Foundation, September 2016, at http://files.kff.org/attachment/Report-Medicaid-Coverage-of-Family-Planning-Benefits-Results-from-a-State-Survey.

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

[298] 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 Candace Gibson and Priscilla Huang, *Protected: Medicaid as an LGBTQ Reproductive Justice Issue: A Primer*, National Health Law Program, June 21, 2019, at https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/. The above-cited Movement Advancement Project, a nonprofit advocacy and research organization, also tracks Medicaid Coverage of Transgender-Related Care at https://www.lgbtmap.org/img/maps/citations-medicaid.pdf and https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies/medicaid.

[299] Christy Mallory and William Tentindo, UCLA School of Law; Williams Institute, "Medicaid Coverage for Gender-Affirming Care," October 2019.

[300] CRS Report R40425, *Medicare Primer*.

[301] Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 1, 2022, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html.

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 childbearing age, including breast and gynecological exams for women, and STI screening and treatment for men and women. As a result, any type of reproductive health service may be sought or advised for at least some Medicare beneficiaries.

Does Medicare Cover Contraceptive Services?

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

Male or female sterilization (e.g., vasectomy, tubal ligation) is covered only where it is a necessary part of the treatment of an illness or injury. For example, removal of reproductive organs may be required to treat cancers of those organs. Sterilization is not covered as an elective procedure or for the sole purpose of preventing any effects of a future pregnancy.[302]

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.[303]

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.[304] 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.

[302] CMS, Medicare National Coverage Determination for Sterilization (230.3), http://www.cms.gov/medicare-coverage-database/.

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

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

Does Medicare Cover Infertility Services?

The Medicare Benefit Policy Manual states that "[r]easonable and necessary services associated with treatment for infertility are covered under Medicare. Infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally is expected to be fertile to seek medical consultation and treatment."[305]

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.[306] 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 Screening, Prevention, and Treatment Services?

Medicare Part B covers a number of preventive services that involve reproductive health. These include, among others, annual wellness visits, breast cancer screening, screening pelvic exams, Pap smears, screening for HIV and other STIs, and prostate cancer screening.[307] 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."[308] The Medicare Appeals Council lifted that exclusion in 2016.[309] In 2016, CMS announced that it would not issue a national coverage determination (NCD) for gender-affirming surgery, instead allowing MACs and MA plans to determine whether surgery is medically necessary on a case-by-case basis.[310]

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[305] CMS, *Medicare Benefit Policy Manual*, Ch. 15 – Covered Medical and Other Health Services, May 2022, pp. 12, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.

[306] Ibid., p. 11.

[307] CMS, "Preventive Services," interactive chart, May 2022, https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html.

[308] Eleesha Lockett, "Gender Affirmation: Does Medicare Cover It?" *healthline*, July 7, 2020, https://www.healthline.com/health/medicare/does-medicare-cover-gender-affirmation.

[309] HHS, Departmental Appeals Board, Decision of Medicare Appeals Council Docket Number: M-15-1069, January 21, 2016, https://www.hhs.gov/sites/default/files/static/dab/decisions/council-decisions/m-15-1069.pdf.

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

Federal Regulation of Private Health Insurance

Private health insurance is the predominant source of health insurance coverage in the United States.[311] The federal government has the authority to regulate private health insurance plans, including by requiring plans to cover certain benefits.

Private health insurance includes both the *group market* (largely made up of employer-sponsored insurance) and the *nongroup market* (commonly referred to as the *individual market*, which includes plans directly purchased from an insurer). The group market is divided into small- and large-group market segments; a *small group* is typically defined as a group of up to 50 individuals (e.g., employees), and a *large group* is typically defined as one with 51 or more individuals.[312] Employers and other group health plan sponsors may purchase coverage from an insurer in the small- and large-group markets (i.e., they may *fully insure*). Sponsors may instead finance coverage themselves (i.e., they may *self-insure*).[313] The individual and small-group markets include plans sold on and off the *health insurance exchanges*—the individual exchanges and Small Business Health Options Program (SHOP) exchanges, respectively.[314]

Covered benefits, consumer costs, and other plan features often vary by plan, subject to applicable federal and state requirements. The federal government has authority to regulate all the coverage types noted above (i.e., individual coverage, fully insured small- and large-group coverage, and self-insured group plans).[315] In general, states are permitted to regulate all but self-insured group plans.[316] Federal and state requirements may vary by coverage type. For the federal reproductive health coverage requirements discussed in this section, applicability to each coverage type is noted.[317]

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[311] See CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*.

[312] 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.

[313] 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.

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

[315] Federal requirements applicable to the coverage types outlined in this section (individual coverage, fully insured small- and large-group coverage, and self-insured group plans) are technically applicable to "group health plans and health insurers offering individual and group health insurance coverage." In this section on private health insurance, references to requirements on "plans" and "coverage types" may include requirements on plans, sponsors, and/or insurers. For more information about types of plans and federal regulation of them, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[316] States are the primary regulators of private health insurance, and they may enact their own benefit coverage requirements on nongroup and/or fully insured group plans. Discussion of state-level requirements is out of scope of this report, but lists of mandated benefits by state are available at CMS, Center for Consumer Information and Insurance Oversight (CCIIO), "Information on Essential Health Benefits (EHB) Benchmark Plans," not dated, at https://www.cms.gov/cciio/resources/data-resources/ehb.

[317] In terms of group coverage, this section on private health insurance requirements focuses on plans sponsored by private-sector employers and other sponsors. Although governmental employers may also offer health insurance coverage to their employees, including coverage provided through private health insurers, the applicability of the requirements discussed in this section may vary with regard to federal, state, local, and other governmental employers. For example, self-insured nonfederal governmental plans are able to opt out of certain federal requirements; see CRS

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 individual or group plans in which at least one individual was enrolled as of enactment of the ACA, and which continue to meet certain criteria.[318] 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.

Certain types of private health coverage arrangements are not subject to, or otherwise do not comply with, some or all federal requirements on private health insurance. This includes, for example, short-term, limited duration insurance (STLDI) and health care-sharing ministries (HCSMs). These are out of scope of this report but are discussed in CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements.*

Plans may voluntarily cover benefits, subject to applicable federal and state laws. This includes providing coverage that exceeds federal or state requirements, or providing coverage where there is no applicable requirement to do so, as long as there is no applicable 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 and the types of services it encompasses, 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.[319] These provisions, along with other federal requirements applicable to specific types of reproductive health services, are discussed below.

Where there is a benefit coverage requirement, one or more details may be specified. For example, coverage requirements may or may not specify any cost-sharing requirements. In general, private health insurance cost sharing includes deductibles, coinsurance, and copayments.[320] Coverage requirements may depend on how or where the service or item is furnished (e.g., by an *in-network* versus *out-of-network* provider).[321] Coverage requirements may

Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

[318] The ACA was enacted on March 23, 2010. For more information about grandfathered plans, and for another type of plan exempt from some requirements otherwise applicable to its market segment (*transitional* or *grandmothered plans*), see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

[319] 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*.

[320] A *deductible* is the amount an insured consumer pays for covered health care services before coverage begins (with exceptions). *Coinsurance* is the share of costs, figured in percentage form, an insured consumer pays for a covered health service. A *copayment* is the fixed dollar amount an insured consumer pays for a covered health service.

[321] Under private insurance, benefit coverage and consumer cost sharing is 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 the overview section of CRS Report R46856, *Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services*.

also specify whether plans are allowed to impose medical management requirements. For example, as a condition for covering the care, some insurers require an enrollee to obtain prior authorization from the insurer for routine hospital inpatient care, or require that primary care physicians provide approval or referrals for specialty care.[322] To the extent that information is available and relevant, these issues are addressed with regard to federal requirements on private health insurance coverage of reproductive health services (see **Table 4**).

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).[323] However, states, rather than the federal government, generally specify the benefit coverage requirements within those categories. Current regulation allows each state to select an EHB "benchmark plan." The benchmark plan serves as a reference plan on which plans subject to EHB requirements must substantially base their benefits packages. Because states select their own EHB-benchmark plans, EHB coverage varies considerably from state to state.[324]

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.[325]

Cost-sharing and medical management requirements are possible for most categories of EHB, subject to applicable federal and state requirements. Federal requirements limit cost sharing on the EHB.[326] Coverage and cost sharing for EHB services furnished by out-of-network providers may vary.

All (nongrandfathered) individual and fully insured small-group plans are required to cover the EHB.

Coverage of Certain Preventive Services Without Cost Sharing

The ACA, via Section 2713 of the PHSA, also requires most plans to cover specified preventive services without cost sharing, "such as a copayment, coinsurance, or a deductible."[327] This includes, at a minimum, four categories of statutorily required coverage: (1) any preventive service recommended with an A or B rating by the USPSTF; (2) any immunization with a

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[322] For more information, see the appendix of CRS Report RL32237, *Health Insurance: A Primer*.

[323] 42 U.S.C. §300gg-6 and 42 U.S.C. §18022.

[324] 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," not dated, at https://www.cms.gov/cciio/resources/data-resources/ehb.

[325] 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.

[326] 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., annual out-of-pocket limits, minimum actuarial value requirements, and prohibition on lifetime limits and annual limits).

[327] 42 U.S.C. §300gg-13; 45 C.F.R. §147.130.

recommendation by the Advisory Committee on Immunization Practices (ACIP), adopted by CDC, for routine use for a given individual; (3) additional preventive care and screenings for infants, children, and adolescents as recommended by the Health Resources and Services Administration (HRSA); and (4) additional preventive care and screenings for women as recommended by HRSA.[328]

Examples of reproductive health preventive services in these four categories include (1) screening and counseling for STIs; (2) universal HIV screening; (3) breast cancer screening, genetic testing, and preventive medications such as Tamoxifen (to lower the risk of developing breast cancer among women with specified risk factors); (4) gynecological exams and Pap smears; (5) well-woman visits; (6) a variety of prenatal care services; and (7) contraception.[329] These services are further discussed under the relevant questions in this section.

Although cost sharing is generally prohibited for specified services and items, cost sharing for office visits associated with a furnished preventive service may or may not be allowed, as specified in regulation.[330] By regulation, plans are generally not required to cover preventive services furnished out of network.[331] Plans are allowed to use "reasonable medical management" techniques, within provided guidelines, which may permit use of a formulary, among other things.[332]

The requirement to cover specified preventive services without cost sharing is incorporated into the EHB category "preventive and wellness services and chronic disease management."[333] These incorporated benefits are the only EHB that must be covered without cost sharing.

