



Contraceptive Equity Primers

By [Liz McCaman Taylor](#)

State laws regulating contraceptive coverage, often referred to as Contraceptive Equity laws, can play a critical role in filling the remaining gaps from the Affordable Care Act (ACA) and accompanying federal guidance, and have the potential to expand equitable access to contraceptive services for all.

Contraceptive Equity laws address three major strategic goals:

1. Expand the range of contraceptives that are covered without cost-sharing;
2. Limit medical management (also known as utilization controls);
3. Create gender equity in contraceptive coverage.

Expanded Range of Contraceptives

While the ACA uses a “methods” framework to determine the range of coverage, Contraceptive Equity laws go further and require coverage of every unique contraceptive or a therapeutic equivalent. Contraceptive Equity laws also explicitly delineate coverage requirements for all services related to contraception including initial and ongoing counseling, device insertion and removal, and management of side effects.

Limited Medical Management

Contraceptive Equity laws strictly limit the ability of insurers to impose restrictions and delays (a.k.a. medical management or utilization controls). For example, they can prohibit quantity limits on contraception, allowing coverage of a year’s worth of contraceptive supplies. They can also prohibit prescription requirements for coverage of over-the-counter contraceptives.

Gender Equity

Unlike the ACA's birth control benefit, which specifically applies to women, Contraceptive Equity laws are gender neutral. They also create equity by eliminating cost-sharing for external condoms, vasectomy, and contraceptive counseling for men.

Primers

In addition to NHeLP's Model Contraceptive Equity Act, which provides template legislative language, the following primers are designed to educate advocates and policymakers on health law issues that may arise during the legislative process:¹

- 1) Contraceptive Equity & Essential Health Benefits
- 2) Contraceptive Equity & Fiscal Notes
- 3) Contraceptive Equity & High-Deductible Health Plans
- 4) Contraceptive Equity & Medicaid
- 5) Contraceptive Equity & Self-Insurance

An implementation toolkit along with additional resources are also available at <https://healthlaw.org/contraceptive-equity/>.²

¹ Liz McCaman Taylor, Nat'l Health Law Program, *Model Contraceptive Equity Act: Legislative Language and Issue Brief* (2021), <https://healthlaw.org/resource/model-contraceptive-equity-act-legislative-language-and-issue-brief/>.

² Liz McCaman Taylor, Nat'l Health Law Program, *Contraceptive Equity in Action: A Toolkit for State Implementation* (2019), <https://healthlaw.org/resource/contraceptive-equity-in-action-a-toolkit-for-state-implementation/>.

Contraceptive Equity & Essential Health Benefits

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).³ The ACA establishes a minimum of ten categories of EHBs 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.⁴ One of the ten EHB categories is preventive services and chronic disease management, 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.⁵ 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 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

³ 42 U.S.C. § 18021(a)(1)(B).

⁴ 42 U.S.C. § 18022(b).

⁵ 45 CFR § 156.100.

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.⁶ 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 whose insurance does not cover hearing aids would get access to these devices. 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. The State was able to put in place a workaround in part because advocates pushed for a targeted approach that focuses solely on underinsured minors. A state could do the same with male contraception.

⁶ 42 U.S.C. § 300gg-13(a)(4).

Contraceptive Equity & Fiscal Notes

Fiscal notes, which estimate a legislative proposal's short-term effects on a state budget, provide useful information for state legislators when voting on Contraceptive Equity bills. While some Contraceptive Equity notes allude to potential savings, most focus on the short-term administrative expenses and potential expenditures by state-funded healthcare programs. To the extent that these notes attempt to measure the public-health benefits or long-term economic impacts of such mandates, they typically rely on existing studies from outside parties rather than independent state-specific research. When advocating for these laws, it is helpful to know how the fiscal note process works and to be prepared with existing public health research that can support a favorable economic analysis.

Cost Considerations

Generally, fiscal notes conduct an accounting-type analysis of the proposed legislation's effects on a state's budget across a few categories. For example, fiscal notes generally consider the administrative costs related to implementing healthcare measures. These costs include hiring staff, updating state databases, and other logistical expenses. Another category is direct costs on state budgets, which are primarily related to increased expenditures on publicly funded health programs like Medicaid, such as the increased cost to the state of providing more contraceptive coverage.

Although potentially substantial, the indirect cost savings of Contraceptive Equity laws are often not referenced in fiscal notes. Such savings relate to reduced state health insurance costs from a lower number of covered births. In California and Florida, fiscal notes approximated the savings by multiplying the projected reduction in births by an average cost of delivery.⁷ Advocates could identify the particular legislative or executive office charged with preparation of fiscal notes, and submit relevant external analyses (see Appendix).

