



**NATIONAL
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OCTOBER 2026

INTENDED VS. IMPLEMENTED:

The Still Unfulfilled Promise
of the Affordable Care Act's
Birth Control Benefit

A Report Based on Learnings From the National Women's
Law Center's CoverHer Hotline

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ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

The Affordable Care Act (ACA) established an important nationwide standard for insurance coverage of contraceptives. Nearly all private health plans, as well as plans offered through the ACA Healthcare Marketplace¹ and the ACA's Medicaid expansion,² must cover the full range of contraceptives and related services for those who can become pregnant,³ without cost-sharing.⁴ This means no copayments, coinsurance, or deductibles.

The ACA requirement that insurance plans cover contraceptive products and services without cost-sharing transformed access to birth control in the United States.⁵ Improvements in coverage have led directly to improvements in contraceptive use, empowering individuals to avoid unintended pregnancies and to plan and space wanted pregnancies.⁶ In addition to its many health benefits, contraception is crucial to women's economic and social equality.⁷ Yet more than a decade after its implementation, the promise of the ACA's birth control benefit remains unfulfilled for far too many.

Despite years of extensive federal guidance detailing insurers' obligations, repeated reports of violations submitted to federal regulators, and enforcement actions against non-compliant plans, violations persist. Continued violations by insurance plans cannot credibly be attributed to confusion, ambiguity, or lack of notice regarding what the law requires. The persistent non-compliance documented in this report, in the face of clear statutory and regulatory direction, represents an unacceptable failure of health plans and insurers to meet well-established legal obligations. This is evidenced by

the first-person accounts of those who seek— but are not able to obtain—no-cost contraceptive coverage as guaranteed by the ACA.

Since 2013, the National Women's Law Center's (NWLC) CoverHer Hotline (CoverHer or Hotline) has been a source of information and assistance to individuals seeking no-cost women's preventive services, including birth control.⁸ The Hotline provides assistance understanding coverage rights, navigating insurance denials or billing issues, and identifying next steps to obtain the no-cost contraceptive care guaranteed under federal law.

Over more than a decade of operation, CoverHer has heard from thousands of individuals who—regardless of insurance type, geographic location, or method of contraception—continue to encounter unlawful denials, unexpected out-of-pocket charges, and administrative barriers when trying to access no-cost contraceptive care. These inquiries provide a unique window into how the contraceptive coverage requirement functions in practice and where it breaks down for patients.



CoverHer data shows clear and recurring patterns of insurer misconduct, including:

- **Excluding entire categories of contraceptive methods from coverage;**
- **Denying coverage for services** that are integral to contraceptive care, including office visits, ultrasounds, anesthesia for sterilization surgery, and follow-up care;
- **Imposing unlawful medical management techniques**, including “try and fail” protocols and age limits, and refusing to cover brand-name contraceptives or sterilization surgery;
- **Failing to provide a way for individuals to get the particular contraceptive product they need** and forcing them to try other processes, like prior authorization or appeals processes that delay care and discourage people from asserting their rights.

Ultimately, these clear and recurring patterns of insurer misconduct cause substantial harm. Individuals contact CoverHer after paying hundreds or thousands of dollars for products and services that should be free, spending months contesting improper denials, or forgoing medically necessary care entirely. Forgoing the contraception that is right for them can increase risks of adverse health outcomes, disrupt management of underlying medical conditions, and cause unintended pregnancies, which as numerous studies have shown and experts agree, can have negative health consequences for both women

and children.⁹ This is particularly true for individuals with medical contraindications like hypertension or diabetes and for communities that already face barriers to reproductive health care—such as those living in areas with few reproductive health providers or health clinics.¹⁰

Collectively, CoverHer data reveals not only widespread denials and insurers’ use of unlawful restrictive practices, but also persistent failures by regulators to meaningfully enforce the law. Though the federal government has set clear standards and has the authority to address the noncompliance documented throughout this report, there is little reason to believe the Trump-Vance administration will do so.

In this moment, given the lack of federal will, states have a particularly critical role to play in addressing these violations and preserving access. Other actors can also help fill enforcement gaps and work to ensure people have the contraceptive coverage they are guaranteed by law.

Ultimately, sustained oversight from multiple stakeholders is necessary to halt the clear and recurring violations of the ACA’s birth control benefit. Noncompliant plans are reinstating the very barriers to contraception that the ACA’s passage was designed to eliminate. Without stronger enforcement, insurer and provider transparency, and system-wide accountability, individuals seeking birth control will continue to bear the consequences.

THE ACA'S CONTRACEPTIVE COVERAGE REQUIREMENT: A PRIMER

Passed in 2010, the Affordable Care Act (ACA) requires health plans to cover, without cost to the individual, a range of preventive health services, including screenings, immunizations, and other preventive care,¹¹ all aimed at improving overall health outcomes.¹² This includes a requirement that insurance plans cover birth control and related services with no out-of-pocket costs.¹³ In other words, the amount a covered individual pays when they obtain contraception at the pharmacy, from their provider, or in another setting should be zero.

In the years since it took effect, the ACA contraceptive coverage requirement has had a major impact on people's health, economic stability, and overall well-being. 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, thereby making it harder for them to control their reproductive and sexual health and, by extension, many other aspects of their lives.¹⁵ The ACA's contraceptive coverage requirement has reduced out-of-pocket costs, helped millions use contraceptives more consistently and effectively, and supported individuals' access to the health, social, and economic benefits of family planning.¹⁶

The ACA contraceptive coverage requirement applies to the vast majority of private health plans,¹⁷ including:

- **Fully insured group health plans**, in which an insurer bears the financial risk of claims
- **Self-insured (self-funded) group health plans**, under which the plan sponsor—typically a large employer—pays claims directly
- **Coverage offered in the individual market**, whether through the ACA's health insurance marketplaces or directly from an issuer
- **Coverage offered in the small group market**, which is generally limited to employers with up to 50 employees, or up to 100 in certain states
- **Coverage offered in the large group market**, which is generally limited to employers with 51 or more employees, or more than 100 in certain states.





Plans with “grandfathered” status, meaning those in existence prior to March 23, 2010, and that have not undergone significant changes in cost-sharing, benefits, or employer contributions as defined under the ACA, do not have to comply with the preventive services requirement and other parts of the ACA.¹⁸ Data from 2019 demonstrated that only 13% of workers covered in employer-sponsored plans were still in grandfathered plans,¹⁹ and the number of grandfathered plans continues to dwindle.

Churches and other houses of worship are exempt from the contraceptive coverage requirement. Certain other employers with religious objections may receive an accommodation, allowing them to exclude contraceptive coverage from their sponsored health plan, but the insurance issuer then separately provides payments for contraceptive services to the enrollees.²⁰

Overall, the vast majority of private plans must comply with the ACA’s contraceptive coverage requirement. As of 2021, an estimated 61.4 million women ages 18–64 had insurance coverage of preventive services, including birth control, without out-of-pocket costs as required by the ACA.²¹

To ensure that beneficiaries get the no-cost contraceptive coverage they are guaranteed, the federal government over the years has issued a range of regulations, guidance, FAQs, and enforcement actions that further detail and clarify the scope of the requirement.²²

When the federal government has taken implementation and enforcement actions, insurers have changed their practices, to the benefit of consumers. These clarifications have often come in response to reports of issuer noncompliance, including reports that the National Women’s Law Center has issued.²³



These regulations, guidance, FAQs, and other enforcement mechanisms have made clear that plans:

- Must cover, at no cost, the full range of U.S. FDA-approved, -cleared, or -granted contraceptives.
- Must cover at least one contraceptive in each method category, and categorical exclusions are not allowed.
- Must cover, at no cost, services integral to contraceptive care—including office visits, screening, education, counseling, anesthesia, and follow-up care, like management, evaluation, and removal.
- May use “reasonable medical management techniques” only within narrow limits.
 - » Plans cannot require individuals to try and fail with other forms of contraception before covering the method originally prescribed by the provider, known as “step therapy” or “fail first” requirements.
 - » Plans cannot deny a brand-name product when there is no therapeutically equivalent alternative that meets the patient’s needs, as determined by the provider.
 - » Plans cannot impose age limits on contraceptive coverage.
- Plans must create and utilize a dedicated

“exceptions” process specifically for contraceptive coverage, through which enrollees can request no-cost coverage for a contraceptive item or service deemed medically necessary. The process must be easy to access, transparent, and handled in a timely manner, and it must follow the attending provider’s medical judgment. Plans may not use their internal appeals process as a substitute for this contraceptive-specific process.

These standards have been clarified and communicated repeatedly over the past 15 years by the federal government and other stakeholders. Plans and providers should not be operating under any misunderstanding about their obligations.

