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**Details & Devils: Contraceptive Coverage, Health Reform's Medicaid Expansion and the
Enduring Importance of the States**

by
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Introduction: Millions of women in the United States rely on contraceptives, and even more so in the challenging economic climate of recent years. In a 2009 Guttmacher Institute survey, 46 percent of women said that economic circumstances impact their decision to have children, and practitioners have observed an increase in the use of reliable birth control methods for both birth control and other health-related reasons.¹

In harmony with this need, the *Patient Protection and Affordable Care Act (ACA)*, the historic health reform law passed by Congress in March 2010, has adopted provisions that will improve access to contraceptives nationally. The ACA requires coverage of contraceptive drugs and devices within private health insurance plans.² In addition, the ACA promises to expand Medicaid significantly, which will result in better access to reproductive health care for more Americans. As a result of the ACA, there is now robust legislative support for family planning coverage at the federal level.

In promoting contraceptive coverage, the ACA codifies a trend that has already emerged over the last two decades: a majority of private health insurance plans cover contraception. The largely successful battle for “contraceptive equity” – the inclusion of contraceptive drugs and devices along with prescription drugs and preventative medication in private health plans – was fought on many fronts over the last twenty years. Reproductive health advocates worked to achieve insurance coverage of contraceptives through the state legislatures, the courts, and through other proposed federal legislation. Because of their efforts, 28 states now require the inclusion of contraceptives within insurance plans.

This paper observes that, given the state statutory scheme for contraceptive coverage that is

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¹ Barbara Mannino, “When it comes to family size, money matters.” *Fox News* (September 30, 2011). Available at <http://www.foxbusiness.com/personal-finance/2011/09/30/when-it-comes-to-family-size-money-matters-in-more-ways-than-one/>; see also Rachel K. Jones, “Beyond birth control: the overlooked benefits of oral contraceptive pills.” Guttmacher Institute (November 2011)

² HealthCare.gov, Preventive Regulations. Available at <http://www.healthcare.gov/center/regulations/prevention/regs.html>. The U.S. Department of Health and Human Services issued regulations in August 2011 clarifying that the ACA would include contraceptives within the ambit of preventive care. See also Adam Sonfield and Rachel Benson Gold, “Holding on to health reform and what we have gained for reproductive health.” *Contraception*, December 2010. According to Sonfield and Gold, the August 2011 regulations “can be expected to include coverage of a broad range of reproductive health services, including those related to family planning, STIs and reproductive cancers.”

already in place, the ACA's Medicaid expansion is potentially health reform's greatest contribution to expanding access to reproductive health care. This paper also observes that state-level activism will continue to be critical for the future of contraceptive access in light of the threats and pushback the ACA's Medicaid provision is facing. Part I of this paper outlines the contraceptive equity movement and accomplishments prior to ACA. Part II examines the ACA's contraceptive coverage and Medicaid provisions. Part III outlines the vulnerabilities the ACA faces, and the need for continued activism in the states. Recognizing the enduring importance of contraception in women's lives,³ this paper aims to provide advocates with perspective and analysis of state and federal contraceptive coverage policy that can inform future activism.

Part I: Pre-ACA Contraceptive Equity Achievements: The movement for insurance coverage of contraceptives took place on numerous fronts, primarily during the 1990s and 2000s. Reproductive health advocates found broad public support for contraceptive coverage; a 1998 Kaiser Family Foundation poll found that 75 percent of Americans believed contraceptives should be covered by insurance even if doing so added to the cost.⁴ Armed with such data, advocates lobbied state legislators, governors and attorneys general to pass contraceptive coverage policies. Advocates also pursued a litigation strategy, making a case for contraceptive coverage under Title VII of the *Civil Rights Act of 1964*. Finally, advocates crafted and introduced a bill in Congress that, if passed, would have made the ACA's contraceptive coverage mandate unnecessary. The campaign found consistent success as the percentage of health insurance plans covering the full range of contraceptives soared from 28 percent to 86 percent between 1993 and 2002.⁵ This section summarizes the efforts and successes within the state legislatures, federal courts, and Congress.

