

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC, 20510

October 2, 2026

RE: Request for Information: Health Coverage That Works for Everyone

Dear Ranking Member Wyden:

Thank you for the opportunity to provide comments to inform the Senate Finance Committee's efforts to advance health coverage that works for everyone. We appreciate and agree with the Committee's assessment that bold, meaningful action is necessary to build a truly equitable health care system and acknowledge that a critical first step towards these goals is repealing the harmful cuts and policies from the so-called "One Big Beautiful Bill Act" (OBBBA).

We are writing today on behalf of the 56 undersigned members and allies of the National Coalition for Gender Justice in Health Policy (NCGJHP), a cross-movement collective of over 110 organizations fighting for equitable access to sexual and reproductive health (SRH) coverage for low-income and underserved communities via Medicaid, the Affordable Care Act (ACA), and federal health care reform. In addition to the recommendations provided herein, we look forward to partnering with the Committee to ensure that health coverage reforms achieve universal access to SRH coverage. We are grateful to support the Committee's work to advance health policies that center communities rather than industry profits.

The following fundamental priorities for coverage reform are reflective of the NCGJHP's work:

1. All health programs and plans must be required to meet the highest standards of coverage, including coverage of all SRH services.¹ Coverage must ensure access across modalities, including in-person and telehealth (asynchronous and synchronous, including audio-only and audio-video) models of service delivery.

¹ Particularly as the Committee explores expanding Medicare or using it as the basis for a federal public option, it should be aware that the program currently offers substandard coverage for many SRH services. In addition to restrictions on abortion due to the Hyde amendment, contraception is not required in any plan, is actively barred from coverage in Parts A and B, and is optional and subject to cost sharing in Part D and Medicare Advantage. Coverage requirements and protections for STI testing, pregnancy care and many other services for private plans under the ACA do not apply to Medicare at all.

2. Coverage should be universal. This means ensuring coverage regardless of immigration status, income, age, race, color, national origin (e.g., Limited English Proficiency), employment status, disability, sex (e.g., gender identity, sexual orientation, pregnancy or related conditions), disability and other personal characteristics.
3. Health care reform must deliver robust, enforceable consumer protections that ensure coverage fully supports access. These include robust protections against health care discrimination, cost-sharing, and other barriers to care in coverage and service delivery contexts.² Reform must include robust due process protections. Reform should also ensure access to robust provider networks, which requires meaningful network adequacy standards, SRH care access via advanced practice and other health care providers, and sufficient and equitable reimbursement rates. Reform must include more comprehensive confidentiality protections and robust guardrails for the use of artificial intelligence and algorithms.
4. Proposals must be intentional about leveraging resources to address the health impacts of generations of structural and interpersonal racism and interlocking systems of oppression. It is not enough for the health care system to produce results “on average”; it must produce equitable results across populations and sub-populations. In addition, it must reduce existing health inequities and chart a course for their elimination.
5. Health care reform must address the unique needs of low-income and underserved individuals and families, and all proposals must explicitly guarantee the benefits and consumer protections that currently exist for low-income populations in Medicaid, so that Medicaid enrollees are not inadvertently harmed by universal health care reform.
6. We appreciate your work to protect the privacy of reproductive and gender-affirming care data, including efforts to advance data minimization requirements, restrict the sale of sensitive personal information by data brokers, and provide oversight of government demands for patients' medical and billing records.³

² Premiums, deductibles, copayments and cost-sharing requirements prevent meaningful access to health care services and should not exist for low-income people, including current Medicaid enrollees. Cost-sharing must also provide protections for people with disabilities and/or chronic conditions, and others who may have heightened health care needs. Any costs to accessing health care should be limited to those with the highest incomes and must be reasonable and predictable for both individuals and families.

³ See Senator Ron Wyden, Wyden, Colleagues Introduce My Body, My Data Act to Protect Reproductive Health Data (Jun. 2022), <https://www.wyden.senate.gov/news/press-releases/wyden-colleagues-introduce-my-body-my-data-act-to-protect-reproductive-health-data>; Senator Wyden, Warren, Whitehouse Renew Push to Protect Americans' Sensitive Data from Greedy Brokers (Dec. 2024), <https://www.wyden.senate.gov/news/press-releases/wyden-warren-sanders-whitehouse-renew-push-to-protect-americans-sensitive-data-from-greedy->

7. Coverage that works for everyone must also be coverage that people can use without fear that their most sensitive health information will be improperly disclosed or misused. Strong privacy and confidentiality protections for reproductive health and gender-affirming care data are essential to ensuring that people can safely seek care and that clinicians can provide appropriate, informed treatment. Health care reform should protect the privacy and confidentiality of sensitive health information, establish clear limits on its use and disclosure, and ensure meaningful accountability when those protections are violated.