⁷ CAL. HEALTH BENEFITS REVIEW PROGRAM ANALYSIS OF SENATE BILL 1053: HEALTH CARE COVERAGE: CONTRACEPTIVES AT 119 (2014); FLA. SENATE COMM. ON HEALTH POLICY, BILL ANALYSIS AND FISCAL IMPACT STATEMENT: SB 410 AT 9 (2019).

Evaluation Period

At a minimum, all fiscal notes evaluate the consequences a proposed law will have on a state's budget for the current and subsequent fiscal year, while some (12 states, plus the District of Columbia) cover a period of at least four years.⁸ Texas and Washington, for example, conduct 10-year analyses.⁹ Short-duration fiscal notes can be misleading in the context of contraceptive mandates because they may catalogue the immediate expenditures associated with contraceptive mandates, such as paying to provide contraceptives, while omitting the attendant long-term revenue benefits, such as fewer instances of unintended pregnancies. This could be particularly problematic in states with strict balanced budget requirements.¹⁰ Expanding the covered period of a fiscal note's analysis to project budgetary effects for a longer period of time would help ensure that longer-term benefits are not excluded from the accounting.

If the offices developing state fiscal notes fail to engage with more comprehensive analyses, advocates can draw attention to the shortcomings of a limited analysis in the healthcare context. Some states, such as New Jersey, allow the sponsor of a bill to formally object to the findings of a fiscal note, and submit additional information to accompany the note.¹¹

⁸ Elizabeth McNichols, et al., CTR. ON BUDGET & POL'Y PRIORITIES, BETTER COST ESTIMATES, BETTER BUDGETS: IMPROVED DISCAL NOTES WOULD HELP STATES MAKE MORE INFORMED DECISIONS at 6 (2015)

<https://www.cbpp.org/sites/default/files/atoms/files/10-15-15sfp2.pdf>

(DC, GA, IA, LA, MD, MN, MT, NC, ND, OR, TX, VA, WA).

⁹ Id.; WA Office of Financial Mgmt, *Agency Fiscal Note Instructions* (Dec. 2020),

<https://ofm.wa.gov/sites/default/files/public/budget/instructions/other/agencyfiscalnoteinstructions.pdf>.

¹⁰ NAT'L CONF. OF STATE LEGISLATORS, STATE BALANCED BUDGET PROVISIONS,

[https://www.ncsl.org/research/fiscal-](https://www.ncsl.org/research/fiscal-policy/state-balanced-budget-requirements-provisions-and.aspx)

[policy/state-balanced-budget-requirements-provisions-and.aspx](https://www.ncsl.org/research/fiscal-policy/state-balanced-budget-requirements-provisions-and.aspx) (last visited Oct. 13, 2020).

¹¹ N.J. Rev. Stat. § 52:13B-11.

Appendix

State Analyses

CAL. HEALTH BENEFITS REVIEW PROGRAM, ANALYSIS OF SENATE BILL 1053: HEALTH CARE COVERAGE: CONTRACEPTIVES (2014), <http://analyses.chbrp.com/document/view.php?id=907>.

CAL. HEALTH BENEFITS REVIEW PROGRAM, ANALYSIS OF SENATE BILL 523: HEALTH CARE COVERAGE: CONTRACEPTIVES (2021), <http://analyses.chbrp.com/document/view.php?id=1559>.

SENATE APPROPRIATIONS COMMITTEE FISCAL SUMMARY, SB 1053 (MITCHELL) - HEALTH CARE COVERAGE: CONTRACEPTIVES (2014), http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_1051-1100/sb_1053_cfa_20140523_132849_sen_comm.html.

SENATE AND HOUSE COMMITTEES ON APPROPRIATIONS, SB 523 (LEYVA) - HEALTH CARE COVERAGE: CONTRACEPTIVES (2021), https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB523.

FLA. SENATE COMM. ON HEALTH POLICY, BILL ANALYSIS AND FISCAL IMPACT STATEMENT: SB 410 (2019), <https://www.flsenate.gov/Session/Bill/2019/410/Analyses/2019s00410.pre.hp.PDF>.

LEGISLATIVE FINANCE COMMITTEE, FISCAL IMPACT REPORT: NM HB89 (2019), <https://www.nmlegis.gov/Sessions/19%20Regular/firs/HB0089.PDF>.

LEGISLATIVE FISCAL ESTIMATE, ASSEMBLY No. 5508, NJ 218TH LEG. (2020), https://www.njleg.state.nj.us/2018/Bills/A9999/5508_E2.HTM.