State Mandates: The multi-pronged campaign for contraceptive coverage over the past two decades has yielded 28 state laws requiring coverage of contraceptive drugs and devices.⁶ Maryland became the first state in 1998 to pass a contraceptive equity law, requiring insurance plans that cover prescription drugs to also include prescription contraceptives.⁷ That same year, nine additional states followed suit. In 2009, Wisconsin became the latest state to add a contraceptive coverage law.

These laws range in their reach. For example, Arizona's law is one of the most expansive, requiring coverage of contraceptives and outpatient drugs and devices, while Kentucky's mandate is limited to small and individual market insurers. While most of these laws were passed by state legislatures, at least two resulted from orders issued by administrative rulings or opinions by state attorneys general.⁸

Despite their variance, these laws have impacted both women within their states and beyond their state lines. Insurance plans that are designed at the national level tend to apply contraceptive coverage provisions even in states where no mandate exists.⁹ As a result, in 2002 almost six in 10 plans in non-mandate states provided comprehensive coverage of contraceptives.

³ See Finer LB and Zolna MR, "Unintended pregnancy in the United States: Incidence and Disparities, 2006. *Contraception* (2011).

⁴ National Women's Law Center, "Guaranteeing Coverage of Contraceptives: Past and Present." (November 18, 2010.)

⁵ Adam Sonfield, "The Movement Against Health Insurance Benefit Mandates: Assessing the Dangers." *Guttmacher Policy Review* (Spring 2006).

⁶ "Insurance Coverage of Contraceptives." *Guttmacher Institute State Policies in Brief* (July 1, 2011).

⁷ National Women's Law Center, "Guaranteeing Coverage of Contraceptives: Past and Present." (November 18, 2010.)

⁸ "Insurance Coverage of Contraceptives." *Guttmacher Institute State Policies in Brief* (July 1, 2011). Michigan's policy is the result of an administrative ruling, and Montana's is the result of an attorney general opinion.

⁹ *Id.*

The past two decades have also demonstrated the durability of these state laws. No state contraceptive coverage mandates have been repealed.¹⁰ Overall, these state laws have served as powerful means of ensuring coverage of the full scope of reproductive drugs and devices nationally.¹¹

However, the varied policies among the states do lead to gaps in coverage, particularly with respect to self-insured plans.¹² The federal *Employee Retirement Income Security Act (ERISA)* law, passed in 1974, preempts state lawsuits against “self-insured” employers and usually inoculates self-insured employers from state mandates, including the state contraceptive equity mandates.¹³

Litigation: To address the ERISA roadblock, reproductive health advocates built a litigation strategy to require employer-sponsored health insurance plans to include plans to cover contraceptives. They raised claims under Title VII and the *Pregnancy Discrimination Act (PDA)*, arguing that failing to cover contraceptives when other preventative drugs and devices are covered constitutes sex discrimination and/or pregnancy discrimination under Title VII of the *Civil Rights Act*. This strategy achieved pro-contraceptive coverage results in a number of federal districts, beginning with the Western District of Washington in *Erickson v. Bartell Drug Company*.¹⁴ *Erickson* held that because Bartell Drug Company’s self-insured employer health plan covers some prescription drugs and preventative medications but excludes prescription contraceptives, it discriminates on the basis of sex in violation of Title VII of the *Civil Rights Act of 1964*. The court agreed with plaintiffs’ claim that Bartell Drug Company’s selective exclusion of coverage of prescription contraceptives is disparate treatment based on women’s “unique, sex-based characteristics, such as the capacity to bear children.” *Bartell* also noted that in enacting the PDA, Congress emphasized that an employer cannot use cost as an excuse for failing to take measures to ensure gender equality.

While *Erickson* resonated in other jurisdictions – at least four other federal courts have agreed that failure to insure contraceptives discriminates on the basis of sex under Title VII – the 8th Circuit Court of Appeals ruled in 2007’s *In Re Union Pacific Railroad Company* that contraceptives do not relate to pregnancy because contraceptives are only relevant “prior to pregnancy.”¹⁵ The Eighth Circuit was not persuaded that Congress intended for the PDA to cover contraceptives, or that failure to cover contraceptives discriminates on the basis of sex under Title VII under plaintiffs’ disparate treatment theory, because Union Pacific’s plan does not cover contraceptives for women or men. This case is still good law and could serve as persuasive authority in other circuits.

