NATIONAL WOMEN'S LAW CENTER
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ACCESS TO BIRTH CONTROL WITHOUT OUT-OF-POCKET COSTS:

Improving and Expanding the Affordable Care Act's Contraceptive Coverage Requirement

EXECUTIVE **Summary**

Today more than 64 million women[1] have insurance coverage of birth control and other critical preventive services without out-of-pocket costs, as a result of the Affordable Care Act (ACA).[2] The ACA's contraceptive coverage requirement—the provision designed to guarantee no-cost coverage of the full range of birth control methods—has increased use of birth control and, as a result, expanded the reach of birth control's health and economic benefits.

But the benefits are not reaching everyone. The Trump administration worked to undermine the ACA's contraceptive coverage requirement by passing sweeping exemptions and neglecting enforcement. Some insurance plans are not in compliance, leaving people unable to access the contraception they need. And there are many individuals who are in plans that are not reached by the ACA and who do not have no-cost contraceptive coverage.

Federal and state policymakers and insurance companies must take action to ensure everyone has access to no-cost contraceptive coverage. This is especially important now, during an economic crisis that has taken a disproportionate toll on women, and particularly on women of color and low-income women.

The Affordable Care Act's CONTRACEPTIVE COVERAGE REQUIREMENT

The Patient Protection and Affordable Care Act (ACA) established an important standard for coverage of contraceptives: nearly all private health coverage, as well as coverage through the Medicaid expansion, must cover the full range of female-controlled contraceptives and related services, without cost-sharing such as coinsurance, co-payments, or deductibles. The ACA's contraceptive coverage requirement is part of the law's preventive health services coverage provision, which is designed to enable individuals to avoid preventable conditions and improve health overall by increasing access to preventive care and screenings.[3]

Before the ACA became law, high out-of-pocket costs prevented many women, particularly women of color, from accessing and obtaining the contraceptive method of their choice,[4] thereby making it harder for them to control their reproductive and sexual health and, by extension, many other aspects of their lives. By removing cost barriers to FDA-approved birth control methods, the ACA contraceptive coverage requirement ensures that people can get the birth control that best meets their needs, while also realizing both the health and economic benefits of using contraception.

WHAT MUST BE COVERED UNDER THE ACA'S CONTRACEPTIVE COVERAGE REQUIREMENT

Plans must cover all 18 different female-controlled contraceptive methods, based on the Food and Drug Administration (FDA) Birth Control Chart,[5] without cost-sharing, as well as any additional methods identified by the FDA. Plans and issuers must cover without cost sharing at least one form of contraception in each of the methods.[6]

Plans must cover without cost-sharing not only the birth control itself, but also the services related to birth control—such as office visits, counseling, or medical services related to a sterilization procedure or insertion of a birth control method.[7] Other related services, such as follow-up visits, management of side effects, counseling for continued adherence, and device removal, must also be covered without cost-sharing.

Insurance companies are allowed to use limited "reasonable medical management techniques"to determine the "frequency, method, treatment, or setting for which a recommended preventive service will be available without cost sharing requirements to the extent not specified in a recommendation or guideline."[8] For example, plans can impose out-of-pocket costs when a preventive service is accessed at an out-of-network provider or impose out-of-pocket costs on a branded

drug when the insurance company covers an available generic equivalent without cost-sharing. But the use of medical management techniques is limited. Plans cannot, for example, require someone to try and fail a contraceptive in one method category before covering a different contraceptive method (e.g., try and fail using a vaginal ring before covering a hormonal IUD.)[9]

When someone needs a *specific* contraceptive product within a method category, insurance companies must have a process in place to waive cost-sharing if that specific contraceptive is not typically covered without cost-sharing. The cost-sharing exceptions process must be "easily accessible, transparent…sufficiently expedient… [and] not unduly burdensome on the individual or a provider."[10] The exceptions process must also defer to the provider's recommendation for that product—the insurer cannot overrule this determination. Federal guidance on this point suggests issuers use the Medicare Part D exceptions form as a basis for the contraceptive cost-sharing exceptions process.[11]

THE REQUIREMENT APPLIES TO MOST PRIVATE INSURANCE COVERAGE, SOME MEDICAID COVERAGE, AND PLANS OFFERED TO CIVILIAN FEDERAL EMPLOYEES BUT NOT TO ALL SOURCES OF COVERAGE OR CARE.