The requirement to cover preventive services does not apply *only* to plans subject to the EHB requirements; rather, it broadly applies to nongrandfathered private health insurance plans offered in the individual, small-group, and large-group markets, as well as self-insured plans.[334]

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[328] For these United States Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP) recommendations, see https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations and https://www.cdc.gov/vaccines/acip/recommendations.html, respectively. The Health Resources and Services Administration (HRSA) adopts the Bright Futures guidelines, developed in partnership with the AAP, for coverage of additional pediatric preventive services; see https://mchb.hrsa.gov/programs-impact/bright-futures. The HRSA guidelines on coverage of additional services for women are at https://www.hrsa.gov/womens-guidelines/index.html.

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

[330] 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. See 45 C.F.R. §147.130(a)(2).

[331] 45 C.F.R. §147.130(a)(3).

[332] As specified, plans are able to use "reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service." 45 C.F.R. §147.130(a)(4).

[333] 45 C.F.R. §156.115(a)(4), referencing 45 C.F.R. §147.130.

[334] 42 U.S.C. §300gg-13; 45 C.F.R. §147.130. While many legal challenges to PHSA Section 2713 have centered on the contraceptive coverage requirement (discussed in the next section), a case pending in federal district court includes broader challenges to the statute's delegations of authority to HRSA, USPSTF, and ACIP, brought by individuals and entities who object to paying for other forms of preventive-care coverage on religious or other grounds. Order at 3, Kelley v. Azar, No. 20-cv-00283 (N.D. Tex. Feb. 25, 2021).

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

The preventive services coverage provision discussed above requires applicable plans to cover, without cost sharing, HRSA-recommended women's preventive healthcare services.[335] Since 2011, the HRSA recommendations on such services have included contraception.[336] Specifically, HRSA guidelines, updated December 2021, currently recommend "that all adolescent and adult women have access to the full range of contraceptives and all 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.[337]

Through rulemaking and guidance, the Departments of HHS, the Treasury, and Labor confirmed that applicable plans (except those exempted, as discussed in the next question) must provide contraceptive coverage as recommended by HRSA.[338] This includes coverage of at least one form of contraception in each of the *methods* (i.e., categories of contraception, such as the copper IUD or the patch) in the FDA Birth Control Guide (see text box in "What Are Contraceptive Services?").[339] Although the FDA Birth Control Guide includes male contraceptive methods (male sterilization and male condoms), they are excluded from the contraceptive coverage requirement because the statutory coverage requirement is specific to women's preventive health services.[340]

Plans are allowed to impose "reasonable medical management" coverage limitations under the preventive services provision. This means, with regard to contraception, that a plan is allowed to cover certain brands of contraception but not others within a method, as long as it does not restrict access to a method altogether.[341]

Nongrandfathered private health insurance plans offered in the individual, small-group, and large-group markets, as well as self-insured plans, are subject to these federal contraceptive coverage

[335] 42 U.S.C. §300gg-13(a)(4). Also see the "Coverage of Certain Preventive Services Without Cost Sharing" section of this report.

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

[337] HRSA, "Women's Preventive Services Guidelines" updated December 2021, at https://www.hrsa.gov/womens-guidelines/index.html.

[338] See, for example, Departments of Labor (DOL), HHS, and the Treasury, "Coverage of Certain Preventive Services Under the Affordable Care Act, Final Rule," 78 *Federal Register* 39869, July 2, 2013, at https://www.federalregister.gov/documents/2013/07/02/2013-15866/coverage-of-certain-preventive-services-under-the-affordable-care-act (hereinafter referred to as "Preventive Services Final Rule, July 2013"). Also see DOL, HHS, and the Treasury, "FAQs about Affordable Care Act Implementation, Part XXVI," May 11, 2015, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html#Affordable%20Care%20Act (hereinafter referred to as "ACA Implementation FAQ XXVI"). "). A January 10, 2022, FAQ (Part 51) by DOL, HHS, and the Treasury also includes updates regarding contraceptive coverage: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-51.pdf.

[339] See the "What Are Contraceptive Services?" section of this report. See also https://www.fda.gov/consumers/free-publications-women/birth-control-chart.

[340] See, for example, Preventive Services Final Rule, July 2013; ACA Implementation FAQ XXVI.

[341] ACA Implementation FAQ XXVI. However, the guidance requires coverage accommodations for "any individual for whom a particular drug (generic or brand name) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the brand or non-preferred brand version."

requirements, unless exempted. States are the primary regulators of private health insurance, and they may implement their own contraceptive coverage requirements on the plans they regulate.[342]

Are There Exemptions for the 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).[343] An exemption is now available to most types of nonprofit and for-profit entities with sincerely held religious or moral beliefs against contraception.[344]

The initial exemption has been revised several times. In 2013, the Departments of HHS, the Treasury, and Labor established an accommodation process for nonprofit, religious organizations with religious objections to some or all forms of contraception that did not qualify for the automatic exemption for houses of worship.[345] Under that accommodation process, an eligible employer could execute a self-certification form provided by HHS documenting its objection and eligibility for the accommodation.[346] The rule required the employer's insurer or third-party administrator (TPA), upon receiving a copy of the form, to exclude the objected-to benefits from the entity's group health plan and separately pay for (or arrange payment for) contraceptive coverage required by the ACA.[347]

Due to litigation over the contraceptive coverage requirement and the accommodation process the Departments expanded accommodations to include closely held, for-profit companies with religious objections, and allowed objecting entities to notify HHS of their objections (along with their insurers' or TPAs' contact information), instead of executing a self-certification form.[348]

In two rules finalized in November 2018, the Departments further revised the regulations to exempt a broader range of entities with sincerely held religious or moral beliefs against contraception, including for-profit and nonprofit nongovernmental employers and health insurance issuers.[349] The rules essentially allow objecting employers to choose between two

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

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

[344] For more detail on the issues discussed in this section, see CRS Report R45928, *The Federal Contraceptive Coverage Requirement: Past and Pending Legal Challenges*. Questions from congressional clients regarding legal issues addressed in this section may be directed to Victoria L. Killion, CRS Legislative Attorney, who contributed to this section.

[345] Preventive Services Final Rule, July 2013. The accommodation also applies to religious nonprofit colleges and universities with student plans; see page 39897 of the July 2013 rule.

[346] Preventive Services Final Rule, July 2013 at 39894–97.

[347] Group plan sponsors that self-insure their coverage may hire a third-party administrator (TPA) to handle certain administrative duties of offering a health plan, such as member services, premium collection, and utilization review. TPAs do not bear risk for paying claims. (See the introduction to this section of this report for additional information about self-insured versus fully-insured group plans.) Requirements and options regarding eligible employers and their issuers or TPAs are at 29 C.F.R. §2590.715-2713A.

[348] DOL, HHS, and the Treasury, "Coverage of Certain Preventive Services Under the Affordable Care Act," 80 *Federal Register* 41317, July 14, 2015, at https://www.federalregister.gov/documents/2015/07/14/2015-17076/coverage-of-certain-preventive-services-under-the-affordable-care-act. Also see Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014); Wheaton Coll. v. Burwell, 573 U.S. 958 (2014).

[349] DOL, HHS, and the Treasury, "Religious Exemptions and Accommodations for Coverage of Certain Preventive

options. They may decline to cover the forms of contraception to which they object, in which case their employees would not receive coverage for such services through the employer's plan. Alternatively, objecting employers can utilize the previously established accommodation process, thereby shifting the responsibility to provide contraceptive coverage to the insurer or TPA, so long as that entity does not also qualify for and invoke the exemption.

A number of states challenged the 2018 rules on various legal grounds. In 2020, the Supreme Court upheld the rules, holding that the ACA authorized HHS to adopt them.[350] While some claims challenging the rules on other legal grounds are still pending in the lower courts,[351] those cases are stayed as of the date of this report's publication.[352] HHS has indicated that it is working on potential amendments to the 2018 rules.[353]

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, employers that provide health coverage to their employees must ensure coverage for such services if a mother's life would be endangered if the pregnancy were carried to term.[354]

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.[355] For example, the ACA specifies that none of its provisions "shall be construed" to require a QHP to cover abortion.[356] In addition, while federal EHB provisions generally require plans in the individual and small-group markets (including QHPs) to provide coverage substantially similar to a state's selected EHB

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

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

[351] See, for example, Memorandum of Law in Support of Plaintiffs' Motion for Summary Judgment 1–2, Pennsylvania v. Trump, No. 2:17-cv-04540 (E.D. Pa. Sept. 29, 2020) (arguing, inter alia, that the rules are "arbitrary and capricious" under the Administrative Procedure Act and violate the First Amendment's Establishment Clause).

[352] See Order, Massachusetts v. HHS, No. 21-1076 (1st Cir. June 9, 2022) (holding appeal in abeyance for an additional 90 days); Order, Pennsylvania v. Biden, No. 2:17-cv-04540 (E.D. Pa. Jan. 3, 2022) (staying the case and directing the federal government to file status reports every 90 days); California v. Becerra, No. 4:17-cv-05783 (N.D. Cal. Aug. 17, 2021) (staying the case and directing the parties to file a joint status report every three months).

[353] Status Report at 3, *California*, No. 4:17-cv-05783 (N.D. Cal. May 2, 2022).

[354] See 42 U.S.C. §2000e(k). Regulations promulgated by the Equal Employment Opportunity Commission (EEOC) further provide: "Health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term ... are not required to be paid by an employer; nothing herein, however, precludes an employer from providing abortion benefits or otherwise affects bargaining agreements in regard to abortion." 29 C.F.R. §1604.10(b).

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

[356] 42 U.S.C. §18023(b).

benchmark plan, there is an exception for abortion. In other words, even if a state selects an EHB benchmark plan that covers abortion services, applicable plans are not *federally* required to cover abortion, in order to meet EHB standards.[357]

States are the primary regulators of private health insurance, and they may implement their own abortion coverage requirements on the plans they regulate.[358] The ACA specifies that states are allowed to prohibit abortion coverage by QHPs offered in their exchange.[359] 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."[360] 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.

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

There are restrictions related to the use of federal funds that reduce the cost of coverage in the individual health insurance exchanges.[361]

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.[362] As discussed above, there are limitations on the use of federal funds for certain abortion services.[363]

Under the ACA, individuals who receive a PTC are permitted to select a QHP that includes coverage for nontherapeutic or elective abortions. However, the issuer of such a plan cannot use any funds attributable to the tax credit to pay for such services.[364] The issuer is required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of health services other than elective abortions, and another payment that reflects an amount equal to the actuarial value of the coverage for elective abortions.[365] The issuer is required to deposit the separate payments into separate allocation

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[357] 45 C.F.R. §156.115(c). Also see the "Coverage of the Essential Health Benefits (EHB)" section of this report.

[358] In general, states may regulate individual market plans and fully insured group plans but not self-insured group plans. (See the introduction to this section of this report.)

[359] 42 U.S.C. §18023(a).

[360] 42 U.S.C. §18023(c).

[361] For more detail on the issues discussed in this section, see the "Health Reform" section of CRS Report RL33467, *Abortion: Judicial History and Legislative Response*.