MULTIPLE AGENCY FISCAL NOTE SUMMARY, SB 6219: REPRODUCTIVE HEALTH COVERAGE (2018), <https://app.leg.wa.gov/committeeschedules/Home/Document/137422>.

JEFFREY S. DEWITT, GOV'T OF THE D.C. OFFICE OF THE CHIEF FIN. OFFICER, FISCAL IMPACT STATEMENT – DEFENDING ACCESS TO WOMEN'S HEALTH CARE SERVICES AMENDMENT ACT (2017), http://app.cfo.dc.gov/services/fiscal_impact/pdf/spring09/FIS%20-%2022-106%20Defending%20Access%20to%20Women%20Health%20Care%20Services%20Amendment%20Act%20of%202017.pdf.

Appendix (continued)

Economics Research

Adam Sonfield, *Beyond Preventing Unplanned Pregnancy: The Broader Benefits of Publicly Funded Family Planning Services*, 17 GUTTMACHER POL'Y REV., Fall 2014, at 2, <https://www.guttmacher.org/sites/default/files/pdfs/pubs/gpr/17/4/gpr170402.pdf>.

Alexandra Wollum et al., *Modeling the Impacts of Price of an Over-the-Counter Progestin-Only Pill on Use and Unintended Pregnancy Among U.S. Women*, WOMEN'S HEALTH ISSUES at 1 (2020)

Diana Foster et al., *Potential Public Sector Cost-Savings from Over-the-Counter Access to Oral Contraceptives*, 91 CONTRACEPTION 373 (2015).

Elizabeth McNichol et al., *Better Cost Estimates, Better Budgets: Improved Fiscal Notes Would Help States Make More Informed Decisions*, CTR. ON BUDGET & POL'Y PRIORITIES at Table 2: Laws & Rules Governing State Fiscal Note Practices (Nov. 24, 2015) <https://www.cbpp.org/research/state-budget-and-tax/better-cost-estimates-better-budgets>.

Gorette Amaral et al., *Public Savings from the Prevention of Unintended Pregnancy: A Cost Analysis of Family Planning Services in California*, 45 HEALTH SERVICES RES. 1960 (2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2254565/>.

HEALTH IMPACT PROJECT, A USER'S GUIDE TO LEGISLATIVE HEALTH NOTES (Apr. 2021), <https://www.pewtrusts.org/-/media/assets/2021/04/apractitionersguidereportfinal.pdf>

James Trussel & Tara Shochet, *Cost-Effectiveness of Emergency Contraceptive Pills in the Public Sector in the USA*, 3 EXPERT REV. OF PHARMACOECONOMICS & OUTCOMES RES. 433 (2003)

UNIVERSITY OF CALIFORNIA SAN FRANCISCO, BIXBY CENTER FOR GLOBAL REPRODUCTIVE HEALTH, COST-BENEFIT ANALYSIS OF THE CALIFORNIA FAMILY PACT PROGRAM FOR CALENDAR YEAR 2007 (2010), https://intranet.bixbycenter.ucsf.edu/publications/files/FamilyPACTCost-BenefitAnalysis2007_2010Apr_Featured.pdf.

Contraceptive Equity & High-Deductible Health Plans

High-deductible health plans (HDHPs) present unique issues for contraceptive coverage because of their interaction with tax law. A consumer with a HDHP in conjunction with a tax-exempt Health Savings Account (HSA) must meet the deductible before receiving any benefits in order to legally contribute to the HSA. This potentially conflicts with Contraceptive Equity laws that prohibit cost-sharing.

Federal law explicitly provides an exemption or “safe harbor” to allow HDHPs to cover preventive services before a patient meets the minimum deductible requirements.¹² IRS guidance from 2013 clarified that all of the FDA-approved contraceptives for women, including women’s sterilization, are considered preventive services for tax purposes because of the women’s preventive services amendment in the Affordable Care Act (ACA).¹³ Thus, contraceptives for women are covered in HDHPs without meeting the deductible.

However, in March 2018, the IRS issued additional guidance stating that because the ACA did not include a men’s preventive services amendment, male sterilization, male condoms, and related services are not considered preventive in the context of HSAs.¹⁴ This conclusion is unfortunate given the current STI crisis and the myriad public health arguments for classifying all contraception as preventive.¹⁵

¹² 26 USC § 223(c)(2).

¹³ I.R.S. Notice 2013-57, <https://www.irs.gov/pub/irs-drop/n-13-57.pdf>.

¹⁴ I.R.S. Notice 2018-12, <https://www.irs.gov/pub/irs-drop/n-18-12.pdf>.