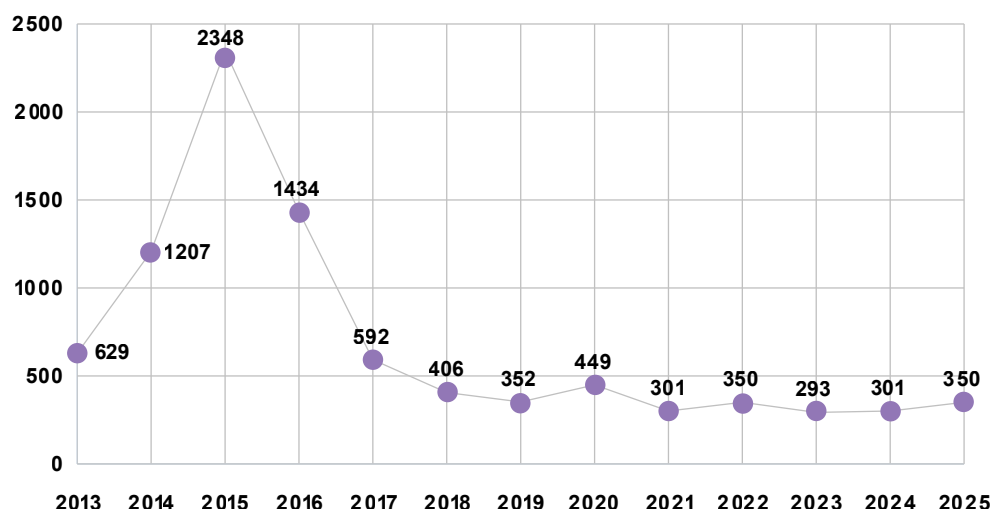
COVERHER: HELPING PATIENTS ACCESS THE COVERAGE THEY'RE GUARANTEED

NWLC established the CoverHer Hotline to help patients understand their rights and ensure they had access to the no-cost contraceptive care and other women's preventive services provided by the ACA. The Hotline's central aim is to support people who experience coverage barriers or denials of the care the law guarantees. Since its launch in 2013, CoverHer has received more than 8,500 requests for support.²⁴

Individuals can contact the Hotline²⁴ for assistance navigating their insurance benefits and advocating for no-cost contraceptive care with their plan or another stakeholder.²⁵ While CoverHer does not provide legal advice or represent individuals in disputes, it helps users understand the law and their plan documents and offers resources such as template insurance plan appeal letters.²⁶

CoverHer received its highest number of requests for assistance in the first years after its launch, with nearly 5,000 requests received between 2014 and 2016. This early surge was driven partly by growing public awareness of the ACA's birth control benefit—which began going into effect in 2012 and 2013—and increased awareness of CoverHer as a resource. But more significantly, insurance plans

NUMBER OF INTAKES RECEIVED BY YEAR



were violating the law in widespread and systematic ways, resulting in large numbers of consumers encountering unlawful coverage denials.

One of the most common early violations involved plans refusing to cover entire categories of contraceptive methods. In 2013, federal guidance clarified that plans must cover “the full range of FDA-approved contraceptive

methods including, but not limited to, barrier methods, hormonal methods, and implanted devices. . . .”²⁷ Some insurers initially interpreted this guidance narrowly, asserting that they were only required to cover one type of barrier method, one type of hormonal method, and one type of implanted device. For example, insurance plans would cover one type of hormonal pill, but not the hormonal ring. This left many consumers without coverage for the contraceptive method they needed.²⁸ These categorical exclusions accounted for 75 percent (1291 of 1722) of CoverHer intakes in 2015. After consumers and advocates reported these violations,²⁹ the federal government issued additional guidance in May 2015 clarifying that all method categories on the FDA Birth Control Guide must be included in the no-cost coverage guarantee.³⁰ Following the release of this guidance, many health plans updated their coverage to comply with the law, and CoverHer calls declined—though calls continued at a sustained lower rate in the years

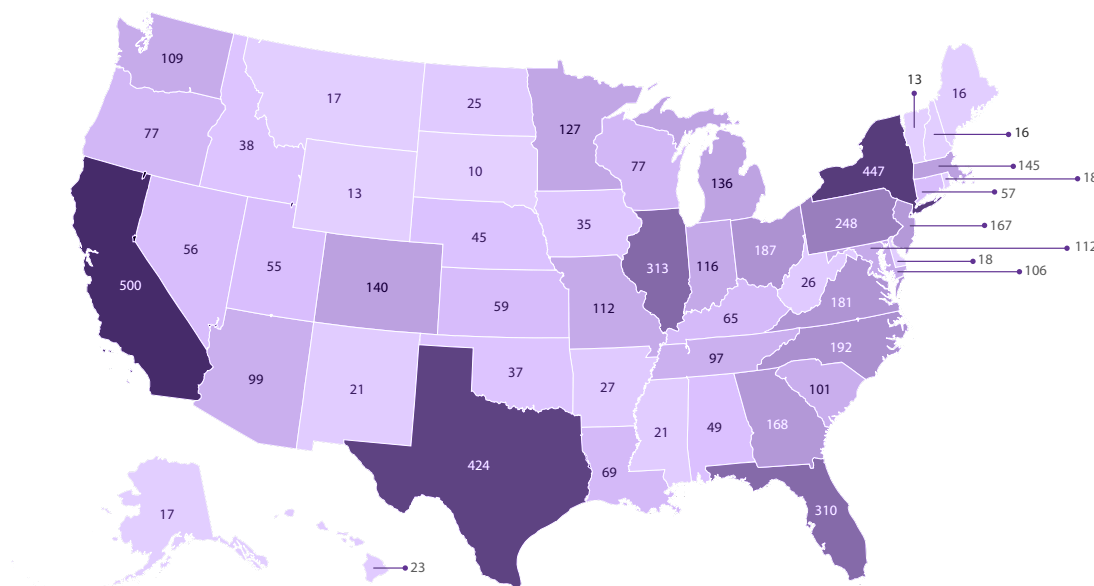
that followed, signaling that gaps in compliance persisted.

Over time, as federal guidance became more detailed and insurers adjusted their practices, requests for support shifted away from high-volume, straightforward method exclusions toward a fewer number of denials reflecting more complex ways that plans appear to skirt the law.

At the same time, broader political and legal developments have periodically driven increases in CoverHer intakes. For example, the Hotline experienced an increase in calls following the 2016 presidential election and similarly after the Supreme Court’s 2022 decision to overturn *Roe v. Wade* in *Dobbs v. Jackson Women’s Health Organization*, both moments when people felt an increased need for contraceptive access amid concerns about the continued availability of contraception and abortion.³¹

GEOGRAPHIC DISTRIBUTION

Intakes by States 2013–2025



Individuals in every state, as well as the U.S. territories Guam and Puerto Rico, have requested support from CoverHer. This demonstrates that compliance problems are

not isolated to one particular state or geographic region; people across the country are facing problems getting their no-cost contraceptive coverage.

As reflected in the map, the greatest number of requests for assistance originate from the most populous states, including California, Texas, Florida, New York, Illinois, and Pennsylvania.³²

CoverHer receives requests for support for all methods of birth control. However, the method prevalence has shifted significantly over time, reflecting both broader reproductive health trends and the changing policy environment.

In 2015, oral contraceptives accounted for approximately 41 percent of all Hotline contacts, making them the method most frequently raised in intakes at the time. Other

short-acting methods, including the vaginal ring, also comprised a significant share of Hotline intake. This pattern is consistent with the widespread use of these methods.

Beginning in 2020, Hotline contacts shifted dramatically toward long-acting reversible contraception, particularly intrauterine devices (IUDs). IUD-related coverage issues accounted for more than half of all Hotline intakes in 2020 (50.7 percent) and nearly two-thirds in 2021 (66.2 percent). This likely reflects both increased utilization of long-acting methods as well as ongoing challenges with insurer compliance with ACA no-cost coverage requirements.

METHOD OF BIRTH CONTROL

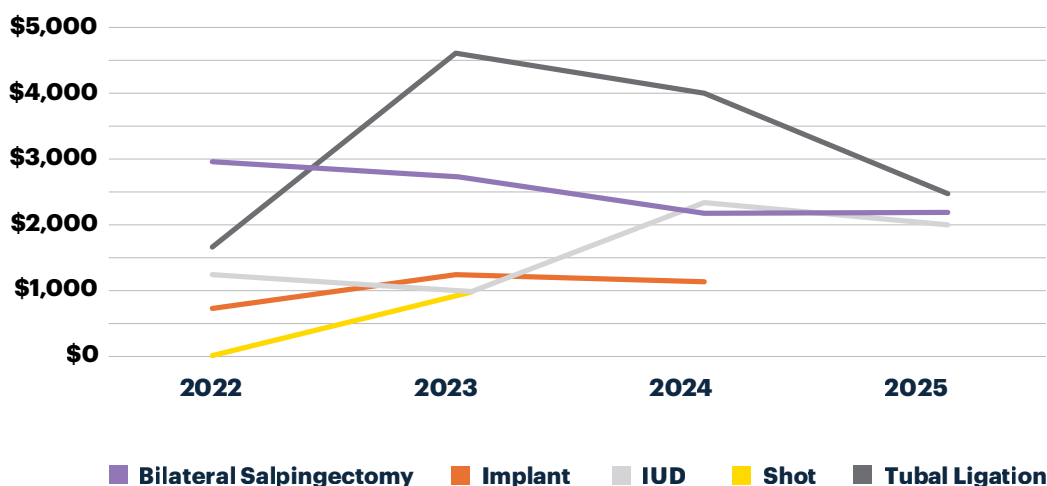
DISTRIBUTION OF HOTLINE INTAKES BY CONTRACEPTIVE METHOD AND YEAR (2015 AND 2020–2025)								
METHOD OF BIRTH CONTROL	2015	2020	2021	2022	2023	2024	2025	OVERALL
ORAL CONTRACEPTIVES	41%	22%	13%	16%	12%	18%	9%	29%
INTRAUTERINE DEVICES	26%	51%	66%	44%	26%	22%	22%	32%
BILATERAL SALPINGECTOMY	0%	0%	0%	22%	51%	43%	61%	14%
THE RING	21%	9%	1%	4%	2%	1%	1%	13%
TUBAL LIGATION	1%	7%	11%	4%	4%	6%	3%	3%
THE IMPLANT	3%	9%	4%	4%	1%	3%	0%	3%
ALL OTHER METHODS ³³	8%	3%	5%	5%	4%	7%	4%	6%

Following the Supreme Court’s decision to overturn *Roe v. Wade*, Hotline reports reveal another major shift. Beginning in 2022, intakes relating to permanent contraception—specifically bilateral salpingectomy—rose sharply. In the first full year following the *Dobbs* decision, bilateral salpingectomy alone accounted for nearly half of all methods (47 percent) discussed in Hotline intakes. This is consistent with a broader increase in individuals seeking permanent contraception amid concerns about reduced access to abortion care.³⁴

Across the full period analyzed, IUDs (31.8 percent) and oral contraceptives (28.6 percent) represent the largest overall share of Hotline intakes. However, the year-to-year distribution illustrates a broader trend toward coverage problems increasingly concentrated among higher-cost, procedure-based methods, including IUDs and permanent contraception. These methods typically involve significant upfront costs and more complex billing structures, including facility fees and related services.