The Affordable Care Act requires all non-grandfathered private group health plans and health insurance issuers offering group or individual coverage to provide contraceptive coverage without cost-sharing.[12] This includes all plans offered on the health insurance marketplace, the vast majority of employer health plans,[13] and fully insured student health plans. The law also applies to coverage for those eligible through Medicaid expansion,[14] as well as all health plans offered through the Federal Employees Health Benefit Program.[15]

The law does not apply to several government sources of health coverage: TRICARE (coverage for military servicemembers and their families); traditional Medicaid programs; and Medicare (coverage for those over 65 years of age and many people with disabilities).[16]

EXEMPTIONS FOR THOSE WITH OBJECTIONS TO BIRTH CONTROL COVERAGE

Through regulations, the federal government created an exemption to the contraceptive coverage requirement for churches and other houses of worship that object to birth control.[17] It also created an "accommodation" that removes contraception from the health plans offered by religiously affiliated non-profits or schools that object to its coverage, while ensuring that impacted employees, families, and students still have contraceptive coverage without cost-sharing.[18] In 2014, in response to the Supreme Court's decision in *Burwell v. Hobby Lobby Stores, Inc.*, the accommodation was extended to closely held for-profit employers with religious objections to birth control.[19]

In 2017, the Trump administration revised the regulations, expanding the exemptions previously available only to houses of worship to include any nongovernmental organization that objected to providing or arranging coverage "for some or all contraceptive services based on sincerely held religious beliefs."[20] The new rulemaking also extended the exemption to nongovernmental organizations that objected to contraceptive coverage based on "sincerely held moral convictions."[21] There are legal challenges to the Trump administration rules that are still working their way through the courts,[22] but the Trump administration's sweeping exemptions are in effect as of publication. The Biden administration has indicated it will undertake new rulemaking to amend the regulations by February 2022 at the latest.[23]

Impact of the ACA's CONTRACEPTIVE COVERAGE REQUIREMENT

Birth control is a cornerstone of health and economic security. When people have access to affordable contraception and can plan whether to have children or the timing and number of their pregnancies, they are better able to complete their education, advance their careers, care for the children they already have, and ensure their economic security over the long-term.[24] Millions of people have had contraceptive coverage without cost-sharing since the requirement went into effect in 2012, including 64.2 million women in 2020 alone.[25] It is no wonder, then, that the ACA's birth control benefit has already had a significant impact on individuals' health and economic outcomes, and will continue to do so.

THE REQUIREMENT HAS INCREASED USE OF CONTRACEPTIVES BROADLY, AND SPECIFICALLY INCREASED USE OF CONTRACEPTIVES THAT MEET PEOPLE'S NEEDS, AND OF THE MOST-EFFECTIVE METHODS THAT HAVE HIGH UPFRONT COSTS.

The ACA contraceptive coverage requirement is associated with an increased use of and adherence to a range of birth control methods. A recent Kaiser Family Foundation survey found that since implementation of the ACA's contraceptive coverage requirement, nearly two-thirds of OBGYNs (63%) reported an increase in contraceptive use by their patients and 69% reported an increase in their patients' use of their *desired* contraceptive method.[26]

The ACA is credited with an increased use of long-acting reversible contraceptive methods (LARCs) that are most effective but have high upfront costs without insurance coverage. One study showed an increase from 2.4% to 14.3% of all birth control users choosing a LARC between 2002 and 2014.[27] Another study showed that the ACA was particularly important for women with high-deductible health plans (HDHP) who face high out-of-pocket costs for care. Uptake of LARCs by women in HDHPs increased by 35% more after the implementation of the ACA than for women in traditional health plans. This is particularly important given the growth of HDHPs in recent years, and given that 30% of workers with employer-based insurance are enrolled in a HDHP (up from 20% in 2014 plans).[28]

THE REQUIREMENT HAS HAD IMMEDIATE FINANCIAL BENEFITS.

