



Q&A: State Contraceptive Equity Laws

By [Liz McCaman Taylor](#)

The Affordable Care Act (ACA) requires most health insurance plans to provide coverage for a broad range of women’s preventive health services without cost-sharing, including all Food and Drug Administration (FDA)-approved methods of contraception. While this requirement is a welcome and significant step forward, gaps in comprehensive coverage remain, which had led to states passing their own more expansive contraceptive coverage laws commonly referred to as Contraceptive Equity bills.

Given the federal requirement, why should states develop their own laws?

Contraceptive Equity bills improve upon the federal provisions to:

- Require coverage of all FDA-approved contraceptive drugs, devices, and products, beyond the ACA requirement of one covered contraceptive method in each of 17 categories for women. The laws provide an exception for therapeutically equivalent products, so long as at least one is covered;
- Strictly limit the ability of insurers to impose restrictions and delays (referred to as medical management or utilization controls);
- Require coverage of over-the-counter (OTC) contraceptives without a prescription;
- Create equity by eliminating cost-sharing for contraception, voluntary sterilization, and contraceptive counseling for men.

In addition, the federal contraceptive coverage requirement is subject to administrative interpretation and enforcement, making state action an important backstop.

How is this different from the wave of contraceptive coverage laws that states passed in the early 2000s?

Back in the late 1990's and early 2000s, about half the states passed Contraceptive Parity laws. These laws state that contraceptives need to be covered in the same manner as any other prescription drugs and medical services. Contraceptive Equity laws, which started to be introduced in states in 2014, go beyond just comparable **coverage** and drastically improve **access** by eliminating all co-pays, strictly limiting medical management, and requiring coverage of OTC contraception and contraception for men. Some state Contraceptive Equity laws also require an extended supply (such as 12 months' worth) of contraception to be dispensed all at once.

What plans are subject to this state requirement?

- Most non-grandfathered commercial plans, including individual and employer sponsored plans (commercial plans that are new or have substantially changed since enactment of the ACA on March 23, 2010);
- All plans purchased through the ACA's marketplaces;
- Medicaid "Alternative Benefit Plans" (for the Medicaid expansion population);
- Medicaid managed care plans.

What plans are not subject to this state requirement?

- Self-funded plans;
- Grandfathered plans (plans that have not substantially changed since March 23, 2010).

Note that grandfathered plans must disclose that status in materials that describe covered benefits to enrollees. Grandfathered group plans may enroll new enrollees without foregoing their grandfathered status. Over time, we expect fewer plans to be classified as grandfathered as they make changes to their policies.

What plans are exempt from this state requirement?

- Health plans sponsored by a narrow category of nonprofit religious employers, such as churches, as defined by the Contraceptive Equity law.

Employees and dependents in exempt plans will not receive contraceptive coverage through their employee health plans. Nonetheless, the exemptions in state Contraceptive Equity bills

are typically much narrower than at the federal level, meaning some employers that may be able to claim an exemption from the federal requirement will nonetheless be bound by state law. Some states, however, may have broader religious exemptions than those found in typical Contraceptive Equity provisions. It is important to know your state law.

Aren't these laws preempted by the ACA?

The federal requirement sets the floor for contraceptive coverage, not the ceiling. Accordingly, if a state law requiring coverage of one or more of the preventive services required to be covered by the ACA is *more generous* to the individual than the federal coverage mandate (without being more restrictive in any way), then the state law likely would not be interpreted as “preventing the application” of the ACA. Because Contraceptive Equity laws provide for more generous benefits for the individual than requirement under federal guidance, they are unlikely to be preempted.

Conclusion

State Contraceptive Equity acts have the potential to expand access to contraceptive coverage and ensure improved access to covered services without cost-sharing. NHeLP is available to provide technical support, including advocacy tips and model language, to state advocates who are considering a Contraceptive Equity bill in their state.¹ We have also developed an implementation toolkit, along with other resources that can found on our Contraceptive Equity webpage at <https://healthlaw.org/contraceptive-equity/>.² For more information, contact Senior Attorney Liz McCaman Taylor at (202) 621-1026 or mccaman@healthlaw.org.

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/>.