AVERAGE OUT-OF-POCKET COSTS

By Method, 2022-2025



The CoverHer data demonstrates the immense immediate financial harm of unlawful birth control coverage denials. These costs are not minimal. Because CoverHer began collecting cost data in 2022, the figures discussed here reflect caller reports from 2022 through 2025. Over that period, the average reported out-of-pocket cost resulting from denied coverage was \$2,097.19 per year. Costs vary widely depending on the method at issue. For example, between 2022 and 2025, CoverHer callers calling about birth control pills, which are typically purchased monthly

or in three-month packs, reported paying anywhere from \$5 per pack to as much as \$700 for a three-month supply. In that same period, callers reported being charged more than \$400 for an ultrasound to confirm IUD placement and more than \$1,000 for anesthesia associated with sterilization. For surgical sterilization, individuals who were denied no-cost coverage faced an average of \$2,700 in out-of-pocket costs with some bills reaching \$12,000 or more, according to caller reports.



INSURER VIOLATIONS IN PRACTICE: TRENDS FROM COVERHER

CoverHer data provides insight into broader, systemic problems.³⁵ CoverHer data reveals persistent and widespread insurer noncompliance with the no-cost coverage requirement.³⁶ Health plans and insurers throughout the country have refused to comply with the ACA's requirements or fail to resolve known coverage issues.

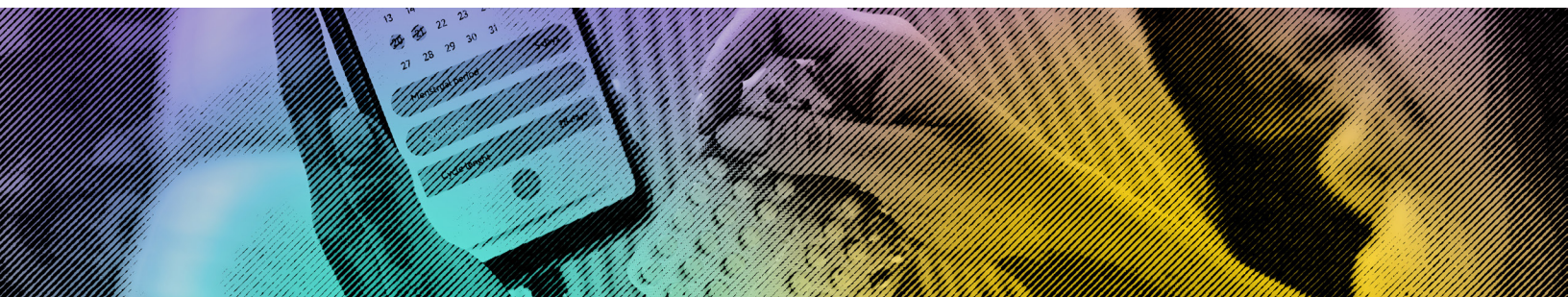
Clear patterns have emerged:

- Excluding coverage of entire contraceptive method categories.
- Denying coverage for related services that are integral to obtaining contraceptive products and services.
- Utilizing unreasonable “medical management techniques” — such as forcing a patient to fail using another method before covering their preferred method, imposing age limits, denying coverage for brand-name contraceptives, or refusing to cover sterilization surgery.
- Failing to provide the legally required, accessible pathway for individuals to obtain their preferred contraceptive method.

Insurance Companies Exclude Coverage of Entire Contraceptive Method Categories

The ACA requires insurers to cover the full range of FDA-approved contraceptives and sterilization procedures for women as part of preventive care.³⁷ However, many individuals report that their plans are categorically excluding certain methods. Based on anecdotal data through CoverHer, this is especially true for methods that are less commonly used, such as the contraceptive ring, or for nonhormonal options such as female condoms or spermicides. These exclusions are in direct violation of the ACA.

Under the law, health plans and insurers must cover without cost-sharing at least one form of contraception in each of the method categories that the FDA has identified for women in its Birth Control Guide.³⁸ As of April 2026, there are 19 methods in the FDA Birth Control Guide that are required to be covered.³⁹ Plans cannot categorically exclude an entire method, which the federal government made clear as long ago as 2015.⁴⁰



Some plans continue to violate the law by denying coverage of an entire category of method. For example:

- » In 2020, an Ohio woman shared that her employer's HMO plan confirmed that they did not cover any type of vaginal ring—including the Annovera 12-month ring, the brand-name Nuvaring, or its generic equivalent. To access her method of choice, she was asked to pay more than \$100 out of pocket as a one-time cost for the ring.
- » In 2023, a Louisiana woman on an ACA Marketplace plan was informed that the plan does not cover IUDs. "I am struggling because my policy does not appear to cover any IUDs. I went in to have my regular annual completed and to get my now expired IUD removed and new one placed. Unfortunately, since it is not covered, I am now attempting to figure out what to do instead. It is way more than just a birth control to me. I have extremely heavy cycles that cause immense pain, so the IUD is a lifesaver that allows me to function throughout the month without being bed-bound. The specialty pharmacy stated that replacing it would cost over \$1,000. I am now extremely confused and wondering what I should do because I am now left with an expired IUD that I cannot afford to remove."

Insurers Deny Services Integral to Contraceptive Care

The ACA requires insurance companies to cover, at no cost to the patient, services that are integral to the furnishing of contraceptive care. The "federal government has made this clear—repeatedly— throughout the years.⁴¹ This required coverage includes not only the contraceptive product itself, but also the items and services necessary to ensure its safe and effective use—such as office visits, consultations, imaging, anesthesia, follow-up care, and services related to the insertion management, continuation, discontinuation,

or removal of a contraceptive method.⁴² When insurers deny coverage of these services, they violate the ACA's contraceptive coverage requirement and shift unlawful costs onto patients.

These denials are particularly harmful because patients reasonably expect that when their contraceptive method is covered at no cost, the services required to furnish that care are covered as well. As a result, individuals are often unprepared for significant and unpredictable expenses and may feel compelled to pay bills they should not owe. The costs can vary widely depending on the service and how it is billed—ranging from tens or hundreds of dollars for office visits or an image to several thousand dollars for anesthesia related to sterilization.

CoverHer regularly hears from individuals who are denied no-cost coverage for contraceptive services that should be covered without cost-sharing:

- » In 2025, a Florida woman insured through CareFirst received a bill exceeding \$1,000 for the anesthesia required during her sterilization surgery, as well as the cost for her recovery room and pharmacy drugs.
- » In 2023, a Massachusetts woman with employer coverage through Blue Cross Blue Shield was denied coverage for an ultrasound recommended by her doctor to confirm proper placement of her IUD, leaving her with a \$669 bill.
- » In 2024, an Ohio woman received a bill for pain management services provided during her sterilization surgery. "I called my insurance to see why [I received a bill], and they told me that they are not required to pay the cost of pain management at 100% and that they never do this. This did not seem to be correct according to other information I had collected prior to surgery." As a result, she was being asked to pay around \$160 in out-of-pocket costs.

Insurers' Unlawful Use of Medical Management

The law allows health plans and insurers a limited ability to determine what is and is not covered within the required preventive services coverage parameters. This is referred to as “reasonable medical management.” Using reasonable medical management, health plans and insurers may determine the frequency, method, treatment, or setting for a recommended preventive item or service to the extent it is not specified in a recommendation or guideline.⁴³ Examples of medical management techniques include, but are not limited to, setting limits on the number of visits or tests, imposing out-of-pocket costs when a preventive service is accessed at an out-of-network provider, or steering patients to generic-equivalent drug options.

But these medical management techniques are limited. The federal government has clarified, for example, that plans cannot require someone to try and fail a contraceptive in one method category before covering a different contraceptive method, that they cannot impose age limits, and that plans must defer to a medical provider’s determination of which particular contraceptive product is necessary for an individual.⁴⁴

CoverHer continues to hear stories of plans imposing unallowed, unreasonable medical management techniques on contraception, resulting in individuals being forced to pay out of pocket or forgo the contraception they need.

Forcing Individuals to “Try and Fail” on One Contraceptive Product Before Covering Another

A practice known as “fail first” or step therapy is when insurance companies require individuals to try and fail with other, often less expensive, forms of contraception before covering the method originally prescribed by their health care provider. Step therapy does not require a patient to become pregnant under their nonpreferred method, although this is a significant risk. Rather, the patient would note any intolerances or unwanted side effects to their provider. Step therapy imposes burdens

on the individual and delays access to an individual’s preferred method.