[362] Certain consumers who receive premium tax credits (PTCs) may also be eligible for cost-sharing reductions (CSRs) that effectively reduce out of pocket costs associated with selected QHPs. The requirements described in this section technically apply to both PTCs and CSRs (see 45 C.F.R. §156.280(e)). For background about CSRs and federal payments, see Bipartisan Policy Center, "Stabilizing the Individual Insurance Market: What Happened and What Next?," March 2018, at https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Stabilizing-The-Individual-Health-Insurance-Market.pdf. Federal CSR payments are currently being litigated; see Katie Keith, "CSR Litigation, New Non-ACA Plan Decision," *Health Affairs Blog*, October 5, 2020, at https://www.healthaffairs.org/do/10.1377/hblog20201005.420115/full/.

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

[364] 42 U.S.C. §18023(b)(2)(A).

[365] Ibid. §18023(b)(2)(B)(i). Through rulemaking, different Administrations have taken varied approaches to

accounts that consist solely of each type of payment and that are used exclusively to pay for the specified services.[366] State health insurance commissioners 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.[367]

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

No federal law specifically addresses private health insurance coverage of infertility services. However, the requirement that certain plans cover 10 categories of EHB may be relevant, depending on state implementation.[368] If a state selects a benchmark plan that includes infertility services in one or more EHB categories, then applicable plans in that state must provide coverage substantially similar to the benchmark plan's coverage. EHB requirements apply to nongrandfathered plans in the individual and small-group markets.

States are the primary regulators of private health insurance, and they may implement their own infertility services coverage requirements on the plans they regulate.[369]

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

There are federal requirements for private health insurance coverage of certain maternity services.

As stated above, one of the EHB categories of coverage is "maternity and newborn care."[370] This means that nongrandfathered plans in the individual and small-group markets must provide coverage of maternity and newborn care services substantially similar 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 and newborn care.

In addition, the preventive services provision described above includes the requirement for applicable plans to cover certain prenatal and postnatal services without cost sharing. This includes, for example, well-woman visits that cover recommended preconception, prenatal, and interconception care services, and breastfeeding services and supplies.[371] Nongrandfathered private health insurance plans offered in the individual, small-group, and large-group markets, as well as self-insured plans, are subject to this coverage provision.

The Pregnancy Discrimination Act of 1978 (PDA, P.L. 95-555, as amended) requires applicable employers offering health insurance to cover "expenses for pregnancy-related conditions on the

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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.

[366] Ibid. §18023(b)(2)(B)(ii).

[367] Ibid. §18023(b)(2)(E)(i).

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

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

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

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

same basis as expenses for other medical conditions" for employees enrolled in the group plan.[372] If the group plan offers coverage to employees' spouses and dependents, the requirement to cover pregnancy-related services also applies to employees' spouses, but not necessarily to other dependents, enrolled in the plan.[373]

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.[374]

Finally, the Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204, as amended) prohibits plans from restricting the length of a hospital stay for childbirth for either the mother or newborn child to less than 48 hours following vaginal deliveries and to less than 96 hours following caesarian deliveries.[375] 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 individual, 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.

States are the primary regulators of private health insurance, and they may implement their own maternity services coverage requirements on the plans they regulate.[376]

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

[373] See 29 C.F.R. §1604 Appendix, questions 21-23 regarding coverage of pregnancy-related conditions for spouses and dependents. Also note that other federal requirements are relevant to employers' offer of coverage for dependents. For example, most plans that offer dependent coverage are required to make that coverage available for both married and unmarried adult children under the age of 26 (42 U.S.C. §300gg-14). In addition, the employer shared-responsibility provisions generally incentivize large employers to offer adequate and affordable health insurance coverage to their full-time employees and full-time employees' children under the age of 26 (26 U.S.C. §4980H). Separately, note that the requirements to cover EHB, and to cover certain preventive services without cost sharing apply to all enrollees in a plan, including spouses and dependents. See 45 C.F.R. §156.115(a)(2) and ACA Implementation FAQ XXVI.

[374] EEOC Q&A. See this source for other entities subject to the PDA that are out of scope of this report.

[375] 42 U.S.C. §300gg-25; 45 C.F.R. §146.130.

[376] In general, states may regulate individual market plans and fully insured group plans but not self-insured group plans. (See the introduction to this section of this report.)

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

The preventive services provision described above includes the requirement for applicable plans to cover certain reproductive health screening and preventive services without cost sharing. This includes, for example, screening and counseling for STIs/STDs; universal HIV screening; 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.[377]

In June 2019, the USPSTF recommended the use of PrEP with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.[378] By regulation, the requirement to cover this service without cost sharing (subject to limitations already discussed) applied for plan years beginning one year later.[379] Per federal guidance, plans are also required to cover ancillary services such as blood testing recommended to monitor one's health status while on PrEP.[380]

If a screening results in a diagnosis of a condition such as an STI or reproductive cancer, no federal laws specifically mandate coverage of treatment services. However, treatments for various conditions may be covered under different EHB categories in the benchmark plans that states select, which would require applicable plans to cover such treatments.[381]

In addition, the Women's Health and Cancer Rights Act of 1998 (P.L. 105-277, as amended) states that if plans provide coverage for mastectomies, they must also cover breast reconstruction services and prostheses. Despite the name of the law, this requirement is applicable for female and male enrollees, and the mastectomy does not need to have been connected to a cancer diagnosis. The requirement applies to individual, small-group, large-group, and self-insured plans, regardless of grandfathered status.[382]

States are the primary regulators of private health insurance, and they may implement their own reproductive health screening and prevention (and treatment) services coverage requirements on the plans they regulate.[383]

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

[378] USPSTF, "Final Recommendation Statement Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis," June 11, 2019, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

[379] 45 C.F.R. §147.130(b). Group plan years do not necessarily align with the calendar year, and this requirement was in effect for any group plans beginning in the second half of 2020. For plans in the individual market, this generally became effective as of plan year (calendar year) 2021.

[380] DOL, HHS, and the Treasury, "FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 47," July 19, 2021, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-47.pdf.

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

[382] 29 U.S.C. §1185b, 42 U.S.C. §300gg-27, and 42 U.S.C. §300gg-52. Also see Employee Benefits Security Administration, "Compliance Assistance Guide: Health Benefits Coverage Under Federal Law…." September 2014, at https://www.dol.gov/general/topic/health-plans/womens. See DOL, HHS, and the Treasury, "Faqs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, And Women's Health And Cancer Rights Act Implementation," April 20, 2016, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf, for additional details.

[383] In general, states may regulate individual market plans and fully insured group plans but not self-insured group plans. (See the introduction to this section of this report.)

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

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

However, the requirement that certain plans cover 10 categories of EHB may be relevant, depending on state implementation. If a state selects a benchmark plan that includes coverage of gender-affirming services in one or more EHB categories, then applicable plans in that state would be required to offer substantially similar coverage.[384]

One federal requirement, Section 1557 of the ACA, has been implemented differently by presidential administrations with respect to private health insurance coverage of gender-affirming services. This provision "prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities."[385] Regulations issued in May 2016 interpreted the prohibition on discrimination "on the basis of sex" to include, among other things, a prohibition on applicable plans from "hav[ing] or implement[ing] a categorical coverage exclusion or limitation for all health services related to gender transition."[386] Regulations issued in June 2020 repealed this prohibition.[387] Following the Supreme Court's decision in *Bostock v. Clayton County*, HHS announced that it will issue a proposed rule addressing prohibited sex discrimination on the basis of sexual orientation and gender identity under ACA Section 1557.[388]

States are the primary regulators of private health insurance, and they may implement their own gender-affirming services coverage requirements on the plans they regulate.[389]

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

[385] Section 1557 of the ACA is codified at 42 U.S.C. §18116.

[386] HHS, "Nondiscrimination in Health Programs and Activities," 81 *Federal Register* 31375, May 18, 2016. See discussion and language adopted for 45 C.F.R. §92.207, which included the gender affirming services provision quoted above, among other coverage-related provisions. Discussion of applicability of this requirement to types of plans and other "covered entities" starts at page 31428 of the rule.

[387] HHS, "Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority," 85 *Federal Register* 37160, June 19, 2020. See pages 37196, 37200-01.

[388] See Bostock v. Clayton Cnty., 140 S. Ct. 1731, 1737 (2020); HHS, Office for Civil Rights (OCR), "Section 1557 of the Patient Protection and Affordable Care Act," updated May 25, 2022, at https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html. For other discussion of prior and potential rulemaking, see Katie Keith, "Final 2023 Payment Rule, Part 1: Essential Health Benefits And Other Market Reforms," April 29, 2022, at https://www.healthaffairs.org/do/10.1377/forefront.20220429.865892/ and CRS Report R46832, *Potential Application of Bostock v. Clayton County to Other Civil Rights Statutes*.

[389] In general, states may regulate individual market plans and fully insured group plans but not self-insured group plans. (See the introduction to this section of this report).

Table 4. Federal Requirements on Private Health Insurance Coverage of Reproductive Health Services

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[a]	Applies Out-of-Network?[b]	Group Market[c]			
					Fully Insured[e]			
					Large Group[g]	Small Group[g]	Self-Insured[f]	Individual Market[d]
Requirements applicable to coverage of various reproductive health services								
42 U.S.C. §300gg-6, 42 U.S.C. §18022 45 C.F.R. §156.100-155, 45 C.F.R. §147.150	Coverage of Essential Health Benefits (EHB)	Applicable plans are required to cover 10 categories of health care services.[h] EHB requirements apply to coverage of certain reproductive health services, in some cases subject to state and plan variation. Cost sharing is possible and may vary by plan. There are provisions limiting cost sharing on the EHB.[i]	Allowed; may vary by plan	No	N.A.	✓	N.A.	✓
42 U.S.C. §300gg-13 45 C.F.R. §147.130-133	Coverage of Preventive Services Without Cost Sharing	Specified items and services (including various reproductive health services) must be covered without cost sharing if recommended by the ACIP or USPSTF, or if listed in HRSA guidelines for women's or pediatric preventive services.[j]	Allowed; may vary by plan	No	✓	✓	✓	✓
Contraceptive services								
42 U.S.C. §300gg-13 45 C.F.R. §147.130-133	*Applicability of preventive services requirement*	Applicable plans are required to cover HRSA-recommended women's preventive services without cost sharing, which includes specified contraceptive items and services.[k] An exemption is available to most types of nonprofit and for-profit entities with sincerely held religious or moral beliefs against contraception.	Allowed; may vary by plan	No	✓	✓	✓	✓