While the ACA increased contraceptive use, it also substantially lowered out-of-pocket costs and improved economic security for reproductive-age women and their families. In 2013 alone, the contraceptive coverage requirement saved women $1.4 billion on out-of-pocket costs just for birth control pills.[29] One study found the median out-of-pocket cost for all types of prescription contraception decreased to $0 after the implementation of the ACA, and that 91.5% of individuals who got an IUD and 87.1% of individuals who got an implant paid $0 out of pocket.[30] Another analysis found that working-age women across all income groups were less likely to report being worried about paying for health care and more likely to

report being able to afford prescription medications and specialist care after the ACA became law.[31] In addition, following the ACA's Medicaid expansion, more women in safety net clinics utilized their coverage to pay for contraceptive services, reducing publicly funded clinics' uncompensated care costs and enabling them to stretch their budgets further.[32]

THE REQUIREMENT WILL HAVE LONG-TERM BENEFITS ON PEOPLE'S HEALTH, ECONOMIC SECURITY, AND FUTURES.

Birth control is critical to the health of individuals and families, and to economic and social equality. It prevents unintended pregnancy, which can have serious negative consequences for women and their children.[33] Birth control is highly effective in preventing and treating a wide array of often severe medical conditions; it decreases the risk of certain cancers, manages menstrual disorders, and treats other diseases.[34] The ability to prevent, plan, and space pregnancies is critical to a person's ability to move forward with their education and career. Studies show that birth control is directly linked to women's increased educational and professional opportunities, and increased lifetime earnings.[35]

IMPORTANCE OF BIRTH CONTROL ACCESS DURING THE PANDEMIC AND ECONOMIC CRISIS

The overlapping public health and economic crises of the last 20 months have taken a disproportionate toll on women, particularly Black and Latina women. They shouldered the greatest number of job losses in the early days of the pandemic—a result of historical and present-day racism and sexism in our labor market that drives women of color into low-wage, insecure work—and they continue to see the slowest job recovery of any other groups.[36] The extraordinary and deeply gendered child care burdens created from daycare and school closures forced millions of women out of the workforce and today the labor market participation rate is the lowest it has been since 1988.[37]

Since the beginning of this crisis, women have reported wanting more control of their reproductive lives. According to a survey in the first months of the pandemic, one-third of women overall wanted to delay pregnancy or have fewer children.[38] That trend was even more pronounced for women who were already more likely to be experiencing intersecting inequities. Black women (44%) and Hispanic women (48%) were more likely than White women (28%) to report wanting to delay pregnancy or have fewer children, and 37% of low-income women reported such feelings, compared to 32% of higher-income women. Additionally, an increased number of women said they were concerned about being able to afford and obtain birth control and other related services, with Black, Hispanic, queer, and low-income women reporting disproportionate concern. Against this landscape, the importance of the ACA contraceptive coverage requirement to enable people to access the contraceptive care they need without financial barriers is even more clear.

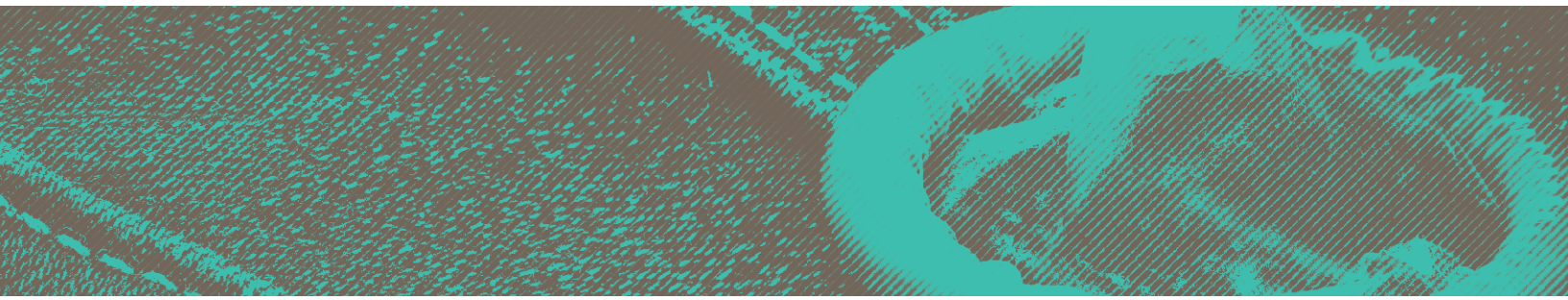
Improving Upon and Expanding NO-COST CONTRACEPTIVE COVERAGE