The federal government has clarified that plans cannot require someone to try and fail a contraceptive in one method category or between method categories before covering a different contraceptive method, and that plans must defer to a medical provider’s determination of which particular contraceptive product is necessary for an individual.⁴⁵ Yet, people contact CoverHer after being forced to try “fail first” protocols when seeking no-cost contraceptive coverage.

- » In 2025, an Illinois woman with Blue Cross Blue Shield employer-sponsored coverage contacted CoverHer after she was denied coverage for a birth control pill that does not have a generic equivalent. Even after her doctor submitted a request for coverage of the pill, her plan requested step therapy before approving the medication. Without coverage, a one-month supply of pills would cost her nearly \$300 dollars.
- » In 2025, CoverHer received a call from a Louisiana woman denied coverage for the brand-name product she needed that does not have a generic equivalent. Her doctor submitted a request based on medical necessity, but she was denied coverage and subjected to a two-month process that required her to try and fail with other contraceptives. After finally receiving approval, she was still subjected to out-of-pocket costs.

Inappropriately Imposing Age Limits

The ACA’s contraceptive coverage benefit covers the full range of contraceptive methods and related services and counseling for people with capacity to become pregnant.⁴⁶ The average woman’s reproductive years are between the ages of 15 and 49, although many individuals have the capacity to become pregnant before the age of 15 and beyond the age of 50. The federal government has made it clear that plans cannot impose age limits on the contraceptive coverage benefit.⁴⁷

Despite this, some health plans and insurers are imposing unallowable and arbitrary age limits that result in a denial of no-cost contraceptive coverage.

- » In 2021, a North Carolina woman contacted CoverHer after her plan charged her a copay for her oral contraceptive pill. When she asked for an explanation, she was told that because she is over the age of 50, she would be charged a copay.

Unlawfully Denying Coverage of Medically Necessary Methods or Brand-Name Contraceptives That Do Not Have a Generic Equivalent

Although plans have some ability to impose cost-sharing within contraceptive method categories to encourage the use of generic products, this ability is not unlimited. Where a product has a generic, a plan still must cover the brand name without cost-sharing if the individual's provider recommends it based on a determination of medical necessity.⁴⁸

Where there is no generic, plans must cover the brand-name product or service. Yet plans continue to deny no-cost coverage to individuals for whom a brand-name product is medically necessary or where a generic is not available.

For example, CoverHer regularly hears from individuals who were denied coverage for brand-name oral contraceptives. Certain birth control pills have been instrumental in preventing pregnancy for women who also live with other serious medical conditions, such as hypertension, diabetes, or migraine headaches with aura, to name a few.⁴⁹ Some of these pills do not have a generic equivalent, leaving a patient seeking coverage for a brand-name drug that may not be available through their health plan's drug formulary.⁵⁰

- » An Illinois resident with a Marketplace plan through Blue Cross Blue Shield of Illinois shared with CoverHer in 2024 that her plan refused to provide no-cost coverage for a brand-name combination birth control pill. The individual reported making no fewer than 13 phone calls and spending more

than 430 minutes on the phone with her insurer to gain coverage, with no success. "My plan refuses to provide my brand-name contraceptive, even though my doctor has filled out two separate forms confirming medical necessity."

- » In 2014, an Alabama resident covered through Blue Cross Blue Shield reported being charged \$75 for an 84-day supply for a brand-name oral contraceptive. "I'm being charged for my birth control pills that are medically necessary. During my first refill, it became increasingly hard to obtain the pills due to them 'no longer being covered.' What I realized was that I was being forced to take the generic brand when I was prescribed the name brand—which works best for my body."
- » A Massachusetts woman contacted CoverHer in 2022 for support accessing a progestin-only birth control pill. Due to a chronic health condition, it was medically necessary that she take an estrogen-free birth control pill. When picking up her prescription, she was told that her insurance did not cover the brand she needed—even though there is no generic equivalent. With the manufacturer's coupon, she was still forced to pay almost \$90 for a three-month prescription.
- » In 2022, a Pennsylvania woman insured through UnitedHealthcare needed coverage for the vaginal birth control ring designed to last a full year, which has no generic equivalent. Despite her provider confirming that it was medically necessary and submitting multiple appeals, she was repeatedly denied coverage. Rather than covering that product, UHC instructed her to switch to a product that must be replaced monthly. "They kept telling me to 'just use [the other product],'" she shared, "even though it's not the same product and isn't what my doctor prescribed. It felt like they were overriding my medical care and leaving me with no real choice."



» In 2024, a Medicaid recipient in California contacted CoverHer after she was denied no-cost coverage of a nonhormonal prescription vaginal gel. On average, the out-of-pocket cost for the gel is around \$300. “The prescription from my doctor has been denied by my insurance twice... I keep getting told that there is no reason I can’t use the alternatives they are providing, which are spermicides.”

Denying No-Cost Coverage of Medically Necessary Sterilization Surgery

The requirement to provide no-cost coverage of the contraceptive that is medically necessary for a patient applies to all methods, including female sterilization. But CoverHer data demonstrates that plans are not in compliance with the ACA’s requirements when it comes to a form of female sterilization known as bilateral salpingectomy.⁵¹ In recent years, bilateral salpingectomy has become the preferred sterilization procedure of many providers because of its superior protection against ectopic pregnancy and ability to reduce ovarian cancer risk by up to 65%–80%.⁵² However, health plans and insurers are largely not covering it; they cover tubal ligation instead.⁵³

CoverHer has received a steady increase in intakes from individuals seeking no-cost coverage for bilateral salpingectomy. In 2022, around 18% of intakes contacted CoverHer about coverage problems with bilateral salpingectomy. As noted above, after the Supreme Court overturned the constitutional right to abortion, surgical sterilization rates among women in the United States increased,⁵⁴ and so did CoverHer intakes. As of 2025, 55% of the Hotline’s intakes sought support for coverage issues related to bilateral salpingectomy.

Due to the surgical nature of the procedure, out-of-pocket costs for bilateral salpingectomy can end up costing more than other forms of contraception. Based on individuals who reported their out-of-pocket costs, patients denied coverage were burdened with an average \$2700 in out-of-pocket costs, and many of them were required by their plan to meet their deductible before the plan would cover the rest. Several individuals have faced upward of \$12,000 or more in out-of-pocket costs.

- » In 2022, an Ohio woman with employer coverage contacted the Hotline, noting that she was waiting for her plan to determine whether she’d be covered for her bilateral salpingectomy totaling nearly \$48,000. “My insurance is claiming they only cover tubal ligation, even though I previously corresponded with my health plan who told me it would be covered. My doctor only does salpingectomies and recommended it to me. Unfortunately, my plan says that bilateral salpingectomies are not considered preventive care. They are requiring that I appeal the claim.”
- » In 2022, a New York woman covered through her employer’s Aetna plan was subjected to \$2,500 in costs because of her plan’s improper use of medical management related to her sterilization surgery. “I am seeking permanent sterilization and my surgeon recommended bilateral salpingectomy rather than tubal ligation because it also has some cancer prevention benefits and is a better fit for me, but my carrier has selected tubal ligation as the 100% covered sterilization procedure. Based on their estimates, I could potentially owe up to my out-of-pocket maximum for this procedure.”

BILLING AND CODING ISSUES RESULT IN DELAYS AND DENIALS IN COVERAGE

Billing and coding errors appear to also factor into no-cost contraceptive coverage denials. Medical billing and coding involve translating health care services into standardized codes required for insurance billing and are processed to determine the patient's financial responsibility.

To ensure no-cost coverage, codes must clearly indicate when items and services are preventive. Although there is a Women's Preventive Services Initiative Coding Guide⁵⁵ and numerous other coding guides⁵⁶ that provide clear guidance on which billing codes should be used, health plans and insurers are claiming that they do not recognize these codes as preventive. This results in plans denying claims or imposing cost-sharing for what should be no-cost services. The federal government has provided guidance on billing and coding for preventive services, including as recently as October 2024, to address reports of insurance plans unlawfully denying claims or imposing cost sharing.⁵⁷

Some CoverHer intakes involve provider error, sending incorrect codes to plans, which, once discovered, can be corrected by the provider. However, when preventive codes are properly sent and then denied by the issuer, it becomes more difficult to resolve and may require greater intervention from the doctor and patient.

» An individual from California on their employer's United Healthcare plan who underwent sterilization reported being charged more than \$5,000, stating that: "My insurer is requiring me to pay 40% cost sharing for a correctly coded female sterilization because the billing code is not on their preventive services list."

A Kansas woman contacted CoverHer in 2023 regarding her denied coverage for sterilization surgery and shared: "United Healthcare denied my coverage. I asked the hospital to switch the 58661 code to the UHC preferred 58670, but [the hospital] said they used the correct code for my procedure. I am now starting the process of an appeal with UHC to cover my surgery as preventive." Without full coverage, she was at risk of paying more than \$3800 for her care.

In 2015, less than 1% of Hotline intakes were denials of no-cost coverage due to billing and coding issues. By 2025, billing and coding issues represented 14% of Hotline intakes. When a beneficiary determines that billing errors were made, they must coordinate with their doctor and insurance provider to correct the error, reinitiate the billing process, and hope that it will result in zero out-of-pocket costs. Often, individuals attempt to correct billing codes with their providers, who either note that codes are correct according to the guidance or are uncomfortable changing the codes. Consequently, patients are left to appeal their denials with their plan in hopes that their plan will finally process the codes as preventive.