Despite longstanding stigmatization and siloing across health care, SRH care is normal and vital care which improves the health and well-being of every person. Consequently, any health reforms must include access to SRH at every stage of a person's life. Access to high-quality SRH care prevents pregnancy-associated morbidity and mortality,⁴ improves birth outcomes,⁵ and has been associated with educational and workforce advancement⁶ and poverty reduction.⁷

In line with global health authorities, our coalition defines reproductive health care as care that helps people achieve their highest attainable standard of physical, emotional, mental, and social well-being related to the reproductive system across all life stages, including but not limited to services related to menstruation, contraception, family formation, pregnancy [e.g., pre-pregnancy, prenatal, labor and birthing, post-pregnancy (including postpartum as well as after pregnancy loss and/or abortion) care, miscarriage

brokers; U.S. Senate Committee on Finance, State Attorneys General Misused Medicaid Authority to Persecute Teens Seeking Gender Affirming Care, Finance Inquiry Finds; Politicized Requests for Patient Information Caused Spike in Teen Crisis Mental Health Calls (Apr. 2024), <https://www.finance.senate.gov/chairmans-news/state-attorneys-general-misused-medicaid-authority-to-persecute-teens-seeking-gender-affirming-care-finance-inquiry-finds-politicized-requests-for-patient-information-caused-spike-in-teen-crisis-mental-health-calls>.

⁴ *Id.*

⁵ Sarah E. Romer et al., *Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs* (Revised 2024), 67 AM. J. PREV. MED. S41, S41–86 (2024), <https://societyfp.org/wp-content/uploads/2025/02/Providing-Quality-Family-Planning-Services-in-the-United-States-Recommendations-of-the-US-Office-of-Population-Affairs-Revised-2024.pdf>.

⁶ Inst. for Women's Policy Research., Contraception Access Increases Women's Educational Attainment and Earnings (Sept. 26, 2019), <https://iwpr.org/press/contraception-access-increases-womens-educational-attainment-and-earnings/>.

⁷ Stephanie P. Browne et al, The Effects of Contraception on Female Poverty, 33 J. POL. ANAL. & MGMT. 602 (2014), <https://doi.org/10.1002/pam.21761>.

management, and abortion], transgender health care, menopause, and conditions affecting the reproductive system (e.g., endometriosis, polyendocrine metabolic ovarian syndrome, fibroids, and breast/chest, prostate, and gynecological cancers).

We define sexual health care as care that helps people achieve their highest attainable standard of physical, emotional, mental, and social well-being in relation to sexual activity and sexuality, such as HIV/HCV/STI-related treatment and preventive services, transgender health care, sexuality education delivered in the course of health care delivery, and services necessary to support sexual pleasure (e.g., pelvic floor therapy, care for vulvodynia, sexual organ atrophy, erectile dysfunction, and other conditions).

In the United States, fragmented federal and state policies inhibit comprehensive and standardized access to SRH care. For example:

- **Abortion:** The Hyde Amendment, an appropriation rider which prohibits coverage of abortion except in limited cases of rape, incest, or when a pregnancy is life endangering, applies to crucial health coverage and care programs like Medicaid, Medicare, and the Indian Health Service. Policies similar to the Hyde Amendment apply to the Children's Health Insurance Program (CHIP) and individuals who receive health care coverage through the federal government like federal employees, military personnel and veterans, and more. As of July 2026, twenty-one states used state funds for abortion coverage through Medicaid.⁸ Meanwhile, 25 states prohibit coverage for abortion beyond narrow exceptions in the ACA Marketplace, and 12 states and DC have no laws regarding coverage.⁹ Without insurance coverage of abortion, those seeking abortions must pay for them out-of-pocket. The cost varies based on location, type, and other factors, but the median cost for a procedural abortion in the first trimester is \$650, which is simply unaffordable for most people.¹⁰

⁸ Guttmacher Inst., State Insurance Coverage of Abortion Under Medicaid, State Laws & Policies (as of July 2026) (2026), <https://www.guttmacher.org/state-policy/explore/state-insurance-coverage-abortion-under-medicaid>.