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[a]	Applies Out-of-Network?[b]	Group Market[c]			Individual Market[d]
					Fully Insured[e]		Self-Insured[f]	
					Large Group[g]	Small Group[g]		
Abortion services and counseling[l]								
42 U.S.C. §18023 45 C.F.R. §156.115(c) and 45 C.F.R. §156.122(b), each referencing 45 C.F.R. §156.280	*Applicability of EHB requirement*	Even if a state selects an EHB benchmark plan that provides abortion coverage, plans in the state that are otherwise subject to EHB requirements are not federally required to provide abortion coverage.	N.A.	N.A.	N.A.	✓	N.A.	✓
42 U.S.C. §18023 45 C.F.R. §156.280[m]	*Provisions affecting QHPs sold in exchanges*	A state is allowed to prohibit abortion coverage by QHPs offered in its exchange. Insurers offering QHPs that cover nontherapeutic abortions may not use federal funds (attributable to eligible individuals' PTCs) to pay for such services. There are related rules about segregation of plan payments for nontherapeutic abortion services versus other covered services.	N.A.	N.A.	N.A.	QHPs in SHOPs	N.A.	QHPs in exchanges
42 U.S.C. §18023 45 C.F.R. §156.280	*Federal non-preemption of state laws*	Federal provisions do not preempt state abortion laws. States may prohibit, require, and otherwise regulate abortion coverage by the plans they regulate.	N.A.	N.A.	✓	✓	N.A.	✓
42 U.S.C. §2000e 29 C.F.R. §1604.10(b)	*Applicability of pregnancy-related conditions requirement*	This provision does not require coverage of abortion, "except where the life of the mother would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion," while "nothing herein, however, precludes an employer from providing abortion benefits or otherwise affects bargaining agreements in regard to abortion."	See "Coverage of Pregnancy-Related Conditions on the Same Basis as Other Medical Conditions" in this table.		✓	✓ (groups over 15)	✓	N.A.

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[a]	Applies Out-of-Network?[b]	Group Market[c]			
					Fully Insured[e]			
					Large Group[g]	Small Group[g]	Self-Insured[f]	Individual Market[d]
Infertility services[l]								
42 U.S.C. §300gg-6, 42 U.S.C. §18022 45 C.F.R. §156.115	*Applicability of EHB requirement*	If a state selects a benchmark plan that includes infertility treatments in one or more EHB categories, applicable plans in that state would be required to offer substantially similar coverage.	Allowed; may vary by plan	No	N.A.	✓	N.A.	✓
Maternity services								
42 U.S.C. §300gg-6, 42 U.S.C. §18022 45 C.F.R. §156.110, 45 C.F.R. §156.115	*Applicability of EHB requirement*	One of the 10 EHB categories is "maternity and newborn care." Applicable plans must cover this category, and services in any other category that may be relevant, in a substantially similar manner as the state's EHB benchmark plan.	Allowed; may vary by plan	No	N.A.	✓	N.A.	✓
42 U.S.C. §300gg-13 45 C.F.R. §147.130	*Applicability of preventive services requirement*	This provision includes the requirement for applicable plans to cover certain prenatal and post-natal services without cost sharing.[j]	Allowed; may vary by plan	No	✓	✓	✓	✓
42 U.S.C. §2000e 29 C.F.R. §1604.10, 29 C.F.R. §1604 Appendix[n]	Coverage of Pregnancy-Related Conditions on the Same Basis as Other Medical Conditions[o]	Applicable employers offering health insurance must cover "expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions" for employees enrolled in the group plan. Plan features (e.g., cost-sharing requirements, medical management requirements, out-of-network coverage) as related to pregnancy-related conditions must not be substantially different than they are for other covered medical conditions. If the plan offers coverage to employees' spouses and dependents, this also applies to employees' spouses, but not necessarily to other dependents, enrolled in the plan.			✓	✓ (groups over 15)	✓	N.A.

Authority	Provision	Coverage and Cost-Sharing Requirements	Medical Management Approaches Allowed?[a]	Applies Out-of-Network?[b]	Group Market[c]			
					Fully Insured[e]			
					Large Group[g]	Small Group[g]	Self-Insured[f]	Individual Market[d]
42 U.S.C. §300gg-25 45 C.F.R. §146.130, 45 C.F.R. §148.170	Minimum Hospital Stay After Childbirth[p]	Plans that cover maternity hospital stays are prohibited from restricting the length of a hospital stay for childbirth for either the mother or newborn child to less than 48 hours following vaginal deliveries and to less than 96 hours following caesarian deliveries. Cost sharing is allowed, as specified.[q]	Prior authorization requirements for these stays, and incentives offered for shorter stays, are prohibited.[q]	Not specified	✓ (GF)[r]	✓ (GF)[r]	✓ (GF)[r]	✓ (GF)[r]
Reproductive health screening, prevention, and treatment services								
42 U.S.C. §300gg-13 45 C.F.R. §147.130	*Applicability of preventive services requirement*	This provision includes the requirement that specified reproductive health screening and preventive services must be covered without cost sharing.[j]	Allowed; may vary by plan	No	✓	✓	✓	✓
42 U.S.C. §300gg-27	Reconstruction After Mastectomy[s]	Plans that provide coverage for mastectomies must also cover breast reconstruction services and prostheses. This applies for women and men, and it need not be connected to a cancer diagnosis. Cost sharing is allowed, if consistent with cost sharing for other covered medical/surgical benefits.[t]	Not specified	Not specified	✓ (GF)[r]	✓ (GF)[r]	✓ (GF)[r]	✓ (GF)[r]
Gender-affirming services[l]								
42 U.S.C. §300gg-6, 42 U.S.C. §18022 45 C.F.R. §156.115	*Applicability of EHB requirement*	If a state selects a benchmark plan that includes gender-affirming services in one or more EHB categories, applicable plans in that state would be required to offer substantially similar coverage.	Allowed; may vary by plan	No	N.A.	✓	N.A.	✓

Source: CRS analysis of relevant legislation, statute, regulation, and guidance.

Notes: *Checkmark* (✓) indicates that the requirement is applicable to that type of health plan. The variation *(✓+GF)* indicates that the requirement is also applicable to grandfathered plans; see table note "r". *N.A.* indicates that the requirement is not applicable to that type of health plan.

EHB = essential health benefits. USPSTF = United States Preventive Services Task Force. ACIP = Advisory Committee on Immunization Practices. HRSA = U.S. Health Resources and Services Administration. FDA = U.S. Food and Drug Administration. QHP = qualified health plan. SHOP = Small Business Health Options Program.

The requirements listed in the table are not a comprehensive list of all federal requirements and standards that apply to all health plans that may be related to reproductive health. Listed requirements are provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended), unless otherwise specified.

a. An example of a medical management technique that insurers may use, as allowed, is requiring that an enrollee obtain prior authorization from the insurer for coverage of certain services before using them. For more information, see the appendix of CRS Report RL32237, *Health Insurance: A Primer*.

b. All requirements apply to services or items furnished in-network. Under private insurance, benefit coverage and consumer cost sharing are often contingent upon whether a service or item is furnished by a provider that the insurer has contracted with (i.e., whether that provider is *in network* for a given plan). In instances where a contract between an insurer and provider does not exist, the provider is considered *out of network.* For more information, see the background section of CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

c. Health insurance may be provided to a group of people who are drawn together by an employer or other organization, such as a trade union. Such groups generally are formed for purposes other than obtaining insurance, such as employment. When insurance is provided to a group, it is referred to as *group coverage* or *group insurance*. In the group market, the entity that purchases health insurance on behalf of a group is referred to as the *plan sponsor*.

d. Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurer in the individual (or nongroup) health insurance market.

e. A *fully insured* health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurer; the insurer assumes the risk of paying the medical claims for benefits covered under the health plan of the sponsor's enrolled members.

f. *Self-insured plans* refer to health coverage that is provided directly by the organization sponsoring coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering medical claims. In general, the size of a self-insured employer does not affect the applicability of federal requirements.

g. In general, for purposes of health insurance requirements, *small groups* are those with 50 or fewer individuals (e.g., employees). States can also define small groups as having 100 or fewer individuals. The definition of *large group* is 51 or more individuals, or 101 or more individuals, depending on the definition of small group.

h. The 10 categories of essential health benefits (EHB) are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

i. 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., annual out-of-pocket limits, minimum actuarial value requirements, and prohibition on lifetime limits and annual limits). Certain types of plans—self-insured plans and plans offered in the large-group market—must comply with these requirements even though they are not required to cover the EHB. HHS has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirement.

j. The preventive services that must be covered are listed in their entirety at Healthcare.gov, "Preventive health services," https://www.healthcare.gov/preventive-care-benefits/. Cost sharing for office visits associated with applicable vaccinations and other preventive services may or may not be allowed. In general, this 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. See 45 C.F.R. §147.130(a)(2).

k. See HRSA, "Women's Preventive Services Guidelines," initially released August 1, 2011, updated December 2021, at https://www.hrsa.gov/womens-guidelines/index.html. Also see FDA, "Birth Control Guide," updated June 2021, at https://www.fda.gov/consumers/free-publications-women/birth-control.

l. No federal law specifically requires or prohibits private health insurance coverage of abortion services and counseling, infertility services, or gender-affirming services. (See the "Does Federal Law Require Private Health Insurance Coverage of Gender-Affirming Services?" section of this report for discussion of the different interpretations of the applicability of ACA Section 1557 to coverage of gender-affirming services.)

m. The individual exchanges and small-business health options program (SHOP) exchanges are virtual marketplaces in which consumers and small businesses, respectively, can shop for and purchase private health insurance coverage. Qualified health plans (QHPs) are private health insurance plans certified to be sold in the individual and SHOP exchanges, and they must meet all requirements applicable to the individual and small-group markets, respectively, plus certain additional requirements. For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

n. Title 29 of the Code of Federal Regulations, Appendix to Part 1604—Questions and Answers on the Pregnancy Discrimination Act, P.L. 95-555, 92 Stat. 2076 (1978).

o. This provision is from the Pregnancy Discrimination Act of 1978 (PDA, P.L. 95-555, as amended).

p. This provision is from the Newborns' and Mothers' Health Protection Act of 1996 (P.L. 104-204, as amended).

q. See the "Does Federal Law Require Private Health Insurance Coverage of Maternity Services?" section of this report for additional details.

r. *Grandfathered plans* are individual or group plans in which at least one individual was enrolled as of enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), and which continue to meet certain criteria. Plans that maintain their grandfathered status are exempt from some federal requirements.

s. This provision is from the Women's Health and Cancer Rights Act of 1998 (P.L. 105-277, as amended).

t. See Employee Benefits Security Administration, "Compliance Assistance Guide: Health Benefits Coverage Under Federal Law…", September 2014, at https://www.dol.gov/general/topic/health-plans/womens. See Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury, "FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation," April 20, 2016, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf, for additional detail.