¹⁵ See Adam Sonfield, *Rounding Out the Contraceptive Coverage Guarantee: Why ‘Male’ Contraceptive Methods Matter for Everyone*, 18 GUTTMACHER POL’Y REV. 34 (2015), <https://www.guttmacher.org/gpr/2015/06/rounding-out-contraceptive-coverage-guarantee-why-male-contraceptive-methods-matter>; U.S. AGENCY FOR INT’L DEV., CONDOM USE: HOW IT RELATES TO HIV AND STI PREVENTION (Sept. 2013), <https://www.usaid.gov/sites/default/files/documents/1864/CondomSTIIssueBrief.pdf>; J. Trussell, et al., *The Economic Value of Contraception: A Comparison of 15 Methods*, 85 AM. J. PUB. HEALTH 494 (1995), <https://www.ncbi.nlm.nih.gov/pubmed/7702112/>; Andrew S. Ferber, et al., *Men with Vasectomies: A Study of Medical, Sexual, and Psychosocial Changes*, 29 PSYCHOSOMATIC MED. 354, 359-62 (1967).

Given this directive, Contraceptive Equity laws fully cover male condoms and vasectomies without cost sharing in HDHPs once the consumer's annual deductible requirements are met.¹⁶ This approach complies with the administration's current interpretation of federal tax law, but does not foreclose the ability of the no cost-sharing provision to kick-in for HDHPs in the case that a future administration makes a determination that male contraception is preventive. In addition, if the US Preventive Services Task Force (USPSTF) issues an A or B rating for male contraception, coverage would be mandated under the ACA.

¹⁶ For additional considerations regarding male contraceptive coverage, see the primer *Contraceptive Equity & Essential Health Benefits*, <https://healthlaw.org/contraceptive-equity-primers>.

Contraceptive Equity & Medicaid

Fiscal notes, which estimate a legislative proposal's short-term effects on a state budget, provide useful information for state legislators when voting on Contraceptive Equity bills. While some Contraceptive Equity notes allude to potential savings, most focus on the short-term administrative expenses and potential expenditures by state-funded healthcare programs. To the extent that these notes attempt to measure the public-health benefits or long-term economic impacts of such mandates, they typically rely on existing studies from outside parties rather than independent state-specific research. When advocating for these laws, it is helpful to know how the fiscal note process works and to be prepared with existing public health research that can support a favorable economic analysis.

Federal Medicaid law requires states to cover “family planning services and supplies” without cost-sharing.¹⁷ As with most other Medicaid services, states have some discretion to determine what family planning services and supplies to cover in their programs, as long the coverage is “sufficient in amount, duration, and scope to reasonably achieve its purpose.”¹⁸ Notably, unlike the ACA's birth control requirement, federal Medicaid law does not explicitly require coverage of all FDA (Food and Drug Administration)-recognized methods. Federal law does explicitly prohibit cost-sharing for family planning in Medicaid.¹⁹

Contraceptive Equity laws can be written to apply all provisions to Medicaid, in addition to other non-grandfathered health plans. This is important because Medicaid managed care plans – through which the majority of Medicaid enrollees receive their coverage – often apply medical management policies like step therapy and prior authorization to family planning. Federal regulations acknowledge that Medicaid managed care organizations (MCOs) may adopt

¹⁷ 42 U.S.C. §§ 1396d(a)(4)(C), 1396a(a)(10); 42 C.F.R. § 447.56(a)(2)(ii) (prohibiting imposition of cost-sharing for family planning services and supplies). States do not have to cover family planning services and supplies for individuals who qualify for Medicaid due to their status as medically needy. See also 42 U.S.C. § 1396o(a)(2)(d).

¹⁸ 42 C.F.R. § 440.230(b); CMS, State Medicaid Manual § 4270.B.

¹⁹ 42 C.F.R. §§ 438.108, 447.56(a)(2)(ii).

methods and procedures to safeguard against unnecessary use of services.²⁰ Often referred to as “utilization management,” these methods and procedures may include requiring prior authorization for services, step therapy (requiring trial and failure of one drug or device before authorizing an alternative drug or device), and quantity limits on services or prescription drugs. Such policies can delay or prevent access to appropriate contraceptive methods and increase the risk of unintended pregnancy.