Federal Law: In 2001, a bill was introduced in Congress that would have made the *Affordable Care Act*’s contraceptive coverage provision unnecessary: *The Equity in Prescription Insurance and*

¹⁰ Wisconsin Governor Walker attempted to repeal his state’s contraceptive equity law in early 2011 but ultimately removed that provision from his proposed budget. See Planned Parenthood Advocates of Wisconsin press release (April 22, 2011). Available at <http://www.ppawi.org/home/news-media/newsroom/press-releases/PR042211.cmsx>

¹¹ Adam Sonfield, Rachel Benson Gold, “New Study Documents Major Strides in Drive for Contraceptive Coverage.” *Guttmacher Report on Public Policy* (June 2004).

¹² Another barrier that this paper will not address is religious exemptions. At least fifteen state mandates exempt religious employers from covering contraceptives. See “Insurance Coverage of Contraceptives.” *Guttmacher Institute State Policies in Brief* (July 1, 2011).

¹³ See Bapat, “Fighting Collectively for Contraceptive Equity: Class Action Litigation and Emerging Labor Union Support for Contraceptive Coverage.” 9 U. Pa. J.Lab. & Emp. L 951 (Fall 2007).

¹⁴ *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001).

¹⁵ Oral Arguments, *Brandi Standridge vs. Union Pacific*, case number 061706 (Nov. 16, 2006) available at <http://www.ca8.uscourts.gov/oralargs/oaFrame.html> (reflecting the 8th circuit judges’ disagreement that exclusion of contraceptives violates the PDA or constitutes sex discrimination).

Contraceptive Coverage Act (EPICC) would have mandated all health insurance plans, including self-insured plans, to cover contraceptives if they cover other prescription drugs, devices, and outpatient services.¹⁶ For several years this bill, first introduced in 1997, remained buried in Congress. Eventually, EPICC was introduced to the Senate one day before the September 11, 2001 terrorist attacks. After the attacks, EPICC essentially fell by the wayside for the remainder of the decade.¹⁷ Notably, the *Federal Employee Health Benefit (FEHB)* program has covered contraceptives for employees of the federal government since 1998.¹⁸

Part II: The ACA’s Impact on Contraceptive Coverage: The ACA’s inclusion of contraceptives within its preventive care coverage is the culmination of the nearly twenty years of state-level activism and legal advocacy described in Part I. In addition, its expansion of Medicaid has the potential to result in even greater impact on contraceptive coverage for more women in the United States.

Contraceptives within the ambit of ‘preventive care’: On August 3, 2011, the US Department of Health and Human Services (DHHS) adopted recommendations, the “Guidelines for Women’s Preventive Services,” that require new health plans to include a range of reproductive health services.¹⁹ The independent, nonprofit Institute of Medicine (IOM) issued the recommendations. The new regulations apply to insurance policies with plans beginning on or after August 1, 2012 and specify that covered services include “FDA-approved contraceptive methods and contraceptive counseling, well-woman visits, HIV screening, and breastfeeding support.”²⁰ DHHS clarified that the rules governing coverage of preventive services, which allow plans to use “reasonable medical management” to help define the nature of the covered service, will apply to women’s preventive services including contraceptives.²¹ Insurers will be able to charge for branded drugs if a generic version is available and safe for patient use – a way in which the ACA can help control costs.

DHHS was acting under the direction of the *Mikulski Amendment* to the ACA. Sponsored by Senator Barbara Mikulski (D-MD, the *Amendment* requires all health plans to cover comprehensive women's preventive care and related screenings, at no additional charge to women.²² The *Mikulski*

¹⁶ EPICC would have amended ERISA to mandate coverage of contraceptives.

¹⁷ Susan A. Cohen, “Federal Law Encouraged as Culmination of Contraceptive Insurance Coverage Campaign.” *The Guttmacher Report on Public Policy*, Vol. 4 No. 5 (October 2001).

¹⁸ “Contraceptive Coverage in the Federal Employee Health Benefits Program.” *Center for Reproductive Rights* (August 2003). Available at <http://reproductiverights.org/en/document/contraceptive-coverage-in-the-federal-employees-health-benefits-program>.