Coding Concerns at Religiously Affiliated Hospitals

In 2025, CoverHer heard from individuals who incurred out-of-pocket costs for sterilization due to billing and coding practices at the religiously affiliated facilities where their procedures were performed. The religiously affiliated hospitals refused to bill sterilization as preventive care, as required for coverage under the ACA. As a result, insurers treated the service as nonpreventive and failed to apply no-cost coverage, leaving patients with substantial bills. This billing and coding barrier can be especially burdensome for individuals in rural or underserved communities, where hospital choice is limited and religiously affiliated facilities may be the only accessible option.⁵⁸

Insurance Companies Fail to Provide a Way for Individuals to Get the Particular Contraceptive Product They Need

Under the law, insurers must create a process by which individuals can access the particular contraceptive product that is medically necessary for them, even when a plan would not typically cover the product without cost-sharing.⁵⁹ This safeguard—commonly referred to as the “exceptions” or “waiver” process—is essential to ensuring that coverage decisions reflect patients’ medical needs rather than insurers’ cost-containment practices.

Federal law requires health plans and insurers to maintain an exceptions process that is “easily accessible, transparent, and sufficiently expedient.”⁶⁰ The process cannot be “unduly burdensome” for either the patient or the provider, and it must defer to the health care provider’s determination of medical necessity.⁶¹ Insurers are not permitted to override that medical judgment.⁶² While some plans offer standardized exception request forms,⁶³ the law does not require a uniform format, resulting in wide variation across insurers.

Failing to Provide the Appropriate, Legally Required Process

Despite these clear requirements, CoverHer data shows that many plans fail to provide an exceptions process that beneficiaries can meaningfully use to access no-cost coverage for the particular contraceptive product that is medically necessary for them.

First, some plans appear to have no exceptions process at all. Individuals contacting CoverHer report being told outright that no such process exists—an explicit violation of federal law.

» In 2024, a Maryland woman seeking no-cost coverage for sterilization surgery was informed by her Blue Cross Blue Shield plan that there was no way to request an exception to obtain coverage.

Second, even when an exceptions process exists, plans often fail to inform—or actively misinform—beneficiaries about it. Under the law, an exceptions process is considered “transparent” only if, at a minimum, information about how to request an exception is clearly and prominently included in plan documents and other materials describing contraceptive coverage.⁶⁴ Yet many CoverHer clients report



that they only learn the exceptions process exists after being denied coverage or charged out of pocket and contacting CoverHer for support.

Third, plans frequently maintain processes that are inaccessible or confusing in practice. To be “easily accessible,” plan documentation must explain how to initiate an exception request without filing an appeal, specify what information is required, and provide contact information for knowledgeable plan representatives.⁶⁵ Instead, beneficiaries often encounter vague or contradictory instructions, incomplete information on insurer websites, and customer service representatives who are unaware of, or misinformed about, the exceptions process. In some cases, plans deny properly submitted exceptions requests without explanation, leaving patients without clarity, recourse, or timely access to care.

These failures are not unique to CoverHer callers. A 2022 U.S. House Oversight Committee investigation found that insurers’ exceptions processes for birth control coverage routinely fell short of the law’s requirements for accessibility, transparency, and timeliness.⁶⁶ Similarly, research published by Power to Decide in 2022 found that information about exceptions processes was often entirely absent from plan materials and, when referenced at all, lacked sufficient detail for patients or providers to identify or navigate the process.⁶⁷

Forcing People to Use the Other Processes to Gain Zero-Cost Coverage

Some plans route individuals seeking no-cost coverage of birth control through the prior authorization process. Prior authorization, sometimes referred to as preauthorization, requires a health care provider to obtain approval from the insurance plan before prescribing a medication or performing a procedure.

Prior authorization is not an adequate process when it comes to birth control coverage. Prior authorization relies on a plan’s determination of medical necessity, rather than deferring to the attending provider’s determination as required under the ACA. Additionally, plans define

“medical necessity” for purposes of prior authorization more narrowly than the exceptions process, which allows consideration of the severity of side effects, differences in permanence and reversibility of the birth control, and ability to adhere to appropriate use of birth control.

Even when a plan approves a service or product through prior authorization, that approval does not guarantee coverage without cost-sharing, as required under the ACA’s birth control benefit. CoverHer data shows that individuals pushed into the prior authorization process often face cost-sharing even after approval.

» In 2022, a Texas woman sought coverage for a progestin-only birth control pill that was medically necessary. Her provider submitted a prior authorization request, which was approved by her employer-based health plan. Despite that approval, her plan did not cover the medication at zero cost. Although she was able to obtain the prescription, she was charged more than \$480 for a three-month supply.

The internal appeals process also is not an appropriate path for contraceptive-specific exceptions. The federal government has made clear that use of the internal appeals process is unduly burdensome and violates the exceptions process requirement.⁶⁸ Yet, intakes from CoverHer suggest that plans are still sending individuals to the internal appeals process.

When Appeals Don’t Deliver: A System That Works Against Patients

For individuals denied an exceptions process, the internal appeals process often becomes the only path to seek relief. While federal law makes clear that the appeals process is not an appropriate substitute for the contraceptive-specific exceptions process, many individuals find themselves navigating it nonetheless, with no other immediate option available to them.



In practice, the appeals process is often ineffective, opaque, and inaccessible, resulting in delayed or denied care and discouraging patients from asserting their rights. The appeals process—which consists of the initial appeal, second-level appeal, and external review—also can take months to years to resolve. Within that time frame, some individuals may decide to pay bills they were charged incorrectly to gain timely access to the contraception they need, particularly when medication must be obtained on a recurring basis.

After months of filing appeals, waiting for the plan's decision, and escalating through every stage of the appeals process, there is still a possibility that the insurer will deny coverage.

» In 2024, a Utah woman spent more than three months in the appeals process trying to obtain no-cost coverage from Aetna after she was charged for an office visit related to a birth control

consultation with her provider. She appealed the coverage twice with Aetna and was denied. On her third appeal, Aetna failed to respond and she never heard back about her appeal. Without another option, she was forced to seek legal counsel to help her with her claim.

The only remedies available for individuals to gain coverage or receive reimbursements for out-of-pocket costs after an appeal is denied is to file a lawsuit or to file a complaint with their state health insurance commissioner. Both options come with major hurdles. Finding an attorney to take on a case can be cumbersome, costly, and time-consuming, leaving it out of reach for many, especially those who lack resources. While filing a complaint through the state's insurance agency is much more accessible, it is not always an option individuals are aware of, and it can still result in untimely delays.

THE HARM OF DENYING NO-COST CONTRACEPTIVE COVERAGE

When plans violate the law and deny individuals no-cost contraceptive coverage, it has both immediate and long-term effects on people's health and well-being. These denials often delay essential care, forcing people to navigate confusing insurance processes, unexpected bills, and difficult trade-offs between their health needs and financial constraints.

As detailed throughout this report, without the no-cost coverage, individuals are left to pay out of pocket for the birth control they need. That could be a financial burden; studies demonstrate that women may not be able to take on low—or any—amounts of cost-sharing for contraception.⁶⁹ And it will likely push them into using a method that is not right for them because of cost.⁷⁰ That could lead to less effective or less consistent use, and ultimately a greater risk of unintended pregnancy.⁷¹

Not having no-cost coverage can also lead to forgoing contraception altogether. Numerous studies have found that even small amounts of cost-sharing reduced the use of preventive services and prescription drugs.⁷²

Unintended pregnancy brings a range of health and financial consequences. It can have an especially harmful effect on certain individuals. For example, unintended pregnancy can be particularly dangerous for a woman over 50 because it can present additional health risks, such as a higher rate of cesarean delivery, preeclampsia, gestational diabetes, stillbirth, and other risks.⁷³ Beyond the immediate health consequences, unintended pregnancy can have profound and lasting economic effects. Research consistently shows

that unintended pregnancy is associated with reduced educational attainment, lower lifetime earnings, and diminished workforce participation—consequences that fall disproportionately on women and can ripple across generations.⁷⁴

Harm is not limited to the risk of unintended pregnancy. Contraception is also a critical tool for managing a wide range of health conditions—such as heavy menstrual bleeding, endometriosis, polycystic ovary syndrome, and migraines—that can severely disrupt daily life, employment, and overall well-being.⁷⁵

For communities that already face barriers to care, like communities of color, low-income individuals, and LGBTQIA+ individuals, any additional barriers from being denied no-cost coverage will only compound health disparities and further jeopardize their ability to get the care they need.⁷⁶

These real-world impacts underscore that contraceptive coverage is not simply a matter of reproductive autonomy, it is a matter of fundamental health care access, affecting individuals' physical, emotional, and economic stability.

HOLDING INSURERS ACCOUNTABLE FOR BIRTH CONTROL COVERAGE VIOLATIONS

FEDERAL ENFORCEMENT SHOULD HAPPEN—BUT IS UNLIKELY

The federal government—specifically the Departments of Health and Human Services, Labor, and Treasury—has substantial authority to address the widespread noncompliance documented in this report.

Each of the following examples fall squarely within existing federal authority and would materially improve compliance.

Federal agencies could:

- Issue updated, detailed sub-regulatory guidance addressing the problems detailed in this report;
- Conduct targeted market conduct investigations of insurers who are the subject of repeated complaints;
- Publicly release compliance audits and corrective action plans;
- Strengthen and standardize the exceptions process to ensure timely access when plans impose medical management;
- Impose civil monetary penalties where appropriate; and
- Provide clearer guidance to Marketplace and employer-sponsored plans regarding enforcement expectations.