⁹ Alina Salganicoff et al., Abortion Coverage Limitations in Medicaid and Private Insurance Plans, KFF, April 2026, <https://www.kff.org/womens-health-policy/abortion-coverage-limitations-in-medicaid-and-private-insurance-plans/>.

¹⁰ Rosalyn Schroeder et al., Trends in Abortion Services in the United States, 2017-2023, Advancing New Standards in Reproductive Health (ANSIRH), University of California, San Francisco, 2024, https://www.ansirh.org/sites/default/files/2024-08/AFD%20Trends%20in%20Abortion%20Services%20in%20the%20United%20States%202017-2023_Final%20UPDATED.pdf.

- **Transgender Health Care:** For too long, legislation and administrative policies and practices across the health system have denied or restricted coverage of medically necessary care related to gender affirmation and the treatment of gender dysphoria. State Medicaid restrictions, the Centers for Medicare and Medicaid Services' recent final rule blocking federal funding for certain services for transgender minors, the Trump administration's rollbacks of implementation of the ACA's protection against health care discrimination based on actual and/or perceived gender identity, and individual coverage denials have undermined or outright blocked access to these essential services.
- **Contraception:** The ACA's preventive services benefit requires most health insurance plans to provide coverage for a broad range of women's preventive health services¹¹ without cost-sharing, including all Food and Drug Administration (FDA)-approved methods of contraception, related counseling, follow-up, side-effect management, and device insertion and removal at an in-network provider. While ACA requirements also impact Medicaid directly via the ACA's Medicaid expansion, which must comply with the ACA's essential health benefits and preventive services requirements, inequities in contraceptive coverage exist for people enrolled in plans not governed by the ACA.¹²
- **Menopause care:** Coverage gaps in menopause care are significant. Medicaid enrollees are 47% more likely to go without treatment for menopause symptoms than people with private insurance.¹³ While Medicaid generally covers some prescription drugs, many menopause therapies rely on widely accepted off-label prescriptions, which are often flagged for prior authorization which can delay or block access to needed care. People undergoing menopause may also require diagnostic services and specialist care, which are often mandatory Medicaid benefits (such as emergency and nonemergency medical transportation and

¹¹ We employ "women" in limited instances when necessary to accurately reference legal terms or cisgender women-centered research and to honor how advocates or groups self-identify. Otherwise, we use gender inclusive language to accurately reflect the scope of people with various reproductive and sexual health care needs and related experiences. More inclusive policy language and research is needed to better serve, understand, and illuminate the needs of all people who need equitable access to health care, including sexual and reproductive care.

¹² Adam Sonfield, *A Fragmented System: Ensuring Comprehensive Coverage in All U.S. Health Insurance Plans*, 24 GUTTMACHER POLICY REVIEW (2021), <https://www.guttmacher.org/gpr/2021/02/fragmented-system-ensuring-comprehensive-contraceptive-coverage-all-us-health-insurance>.

¹³ Maria I. Rodriguez et al., *Association of insurance type with unmet need for menopause care in Oregon*, 1 MENOPAUSE 31 (2024) <https://pubmed.ncbi.nlm.nih.gov/39352123/>.

inpatient hospital services). However, individuals may face barriers to meaningful access such as state- and plan-imposed medical necessity standards, inadequate reimbursement rates, and more.¹⁴

- **Pregnancy-related care:** Despite the overwhelming evidence highlighting the importance of comprehensive health coverage before, during, and after pregnancy, significant coverage variation exists across geographies and coverage type. While the ACA mandated maternity care as an essential health benefit and Medicaid continues to provide coverage for almost half of all births across the country and over 60% of Black and Indigenous births, people still struggle to access adequate health care during their pregnancies. All State Medicaid programs must cover pregnant people with low incomes, but the specific set of benefits they provide varies widely. In the commercial market, maternity care is an Essential Health Benefit (EHB) that all Marketplace plans must cover. However, a 2021 inventory of the EHB benchmark plans in all 50 states and the District of Columbia found significant variation in covered maternity services across EHB benchmark plans and that plans in every state frequently have limits that could impede access to care.¹⁵
- **Assisted reproduction (AR):** AR refers to treatments, interventions, or procedures intended to cause or assist in causing pregnancy through means other than by sexual intercourse, such as in vitro fertilization. AR coverage access is deeply inequitable in the U.S., leaving low-income and underserved communities, and especially same-sex couples, non-partnered people, BIPOC, and people with disabilities, unable to start families.¹⁶
- **Pelvic floor therapy:** Pelvic floor therapy is critical to various aspects of SRH: Postpartum recovery, menopause, and pain and impaired sexual functioning from chronic conditions and disabilities such as endometriosis, Ehlers-Danlos