THE TRUMP ADMINISTRATION'S SWEEPING EXEMPTIONS MUST BE RESCINDED AND PEOPLE SHOULD GET THE COVERAGE TO WHICH THEY ARE ENTITLED.

The Trump administration's sweeping exemptions to the ACA's contraceptive coverage requirement allow virtually any employer or university claiming religious or moral objections to refuse to comply with the requirement. These exemptions are illegal and discriminatory and threaten the health and economic security of individuals nationwide. The Trump administration estimated that 126,000 women could lose coverage of birth control as a result of the rules,[39] but the true estimate is in the hundreds of thousands.

The harms from the Trump administration rules fall most heavily on people in low-wage jobs—who are disproportionately people of color—and young people.[40] These individuals have the fewest resources to pay out-of-pocket for birth control and absorb the costs of an unintended pregnancy.

By taking away birth control coverage that individuals should be getting through an employer or school, the Trump administration rules impose logistical, informational, and administrative barriers to accessing birth control.[41] Many people who lose birth control coverage because of the exemptions will be forced to go outside their existing insurance systems and network of health care providers, losing continuity of care. Navigating the health care system without insurance is time- and resource-intensive, requiring access to phone, internet, and transportation, as well as language comprehension, predictable work schedules, and free time. Having to navigate the system is daunting for anyone, but particularly for people with limited English proficiency, people of color, transgender men, and others who already face multiple barriers to accessing reproductive health care, including language barriers, cultural incompetence, implicit bias, and discrimination.



ACTION **Needed**

The **Departments of Health and Human Services, Treasury, and Labor** must rescind the religious and moral exemptions to the contraceptive coverage requirement created by the Trump administration.

At the same time, the **Departments of Health and Human Services, Labor, and the Treasury** must issue new rulemaking that ensures people get the birth control coverage they are guaranteed under the ACA. The rules must *not* remove contraception from the employee's regular insurance system, impose additional logistical burdens, or reinstate the very economic hardships that the contraceptive coverage benefit was designed to remove.

States legislatures should enact laws that require contraceptive coverage without cost-sharing if their state does not already require it. Where states have already passed this legislation, **state executive branches** must enforce it, with particular attention paid to where state-level exemptions may be narrower than any in federal regulations so that state law requires coverage even if federal law does not.

INSURANCE PLANS MUST FULLY COMPLY WITH THE ACA CONTRACEPTIVE COVERAGE REQUIREMENT

Many people in plans covered by the ACA continue to face challenges accessing no-cost contraception. Research has shown that while the ACA dramatically reduced the cost of birth control, some out-of-pocket costs remain, due, at least in part, to noncompliance with the requirement.[42] A lack of enforcement from federal and state agencies—especially during the last four years —has also contributed to the problem. At the same time, insurers and federal and state agencies have not been proactive in ensuring that the requirement and plan coverage tracks new developments in contraceptive methods.

Since the contraceptive coverage requirement first went into effect in August 2012, NWLC has been assisting people who are facing challenges securing no-cost birth control. NWLC's CoverHer hotline and associated website (www.coverher.org) provide a way for individuals to get individualized assistance, information, and resources. CoverHer explains the contraceptive coverage requirement and assists people who are not getting the coverage they should. Over the last nine years, people have contacted CoverHer from every state and Washington, D.C., sharing the challenges they face securing cost-free contraception and seeking advice for how to navigate the byzantine insurance, provider, and pharmaceutical systems. The stories that make it to the CoverHer hotline likely reflect just a small percentage of the problems people across the United States are actually experiencing, and a small percentage of the population, given that it represents individuals who have the time, energy, and ability to find and contact CoverHer.

