Contraceptive Equity & Essential Health Benefits

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Contraceptive Equity laws require coverage of all unique contraceptives without inappropriate medical management. This fact sheet is part of a series of primers on health law issues that may arise when advocating for state Contraceptive Equity laws. To access additional primers, visit https://healthlaw.org/contraceptive-equity-primers.

Essential Health Benefits (EHBs) are a set of benefits that non-grandfathered, individual, small-business, and Medicaid Alternative Benefit Plans are required to cover under the Affordable Care Act (ACA).[1] The ACA establishes a minimum of ten EHB categories for plans to cover and provides the Department of Health and Human Services (HHS) Secretary with the authority to define the specific benefits to be covered within each EHB category.[2] One of the ten EHB categories is preventive services, which includes contraceptive care.

Since HHS has declined to create national standards, each state is required to select a "benchmark" plan from among a group of existing insurance plans identified by HHS to define the scope of services covered in each of the ten categories.[3] The benchmark plan then serves as a reference plan for the purposes of identifying the specific services (and limitations) to be covered as part of the EHB package.

If a state enacts new benefit mandates in addition to the EHB, federal law requires the state to defray the cost of those additional benefits through payments to enrollees or plan issuers. (Note that the state's required payment for additional mandated benefits only applies to subsidized individuals enrolled in Qualified Health Plans – plans bought and sold in the state and federal insurance Marketplaces created by the ACA.) For this reason, some states may be

[1] 42 U.S.C. § 18021(a)(1)(B).
[2] 42 U.S.C. § 18022(b).
[3] 45 CFR § 156.100.

reluctant to pass any new benefit mandates that fall outside of the EHB. Nevertheless, contraception is documented to ultimately save money and the state cost may be low.

HHS has clarified that only new state mandates requiring that a health plan cover specific care, treatment, or services are considered for the purpose of evaluating whether state mandates are in excess of the EHB. Contraceptive Equity provisions that apply to women are already incorporated in the EHB through federal regulations and therefore are not new. Rather, Contraceptive Equity laws address **how** those services are delivered and remedy insurance practices that have undermined access to those services.

The ACA birth control requirements do not include contraceptive services for men.[4] Therefore, the EHB preventive services requirement does not include these services. Yet if these services are included in the state's EHB benchmark plan, the additional cost-sharing protection required under Contraceptive Equity does not constitute a new state mandate for purposes of the EHB and therefore does not trigger a requirement that the state defray the associated costs. For example, vasectomy with cost-sharing is already a benefit under California's benchmark plan but external condoms are not covered. Required coverage of vasectomy with no cost-sharing in the state would not be a new mandate, but required coverage of external condoms with no cost-sharing would create a new mandate requiring defrayal.

To avoid being subject to defrayal, states could utilize the benchmarking process to expand or improve coverage. While this process may take longer than enacting legislation or implementing regulations requiring additional coverage (states must submit proposed changes 19 months in advance of their effective date and must submit actuarial certification that the resulting base-benchmark plan complies with typicality and generosity requirements), it is currently the only way to avoid having to defray the cost of new coverage mandates. It does have the downside of being subject to administrative whim.

States also have the option of creating targeted funds to cover the cost of the additional benefits during the months before the benchmarking changes become effective. In California, for example, the Governor's 2020 budget included a special fund to ensure that all children would get access to hearing aids. This move leaves open the possibility that the State would seek changes to its base-benchmark plan that would require coverage of hearing aids for all enrollees beginning in plan year 2023. California decided to take this step after realizing it would be subject to defrayal if proposed legislation to require all plans to cover hearing aids for minors became law. A state could do the same with male contraception.

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[4] 42 U.S.C. § 300gg-13(a)(4).