# State Actions to Expand Contraceptive Coverage

June 2023

Since 2014, nearly a third of states have undertaken efforts to expand contraceptive access by mandating that health insurance plans cover the full range of contraceptive methods without cost-sharing and with limits on utilization controls.[1] Whether prompted to build upon their own state statutes, the federal contraceptive coverage requirement, or both, these state laws (sometimes referred to as "contraceptive equity laws") represent important steps to ensure everyone can access the contraception they need to pursue the future they want for themselves.

At the federal level, guidelines implementing the Women's Preventive Services provision of the Affordable Care Act (ACA) require all women covered by Medicaid expansion, marketplace, and employer-based plans—that are not grandfathered—to cover at least one contraceptive for each of the FDA approved methods for women, as prescribed, without copays or deductibles. Federal guidance also requires that plans reduce administrative barriers for patients.[2] An estimated 64.3 million women benefit from the Women's Preventive Services provision. Women saved at least $1.4 billion in out-of-pocket costs for birth control pills in a single year, and there is evidence that the provision is increasing the ability of women to obtain more effective birth control methods for those who want it.

Despite evidence of the benefits of the ACA's contraceptive coverage requirement, over the last decade there have been numerous legal challenges to this provision and the ACA itself. In addition, the Trump administration issued regulations allowing more employers and universities to exempt themselves from covering some or all methods of birth control in their health plans.[3] Advocates have called upon the Biden-Harris administration to rescind the rules and take other actions to strengthen the contraceptive coverage guarantee. In response, the administration issued additional guidance reaffirming the ACA's contraceptive coverage requirements for health insurers.[4]

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[1] Utilization controls (or medical management techniques) that have been used for contraceptives include prior authorization and step therapy. For more background, see https://files.kff.org/attachment/report-coverage-of-contraceptive-services-a-review-of-health-insurance-plans-in-five-states.

[2] In 2015, HHS issued guidance clarifying the contraceptive coverage requirements, see https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf.

[3] For more information, see https://powertodecide.org/about-usnewsroom/power-decide-statement-supreme-court-decision-allowing-employers-deny.

[4] For more information, see https://powertodecide.org/contraceptive-coverage-and-access.

Recognizing the opportunity to buttress the federal contraceptive coverage requirement at the state level, state legislatures have codified—and even expanded—upon it. States have provided contraceptive coverage beyond what is required by the ACA by including one or more of the following: coverage of *all* FDA-approved contraceptive drugs, devices, and products in each of 18 categories (with an exception for therapeutically equivalent products, as long as at least one is covered without cost-sharing); coverage for over-the-counter (OTC) methods without a prescription; coverage for male sterilization; and coverage for an extended supply of prescription contraceptives.

These state actions are positive steps in the right direction, but it is worth noting that state insurance laws usually only apply to plans regulated by the state.[5] Hence, state laws do not necessarily provide a substitute for the federal contraceptive coverage requirement—and in the case of some plans, state laws simply *are not* a stopgap for the federal provision. The chart below provides more details on each of the states' policies.

| + State | Bill/ Guidance | Year Passed | When the Law Applies to Plans[4] | Covers Emergency Contraception w/out a Rx? | Other Limits (-) or Features (+) |
|---|---|---|---|---|---|
| **California~** | SB 525 | 2022 | January 1, 2024 | Yes | (+) Expands on SB 1053 to cover OTC contraceptive drugs, devices, & products w/o a Rx at in-network pharmacies |
| | SB 1053 | 2014 | January 1, 2016 | No | + Covers all FDA-approved contraceptive drugs, devices, and products in private insurance, with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing).<br>+ Covers 12-month contraceptive supply in private insurance and Medicaid Managed Care[1] |
| **Connecticut** | Sub. HB 5210 | 2018 | January 1, 2019 | No[5] | + Covers of all FDA-approved contraceptive drugs, devices, and products in private insurance, with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing).<br>+ Covers OTC contraceptive drugs[5]<br>+ Covers 12-month contraceptive supply[1]<br>- Co-pays may apply for out-of-network providers |
| **Delaware~** | SB 151 | 2018 | July 11, 2018 | Yes | + Applies to public and private plans<br>- Coverage not required for male condoms<br>+ Covers 12-month contraceptive supply[1] |
| **District of Columbia~** | B 22-106 | 2018 | January 1, 2019 | No[5] | + Covers all FDA-approved contraceptive drugs, devices, and products in private insurance and Medicaid, with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing).<br>+ Covers OTC contraceptives[5] |

[5] Most state insurance mandates do not apply to self-funded plans, see: Kaiser Health News. (2017). *For Millions of Insured Americans, State Health Laws Don't Apply* For Millions of Insured Americans, State Health Laws Don't Apply. According to the Kaiser Family Foundation 2020 Survey of Employer Health Benefits, 67% of covered workers are in a plan that is self-funded.

(For more state policy resources, visit our state policy page.)