The National Women's Law Center hears reports directly from individuals whose insurance plans are violating the ACA contraceptive coverage requirement. The Law Center has identified three noncompliance trends based on reports to CoverHer from January 2020 through July 2021:

- Plans are denying coverage for the specific contraceptive product needed, do not have the required cost-sharing exceptions process, and are not deferring to physician and patient determinations on what is the most appropriate method for the patient;
- Plans are failing to cover the services associated with birth control without out-of-pocket costs; and,
- Plans are failing to provide coverage of newly approved birth control methods.

For further explanation of the non-compliance trends, including specific examples from people who have contacted the CoverHer hotline, please see the Law Center's report The Biden Administration Must Ensure the Affordable Care Act Contraceptive Coverage Requirement Is Working for All.

These violations of the ACA requirement are not trivial; they ultimately result in cost barriers to contraception that are insurmountable for many people, leaving them to use a method that is not right for them because of cost, or to forego contraception entirely.

ACTION **Needed**

Federal agencies must ensure full compliance with the ACA contraceptive coverage requirement.

The Departments of Health and Human Services, Labor, and the Treasury must clarify insurers' requirements to comply with the ACA's contraceptive coverage requirement. The Departments must:

- Specify that all birth control methods for women identified in the FDA's Birth Control Guide must be covered without out-of-pocket costs, *including* newly approved methods;
- Reiterate that all services associated with contraception, including but not limited to counseling, insertion, removal, and follow-up for side effects, must be covered without cost-sharing;
- Reiterate the requirement that plans have a cost-sharing exceptions process that enables coverage without cost-sharing of the specific product a person needs, that is "easily accessible, transparent…sufficiently expedient…[and] not unduly burdensome on the individual or a provider," and that defers to the provider's determination;
- Create a standard, easy-to-use cost-sharing exceptions form to be used across issuers, which should be no longer than 1-2 pages, only ask for necessary information needed, and include timely deadlines – such as 24 to 48 hours – to ensure people can access their product as quickly as possible; and
- Prohibit insurers from requiring a prescription to obtain no-cost coverage of over-the-counter birth control products.

The Departments of Health and Human Services, Labor, and the Treasury must disseminate the new guidance to all agencies that enforce the contraceptive coverage requirement and/or handle noncompliance complaints, including:

- state enforcement agencies;
- regional offices of the Department of Labor, which oversees self-funded plans;
- the Office of Personnel Management, which oversees the Federal Employee Health Benefits Program; and
- the Center for Consumer Information and Insurance Oversight, Compliance & Enforcement Division/Oversight Group, which oversees non-federal government plans.

Those Departments responsible for enforcement must prioritize enforcement, both proactively and in response to complaints. This includes:

- Robustly enforcing the law in response to complaints from individuals or documented instances of plan non-compliance.
- When reviewing plan documents, ensuring that plans are in compliance with the requirements of the ACA contraceptive coverage requirement.

The Food and Drug Administration should update its Birth Control Guide to include all contraceptive methods, including methods that have been recently approved. It should also establish a process for regular updates in the future.

The Department of Health and Human Services, the Department of Labor, and the Office of Personnel Management must conduct a public awareness campaign to ensure that all individuals are aware of the ACA's contraceptive coverage requirement, what they should expect in terms of no-cost coverage, and how to file complaints for non-compliance.

The Department of Health and Human Services should work to educate health care providers, so that they properly bill for these preventive services and so that they can be advocates for their patients in getting the coverage they deserve.

State agencies must ensure full compliance with the ACA contraceptive coverage requirement.