¹⁴ Briana Torres, National Health Law Prog. Improving Access to Menopause Care, <https://healthlaw.org/improving-access-to-menopause-care/> (last visited Sep. 25, 2026).

¹⁵ Center for American Progress, States' Essential Health Benefits Coverage Could Advance Maternal Health Equity (2021), <https://www.americanprogress.org/article/states-essential-health-benefits-coverage-advance-maternal-health-equity/>.

¹⁶ See Ashley Wiltshire et. al, *Infertility Knowledge and Treatment Beliefs among African American Women in an Urban Community*, 4 CONTRACEPT. REPROD. MED. 16 (2019), <https://pubmed.ncbi.nlm.nih.gov/31572616> (concluding that Black women between the ages of 33-44 are twice as likely to experience infertility as white women in the same age demographic); Liz McCaman Taylor et al., Nat'l Health Law Prog., *Principles on Assisted Reproduction* (2021), <https://healthlaw.org/resource/nhelp-principles-on-assisted-reproduction/>.

Syndrome, and fibroids, and more. Though most state Medicaid programs cover physical therapy for adults, enrollees often cannot access pelvic floor therapy due to network adequacy and reimbursement adequacy challenges.¹⁷

Any reforms to health coverage should be targeted at addressing these and other inequities in coverage and access, and ensuring that all people, especially low-income and underserved individuals and families, are able to access the highest standard of SRH care.

To achieve the priorities described above, we recommend the following actions:

REFORMS TO REVERSE CUTS AND ENVISION A BETTER PATH

Reverse and Mitigate Harms of OBBBA: OBBBA negatively impacts eligibility and enrollment for Medicaid and Marketplace applicants by restricting access to Medicaid and Marketplace eligibility and imposing administrative barriers that make it harder to enroll in, retain, and afford coverage. The Committee must pass legislation to repeal health care cuts under OBBBA.

Close Medicaid coverage gaps. Ending unnecessary and harmful gaps for people in non-expansion states and immigrants is critical to advance health equity and SRH access for BIPOC in the United States. Failure to address these gaps contributes to racial injustices in public health crises such as the COVID-19 pandemic, our national Black and Indigenous maternal mortality epidemic, the Southern HIV epidemic, and more.¹⁸ Congress should enact legislation to:

¹⁷ KFF, Medicaid Benefits: Physical Therapy Services, <https://www.kff.org/medicaid/state-indicator/physical-therapy-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹⁸ See L. Silvia Muñoz-Price et al., Racial Disparities in Incidence and Outcomes Among Patients with COVID-19, 3(9) JAMA NETWORK OPEN (Sep. 25, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770961>; Samantha Artiga et al., *Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010–2018*, KFF (Mar. 5, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-raceand-ethnicity-since-the-aca-2010-2018/>; Samantha Artiga et al., Racial Disparities in Maternal and Infant Health: An Overview, KFF (Nov. 10, 2020), <https://www.kff.org/report-section/racial-disparitiesin-maternal-and-infant-health-an-overview-issue-brief/>; Adam Searing & Adaora Adimora, Georgetown Ctr. For Children & Families, HIV and Medicaid Expansion: Failure of Southern States to Expand Medicaid Makes Elimination of HIV Infection in the United States Much Harder to Achieve (Nov. 2020), <https://ccf.georgetown.edu/2020/11/29/hiv-and-medicaid-expansion-failure-of-southern-states-toexpand-medicaid-makes-elimination-of-hiv-infection-in-the-united->

- Provide Medicaid look-like coverage for people caught in the Medicaid expansion coverage gap; and
- End the five-year bar on Medicaid and CHIP eligibility for certain lawfully present immigrants; ensure that all immigrants with federally authorized presence in the U.S. (e.g., Deferred Action for Childhood Arrivals recipients) are considered lawfully present for Medicaid, CHIP, and Marketplace plan eligibility (including eligibility for Marketplace premium subsidies and cost-sharing reductions); and end the exclusion of undocumented immigrants from Marketplace plans, related premium tax credit and cost-sharing reductions, and state Basic Health Programs.