¹⁹ The HHS directed the IOM to conduct a scientific review and provide recommendations on specific preventive measures that meet women’s unique health needs and help keep women healthy. HHS’ Health Resources and Services Administration (HRSA) used the IOM report issued July 19, when developing these guidelines. The IOM’s report relied on independent physicians, nurses, scientists, and other experts to make these determinations based on scientific evidence.

²⁰ DHHS, “Affordable Care Act Ensures Women Receive Preventive Services at No Additional Cost.” Available at <http://www.hhs.gov/news/press/2011pres/08/20110801b.html>

²¹ Id. The administration also released an amendment to the prevention regulation that allows religious institutions that offer insurance to their employees the choice of whether or not to cover contraception services. This regulation is modeled on the most common accommodation for churches available in the majority of the 28 states that already require insurance companies to cover contraception.

²² “Senate passes Mikulski’s Overhaul Amendment on Women’s Health.” *National Public Radio* (December 3, 2009). Available at http://www.npr.org/blogs/health/2009/12/senate_passes_womens_health_am.html

Amendment passed in December 2009, effectively defeating a competing plan proposed by Senator Lisa Murkowski (R-AK) that would have prevented the federal Government from adopting “binding” health guidelines. Mikulski’s sponsorship of this critical amendment is fitting given that her state of Maryland was the first state to ever enact a contraceptive coverage mandate in 1998.

This provision demonstrates federal support for contraceptive coverage as well as the recognition that preventive care is of greater need for women, and at the same time often less accessible to them due to disparities in wealth and income.²³ The ACA’s provision eliminates the self-insured barrier that state mandates cannot overcome and it relieves cost-sharing provisions for many women. It achieves the goals that EPICC set out to achieve so many years ago, and is reflective of the political will of the current administration and the 2008 Congress.

However, the ACA’s Medicaid expansion, if not repealed or restructured, is poised to make a deeper impact on expanding access to health care for more Americans – including contraceptive coverage and reproductive health services.

Medicaid Expansion: Arguably the ACA’s most critical value-added in terms of contraceptive coverage and reproductive health care lies in its expansion of Medicaid. Indeed, the ACA’s historic relevance and impact lies in its recognition of income and wealth disparities that impede health care access and coverage.²⁴ Through expanding Medicaid, the ACA provides health coverage for millions of Americans who normally would not have received it. Concomitantly, this expansion will increase access to contraceptives for lower-income Americans.

Prior to the ACA, Medicaid was already the “most important US program in support of reproductive health services.”²⁵ Medicaid enrollees have historically received a wide range of reproductive health services, including family planning services and supplies.²⁶ Now, the ACA calls for standardization of eligibility criteria across states and shifting criteria to focus primarily on income.²⁷ By 2019, these provisions could result in Medicaid insuring up to 16 million Americans, mostly poor, who normally would be uninsured.

In addition, the ACA gave states immediate authority to provide Medicaid coverage of family planning services and related care to women and men who earn at levels equal to what the state already provides for pregnancy-related health care. Twenty-two states operate such eligibility expansions, four of them under this new authority and another 18 via waiver from the Centers for Medicare and Medicaid Services (CMS). Finally, all 50 states cover treatment for uninsured women diagnosed with breast or cervical cancer.²⁸

For Americans facing economic challenges – a group that is growing in numbers given the economic downturn – Medicaid is a critical source of reproductive health services. The current economic climate makes clear that the need for insurance coverage of contraceptives and related

²³ “Affordable Care Act Rules on Expanding Access to Preventive Services for Women.” (August 1, 2011). Available at www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html

²⁴ See Sara R. Collins, “How the Affordable Care Act will Impact Low-and-Moderate Income Families.” (July 13, 2010). The Commonwealth Fund. Available at <http://www.commonwealthfund.org/Blog/How-the-Affordable-Care-Act-of-2010.aspx>

²⁵ Sonfield, Adam. “Political Tug-of-War Over Medicaid Could Have Major Implications for Reproductive Health Care.” *Guttmacher Policy Review*. (Summer 2011)

²⁶ Id.