- **State agencies** should provide a thorough review of the insurance plans they regulate, to confirm compliance with the ACA's contraceptive requirement.
- Prior to approving any plan to be offered as insurance coverage in the state, either on the marketplace or through an employer, the state agency tasked with reviewing the plan must ensure that the plan is in compliance.
- Should a person be charged inappropriate cost sharing for birth control and file a complaint with the state, the state agency responsible for enforcement must deal with their complaint swiftly and appropriately.
- State regulators should provide guidance on allowing cost-sharing exceptions and clearly specify a process for insurers to follow. This would assist insurance companies applying to offer coverage in the state, streamline the plan approval process, and would have the added benefit of ensuring health care providers only have to deal with one type of process across insurance companies.

Insurance providers need to come into full compliance with the ACA contraceptive coverage requirement.

- **Insurance providers** should conduct a thorough self-audit of the coverage they provide to ensure it complies with the ACA's contraceptive coverage requirement. Specifically, plans and issuers should ensure that they are providing coverage of: all birth control methods, including methods approved by the FDA in the last several years; all services associated with birth control without cost-sharing; and, that they have a contraceptive cost-sharing exceptions process that complies with the ACA.
- **Insurance providers** should offer up-to-date billing and coding information and training to health care providers and their staff to make sure birth control and associated services associated are accurately coded and covered as required by the ACA.

OTHER HEALTH COVERAGE AND PROGRAMS SHOULD BE BROUGHT UP TO THE ACA CONTRACEPTIVE COVERAGE REQUIREMENT'S FLOOR

The ACA's preventive services provision, including the contraceptive coverage requirement, was intended to reform insurance coverage in the private market, and thus did not reach many types of government coverage and care that existed prior to the ACA.[43] Given the enormous benefits no-cost contraceptive coverage provides and its demonstrated effectiveness in helping people access the right birth control method for them, the requirement should be replicated across non-private coverage and programs that do not already offer coverage of or access to contraceptives without out-of-pocket costs.

TRICARE: NON-ACTIVE DUTY SERVICE MEMBERS AND MILITARY FAMILIES STILL HAVE OUT-OF-POCKET COSTS FOR CONTRACEPTIVES.

The contraceptive coverage requirement does not extend to plans and beneficiaries of TRICARE, which is the health care program for uniformed service members, retirees, and their families. While active duty service members have coverage of all prescription drugs—including birth control—without cost-sharing, non-active duty service members and military family dependents are still subjected to out-of-pocket costs. Only 20% of contraceptives covered by TRICARE are dispensed to active duty service members, which means that the vast majority of people who access contraceptives through TRICARE still have out-of-pocket costs.[44] Without full coverage of contraceptive care, TRICARE beneficiaries face the same cost barriers to accessing birth control as their civilian counterparts did prior to the implementation of the ACA's contraceptive coverage requirement.

With more than 1,570,000 women of reproductive age covered by TRICARE as of 2019,[45] lack of no-cost coverage has a real impact. The Law Center has heard from women covered by TRICARE who cannot afford the out-of-pocket costs for the birth control they need.

DEPARTMENT OF VETERANS AFFAIRS: VETERANS HAVE OUT-OF-POCKET COSTS FOR CONTRACEPTIVES.

The ACA contraceptive coverage requirement does not apply to care received through the Department of Veterans Affairs (VA). Veterans who receive contraceptive care at the VA must still pay out-of-pocket for it. Women veterans now make up the fastest growing group of veterans enrolling in VA health care;[46] small co-pays can be prohibitive for veterans struggling to make ends meet. Veterans should not face barriers to full coverage for basic preventive care, care for which their civilian counterparts do not pay.

ACTION **Needed**

Congress must pass legislation to guarantee no-cost contraceptive coverage for non-active duty service members and their dependents. A one-year provision to prohibit cost-sharing for contraceptive care was included in the House-passed National Defense Authorization Act in September 2021, but this is not enough. Service members need this as a permanent benefit. There are bills pending in Congress to provide comprehensive birth control coverage and counseling for those who rely on the military for health care, which Congress must prioritize and pass.[47]

ACTION **Needed**

Congress must pass pending legislation to remove cost-sharing for veterans obtaining contraceptives through the Department of Veterans Affairs.[48] This would bring the VA in line with group and individual plans governed by the ACA.