Mandate abortion coverage without restrictions and end other barriers: Abortion funding restrictions such as the Hyde Amendment harm people who already face systemic barriers to accessing care, including people with low incomes, BIPOC, people with disabilities, young people, LGBTQI+ individuals, and other underserved communities. Congress must:

- Mandate abortion coverage across modalities (synchronous audio-video, asynchronous, remote monitoring) and without restrictions, such as policies enabling refusals of care (e.g., Weldon and Coats-Snowe amendments) or age restrictions:
 - In all existing health insurance programs and plans, such as Medicaid and the marketplaces; and
 - In any new public health coverage programs.
- Ensure that abortion reimbursement rates are adequate to support access, including for abortion later in pregnancy;
- A federal right to abortion access is needed to fully realize such coverage, lest state bans undermine its reach.

Require comprehensive coverage of transgender health care: Congress must not capitulate to efforts to ban or restrict this care nationwide. Health care reform must ensure meaningful coverage for transgender health care without discriminatory age restrictions, strengthen protections against sex discrimination (see “Enhance Protections” section on page 8), protect transgender patient privacy beyond what HIPAA currently provides, appropriate resources to support LGBTQI+ cultural competency and clinical training for

[states-much-harder-to-achieve/](#); see also Racial Inequities in HIV, 7(7) Lancet HIV (Jul. 2020), [http://thelancet.com/journals/lanhiv/article/PIIS2352-3018\(20\)30173-9/fulltext](http://thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30173-9/fulltext); Addressing Health Disparities in Diabetes, Ctrs. For Disease Control & Prev. (Apr. 15, 2019), <https://www.cdc.gov/diabetes/disparities.html>.

providers and health care workers, and appropriate resources to support care navigation for transgender people and their families affected by care disruptions. Congress should also address the scarcity of structured medical workforce training opportunities and funding efforts at the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), and Health Resources and Services Administration (HRSA) to foster innovation, improve health outcomes, and to support the delivery of high-quality clinical and public health research on the full spectrum of transgender people's health needs.

Ensure access to non-emergency medical transportation (NEMT): Medicaid's NEMT benefit helps beneficiaries with limited access to transportation access covered health care services, including abortion, transgender health care, and other SRH care. Despite its importance, several states have received approval to waive the NEMT benefit, which should not be permitted.¹⁹ Notably, in 2020, Congress amended the Medicaid Act to make its NEMT requirement explicit.²⁰ With these changes, Congress expressed its clear intent that states cover NEMT, including for the Medicaid expansion population.

Strengthen and standardize contraceptive coverage: Federal law has long included numerous requirements and protections for contraceptive coverage under private and public health plans and programs. Despite these longstanding federal protections, coverage of contraception and related services is inconsistent, incomplete, and inadequately delineated and enforced.

The ACA's contraceptive coverage requirement must be extended to all current and future types of health coverage, regardless of plan duration, including but not limited to: coverage programs for federal employees, military personnel, veterans and their families; short-term limited duration health insurance; and any future reforms, including programs modeled on the expansion of Medicare or using Medicare as the basis for a federal public option. We additionally recommend the following actions to align existing programs with the highest standards of care and coverage:

- Amend the Medicaid and CHIP statutes to explicitly require that all enrollees of reproductive age, regardless of state or eligibility group, should have coverage for all contraceptive services and items, without cost sharing.

¹⁹ MaryBeth Musumeci and Robin Rudowitz, KFF, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, <https://www.kff.org/medicaid/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/> (Feb. 2016), <https://www.kff.org/medicaid/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers>.

²⁰ See Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 209(a), 134 Stat. 1182, 2986 (2020) (amending 42 U.S.C. §§ 1396a(a)(4), 1396b(i), 1396u-7(a)).