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 teen pregnancy prevention programs—discuss each of the six reproductive health service categories included in this report. The final three questions 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.[390] Title X provides grants to public and nonprofit agencies for family planning services, research, and training. The Office of Population Affairs (OPA) within HHS administers Title X, which is the only domestic federal program devoted solely to family planning and related preventive health services.[391]

In 2019, HHS promulgated a rule that, among other things, prohibited Title X projects from referring clients for abortion as a method of family planning. It also required physical separation between Title X projects and certain abortion-related activities. The 2019 rule took effect in all states except Maryland, where it was enjoined.[392]

In 2021, HHS promulgated a new rule that, among other things, revokes the 2019 rule in its entirety. For example, it requires Title X projects to provide an abortion referral if requested by the client and removes the physical separation requirement. The 2021 rule has been in effect since November 8, 2021.[393] This report describes the Title X program under the 2021 rule that is currently in effect.

Title X grantees can provide family planning services directly or they can subaward Title X monies to other entities to provide services. In 2020, the most recent year for which client data are available, Title X projects served 1.5 million clients through 3,031 clinics operated by 75 grantees or their 867 subrecipients (also known as subgrantees or subawardees).[394]

In 2022, HHS told CRS:

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[390] 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.

[391] CRS In Focus IF10051, *Title X Family Planning Program*.

[392] Office of the Assistant Secretary for Health (OASH), Office of the Secretary, HHS, "Compliance With Statutory Program Integrity Requirements," 84 *Federal Register* 7714, March 4, 2019, https://www.federalregister.gov/d/2019-03461; CRS In Focus IF11142, *Title X Family Planning Program: 2019 Final Rule*.

[393] Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services (HHS), "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services," 86 *Federal Register* 56144-56180, October 7, 2021, https://www.federalregister.gov/d/2021-21542; CRS In Focus IF11986, *Title X Family Planning Program: 2021 Final Rule*.

[394] Christina Fowler, Julia Gable, and Beth Lasater, *Family Planning Annual Report: 2020 National Summary*, HHS, OPA, September 2021, https://opa.hhs.gov/sites/default/files/2021-09/title-x-fpar-2020-national-summary-sep-2021.pdf. More grantees are participating in the program for FY2022; the May 2022 Family Planning Directory lists 96 grantees that operate Title X family planning services projects. HHS, OPA, *Title X Family Planning Directory*, May 2022, https://opa.hhs.gov/sites/default/files/2022-06/Title%20X%20Directory%20-%20May_2022_508.pdf. Current and past directories of Title X grantees, subawardees, and service sites are at HHS, OPA, *Current Title X Service Grantees*, https://opa.hhs.gov/grant-programs/title-x-service-grants/current-title-x-service-grantees.

> HHS's Title X grantees provide contraceptive education and counseling; breast and cervical cancer screening; testing for sexually transmitted infections and HIV, referral, and prevention education; and pregnancy diagnosis and counseling, using a combination of funding sources to cover the costs for eligible clients. Under the 2021 Title X final rule, Title X funds are awarded to provide high-quality, affordable, and confidential voluntary family planning and related preventive health services to either help achieve or prevent pregnancy. HHS's Office of Population Affairs requires all family planning services to be delivered consistent with nationally recognized standards of care, including nondirective pregnancy options counseling and referral. Moreover, Title X-funded sites not offering a broad range of methods on-site must provide a prescription to the client for their method of choice or referrals, as requested.[395]

Title X projects are required to provide services free of charge for individuals under 100% of the federal poverty level and to provide sliding scale fees for individuals between 100% and 250% of the federal poverty level. For unemancipated minors who request confidential services, eligibility for discounts is based on the minor's own income.[396]

Do Title X Projects Provide Reproductive Health Services?

Title X regulations define *family planning services* to include certain reproductive health services, such as

> a broad range of medically approved services, which includes Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods, for clients who want to prevent pregnancy and space births, pregnancy testing and counseling, assistance to achieve pregnancy, basic infertility services, sexually transmitted infection (STI) services, and other preconception health services.[397]

The program's clinical guidelines include reproductive health services, such as breast and cervical cancer screening and prevention; STD and HIV prevention education, counseling, testing, and referral; preconception health services; basic infertility services; and counseling on establishing a reproductive life plan.[398]

Do Title X Projects Provide Contraceptive Services?

As noted above, program regulations define *family planning services* to include FDA-approved contraceptive products.[399] Program regulations require that each Title X project must provide "a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods).... If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of acceptable and effective medically approved family planning methods and services. Title X service sites that are unable to provide clients with access to a broad range of acceptable and

[395] Email from the HHS Office of the Assistant Secretary for Legislation, July 1, 2022.

[396] 42 C.F.R. §59.2, definition for "Low-income family"; 42 C.F.R. §59.5(a)(7)-(8).

[397] 42 C.F.R. §59.2, definition for "Family planning services."

[398] Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf; and HHS, OPA, *Quality Family Planning*, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning. See also HHS, OPA, *Key Issues for Title X Grantees*, https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/key-issues-title-x-grantees.

[399] 42 C.F.R. §59.2; see text box in "What Are Contraceptive Services?".

effective medically approved family planning methods and services, must be able to provide a prescription to the client for their method of choice or referrals to another provider, as requested."[400] Program regulations also require projects to "provide for medical services related to family planning (including consultation by a clinical services provider, examination, prescription and continuing supervision, laboratory examination, contraceptive supplies), in person or via telehealth, and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices." The regulations permit the HHS Secretary to omit this requirement, with an established good cause.[401]

Title X clinical guidelines published in 2014 advise providers that "contraceptive services should include consideration of a full range of FDA-approved contraceptive methods, a brief assessment to identify the contraceptive methods that are safe for the client, contraceptive counseling to help a client choose a method of contraception and use it correctly and consistently, and provision of one or more selected contraceptive method(s), preferably on site, but by referral if necessary" (see text box in "What Are Contraceptive Services?").[402]

The *Family Planning Annual Report* presents the following 2020 data on female Title X clients' primary contraceptive methods:[403]

- 19% relied on the "most effective" methods (including vasectomy, female sterilization, implants, and IUDs);
- 38% relied on "moderately effective" methods (including injectable contraception, vaginal ring, contraceptive patch, pills, diaphragm with spermicidal cream/jelly, and the cervical cap);
- 16% relied on "less effective" methods (including male condoms, female condoms, the vaginal sponge, withdrawal, fertility awareness-based methods (FAM) and lactational amenorrhea methods (LAM), and spermicides);
- 5% relied on abstinence;
- 14% used no contraceptive methods, for example because they were pregnant or seeking to become pregnant; and
- for 7%, the primary contraceptive method was unknown.

[400] 42 C.F.R. §59.5(a)(1).

[401] 42 C.F.R. §59.5(b)(1).

[402] Title X clinical guidelines are laid out in HHS, OPA, *Quality Family Planning,* https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning. See also HHS, OPA, *Key Issues for Title X Grantees,* https://opa.hhs.gov/grant-programs/title-x-service-grants/about-title-x-service-grants/quality-family-planning. FDA-approved contraceptive methods are listed in Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," Figure 3, "The typical effectiveness of Food and Drug Administration–approved contraceptive methods," p. 10; and FDA, *Birth Control Chart,* https://www.fda.gov/consumers/free-publications-women/birth-control-chart.

[403] Christina Fowler, Julia Gable, and Beth Lasater, *Family Planning Annual Report: 2020 National Summary*, pp. 34-35. Percentages may not sum to 100% due to rounding. Illustrations of contraceptive methods and their effectiveness are in Kathryn M. Curtis, Naomi K. Tepper, Tara C. Jatlaoui, et al., "U.S. Medical Eligibility Criteria for Contraceptive Use, 2016," *Morbidity and Mortality Weekly Report, Recommendations and Reports*, July 29, 2016, "Figure: Effectiveness of Family Planning Methods," https://www.cdc.gov/mmwr/volumes/65/rr/rr6503a1.htm#F-1-1_down.

Do Title X Projects Provide Abortions or Abortion Counseling?

By law, Title X funds may not be used for abortions.[404] 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. The grantee's abortion activities have to be "separate and distinct" from the Title X project activities.[405] The guidance notes that "a Title X project may not provide services that directly facilitate the use of abortion as a method of family planning, such as providing transportation for an abortion, explaining and obtaining signed abortion consent forms from clients interested in abortions, negotiating a reduction in fees for an abortion, and scheduling or arranging for the performance of an abortion, promoting or advocating abortion within Title X program activities, or failing to preserve sufficient separation between Title X program activities and abortion-related activities."[406]

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.[407] 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."[408]

Do Title X Projects Provide Infertility Services?

Title X regulations require projects to provide "basic infertility services"[409] and clinical guidelines state that "infertility visits to a family planning provider are focused on determining potential causes of the inability to achieve pregnancy and making any needed referrals to specialist care."[410]

A 2015 survey of publicly funded family planning clinics found that 60% of Title X clinics provided infertility counseling onsite, while 37% referred clients to another clinic or provider.

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[404] 42 U.S.C. §300a-6. In addition, language in annual Departments of Labor, Health and Human Services, and Education, and Related Agencies appropriations bills have also stated that Title X funds "shall not be expended for abortions." (In FY2022, this provision appeared in Consolidated Appropriations Act, 2022 [P.L. 117-103], Division H, Title II).

[405] HHS, OPA, "Provision of Abortion-Related Services in Family Planning Services Projects," 65 *Federal Register* 41281-41282, July 3, 2000, https://federalregister.gov/a/00-16759. Program guidance states that a grantee's abortion-related activities and its Title X project activities can share the same facility, staff, waiting room, and records system, "so long as it is possible to distinguish between the Title X supported activities and non-Title X abortion-related activities," for example, through allocating and prorating costs. Specifically, a Title X project's non-Title X abortion-related activities have to be distinguishable from the project's Title X activities. The above 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)."

[406] 65 *Federal Register* 41281.

[407] 42 C.F.R. §59.5(a)(5)(i).

[408] 42 C.F.R. §59.5(a)(5)(ii). The Title X program funds the Reproductive Health National Training Center (RHNTC), which offers training to Title X providers; RHNTC training resources on nondirective counseling include *Exploring All Options: Pregnancy Counseling Without Bias Video*, https://rhntc.org/resources/exploring-all-options-pregnancy-counseling-without-bias-video.

[409] 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).

[410] Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs."

Fifty-four percent of Title X clinics provided basic infertility testing (such as pelvic exams or hormone levels) onsite, while 37% referred clients to another clinic or provider. [411]

Do Title X Projects Provide Maternity Services?