MEDICARE: PEOPLE WHO RELY ON MEDICARE FOR HEALTH COVERAGE HAVE NO GUARANTEED COVERAGE OF ALL FDA-APPROVED CONTRACEPTIVES WITHOUT CO-PAYS.

Medicare was designed as a health coverage program to meet the needs of our nation's elderly population, but now also includes coverage of at least 9.1 million people under age 65.[49] This includes nearly 3.5 million women and girls of reproductive age with disabilities that qualify them for Medicare coverage.[50] Since 2006, Medicare beneficiaries have had access to prescription drug coverage through Part D,[51] but while formularies under Part D often include *some* contraceptive pills, transdermal patches, and vaginal rings, there is no statutory or regulatory guarantee that all Medicare beneficiaries have access to the full range of FDA-approved contraceptives or that no cost-sharing is applied to them. Moreover, only 76% of Medicare beneficiaries under 65 have Part D coverage.

Some people with low incomes enrolled in Medicare are "dually eligible" for Medicaid, which then covers services Medicare does not cover or picks up Medicare costs. In some instances, Medicaid covers the costs of contraception for people who are dually eligible, but CoverHer regularly is contacted by people who are enrolled in both Medicare and Medicaid and still have unaffordable out-of-pocket costs for birth control.

ACTION **Needed**

The Centers for Medicare & Medicaid Services should undertake an internal exploration of options to require coverage of contraception without cost-sharing for Medicare beneficiaries. Should administration action not be sufficient to ensure contraceptive coverage, CMS should recommend any necessary legislative fix to Congress.

Conclusion

The ACA's contraceptive coverage requirement has dramatically expanded access to no-cost birth control —extending coverage to millions of women. But action is required by issuers and federal and state agencies to improve coverage now. It must be enforced, and new regulations and guidance are necessary to address gaps created by the Trump administration. And the health and economic successes of the ACA contraceptive coverage requirement should no longer be limited to those with coverage in the private market and Medicaid expansion. The Biden administration and Congress must act to replicate the contraceptive coverage requirement everywhere cost barriers to contraception remain.

ENDNOTES

1 The ACA contraceptive coverage requirement reaches cisgender women, transgender men, nonbinary people, and others with a need to prevent pregnancy. This report uses the term "woman" or "women" in circumstances where the data cited is not inclusive of everyone, regardless of gender, who has a need to prevent pregnancy.

2 Nat'l Women's L. Ctr. (NWLC), *New Data Estimates 64.3 Million Women Have Coverage of Birth Control and Other Preventive Services Without Out-of-Pocket Costs* (Nov. 2020), https://bit.ly/3izqgQY.

3 42 U.S.C. §300 gg-13 (2021).

4 Inst. Of Med., Clinical Preventive Services for Women: Closing the Gaps (Washington, DC: The Nat'l Academies, ed.) (2011).

5 U.S. Food & Drug Admin., Birth Control Guide, https://www.fda.gov/media/135111/download (last visited Nov. 11, 2021). Notably, since that time, the FDA has updated the chart because on female sterilization method was removed from the U.S. market. Currently, the chart has 17 birth control methods for women.

6 Ctrs. for Medicare & Medicaid Servs., FAQs About Affordable Care Act Implementation (Part XXVI) (May 11, 2015), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf [hereinafter 2015 Guidance].

7 *Id*.

8 *See* 26 C.F.R. § 54.9815-2713(T)(a)(4) (2020); 29 C.F.R. § 2590.715-2713(a)(4) (2020); 45 C.F.R. § 147.130(a)(4) (2020).

9 2015 Guidance, *supra* note 6.

10 *Id*.

11 U.S. Dep't of Labor, FAQs on Affordable Care Act Implementation Pt. 31, Mental Health Parity Implementation, & Women's Health & Cancer Rights Act Implementation (April 20, 2016), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf.

12 42 U.S.C. §300 gg-13 (2021).

13 Employer plans that are "grandfathered" – meaning they have not changed significantly since the Affordable Care Act became law in 2010 – do not yet have to comply with the preventive services requirement. The most recent data show that 14% of employees are still in grandfathered health plans. Gary Claxton et al., Kaiser Family Found., Employer Health Benefits: 2020 Annual Survey (2020), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf.