However, rather than strengthen the birth control benefit, the Trump administration has sought to undermine it. In 2018, during Trump's first term, federal agencies issued rules creating broad exemptions to the contraceptive

coverage requirement that allowed virtually any employer to refuse to comply for any reason. Though a federal court vacated those rules, the Trump administration appealed the case, and the threat is still ongoing.⁷⁷

For Trump's second term, the administration is closely following Project 2025, a policy blueprint that outlines pathways for restricting access to contraception as a preventive service. These proposals include reconsidering which contraceptive methods must be covered under the ACA and restructuring or limiting the role of expert bodies.⁷⁸ If, as expected, the Trump administration follows these recommendations, it will lead to attempts to carve out specific methods or substitute political oversight for expert-driven recommendations.

Given this federal landscape, it is not prudent to expect that the coverage violations and barriers detailed in this report will be addressed by federal agencies.

States Must Do More to Ensure No-Cost Contraceptive Coverage

States have significant authority to regulate fully insured plans and to address the compliance problems plaguing their residents.

Several states have already been active in this enforcement work. States such as Vermont, New York, and California have demonstrated the impact of robust state-level enforcement.

- **Vermont.** After receiving consumer complaints in 2021, Vermont’s Department of Financial Regulation audited contraceptive coverage claims from the state’s three largest insurers. The audit uncovered more than 14,000 claims in which Vermonters were improperly charged cost-sharing for contraceptive services under state and federal law, which had resulted in consumers bearing more than \$1.5 million in unlawful costs. The state required insurers to return these amounts with interest and to take corrective action to prevent future violations.⁷⁹
- **New York.** In June 2024, New York Attorney General Letitia James secured a \$1 million settlement with UnitedHealthcare of New York, Inc. (UHC) after UHC repeatedly failed to provide contraceptive coverage in compliance with New York state’s no-cost contraceptive coverage law, which mirrors and expands upon ACA coverage. The settlement resolved an investigation triggered

by a complaint from a beneficiary whose oral contraceptive was denied, with the plan improperly requiring prior authorization and step therapy, which is expressly prohibited under the state law. Beyond the monetary penalty, UHC was required to ensure all of its plans fully comply with the law and to train staff on proper claims processing.⁸⁰

- **California.** In August 2024, the California Department of Managed Health Care fined Blue Shield of California \$250,000 for improperly billing members for contraceptive services that should have been covered without cost-sharing under state law. The regulator’s investigation, prompted by a consumer complaint, found that the insurer had wrongly charged patients for contraceptive care—including the removal of IUDs.⁸¹

These examples illustrate how states can identify violations, require restitution to consumers, and impose meaningful penalties on noncompliant insurers. Where states have their own contraceptive coverage requirements that mirror or expand upon federal law, state executive agencies can actively enforce those protections as well.



Importantly, states do not need to wait for individual complaints to take action. Insurance departments can engage in proactive oversight to identify systemic compliance failures. For example, regulators can conduct proactive audits, issue supplemental billing and coding guidance, and impose penalties on insurers that repeatedly violate state law. Collecting and publicly reporting data on contraceptive coverage denials can also deter noncompliance while helping regulators identify patterns of unlawful conduct and recover costs that consumers were forced to pay in violation of contraceptive coverage laws.

In this moment of federal inaction, state regulators, attorneys general, and other state stakeholders play a critical role in safeguarding access to no-cost contraceptive coverage. Robust enforcement can make a meaningful difference for residents by ensuring that the contraceptive coverage guarantee exists not only on paper, but in practice.

States can also go further by enacting their own contraceptive coverage laws—establishing protections that mirror or expand upon the ACA’s guarantee and that states can enforce directly, independent of federal action. As the examples of Vermont, New York and California demonstrate, strong state laws create additional enforcement tools and provide a critical backstop for residents when federal oversight falters.

Other Actors Also Play an Important Role

There are others who can also play an important role in helping to ensure that the guarantee of no-cost contraceptive coverage is truly a reality.

- **Individuals.** Individual advocacy can sometimes resolve coverage problems. Beneficiaries can appeal improper denials, request itemized bills from their doctor’s billing office or health plan to better assess coding problems, ask providers about preventive coding to ensure products and services are coded correctly, and report violations to state insurance regulators or the

U.S. Department of Labor. These actions surface patterns of noncompliance and inform regulators’ enforcement priorities.

- **Employers.** Employers can help ensure their workers receive the contraceptive coverage guaranteed under the law. Human resources, external benefits consultants, brokers, or third-party administrators can review plan documents and vendor contracts to confirm that plans being offered to them cover contraception without cost-sharing as required by the ACA. They can also establish clear channels for employees to report coverage denials, elevate those issues to insurers or administrators, and request their payer to correct claims processing errors and reimburse employees who were improperly charged. By actively monitoring plan compliance and responding to employee-related barriers, employers can identify and resolve violations more quickly.
- **National Association of Insurance Commissioners and Similar Organizations.** Multi-state regulatory bodies and insurance industry associations, such as the National Association of Insurance Commissioners (NAIC),⁸² can play a meaningful role in expanding access to no-cost contraceptive coverage. These organizations can elevate the experiences of individuals affected by coverage violations, develop “best practices” guidance for regulators, publish reports identifying common contraceptive coverage compliance issues across states, and create opportunities for learning from one another’s state-led efforts.

Ultimately, meaningful compliance with the ACA’s contraceptive coverage requirement depends on sustained enforcement, transparency, and accountability driven by a range of actors. Without these actions, insurers will continue to violate the law and individuals will continue to face unlawful barriers to accessing the contraceptive care they need.

ENDNOTES

- 1 Healthcare.gov, <https://www.healthcare.gov/> (last visited Apr. 7, 2026).
- 2 See KFF, Status of Medicaid Expansion Decisions (Feb. 13, 2026), <https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/>.
- 3 The ACA contraceptive 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 identity, who has a need to prevent pregnancy.
- 4 42 U.S.C. § 300gg-13(a).
- 5 See Dep’t of Health & Human Servs., Assistant Sec’y for Plan. & Evaluation, Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act (Jan. 11, 2022), <https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf>; H. Comm. on Educ. & Lab., No Right to Deny Care: The Importance of Preserving Preventive Care in the Affordable Care Act 5 (Sept. 2022), https://democrats-edworkforce.house.gov/imo/media/doc/no_right_to_deny_care_the_importance_of_preserving_preventive_care_in_the_affordable_care_act.pdf.
- 6 Nat’l Women’s L. Ctr., The Affordable Care Act’s Contraceptive Coverage Requirement: Importance and Impact 2 (Nov. 2024), <https://nwlc.org/wp-content/uploads/2024/11/ACA-Brief.pdf>.
- 7 *Id.* at 2.
- 8 CoverHer, Nat’l Women’s Law Ctr., <https://nwlc.org/birth-control-coverher/> (last visited Apr. 9, 2026); Individuals contact CoverHer in a variety of ways: they can submit questions through an online intake form, send an email describing their coverage problem, or receive a referral. In most cases, NWLC staff work directly with individuals to review insurance communications, explain relevant legal protections, and help them pursue appeals or request exceptions.
- 9 See, e.g., Inst. of Med. of the Nat’l Acads., Clinical Preventive Services for Women: Closing the Gaps 15-20 (2011), available at <https://www.nationalacademies.org/read/13181/chapter/2>.
- 10 See, e.g., Comm. on Health Care for Underserved Women, Health Disparities in Rural Women, ACOG 586 (Feb. 2014), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/02/health-disparities-in-rural-women>.
- 11 The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), <https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>.
- 12 See, e.g., 155 Cong. Rec. S12,021, S12,027 (daily ed. Dec. 1, 2009) (statement of Sen. Gillibrand) (“Women must shoulder the worst of the health care crises...In America today, too many women are delaying or skipping preventive care because of the costs of copays and limited access. In fact, more than half of women delay or avoid preventive care because of its cost.”); 155 Cong. Rec. S12,033, S12,052 (daily ed. Dec. 1, 2009) (statement of Sen. Franken) (“[A]ffordable family planning services must be accessible to all women in our reformed health care system.”).
- 13 The ACA requires no-cost coverage of “women’s preventive services” as determined by the Health Resources and Services Administration (HRSA). In addition to requiring no-cost coverage for birth control, HRSA supports no-cost coverage for other women’s preventive services such as well-woman visits, breast cancer screening, screening and counseling for intimate partner violence, and lactation support, services, and supplies, among others. Health Res. & Servs. Admin., Women’s Preventive Services Guidelines, <https://www.hrsa.gov/womens-guidelines> (last visited Apr. 7, 2026).
- 14 Nat’l Women’s Law Ctr., *supra* note 6.
- 15 See, e.g., Brief for Nat’l Women’s L. Ctr. as Amici Curiae Supporting Defendants-Appellants/Cross-Appellees, *Braidwood Mgmt. v. Becerra*, 104 F.4th 930 (2023)(No. 23-10326), <https://nwlc.org/wp-content/uploads/2023/10/Braidwood-Management-Incorporated-v.-Xavier-Becerra.pdf>.
- 16 *Id.*; Nat’l Women’s Law Ctr., *supra* note 6.
- 17 The contraceptive coverage requirement also applies to Medicaid expansion plans. To date, 41 states (including DC) have adopted Medicaid expansion. KFF, Status of State Medicaid Expansion Decisions (Mar. 12, 2026), <https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/>.
- 18 Grandfathered health insurance plans, Healthcare.gov, <https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/> (last visited Apr. 6, 2026).
- 19 KFF, Preventive Services Covered by Private Health Plans under the Affordable Care Act (Feb. 28, 2024), <https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-covered-by-private-health-plans/#:~:text=ACA%20Requirements%20for%20Coverage%20of,on%20patients%20receiving%20these%20services>.
- 20 Federal rules governing religious exemptions to the contraceptive coverage requirement have changed over the past decade. During President Trump’s first term, the Trump-Pence administration issued rules allowing virtually any employer to refuse to provide contraceptive coverage, for any reason. Those rules were challenged in court and are currently vacated nationwide. That decision is now on appeal to the U.S. Court of Appeals for the Third Circuit. *Pennsylvania v. Trump*, 795 F. Supp. 3d 607 (2025).
- 21 Nat’l Women’s Law Ctr., New Data Estimates 62.1 Million Women Have Coverage of Birth Control and Other Preventive Services Without Out-of-Pocket Costs (Dec. 2021), https://nwlc.org/wp-content/uploads/2022/01/NWLC_FactSheet_Preventative-Services-Estimates-1.5.22.pdf.
- 22 See, e.g., U.S. Dep’t of Labor, Dep’t of Health & Hum. Servs., & Dep’t of the Treasury, FAQs about Affordable Care Act Implementation (Part XII) (Feb. 20, 2013), <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-12> [hereinafter FAQs Part XII]; U.S. Dep’t of Labor, Dep’t of Health & Hum. Servs., & Dep’t of the Treasury, FAQs about Affordable Care Act Implementation (Part XX) (July 17, 2014), <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-20> [hereinafter FAQs Part XX]; Press Release, Ctrs. for Medicare & Medicaid Servs., HHS, DOL, and Treasury Issue Guidance Regarding Birth Control Coverage (July 28, 2022), <https://www.cms.gov/newsroom/press-releases/hhs-dol-treasury-issue-guidance-regarding-birth-control-coverage>; U.S. Dep’t of Labor, Dep’t of Health & Hum. Servs. & Dep’t of the Treasury, FAQs about Affordable Care Act Implementation Part 54 (July 28, 2022), <https://www.cms.gov/files/document/faqs-part-54.pdf?source=email> [hereinafter FAQs Part 54].