HHS told CRS in 2020:

> Title X grantees provide a broad range of family planning and preventive services related to achieving pregnancy, preventing pregnancy, and assisting women, men, and couples with achieving their desired number and spacing of children. Services centered around preconception health and achieving pregnancy, include:
>
> - Basic infertility services;
> - Sexually transmitted infection (STI) prevention education, screening, and treatment;
> - HIV testing and referral for treatment when appropriate; and
> - Screening for substance use disorders and referral when appropriate to help reduce adverse pregnancy-related outcomes and improve individuals' reproductive health generally.
>
> Services to manage pregnancy (e.g., prenatal and delivery care) are out of the scope of Title X funding.[412]

Program regulations require Title X projects to provide a broad range of family planning services, including "pregnancy testing and counseling."[413] With respect to pregnancy counseling, 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.[414] 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."[415]

With respect to referrals, 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

[411] Mia R. Zolna and Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, pp. 36, 52. An earlier 2013-2014 survey, conducted before Title X's current clinical guidelines were published, asked a sample of Title X clinics about infertility services; see Ana Carolina Loyola Briceno, Katherine A.Ahrens, Marie E.Thoma, et al., "Availability of Services Related to Achieving Pregnancy in U.S. Publicly Funded Family Planning Clinics," *Women's Health Issues*, vol. 29, no. 6 (November-December 2019), pp. 447-454. It states: "Our study characterizes the delivery of these services in publicly funded clinics before the publication of the 2014 QFP [Quality Family Planning] recommendations." QFP contains Title X clinical guidelines.

[412] Email from the HHS Office of the Assistant Secretary for Legislation, July 1, 2022.

[413] 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).

[414] 42 C.F.R. §59.5(a)(5)(i).

[415] 42 C.F.R. §59.5(a)(5)(ii). Title X funds the Reproductive Health National Training Center (RHNTC), which offers training to Title X service providers; RHNTC training resources on nondirective counseling include *Exploring All Options: Pregnancy Counseling Without Bias Video*, https://rhntc.org/resources/exploring-all-options-pregnancy-counseling-without-bias-video.

to the Title X site, when feasible, in order to promote access to services and provide a seamless continuum of care."[416]

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

Title X clinical guidelines recommend that providers offer STI services in accordance with the CDC's STI treatment and HIV testing guidelines, and cervical and breast cancer screening in accordance with professional recommendations such as USPSTF recommendations.[417] Title X clinical guidelines also recommend certain other "related preventive health services", such as taking a medical history.[418] A 2015 survey of publicly funded family planning clinics found the following percentages of Title X clinics that provided certain services onsite:

- 94% provided HIV testing,
- 26% provided PrEP for HIV,
- 99% provided chlamydia/gonorrhea screening/testing, 94% offered syphilis screening/testing, 97% provided Pap tests,
- 69% provided combined Pap and DNA testing,
- 36% provided colposcopy (examination of the cervix and vagina),
- 98% provided clinical breast exams, and
- 14% provided mammography. [419]

In March 2019, an HHS blog post stated that "currently, nearly 90 percent of Title X sites provide HIV testing and approximately one-third of sites offer PrEP."[420]

In general, Title X services focus on family planning and related *preventive* health services, but treatment services are more limited. Title X clinical guidelines do recommend that providers offer STI services in accordance with the CDC's STI treatment guidelines.[421] A 2015 survey of publicly funded family planning clinics found that 99% provided or prescribed STI treatment onsite.[422]

With regard to HIV/AIDS and cancers of reproductive organs, Title X clinical guidelines recommend various services related to prevention and screening, but the guidelines do not

[416] 42 C.F.R. §59.5(a\b)(8).

[417] Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs."

[418] Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs." See for example "Related preventive health services" (p. 20), Table 2, Checklist of family planning and related preventive health services for women (p. 22), and Table 3, Checklist of family planning and related preventive health services for men (p. 23).

[419] Mia R. Zolna and Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, pp. 36, 50.

[420] Diane Foley, Deputy Assistant Secretary, OPA, HHS, *Increasing the Availability of PrEP Services in Title-X Funded Family Planning Service Sites: Development of a Decision Tool*, March 8, 2019, https://www.hiv.gov/blog/increasing-availability-prep-services-title-x-funded-family-planning-services-sites-development.

[421] Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs."

[422] Mia R. Zolna and Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, Guttmacher Institute, November 2016, pp. 36, 49, 50, 51, 53, https://www.guttmacher.org/sites/default/files/report_pdf/publicly-funded-family-planning-clinic-survey-2015_1.pdf.

explicitly address treatment.[423] Title X regulations require projects more generally to provide for coordination and use of referrals and linkages with primary healthcare providers, other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects supported by other federal programs, 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."[424] In 2022, HHS told CRS:

> 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.[425]

Do Title X Projects Provide Gender-Affirming Services?

In 2022, HHS told CRS:

> Gender affirming procedures and/or medication are not eligible for Title X funding, however gender affirming approach to all clients is expected to be incorporated into quality family planning services. As mentioned previously, because Title X program funding is limited to services necessary to prevent or achieve pregnancy, and to help individuals determine the number and spacing of children, gender affirming procedures and/or medications would be outside the scope of the Title X program.[426]

Title X clinical guidelines "encourage taking a client-centered approach" by, among other things, delivering services in "a culturally competent manner so as to meet the needs of all clients, including … those who are lesbian, gay, bisexual, transgender, or questioning their sexual identity (LGBTQ)."[427] The guidelines state: "In addition, professional recommendations for how to address the needs of diverse clients, such as LGBTQ persons or persons with disabilities, should be consulted and integrated into procedures, as appropriate. For example, as noted before, providers should avoid making assumptions about a client's gender identity, sexual orientation, race, or ethnicity; all requests for services should be treated without regard to these characteristics."[428]

The Title X program funds the Reproductive Health National Training Center, which offers training to Title X providers.[429] The center's website lists resources related to gender-affirming

[423] Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs."

[424] 42 C.F.R. §59.5(b)(8).

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

[426] Emails from the HHS Office of the Assistant Secretary for Legislation, February 3, 2020, December 1, 2020, February 9, 2021, and July 1, 2022.

[427] Loretta Gavin, Susan Moskosky, Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs."

[428] Ibid.

[429] Title X training grants are authorized under Title X of the PHSA, Section 1003, codified in the *U.S. Code* at 42 U.S.C. §300a-1. The Family Planning National Training Center's LGBTQ Services Resources are listed at https://www.fpntc.org/training-packages/lgbtq-services.

services, including *The Need for Accepting and Affirming Care in Title X Settings Video,*[430] *Support LGBTQ+ Clients with Affirming Language Job Aid,*[431] and *Innovative Models for PrEP Programs in Family Planning Sites Webinar*, which discusses "services integrating PrEP and gender-affirming care."[432]

What Are Teen Pregnancy Prevention Programs?

Given the consequences associated with teen births for both adolescents and their children, federal law authorizes programs designed to delay sexual activity and prevent pregnancies among teenagers.[433] Four HHS programs focus exclusively on providing teen 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.[434] All of the programs serve children and teenagers, with a focus on those with risk factors for teenage pregnancy. HHS competitively awards program funding to grantees that include states, community-based organizations, and selected other entities. The programs provide education and social supports in schools, afterschool programs, community centers, and other settings. The activities carried out under these programs vary, but they generally seek to support youth in making healthy choices about engaging (or not) in sex and reducing sexual risk behaviors.

Do Teen Pregnancy Prevention Programs Provide Reproductive Health Services?

Teen pregnancy prevention programs are intended to prevent pregnancy, STIs, and associated sexual risk behaviors for children and teens. The programs vary in their approaches to prevention education.[435] 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."[436] Under the TPP program, either or both approaches may be used.

Grantees that receive funding under the four programs use education models that have been developed by research organizations and other entities, with curriculum that is generally carried

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[430] Reproductive Health National Training Center, *The Need for Accepting and Affirming Care in Title X Settings Video*, https://rhntc.org/resources/need-accepting-and-affirming-care-title-x-settings-video.

[431] Reproductive Health National Training Center, *Support LGBTQ+ Clients with Affirming Language Job Aid*, https://rhntc.org/resources/support-lgbtq-clients-affirming-language-job-aid.

[432] Family Planning National Training Center, *Innovative Models for PrEP Programs in Family Planning Sites Webinar*, https://www.fpntc.org/resources/innovative-models-prep-programs-family-planning-sites-webinar. PrEP refers to preexposure prophylaxis for HIV prevention.

[433] For further information about teen birth rates and consequences of teen pregnancy, see CRS Report R45184, *Teen Birth Trends: In Brief*.

[434] Despite their similar names and purposes, the latter two programs have different authorizing laws and funding mechanisms. For FY2022, 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 further information, see CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

[435] CRS Report R45183, *Teen Pregnancy: Federal Prevention Programs*.

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

out by trained facilitators. Some of these programs were 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.[437] Grantees that use a sexual risk avoidance approach prioritize *sexual risk avoidance education*, or not engaging in consensual sexual activity. They may also address *sexual risk cessation*, or discontinuing consensual sexual activity after having engaged in it.[438] 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.[439] Grantees that use broader sexual health education programs may focus on teaching education that focuses on increasing participants' knowledge about STDs and HIV and reducing risk behaviors, while building skills in problem solving and negotiation related to relationships and sexual activity. Some programs may additionally encourage abstinence, negotiating skills around abstaining from sex, improving contraceptive use, and using condoms correctly, among other topics.[440]

Do Teen Pregnancy Prevention Programs Provide Contraceptive Services?

As noted, grantees that use a broader approach to providing sexual health education can use program models that provide information about contraceptives, including proper use of contraceptives. Given the focus on contraceptive education among some programs, and no identified prohibition on distributing them in statute or guidance, grantees may potentially provide contraceptives such as condoms.

Do Teen 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.[441] Two of the teen pregnancy prevention programs, the GDM

[437] 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) Family and Youth Services Bureau (FYSB), and the former Office of Adolescent Health (OAH) within OASH. HHS contracted with Mathematica Policy Research, Inc., a social policy research organization, to review studies of teen pregnancy prevention programs. The review was active from 2010 to 2019, and funding was set aside to reestablish it as part of FY2022 appropriations. See Juliet Lugo-Gil et al., *Updated Findings from the HHS Teen Pregnancy Prevention Evidence Review: August 2015 through October 2016*, Mathematica Policy Research for HHS, ASPE, April 2018. The website for these models and studies are now at Youth.gov, HHS Teen Pregnancy Prevention Evidence Review, https://tppevidencereview.youth.gov/EvidencePrograms.aspx.

[438] Mathematica, *Conceptual Models to Depict the Factors that Influence the Avoidance and Cessation of Sexual Risk Behaviors Among Youth* for HHS, OASH and ACF, Office of Planning, Research, and Evaluation (OPRE), February 2020.

[439] See for example, Youth.gov, HHS Teen Pregnancy Prevention Review, "Making a Difference! Program Overview" and "Heritage Keepers Abstinence Education Program Overview." These are examples of abstinence education approaches and are included for illustrative purposes only.