14 42 C.F.R. § 440.347; 45 C.F.R. § 156.115(a)(4); CMS, Contraception in Medicaid: Improving Maternal and Infant Health Questions and Answers, https://www.medicaid.gov/medicaid/quality-of-care/downloads/contraception-qand-a.pdf (2015).

15 U.S. Office of Personnel Management, FEHB Program Carrier Letter No. 2021-02, Consolidated Pharmacy Benefits Guidance for the FEHB Program 11; U.S. Office of Personnel Management, FEHB Program Carrier Letter No. 2019-01, at 6.

16 Because the law applies to coverage, not health service providers, it is not applicable in the context of care received through the Department of Veterans Affairs or Indian Health Services, or at Title X service sites. Under the ACA, American Indians and Alaskan Natives can continue to receive care through IHS, tribal, or urban Indian health program, opt to enroll in marketplace coverage that includes the contraceptive coverage requirement, or enroll in Medicare or Medicaid if eligible. This paper does not provide recommendations as to the scope of care or cost-sharing requirements for services delivered through IHS or at Title X sites. The cost-sharing recommendations in this report for the Department of Veterans Affairs would align it with the recommendations for TRICARE and civilian federal employees.

17 Coverage of Certain Preventive Services Under the Affordable Care Act, 45 C.F.R. §§ 147, 156 (2013).

18 *Id.; see also* 45 C.F.R. § 147 (2015).

19 *Burwell v. Hobby Lobby Stores, Inc.,* 573 U.S. 682 (2014); 45 C.F.R. § 147 (2015).

20 Religious Exemptions & Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 45 C.F.R. § 147 (2017) [hereinafter Religious Exemptions Rule].

21 Moral Exemptions & Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 45 C.F.R. § 147 (2018).

22 *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania,* 140 S. Ct. 2367 (2020) (holding that the Affordable Care Act authorized the Health Resources and Services Administration to promulgate rules exempting employers with religious or moral objections from providing contraceptive coverage to their employees, without deciding whether the Rules violated Sections 1554 or 1557 of the ACA, Title VII, the APA, the Establishment Clause, or the Equal Protection Clause), *remanded to Pennsylvania v. Trump,* 816 F. App'x 632 (3d Cir. 2020), *remanded* to No. 2:17-cv-04540-WB (E.D. Pa. 2020).

23 U.S. Department of Health & Human Services, U.S. Department of Labor, & U.S. Treasury, (Aug. 16, 2021) FAQs on Affordable Care Act Implementation 48, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-48.pdf

24 *See, e.g.,* Jennifer J. Frost & Laura Duberstein Lindberg, *Reasons for Using Contraception: Perspectives of US Women Seeking Care at Specialized Family Planning Clinics,* 87 Contraception 465, 467 (2013). ("Economic analyses have found clear associations between the availability and diffusion of oral contraceptives[,] particularly among young women, and increases in U.S. women's education, labor force participation, and average earnings, coupled with a narrowing in the age gap between women and men." *See, e.g.,* Martha J. Bailey et al., *The Opt-In Revolution? Contraception and the Gender Gap in Wages,* Nat'l Bureau of Econ. Research 26-27 (2012), *available at* https://www.nber.org/papers/w17922.

25 *See supra* note 2.

26 Kaiser Family Found., *Survey: OBGYNs Report That the Affordable Care Act Has Increased Use of Contraceptives Among Patients but the Cost of Reproductive Health Care Still a Burden for Their Low-Income Patients* (Feb. 25, 2021), https://www.kff.org/womens-health-policy/press-release/survey-obgyns-report-that-the-affordable-care-act-has-increased-use-of-contraceptives-among-patients-but-the-cost-of-reproductive-health-care-still-a-burden-for-their-low-income-patients/.

27 Lydia E. Pace et al., *Early Impact of the Affordable Care Act on Oral Contraceptive Cost Sharing, Discontinuation, and*

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