- 23 See, e.g., Nat'l Women's L. Ctr., *The Affordable Care Act's Birth Control Benefit: Progress on Implementation and Continuing Challenges* (July 2016), <https://nwlc.org/wp-content/uploads/2016/07/The-ACAs-BC-Benefit-Report-1.pdf>; Nat'l Women's L. Ctr., *The Biden Administration Must Ensure the Affordable Care Act Contraceptive Coverage Requirement Is Working for All* (Oct. 14, 2021), https://nwlc.org/wp-content/uploads/2021/11/final_Long_nwlc_2021_BC_AffordCareAct-003.pdf.
- 24 CoverHer data only captures a fraction of the problem prevalence due to the fact that people may be unaware that their health plan is required to cover their birth control, do not know CoverHer exists, or may seek help elsewhere.
- 25 Individuals may contact CoverHer via our online form or leave a voicemail via our phone Hotline. CoverHer, Nat'l Women's Law Ctr., <https://nwlc.org/birth-control-coverher/>.
- 26 See *Having Trouble Getting Birth Control Without Co-Pay or Out-of-Pocket Costs?*, Nat'l Women's Law Ctr., <https://nwlc.org/having-trouble-getting-birth-control-without-co-pay-or-out-of-pocket-costs/>.
- 27 FAQs Part XII, *supra* note 23, at 7, Q14.
- 28 See, e.g., Michelle Andrews, *Some Insurers Refuse to Cover Contraceptives, Despite Health Law Requirement*, KFF Health News, Aug. 22, 2014, available at <https://kffhealthnews.org/news/michelle-andrews-on-contraceptive-coverage/>.
- 29 See, e.g., Nat'l Women's L. Ctr., *State of Birth Control Coverage: Health Plan Violations of the Affordable Care Act* (2015), <https://nwlc.org/wp-content/uploads/2021/11/stateofbirthcontrol2015final.pdf>.
- 30 U.S. Dep't of Labor, Dep't of Health & Hum. Servs. & Dep't of the Treasury, *FAQs About Affordable Act Implementation (Part XXVI)* (May 11, 2015), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-26.pdf> [hereinafter FAQs Part XXVI].
- 31 See, e.g., Erin Ross, *Women Rush to Get Long-Acting Birth Control After Trump Wins*, NPR, Nov. 11, 2016, available at <https://www.npr.org/sections/health-shots/2016/11/11/501611813/women-rush-to-get-long-acting-birth-control-after-trump-wins>; Tara Law, *21% of Women Reported Switching Their Birth Control Method Post-Roe*, TIME, July 26, 2022, updated Dec. 11, 2023, <https://time.com/6200542/women-birth-control-switching-methods-abortion/>.
- 32 U.S. Census Bureau, *Total Population by Geography*, <https://data.census.gov/chart/DECENNIALCD1182020.P1> (last visited Apr. 7, 2026).
- 33 "All Other Methods" includes: Essure, the shot, the patch, female condoms, emergency contraception, diaphragms, external male condoms, and the Natural Cycles App.
- 34 See Aaron Bolton, *How Ob-gyns are handling more requests for sterilization after 'Roe' was overturned*, NPR (July 2, 2024), <https://www.npr.org/sections/health-shots-health-news/2024/07/02/nx-s1-5025682/tubal-ligation-tied-vasectomy-ob-gyns-more-requests-sterilization-after-dobbs-roe-overturned>; Julia Strasser et al., *Tubal Sterilization and Vasectomy Increased Among US Young Adults After the Dobbs Supreme Court Decision in 2022*, *Health Affairs* 44(1) (Jan. 2025), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2024.00824>.
- 35 Each CoverHer intake represents not only the individual's denial, but also possible coverage trends related to specific methods, employers, insurers, and states.
- 36 In this report, where CoverHer contacts provided their home state, age, the name of their insurance company or pharmacy benefits manager, or their source of coverage (marketplace or employer), that is included.
- 37 See, e.g., U.S. Dep't of Labor, Dep't of Health & Hum. Servs., & Dep't of the Treasury, *FAQs About Affordable Care Act Implementation Part 64*, 2 (Jan. 22, 2024), <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-64> [hereinafter, FAQs Part 64]. ("The HRSA-supported Guidelines further recommend that the full range of U.S. Food and Drug Administration (FDA)-approved, -cleared, or -granted contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care.")
- 38 See, e.g., FAQs Part XXVI, *supra* note 40, at 4.
- 39 There are 20 distinct birth control methods listed in the FDA Birth Control Guide but one of these—male sterilization—is not required to be covered without cost-sharing under the ACA women's preventive services provision. Male condoms are covered as long as they are prescribed for someone who can become pregnant. See, Health Resources & Services Admin., *Women's Preventive Services Guidelines*, <https://www.hrsa.gov/womens-guidelines#note-1> (last visited Apr. 9, 2026) ([The full range of contraceptives includes those currently listed in the FDA's Birth Control Guide]...with the exception of sterilization surgery for men, which is beyond the scope of the WPSI.); See also I.R.S. Notice 2024-75, <https://www.irs.gov/pub/irs-drop/n-24-75.pdf> ("This notice expands the list of preventive care benefits permitted to be provided by a high deductible health plan ... without a deductible...to include over-the-counter (OTC) oral contraceptives (including emergency contraceptives) and male condoms.")
- 40 FAQs Part XXVI, *supra* note 40, at 5, Q2. ("... [a] plan's exclusion of some of the methods for women currently identified by the FDA means the plan fails to comply with PHS Act section 2713 and its implementing regulations.")
- 41 See FAQs Part 54, *supra* note 23, at 2 ("... plans and issuers subject to section 2713 of the PHS Act must cover, without cost sharing, items and services that are integral to the furnishing of a recommended preventive service, regardless of whether the item or service is billed separately."); 85 FR 71142, 71174 (Nov. 6, 2020) (discussing examples provided in *Coverage of Certain Preventive Services Under the Affordable Care Act* ("2015 Final Regulations"), 80 FR 41318 (July 14, 2015)); see also 2015 Final Regulations, 80 FR 41318, 41319 (July 14, 2015) (discussing previous guidance).
- 42 *Id.*, at 4, Q1 ("The requirement to cover, without cost sharing, items and services that are integral to the furnishing of a recommended preventive service also applies to coverage of contraceptive services under the HRSA-Supported Guidelines, including coverage for anesthesia for a tubal ligation procedure or pregnancy tests needed before provision of certain forms of contraceptives, such as an intrauterine device (also known as an IUD), regardless of whether the items and services are billed separately.")

43 See, U.S. Dep’t of Labor, Dep’t of Health & Hum. Servs. & Dep’t of the Treasury, FAQs About Affordable Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation 10 (Jan. 10, 2022), <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-51#f22> [hereinafter, FAQs Part 51] https://nwlc.org/wp-content/uploads/2021/11/NWLC_BC_AffordCareAct-Oct_2021.pdf (“If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service, then the plan or issuers may use reasonable medical management to determine any such coverage limitations.”); See also 6 CFR 54.9815-2713(a)(4); 29 CFR 2590.715-2713(a)(4); 45 CFR 147.130(a)(4).