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|---|---|---|---|---|---|
| **District of Columbia~ (cont.)** | | | | | + Covers 12-month contraceptive supply[1]<br>+ Public and private plans must cover a wide range of women's preventive services |
| **Illinois** | HB 5576 | 2016 | January 1, 2017 | No[5] | + Covers all FDA-approved contraceptive drugs, devices, and products in private insurance, with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing).<br>+ Covers male sterilization<br>+ Covers all OTC methods, except male condoms[5] |
| **Maine** | LD 1954 | 2022 | January 1, 2023 | No | + Expands on LD 1237 to require private insurers to cover all FDA-approved contraceptive drugs, devices, and products with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing). LD 1237 required coverage of at least one contraceptive in each of the FDA-approved contraceptive method *categories*. |
| | LD 1237 | 2017 | January 1, 2019 | No | + Covers 12-month contraceptive supply |
| **Maryland** | HB 1005 | 2016 | January 1, 2018 | Yes | + Covers all FDA-approved contraceptive drugs, devices, and products in private insurance, with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing).<br>+ Covers male sterilization<br>+ Prohibits public and private plans from requiring prior authorization for long-acting reversible contraceptives (LARC)<br>+Covers 12-month contraceptive supply[1] |
| **Massachusetts~** | H 4009 | 2017 | August 2018 | Yes | + Also applies to Medicaid Managed Care and state employee health insurance<br>+ Covers of all FDA-approved contraceptive drugs, devices, and products<br>- Coverage not required for male condoms or FDA-approved oral contraceptives without a therapeutic equivalent<br>+ Covers 12-month contraceptive supply[1] |
| **New Hampshire** | HB 421 | 2018 | January 1, 2019 | No | + Covers 12-month contraceptive supply[1]<br>+ Applies to public and private plans |
| **New Jersey** | A 5508 | 2020 | April 16, 2020 | Yes | + Covers male sterilization and male condoms (but cost-sharing is permitted in high-deductible plans)<br>+Covers OTC contraceptive drugs w/o a Rx |
| **New Mexico** | HB 89 | 2019 | January 1, 2020 | Yes | + Covers a 6-month contraceptive supply for private plans[1]<br>+ Covers OTC contraceptives without Rx[5] |

(For more state policy resources, visit our state policy page.)

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| **New Mexico (cont.)** | | | | | + Covers male sterilization and condoms, except in high-deductible plans, before deductible is met. |
| **New York** | SB 659A | 2019 | January 1, 2020 | Yes | + Covers all FDA-approved contraceptive drugs, devices, and products in private insurance, with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing).<br>+ Covers OTC contraceptive drugs, devices and supplies[5] |
| | DFS-06-17-00015-A | 2017 | August 27, 2017 | No[3] | + Covers 12-month contraceptive supply[1] |
| **Nevada** | AB 249 | 2017 | January 1, 2018 | No | + Covers 12-month contraceptive supply[1]<br>+ Applies to Medicaid managed care plans and private plans |
| **Oregon~** | HB 3391 | 2017 | January 1, 2019 | No[5] | + Private insurers must cover *all* Women's Preventive Services required by federal guidelines as of 1/1/17<br>+ Covers all FDA-approved contraceptive drugs, devices, and products in private insurance, with an exception for therapeutically equivalent products (if at least one is covered w/out cost-sharing).<br>+ Directs the state to appropriate funds to provide coverage for the aforementioned to women who are of reproductive age but are temporarily ineligible for Medicaid due to their immigration status<br>+ Requires a report on insurer compliance |
| **Vermont** | H 620 | 2016 | October 1, 2016 (Medicaid)<br>October 1, 2017 (private plans) | No | + Applies to public and private plans<br>+ Plans must cover sterilizations for men and women, with some limits<br>+ Directs the state's Department of Health Access to establish and implement value-based payments for LARC insertion and removal[2] |
| **Washington** | Sub.SB 6219 | 2017 | January 1, 2019 | Yes | + Covers all FDA-approved contraceptive drugs, devices, and products in private insurance.<br>+ Plans must cover male sterilization<br>+ Covers all OTC methods without a Rx |

Table Notes

~ State law specifies that coverage is not excluded for contraception prescribed for reasons other than contraception. This does not necessarily mean that this would be excluded in states where such coverage is not specified.

[1] These laws/regulations include coverage for an extended supply of prescription contraceptives. For more details: https://powertodecide.org/what-we-do/information/resource-library/extended-supply-contraception.

[2] Value-based payments reward providers for the value of the care they deliver, thus value-based payments for LARC should take into account the value of preventing unintended pregnancy.

[3] This is required for Medicaid beneficiaries pursuant to regulation HLT-39-16-00031.

[4] This applies to plans issued or renewed after the effective date. As explained earlier, these policies generally do not apply to self-funded plans. Also, most states have exemptions for religiously affiliated employers.

[5] Connecticut and Oregon require health insurers to cover OTC contraceptive drugs, D.C. requires coverage for OTC contraceptives, and Illinois and New York require coverage for all OTC contraceptive drugs, devices, and products—none of these state laws specify that such coverage is required for OTC contraception *without* a prescription.