[440] See for example, Youth.gov, *HHS Teen Pregnancy Prevention Review*, "¡Cuídate! Program Overview" and "Be Proud! Be Responsible Program Overview." These are examples of sexual health education approaches and are included for illustrative purposes only.

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

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 2020 funding announcements for the Title V Sexual Risk Avoidance Education program, HHS has specified that "HHS does not allow federal programs to make referrals for abortions or to facilities where abortion is a method of family planning." HHS further specified that "referral resources should include, but not be limited to, substance use and abuse and mental health services. Referrals cannot be made to family planning organizations that provide abortions."[442] PREP grant announcements do not appear to address abortion. [443] In the absence of program guidance on the topic, general HHS guidance on prohibiting funding for abortions applies.[444]

Do Teen Pregnancy Prevention Programs Provide Infertility Services?

The teen pregnancy prevention programs do not provide infertility services.

Do Teen Pregnancy Prevention Programs Provide Maternity Services?

The teen pregnancy prevention programs do not provide maternity services.

Do Teen Pregnancy Prevention Programs Provide Reproductive Health Screening, Prevention, and Treatment Services?

The teen 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 Teen Pregnancy Prevention Programs Provide Gender-Affirming Services?

The teen pregnancy prevention programs do not provide gender-affirming services.

What Federal Grant Programs Address Sexually Transmitted Infections (STIs)?

Both CDC and HRSA provide funding to address STIs. CDC's program focuses on multiple STIs, while HRSA's targets HIV/AIDS specifically.

[442] See, for example, HHS, ACF, Administration on Children, Youth, and Families (ACYF), FYSB, *Standing Announcement for Title V State Sexual Risk Avoidance Education*, HHS-2020-ACF-ACYF-SRAE-1848, 2020.

[443] See, for example, HHS, ACF, FYSB, *State Personal Responsibility Education Program (PREP)*, HHS-2016-ACF-ACYF-PREP-1138, 2016.

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

What Centers for Disease Control and Prevention (CDC) Programs Address STIs?

A number of federal programs administered by CDC address STIs. Chief among them are several cooperative agreements (a type of grant program) administered by the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP).[445] 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.[446]
- **STD Prevention and Control:** CDC funds cooperative agreements for STD 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. The current program targets three major STDs: chlamydia, gonorrhea, and syphilis.[447]

These are long-standing assistance programs, although award structures, goals, and amounts often change from one year to the next. Current programs support a number of activities, for example, referrals for screening and treatment, contact tracing and partner notification, and provider education and training. Additional CDC assistance programs may address HIV and STD prevention in part. These include programs for adolescent and school health and for state epidemiology and laboratory capacity, among others.

What Is the Ryan White HIV/AIDS Program?

The main federal program that targets HIV/AIDS prevention and treatment is the Ryan White HIV/AIDS program ("Ryan White"), administered by HRSA. The program provides grants to metropolitan areas and states to provide HIV-related services, including testing and treatment, to a safety net population.[448] States also receive funding for the AIDS Drug Assistance Program (ADAP), which is used to pay for HIV/AIDS drugs for individuals who do not have another source of payment. The Ryan White program is considered to be a residual payer; its funds are not used to provide services to individuals with another source of coverage (e.g., private health insurance).[449] Ryan White Part C provides grants to health centers, family planning clinics, and

[445] CDC, NCHHSTP, https://www.cdc.gov/nchhstp/partners-programs.htm. A cooperative agreement is a type of grant for which there is substantial involvement of both the federal awarding agency and the nonfederal recipient entity in carrying out the purposes of the federal award. See Grants.gov, "What is a cooperative agreement?," https://grantsgovprod.wordpress.com/2016/07/19/what-is-a-cooperative-agreement/.

[446] CDC, HIV Program Resources, https://www.cdc.gov/hiv/programresources/index.html; and CDC, HIV Funding and Budget, https://www.cdc.gov/hiv/funding/index.html.

[447] CDC, Strengthening STD Prevention and Control for Health Departments (STD PCHD), https://www.cdc.gov/std/funding/pchd/default.htm.

[448] For more information about the Ryan White Program, see CRS Report R44282, *The Ryan White HIV/AIDS Program: Overview and Impact of the Affordable Care Act*, and HRSA, "HIV/AIDS Programs," http://hab.hrsa.gov/. Ryan White has six parts each with multiple components; for further information, see the Appendix in CRS Report R44282, *The Ryan White HIV/AIDS Program: Overview and Impact of the Affordable Care Act*.

[449] 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 2013, https://hab.hrsa.gov/sites/default/files/hab/Global/happartamanual2013.pdf.

community-based organizations, among others, to support outpatient HIV early intervention services to the safety net population. The program is required to serve people with HIV/AIDS and, as such, does not provide PrEP; it does, however, through the Part C-Early Intervention Service program, provide testing and counseling for individuals at risk of acquiring HIV.[450] Ryan White 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 Ryan White-funded entities to support education and outreach to increase minority access to Ryan White services. The program has also received funding through the Ending the HIV Epidemic in the United States initiative. In 2022, the program received additional funding for states and metropolitan areas to reduce new HIV infections, for workforce development, and for technical assistance to support health care and social systems coordination.[451] Additional funding was also provided in 2021 and 2020 for this initiative.[452]

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. This program provides low-income, uninsured, and underserved women access to screening and diagnostic services to detect breast and cervical cancer at an early stage.[453] Currently, the program funds 70 grantees: all 50 states, the District of Columbia, six U.S. territories, and 13 American Indian/Alaska Native tribes or tribal organizations.

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

> During 2015-2017, about 5.7% of U.S. women were eligible for NBCCEDP cervical cancer screening services, and the program served 6.8% of eligible women. During 2016-2017, about 5.3% of U.S. women were eligible for NBCCEDP breast cancer screening services, and the program served 15.0% of eligible women.[455]

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-

[450] Ibid.

[451] HHS Press Office, "HHS Awards $115 Million to Support Ending the HIV Epidemic in the United States," press release, June 16, 2022, https://www.hhs.gov/about/news/2022/06/16/hhs-awards-115-million-to-support-ending-hiv-epidemic-in-united-states.html.

[452] HHS, HRSA, "HRSA Awards $99 Million to End the HIV Epidemic in the United States," March 4, 2021, https://www.hrsa.gov/about/news/press-releases/hrsa-awards-99-million-to-end-hiv-epidemic, and HHS Press Office, "HHS Awards $117 Million to End the HIV Epidemic in the United States," February 26, 2020, https://public3.pagefreezer.com/content/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2020/02/26/hhs-awards-117-million-to-end-hiv-epidemic-in-the-united-states.html.

[453] CDC, National Breast and Cervical Cancer Early Detection Program, https://www.cdc.gov/cancer/nbccedp/.

[454] CDC, *Justification of Estimates for Appropriation Committees, FY2023*, p. 167, https://www.cdc.gov/budget/documents/fy2023/FY-2023-CDC-congressional-justification.pdf.

[455] CDC, National Breast and Cervical Cancer Early Detection Program, https://www.cdc.gov/cancer/nbccedp/about.htm. 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. 26, pp. 649-650, March 21, 2015, https://link.springer.com/content/pdf/10.1007%2Fs10552-015-0561-0.pdf.

19 pandemic.[456] Individuals who screen positive in CDC's discretionary-funded Breast and Cervical Cancer Early Detection Program are given presumptive Medicaid eligibility for services including, but not limited to, treatment of the cancer.

Grant Programs That May Be Used to Support Reproductive Health Services

The following questions discuss federal programs that have broad purposes but may provide some types of reproductive health services. General descriptions of these programs, and brief explanations of the extent of their focus on reproductive health, appear below.

How Does the Federal Health Center Program Support Reproductive Health Services?

The Federal Health Center Program, administered by HHS's HRSA,[457] 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.[458] Health centers focus on providing primary care services and are required to provide voluntary family planning services. Health center data from 2020 reports that more than 2.5 million visits were for contraceptive management, provided to nearly 1.5 million patients.[459] While specific health services may vary by facility, health centers generally provide preventive health services, including reproductive health screenings. In 2020, health centers provided more than 900,000 mammograms, according to health center data. Health centers also provide STI testing and treatments. In particular, from 2020 to 2022, health centers received supplemental funding as part of the Ending the HIV Epidemic: A Plan for America initiative to identify individuals who may be at risk for contracting the virus, provide preventive services, test for HIV, and prescribe PrEP when appropriate.[460] Health centers must provide access to pharmaceutical services either onsite or through contracts. Health centers may receive Title X grants and must comply with program requirements if they do. Health centers are prohibited from using federal funds to provide abortions.[461] No information is available about whether health centers provide infertility services.

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[456] 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.

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

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

[459] HHS, HRSA, "Uniform Data System National Report 2020, Table 6A: Selected Diagnoses and Services Rendered," https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6A&year=2020.

[460] HHS, HRSA, "HHS Awards $117 Million to End the HIV Epidemic in the United States," February 26, 2020, https://www.hhs.gov/about/news/2020/02/26/hhs-awards-117-million-to-end-hiv-epidemic-in-the-united-states.html, HHS, HRSA, "HHS Awards Over $48 Million to Health Centers for Ending the HIV Epidemic in the U.S. Initiative," https://www.hhs.gov/about/news/2021/09/16/hhs-awards-48-million-to-health-centers-to-end-the-hiv-epidemic.html. As of the date of this report's publication, HRSA has not awarded the FY2022 funds for this initiative; however, P.L. 117-103 included $122.5 million for health centers for the Ending the HIV Epidemic Initiative.

[461] 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 has applied Hyde language in appropriations to

How Does the Title V Maternal Child Health Services Block Grant Support Reproductive Health Services?

HRSA's Maternal Child Health Bureau administers the Maternal Child Health (MCH) Services Block Grant, which is authorized in Title V of the SSA.[462] The block grant provides flexible funding to states and territories to operate programs that seek to improve the health and well-being of low-income pregnant women, mothers, and children. This includes support for direct health services, including family planning. Each state is required to submit a state action plan that details how funding will be used. Most of these plans aim to increase access to family planning services and preventive screenings for the women served by the program. In some cases, state MCH programs may use funding to provide services directly; however, they may also refer and connect patients to services through other providers (e.g., health centers). In addition, state MCH programs are required to coordinate with other federal programs, including Medicaid and the Title X program.[463] State MCH programs are not required to provide specific services directly; flexible funds are provided to states that determine how to best meet a state's needs. Because of this, the degree to which the MCH Service Block grant includes or excludes specific services is unclear. The grant receives its funding from discretionary appropriations provided in the annual appropriations measure for the Departments of Labor, HHS, and Education, and Related Agencies (LHHS). As such, these funds are subject to the LHHS bill's abortion restrictions (commonly referred to as the Hyde Amendment).[464]

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.[465] Federal regulations issued in 1993 established uniform definitions for 28 main SSBG service categories, including *family planning services, pregnancy and parenting,* and *health related and home health services*.[466] States are not required to spend SSBG funds in any particular service category and may support other services as well. In FY2020, the most recent year for which complete data are available, roughly 0.3% of all SSBG expenditures were spent on family planning services, 0.3% were spent on pregnancy and parenting, and roughly 0.9% were spent on health related and home health services.[467] The SSBG is an annually appropriated capped entitlement. Mandatory appropriations for the SSBG are provided each year

these funds. See Section 301(d) of Title III, Subtitle A, of P.L. 116-260.