- Require health plans governed by the ACA preventive services benefit to cover current and future FDA-approved, -cleared, or -granted over-the-counter (OTC) contraceptive items without cost sharing and without a prescription.
- Require health plans governed by the ACA's preventive services benefit to cover vasectomies and any other contraceptives used by men without cost sharing.
- Require health plans governed by the ACA's preventive services benefit to cover all contraceptive products unless there is a therapeutic equivalent as defined by the FDA's orange book.
- Require health plans governed by the ACA to cover a full year's supply of prescription or OTC contraceptives at one purchase.
- Amend the Medicare statute to provide coverage of contraceptive items and services at no cost-sharing under the Medicare program, ensuring comparable coverage for dual-eligible individuals.
- Enact legislation to appropriate funds for a national technical assistance programs, embedding practice coaches to work with primary care practices, Federally-Qualified Health Centers (FQHCs), and other safety-net providers on integrating contraceptive care.
- Protect and support access to family planning services for all people by fully funding the Title X Family Planning Program.

Ensure comprehensive pregnancy-related coverage: Prompt access to high-quality health care is critical to ensuring the health of pregnant people and their babies. All programs and plans must cover the full scope of pregnancy care, as described above. We additionally recommend the following changes to align existing programs with the highest standards of comprehensive pregnancy care:

- Establish a Special Enrollment Period (SEP) for Pregnancy for individuals in the Marketplace.
- Enact legislation to make doula coverage a mandatory Medicaid benefit across all states.
- Enact legislation to make a minimum of 12 months of post-pregnancy coverage mandatory for all types of health insurance.

- Enact legislation to appropriate funds for scholarships, loan repayment, and training programs that build Black and culturally and linguistically appropriate maternity workforce capacity within Medicaid.

Ensure access to affordable comprehensive and evidence-based AR coverage across all health programs and plans, including Medicaid: All health programs and plans, including current coverage vehicles and universal health coverage proposals, should include AR as a standard benefit. Reform should not provide AR as a limited excepted benefit, as the the Department of the Treasury, Department of Labor, and the Department of Health and Human Services recently proposed.²¹

REFORMS TO MAKE HEALTH CARE SIMPLER FOR FAMILIES

Streamline enrollment to advance SRH access: We agree with the Committee’s assertion that significant work is necessary to ensure that systems to access health insurance are “easy to understand and quick to complete.” Many forms of SRH care are particularly time-sensitive, creating particular urgency around this issue. To address these challenges, we recommend:

- Establishing baseline coverage categories for pregnancy, post-pregnancy, and contraceptive care, including related supports (counseling, lactation, interpretation, transportation, pain management), modeled after Early and Periodic Screening, Diagnostic, and Treatment requirements.
- Enacting legislation to amend the Medicaid statute to make presumptive eligibility for pregnancy and family planning mandatory for all states.
- Restoring and enhancing funding for the Navigator program, including support for language accessibility.

Make insurance easier to use and understand. Improving coverage and health outcomes necessitates investing in systems and materials which are easier to understand, including by prioritizing language and disability access. To improve accessibility, we recommend:

²¹ This proposal seems to only target large employer insurance, which only constitutes a portion of the U.S. health care system, excluding other key populations, such as Medicaid enrollees, that need access. As well, large employers are already more likely than small group employers to include fertility benefits in employer-sponsored plans. The proposal disincentivizes AR coverage since excepted benefits are traditionally not subsidized by an employer. This designation could eliminate or restrict access to such treatments as an essential health benefit. U.S. Depts. of Treasury, Labor, and Health and Human Srvs., Excepted Fertility Benefits Proposed Rule, 91 Fed. Reg. 27140–27173 (May 13, 2026), <https://www.govinfo.gov/content/pkg/FR-2026-05-13/pdf/2026-09479.pdf>.

- Enacting legislation prohibiting prior authorization and other medically unnecessary utilization management requirements for SRH services.
- Enacting legislation requiring plain-language explanations of claims denials, which include justifications and transparency around appeals processes.
- Repealing the public charge ground of inadmissibility, which deters immigrant families from enrolling in health coverage and health-related social programs.

Enhance protections for the coverage and delivery of SRH care. Meaningful access to SRH requires robust nondiscrimination protections, network adequacy standards, and enforceable rights. Policies must expand upon existing protections against health care discrimination based on any personal characteristics. This includes sex discrimination based on pregnancy or related conditions (including abortion, lactation, miscarriage, fertility, and contraception), gender identity, sex stereotypes, sex characteristics (including intersex traits), and marital, parental, or family status; race; color; national origin (including Limited English Proficiency); disability; age; and any combination thereof; as well as disparate impact discrimination. Federal policy must also include clear protections that ensure that SRH providers may not be excluded or otherwise restricted from participating in plan networks.