44 See, e.g., FAQs Part 54, *supra* note 23, at 9, Q8.

45 See, e.g., *id.*; Ctrs. for Medicare & Medicaid Servs., Contraceptive Coverage Requirements Under Section 2713 of the Public Health Service Act 12 (last visited April 9, 2026), <https://www.cms.gov/ccio/resources/training-resources/downloads/contraceptive-coverage-slides-ppt.pdf>.

46 See, e.g., FAQs Part 64, *supra* note 47 (clarifying that it is unreasonable medical management to “apply age-related restrictions for a contraceptive service or product that is medically necessary for the individual, as determined by the individual’s attending health care provider”).

47 FAQs Part 54, *supra* note 23, at 9, Q8 (“Examples of unreasonable medical management techniques (which are the subject of a number of complaints regarding health plans and insurers, as well as their pharmacy benefits managers or other service providers) may include situations like the following: . . . Imposing an age limit on contraceptive coverage instead of providing these benefits to all individuals with reproductive capacity.”).

48 See, e.g., FAQs Part XII, *supra* note 23, at 13, Q14. The federal government has continued to provide guidance and clarification around this. In 2024, the federal government identified the “therapeutic equivalence approach.” See, FAQs Part 64, *supra* note 47, at Q2. This approach allows health plans and insurers to utilize reasonable medical management when a contraceptive drug is therapeutically equivalent to another drug, as determined by the FDA’s Approved Drug Products with Therapeutic Equivalence Evaluations—commonly known as the “Orange Book.” For example, Yasmin is a popular contraceptive pill brand. According to the Orange Book, Yasmin has a therapeutic equivalent. This means that a plan can use reasonable medical management to cover the generic version of the pill (drospirenone and ethinyl estradiol) without cost-sharing but may impose cost-sharing on Yasmin. In comparison, Lo Loestrin FE has no therapeutic equivalent. This means that the plan must cover Lo Loestrin FE without cost-sharing.

49 Rachel A. Bonnema, Megan C. McNamara, & Abby L. Spencer, Contraception Choices in Women with Underlying Medical Conditions, *American Family Physician* (Sept. 15, 2010), <https://www.aafp.org/pubs/afp/issues/2010/0915/p621.html#afp20100915p621-b6>.

50 A drug formulary is a list of prescription medications that are covered by a health insurance plan.

51 Bilateral salpingectomy is a form of sterilization surgery that involves the surgical removal of the fallopian tubes. See Salpingectomy, Johns Hopkins Med., <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/salpingectomy> (last visited Apr. 7, 2026).

52 Bilateral salpingectomy decreases the risk of epithelial ovarian cancer and reduces post-sterilization contraceptive failure compared with traditional sterilization techniques, without increasing surgical risk. Sarah Marino et al., Tubal Sterilization, *StatPearls* (Feb. 16, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK470377/>.

53 Tubal ligation is a sterilization method that uses a band or clamp to close the fallopian tubes. See Tubal Ligation, Johns Hopkins Medicine, <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/tubal-ligation> (last visited Apr. 7, 2026).

54 Columbia Univ. Irving Med. Ctr., Sterilization Rates Among Women Rose After Supreme Court Abortion Ruling (Sept. 11, 2024), <https://www.cuimc.columbia.edu/news/sterilization-rates-among-women-rose-after-supreme-court-abortion-ruling>.

55 Women’s Preventive Services Initiative (WPSI), WPSI 2025 Coding Guide, www.womenspreventivehealth.org/wp-content/uploads/Womens-Preventive-Services-Initiative-WPSI-2025-Coding-Guide.pdf (last visited Feb. 21, 2026) (on file with author).

56 See, e.g., Ctrs. for Disease Control & Prevention, Nat’l Ctr. for Health Statistics, ICD-10-CM (June 7, 2024), <https://www.cdc.gov/nchs/icd/icd-10-cm/index.html>.

57 See, U.S. Dep’t of Labor, Dep’t of Health & Hum. Servs., & Dep’t of the Treasury, FAQs about Affordable Care Act and Women’s Health and Cancer Rights Act Implementation Part 68 (Oct. 21, 2024), <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-68> [hereinafter FAQs Part 68].

58 See, e.g., Elizabeth Reiner Platt et al., The Southern Hospitals Report: Faith, Culture, and Abortion Bans in the U.S. South, Columbia L. Sch. Law, Rights & Religion Project (2021), [https://lawrightsreligion.law.columbia.edu/sites/lawrightsreligion.law.columbia.edu/files/content/Reports/The Southern Hospitals Report.pdf](https://lawrightsreligion.law.columbia.edu/sites/lawrightsreligion.law.columbia.edu/files/content/Reports/The%20Southern%20Hospitals%20Report.pdf).

59 According to federal guidance, “Medical necessity may include considerations such as severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by the attending provider.” FAQs Part XXVI, *supra* note 40, at 4.

60 *Id.*

61 *Id.*

62 “The plan or issuer must defer to the determination of the attending provider.” *Id.*

63 See, e.g., BlueCross BlueShield Federal Employee Program, Contraceptive Exception Member Request Form, https://www.caremark.com/portal/asset/Contraception_Exception_Form.pdf (last visited Apr. 7, 2026).

64 FAQs Part 54, *supra* note 23, at 10.

65 *Id.*

66 Cmte. Oversight & Reform, U.S. House of Reps., Barriers to Birth Control: Analysis of Contraceptive Coverage and Costs for Patients with Private Insurance 2 (Oct. 25, 2022), <https://oversightdemocrats.house.gov/sites/evo-subsites/democrats-oversight.house.gov/files/2022-10-25.COR%20PBM-Insurer%20Report.pdf>.

- 67 “Research identified public documents describing acceptable exceptions processes for only two of the 42 health plans or pharmacy benefit managers assessed”; “many plans provide no information at all about an exceptions process in their online documents. . . and/or in phone conversations with customer service representatives.” Adam Sonfield, *When Your Birth Control Isn’t Covered: Health Plan Non-Compliance with the Federal Contraceptive Coverage Requirement*, Power to Decide 4 (2022), <https://powertodecide.org/sites/default/files/2022-04/ACA%20Contraception%20Exception%20Report.pdf>.
- 68 See, e.g., FAQs Part 51, *supra* note 53, at 15.
- 69 A study found that 33% of female voters in 2017 said they could not afford more than \$10 a month for contraception, and another 14% said they could not afford to pay anything at all. PerryUndem, *Contraceptives and Policy Through a Gender Lens: Results from a National Survey 10* (Mar. 22, 2017), <https://www.scribd.com/document/342699692/PerryUndem-Gender-and-Birth-Control-Access-Report>.
- 70 A study found that 23% of low-income female contraceptive users would use a different method if not for the cost. *Id.*
- 71 *Id.*
- 72 See, Megan Kavanaugh et al., *Associations Between Unfulfilled Contraceptive Preferences Due to Cost and Low-Income Patients’ Access to and Experiences of Contraceptive Care in The United States, 2015–2019*, 4 *Contraception*: X (2022), <https://doi.org/10.1016/j.conx.2022.100076>.
- 73 Hamisu M. Salihu et al., *Childbearing beyond maternal age 50 and fetal outcomes*, *Obstet. Gynecol.* 102(5, Part 1):1006-1014 (Nov. 2023), [https://doi.org/10.1016/s0029-7844\(03\)00739-7](https://doi.org/10.1016/s0029-7844(03)00739-7).
- 74 See generally Anna Bernstein & Kelly M. Jones, *The Economic Effects of Contraceptive Access: A Review of the Evidence*, *Inst. of Women’s Pol’y Rsch.* (2020), https://iwpr.org/wp-content/uploads/2020/07/B381_Contraception-Access_Final.pdf (exploring the ways that access to contraception has affected women’s economic outcomes).
- 75 See, e.g., Josep Perelló-Capó et al., *Beyond Contraception: Exploring Health Benefits of Short-Acting Reversible Contraceptives – A Narrative Review*, *Women’s Health Reports* 6.1 (Oct. 29, 2025), <https://journals.sagepub.com/doi/epdf/10.1177/26884844251405066>.
- 76 Nat’l Women’s L. Ctr., *supra* note 6, at 3.
- 77 *Pennsylvania v. Trump*, 795 F. Supp. 3d 607 (E.D. Pa.), appeal filed (3d Cir. 2025).
- 78 See Lauren Wallace, *All the Ways Project 2025 Wants to Undermine Birth Control Access*, NWLC, <https://nwlc.org/all-the-ways-project-2025-wants-to-undermine-birth-control-access/> (last visited Apr. 7, 2026).
- 79 State of Vermont, Dep’t. Fin. Reg., *DFR Investigation Results in Restitution for Contraceptive Services*, Oct. 12, 2023, <https://dfr.vermont.gov/press-release/dfr-investigation-results-restitution-contraceptive-services>.
- 80 Letitia James, NY State Atty. Gen., *Attorney General James Announces Settlement with United Healthcare for Failing to Provide Coverage of Birth Control* (June 20, 2024), <https://ag.ny.gov/press-release/2024/attorney-general-james-announces-settlement-unitedhealthcare-failing-provide#:~:text=NEW%20YORK%20%E2%80%93%20New%20York%20Attorney.control%20through%20its%20health%20plans>.
- 81 DMHC Press Release, *DMHC Fines Blue Shield of California \$250,000 for Illegally Billing Members for Contraceptive Health Services* (Aug. 29, 2024), <https://www.dmhc.ca.gov/Resources/Newsroom/PressReleases/August29,2024.aspx>.
- 82 NAIC, <https://content.naic.org/> (last visited Apr. 7, 2026).