[462] CRS Report R44929, *Maternal and Child Health Services Block Grant: Background and Funding*.

[463] Section 501 of the SSA.

[464] 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*.

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

[466] These regulations were codified at 45 C.F.R. §96, Appendix A.

[467] For more information, see HHS, ACF, Office of Community Services, *Social Services Block Grant Program Annual Report 2020*, https://www.acf.hhs.gov/sites/default/files/documents/ocs/RPT_SSBG_Annual%20Report_FY2020.pdf. 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.

in the LHHS Appropriations Act and, as such, are subject to the LHHS bill's abortion-related restrictions (commonly referred to as the Hyde amendment).[468]

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.[469] 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. At the federal level, the 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 Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) provided $400 million annually through FY2022.

In recent years, HHS has distributed MIECHV funding to states based primarily on a formula that accounts for poverty and selected other factors. Territories and tribes also receive funding.[470] Generally, a jurisdiction's public health or social services department is the lead agency that administers MIECHV program funds.[471] The agency determines which home visiting model(s) to implement in the state, though 75% of each jurisdiction's funds must be expended for using models that HHS has determined to be evidence-based at improving certain outcomes, including maternal and newborn health.[472] Depending on the model, home visits may be conducted by nurses, mental health clinicians, social workers, 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.[473]

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[468] For more information, see the "Restrictions Related to Certain Controversial Issues" section in CRS Report R47029, *Labor, Health and Human Services, and Education: FY2022 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*.

[469] CRS Report R43930, *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Background and Funding*.

[470] CRS Report R43930, *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Background and Funding*. The statute is silent about how funds are to be distributed under the program, except to require that HHS reserve 3% of the annual appropriation for Indian tribal entities and another 3% for training, technical assistance, and evaluations. In addition, HHS must use the most accurate data available for eligible jurisdictions if funding is awarded on the basis of relative population or poverty considerations. Section 511(j) of the SSA.

[471] For further information, see CRS Report R43930, *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Background and Funding*. Under the law, HHS may make grants to nonprofit organizations to carry out a home visiting program in a state that did not apply, or receive approval, for a grant as of FY2012. Nonprofit organizations operate Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)-funded home visiting programs in three states (Florida, North Dakota, and Wyoming).

[472] Section 511(d)(3)(iii). HHS, HRSA and ACF, "Maternal, Infant, and Early Childhood Home Visiting Program," 75 *Federal Register*, July 23, 2010.

[473] See Appendix B of CRS Report R43930, *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Background and Funding*. See also Charles Michalopoulos et al., Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation, HHS, ACF, OPRE, OPRE Report 2019-07.

The MIECHV law requires states to demonstrate improvements in certain outcome areas, including maternal and newborn health. The maternal and newborn health outcome includes performance metrics for (1) preterm birth, (2) breastfeeding, (3) depression screening, (4) well-child visit, (5) postpartum care, and (6) tobacco cessation referrals. Most states and territories (81%) demonstrated improvements in maternal and newborn health during the first three years of the program.[474] MIECHV law also required an evaluation of the program, and found mixed outcomes regarding maternal and child health across four home visiting models.[475] Regarding maternal health, the study found that program participation generally did not affect whether mothers had a subsequent pregnancy by the time their children were 15 months old, but found that participation did result in increased health care coverage for mothers. In addition, mothers receiving services were also significantly less likely to report that their health was fair or poor and to report fewer depressive symptoms.

The MIECHV statute is silent about abortion, and past grant announcements do not appear to address the topic.[476] In the absence of guidance specific to the program, the general HHS guidance on prohibiting funding for abortions applies.[477]

How Does the Pregnancy Assistance Fund (PAF) Program Support Reproductive Health Services?

The Pregnancy Assistance Fund (PAF) sought to improve the educational, health, and social outcomes for vulnerable individuals during pregnancy and the postnatal period.[478] 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.[479] (No new grants were issued after FY2019, effectively terminating the program; the ACA provisions that apply to the program have not been repealed.)

HHS distributed PAF funding on a competitive basis to states, the District of Columbia, U.S. territories, and tribal entities. These grantees could decide how to use funding under four purpose areas. Three of the purpose areas focused on providing services to the eligible expectant and parenting population through subgrants and partnerships.[480] In general, grantees provided

[474] HHS, ACF, and HRSA, *Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*, March 2016. Most tribal grantees also demonstrated improvement in maternal and newborn health. Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, HHS, ACF, OPRE, OPRE Report 2015-88, November 2015. In addition to the initial reporting on outcomes, jurisdictions must report to HHS about the benchmarks at least 30 days after the end of FY2020 and every three years thereafter. The metrics cited here were implemented in FY2017. Prior to that time, the maternal and newborn health metrics included additional items such as inter-birth intervals, breastfeeding, and maternal and child health insurance status.

[475] Charles Michalopoulos et al., *Impacts on Family Outcomes of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*, HHS, ACF, OPRE, OPRE Report 2019-07.

[476] See, for example, HHS, HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Formula Awards*, FY 2020 Non-Competing Continuation Update, 2020.

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

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

[479] 42 U.S.C. §18201-18204.

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

subgrants to school districts, community service organizations, and institutions of higher education (IHE) that directly served the expectant and parenting population.[481] For the most recent year of available data (2017-2018), the most common services provided to expectant and recent parents were parenting supports, concrete supports (e.g., transportation), and health care services.[482] 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.[483] 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.[484]

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."[485]

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

[482] 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).

[483] 42 U.S.C. §18203(b)(4).

[484] 42 U.S.C. §18203(d)(3).

[485] 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
ART	Assisted Reproductive Technology
ASPE	Assistant Secretary for Planning and Evaluation
BBA 2018	Bipartisan Budget Act of 2018 (P.L. 115-72)
BOP	Bureau of Prisons
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	Children's Health Insurance Program
CMCS	Center for Medicaid, CHIP and Survey & Certification
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
CRS	Congressional Research Service
CSR	Cost-Sharing Reduction
DHA	Defense Health Agency
DHS	Department of Homeland Security
DOD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
DPP	Deployed Prescription Program
EC	Emergency Contraceptive
EEOC	Equal Employment Opportunity Commission
EHB	Essential Health Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ERO	Enforcement and Removal Operations

Acronym	Definition
FAM	Fertility Awareness-Based Method
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSH	Follicle Stimulating Hormone
FY	Fiscal Year
FYSB	Family and Youth Services Bureau
GAO	U.S. Government Accountability Office
GDM	General Departmental Management (Sexual Risk Avoidance Education Program)
GID	Gender Identity Disorder
GRS	Gender Reassignment Surgery
HCFA	Health Care Financing Administration
HCSM	Health Care Sharing Ministry
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
ICE	U.S. Immigration and Customs Enforcement
IHE	Institute of Higher Education
IHS	Indian Health Service
IUD	Intrauterine Device
IUI	Intrauterine Insemination
IVF	In Vitro Fertilization
LAM	Lactational Amenorrhea Method
LARC	Long-Acting Reversible Contraceptive
LGBTQ	Lesbian, Gay, Bisexual, Transgender, or Questioning Their Sexual Identity
LH	Luteinizing Hormone
LHHS	Appropriation bill that provides funding for the Departments of Labor, HHS, and Education, and Related Agencies
LTSS	Long-Term Services and Supports
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MACPAC	Medicaid and CHIP Payment and Access Commission
MAGI	Modified Adjusted Gross Income

Acronym	Definition
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
NDAA	National Defense Authorization Act
NDS	National Detention Standards
OAH	Office of Adolescent Health
OASH	Office of the Assistant Secretary for Health
OB/GYN	Obstetrician/Gynecologist
OCR	Office for Civil Rights (HHS)
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPA	Office of Population Affairs
OPRE	Office of Planning, Research, and Evaluation
PAF	Pregnancy Assistance Fund
PBNDS	Performance-Based National Detention Standards
PDA	Pregnancy Discrimination Act of 1978 (P.L. 95-555)
PEP	Post-Exposure Prophylaxis
PHSA	Public Health Service Act
PRC	Purchased Referred Care Program
PrEP	Pre-exposure Prophylaxis
PREP	Personal Responsibility Education Program
PTC	Premium Tax Credit
QFP	Quality Family Planning
QHP	Qualified Health Plan
RRC	Residential Reentry Center
SARC	Short-Acting Reversible Contraceptive
SHO	State Health Official
SHOP	Small Business Health Options Program
SMDL	State Medicaid Directors Letter
SRS	Sex Reassignment Surgery

Acronym	Definition
SSA	Social Security Act
SSBG	Social Services Block Grant Program
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STLDI	Short-Term, Limited Duration Insurance
TANF	Temporary Assistance for Needy Families
TPA	Third-Party Administrator
TPP	Teen Pregnancy Prevention Program
TSH	Thyroid Stimulating Hormone
UIO	Urban Indian Organization
USC	*U.S. Code*
USCG	U.S. Coast Guard
USPSTF	United States Preventive Services Task Force
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Appendix B. Policy Experts Table

Topic	Contact
Reproductive Health Services (General)	Taylor R. Wyatt
Abortion (Services)	Taylor R. Wyatt
Abortion (Legal issues)	Jon Shimabukuro
Regulation of Contraceptives	Agata Bodie, Hassan Z. Sheikh
Maternal Mortality	Kavya Sekar
Bureau of Prisons (BOP)	Nathan James
Department of Defense (DOD)	Bryce H.P. Mendez
U.S. Immigration and Customs Enforcement (ICE)	Abigail F. Kolker; Audrey Singer
Indian Health Service	Elayne J. Heisler
The U.S. Coast Guard	Bryce H.P. Mendez
Department of Veterans Affairs	Jared S. Sussman
Medicaid	Evelyne P. Baumrucker
Medicare	Paulette C. Morgan
Private Health Insurance	Vanessa C. Forsberg
Private Health Insurance (Legal Issues)	Jennifer A. Staman
Federal Contraceptive Coverage Requirement (Legal Issues)	Victoria L. Killion
Title X Program	Angela Napili; Taylor R. Wyatt
Teen Pregnancy Prevention Program	Jessica Tollestrup
Sexually Transmitted Infections (STI) Prevention Grants	Kavya Sekar
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