Some Medicaid enrollees, and in particular those in the ACA’s Medicaid expansion population, receive their benefits through Alternative Benefit Plans (ABPs). ABPs must cover all of the contraceptive services that most commercial insurance plans must cover under the ACA, without cost-sharing.²¹ A growing number of states also align their ABPs with Medicaid for the non-expansion population, in which case those enrolled in traditional Medicaid have coverage that meets the ACA’s contraceptive coverage standards. Depending on how the state aligns its benefits, advocates may consider whether application of a Contraceptive Equity law to Medicaid managed care, Medicaid fee-for-service, and/or the Children’s Health Insurance Program (CHIP) would be beneficial in their states.²²

²⁰ 42 C.F.R. § 438.210(a)(3)(iii) (allowing plans to place limits on services for the purpose of utilization control so long as the services furnished can reasonably be expected to achieve their purpose), 438.201(b)-(d) (establishing requirements for prior authorization processes).

²¹ 42 C.F.R. § 440.347(a); 45 C.F.R. §§ 156.115(a)(4), 147.130(a)(1)(iv).

²² The Children’s Health Insurance Program (CHIP) provides health coverage to eligible children up to age 19, and states have the option to implement this coverage through Medicaid, through a separate CHIP program, or through a combination program (i.e. children ages 0-5 are in Medicaid and age 6-18 in a separate program). In states that operate CHIP through Medicaid, children’s coverage must comply with state and federal Medicaid contraceptive coverage requirements, including Contraceptive Equity laws. In states that operate CHIP as a separate or combination program, a Contraceptive Equity provision can help guarantee contraceptive coverage for young adults.

Contraceptive Equity & Self-Insurance

If someone receives health insurance through their job, an employer can generally offer two types of plans: fully-insured or self-funded.²³ In a fully insured plan, an employer pays premiums each month to a carrier and if something catastrophic happens, like an employee gets into a car accident or develops complications from coronavirus, the carrier will foot the bill to pay for the employee's coverage in accordance with the policy.

Compare that with a self-funded or self-insured plan. The employer still pays premiums each month to a carrier to administer benefits; however, if an employee needs care that goes beyond the pot of money accrued through premiums, the employer itself is responsible for footing the bill. This is low risk for the carrier and high risk for an employer, and tends to be more common among larger employers because they can spread the risk of costly claims over a large number of workers and dependents.²⁴

As an employee policyholder, it can be difficult to discern whether a plan is fully-insured or self-funded. Nonetheless, it is important to determine because the two types of plans have different legal coverage requirements. Fully-insured plans must comply with both state and federal contraceptive coverage laws, including state laws that mandate a higher level of benefits. Therefore, Contraceptive Equity laws apply to non-grandfathered fully-insured plans.

Employee-sponsored self-funded plans, on the other hand, are not subject to state mandates because their regulation is preempted by the Employee Retirement Income Security Act of 1974 (ERISA). Any for-profit company or non-profit organization can self-insure, and therefore

²³ Emily Bazar, For Millions of Insured Americans, State Health Laws Don't Apply, Kaiser Health News (Nov. 16, 2017), <https://khn.org/news/for-millions-of-insured-americans-state-health-laws-dont-apply/>.

²⁴ Kaiser Family Foundation, *2020 Employer Health Benefits Survey, Section 10: Plan Funding* (Oct. 8, 2020), <https://www.kff.org/report-section/ehbs-2020-section-10-plan-funding/>.

not be required to comply with Contraceptive Equity laws, while the federal birth control requirement does apply to those plans.²⁵

States can enact benefit mandates for self-funded plans when the state itself is acting as the employer. The California Public Employees' Retirement System (CalPERS), for example, is a public employer purchaser of health benefits in the state.²⁶ The legislature can enact standards for public employees' health benefits, including potentially a Contraceptive Equity mandate.²⁷

Much like employer sponsored insurance, student health plans can be fully-insured or self-funded. Fully insured student health plans must comply with the federal birth control benefit; however, they may or may not be required to comply with state Contraceptive Equity laws.²⁸ In California, for example, student health plans are exempted from the state's Knox-Keene Act regulating health care service plans so the state's Contraceptive Equity law does not apply to them.²⁹

Self-funded student health plans, unlike self-funded employer sponsored insurance, are **not** subject to the Affordable Care Act. They may or may not be required to comply with state Contraceptive Equity laws, depending on the state's scope of health plan regulation.

²⁵ 29 U.S.C. § 1144.

²⁶ CalPERS, Facts at a Glance: Health Benefits (FY 2019-20), <https://www.calpers.ca.gov/docs/forms-publications/facts-health-benefits.pdf>.

²⁷ Cal. Gov. Code § 22853.

²⁸ Kaiser Family Foundation, *Does My Student Health Plan Have to Cover Contraceptives?* <https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/does-my-student-health-plan-have-to-cover-contraceptives/>.

²⁹ Cal. Health & Safety Code § 1343(e)(2).