Access should be measured by appointment wait times, geographic availability, provider capacity, language access, range of services, and culturally competent and confidential care. Further, Congress and federal agencies should strengthen oversight by requiring SRH-specific network data, reimbursement information, appointment availability results, and provider exclusions that decrease access to care. Regulators should be able to require corrective action from programs and plans as well as impose penalties, deny certification, or remove repeat offenders when plans maintain inadequate or misleading networks and fail to ensure timely access to covered SRH services. Finally, reimbursement must fully and adequately compensate providers to support patient health services and sustain the SRH workforce. To achieve these goals, we recommend enacting federal policy that would require all ACA Marketplace plans follow an “any willing provider” standard to contract with all family planning essential community providers in their area.

REFORMS TO TAKE ON CORPORATE GREED

Mitigate the impacts of consolidation on SRH access. As of 2020, one in six hospital beds in the United States was at a hospital with a Catholic affiliation.²² Religious care

²² Rachana Pradhan and Hannah Recht, *The Powerful Constraints on Medical Care in Catholic Hospitals Across America*, KFF News (Feb 17, 2024),

guidelines are often at odds with medical standards of care and can significantly increase geographic inequities in care access for people seeking contraception, abortion, gender affirming care, or other types of SRH care. Congress should take action to ensure that the growing consolidation among Catholic health systems does not reduce patients' access to comprehensive SRH care.

Thank you for the opportunity to provide feedback on the Committee's efforts to expand coverage and build a health care system that works for everyone. Our signatories are committed to advancing universal coverage that works for all people. We recommend the following resources as additional resources for the Committee to utilize during the course of your ongoing health reform efforts: [Reproductive Justice Principles for Universal Health Reform](#); [Closing the Medicaid Coverage Gap: Preventing a Separate and Unequal Result](#); [NHeLP Principles on Assisted Reproduction](#); [Data Privacy & Reproductive Freedom](#).

We look forward to partnering with the Committee on this important work and supporting efforts to ensure that SRH is meaningfully included in health coverage reform. If we can provide any additional information, please reach out to:

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Sincerely,

National Groups

Advocates for Trans Equality
AIDS United
American Atheists
Autistic People of Color Fund
CenterLink
Community Catalyst
Disability Rights Education and Defense Fund (DREDF)
Guttmacher Institute
Healthy Teen Network
Ibis Reproductive Health

<https://kffhealthnews.org/health-industry/catholic-hospitals-affiliates-ethical-religious-directives-reproductive-care/>.

Implementing Contraceptive Access Now (ICAN!)
Institute for Women's Policy Research
Jacobs Institute of Women's Health
Physicians for Reproductive Health
Planned Parenthood Federation of America
Power to Decide
Religious Community for Reproductive Choice
Transgender Law Center
Movement Advancement Project
National Abortion Federation
National Asian Pacific American Women's Forum
National Family Planning & Reproductive Health Association
National Health Law Program
National Latina Institute for Reproductive Justice
National Partnership for Women and Families
National Women's Law Center
Religious Community for Reproductive Choice
Reproductive Health Access Project
SIECUS: Sex Ed for Social Change
State Innovation Exchange Action
TransFamily Support Services
URGE: Unite for Reproductive & Gender Equity
Whitman-Walker Health

California

ACT for Women and Girls
California Women's Law Center
LGBTQ Center Orange County
Lyon-Martin Community Health Services
SF LGBT Center
TransCanWork, Inc.
TEACH: Training in Early Abortion for Comprehensive Healthcare
URGE CA

Colorado

Clinics for Abortion and Reproductive Excellence

District of Columbia

Whitman-Walker Health

Florida

Compass Community Center
Naples Pride
The Pride Center at Equality Park

Indiana

Muncie OUTreach LGBTQ+ Center

Louisiana

Beurre Roux Inc

Massachusetts

North Shore Alliance of LGBTQ+ Youth (NAGLY)

Montana

Montanans for Choice Take Action

New Mexico

The Human Rights Alliance
Mariposa Fund

North Carolina

Charlotte Trans Health

Ohio

Abortion Forward

Oregon

Friendly House

Pennsylvania

Eastern PA Trans Equity Project

Texas

Avow

Washington

Pride Across the Bridge