²⁷ Sonfield, Adam. “Political Tug-of-War Over Medicaid Could Have Major Implications for Reproductive Health Care.” *Guttmacher Policy Review* (Summer 2011). In addition, all states are required to cover pregnancy-related care for women during pregnancy and postpartum care for up to 60 days, with a minimum income ceiling of 133% of poverty. Most states set that ceiling at or near 200%.

²⁸ Id. States were given the option in 2000 to cover the treatment and early detection programs. As a result Medicaid accounted for 71% of all federal and state spending on family planning services and supplies that same year.

reproductive health services is greater. The ACA's expansion of Medicaid promises to enhance access to reproductive health care for many more Americans.

Part III: Health Reform's Vulnerabilities and Strategies for the Road Ahead: The political landscape, the economic downturn, and budget shortfalls have placed great emphasis on cost savings and budget cuts – which in particular render the ACA's Medicaid expansion vulnerable at the federal and state levels.²⁹ Current leadership in the US House of Representatives, as well as some Governors, have expressed support for restructuring Medicaid into block grants, as well as the repeal of the ACA in its entirety. Given the leadership in the House of Representatives as well as states' desire to have greater flexibility in Medicaid, a restructuring of Medicaid seems plausible. Additionally, the ACA passed at a financially precarious time. States have sued, arguing that it is unconstitutional to force them to pay the costs associated with the Medicaid expansion. Reform of Medicaid or striking down its expansion could jeopardize reproductive health care for low-income Americans.

Medicaid Restructuring: After Republicans took control of the House of Representatives in November 2010, Medicaid emerged as one of the new leadership's primary targets for budget cuts.³⁰ Representative Paul Ryan, Chair of the House Budget Committee, developed a plan in early 2010 that called for turning Medicaid into a block grant program that would provide a finite grant amount for each state versus the current system in which the federal government pays a percentage of the costs. Block grants give states greater control in spending their Medicaid funds and Medicaid block grants was one of the key cost-saving provisions of the 2012 budget proposal authored by Representative Ryan and was sought by Republican negotiators during the debt ceiling negotiations. A block grant approach is not novel – such proposals have been offered repeatedly over Medicaid's history by conservative policymakers. It remains appealing to states because it can provide them control over the program and greater predictability in costs. In addition, Representative Ryan's block grant plan would guarantee cost savings because it would require states' grants to be based on population growth and overall inflation. However, such an approach would result in severe restrictions on enrollment and services –including reproductive health services. According to the Guttmacher Institute: “The Center on Budget and Policy Priorities contends that a rollback in funding of this magnitude, combined with increased state flexibility, would inevitably lead to substantial restrictions in enrollment, services and access to providers, along with increases in patient cost-sharing. If that scenario were to prove true, the impact on reproductive health care could be considerable.”³¹

In line with Representative Ryan's approach, Republican candidates for President as well as some Governors have been discussing the option of evolving Medicaid into block grants.³² The debt ceiling compromise helped make budget cuts and cost savings a major part of political discussion, and

²⁹ Medicaid and Medicare account for over half the federal budget. Concerns over costs have led to cuts in Medicaid benefits. See “Wisconsin Republicans approve Medicaid cuts.” *Bloomberg Businessweek* (Nov. 10, 2011). Available at <http://www.businessweek.com/ap/financialnews/D9QU3CRO1.htm>

³⁰ Sonfield, Adam. “Political Tug-of-War Over Medicaid Could Have Major Implications for Reproductive Health Care.” *Guttmacher Policy Review*. (Summer 2011)

³¹ Sonfield, Adam. “Political Tug-of-War Over Medicaid Could Have Major Implications for Reproductive Health Care.” *Guttmacher Policy Review*. (Summer 2011)

³² “Romney plan calls for Medicaid block grants, repeal of Obama health law.” *The Hill*, (September 6, 2011). Available at <http://thehill.com/blogs/healthwatch/politics-elections/179725-romney-plan-calls-for-medicaid-block-grants-repeal-of-obama-health-law>

the 2012 presidential election has provided an avenue for Republicans to discuss the block grant strategy as a major cost savings for the federal government. For example, Republican presidential candidate Mitt Romney recently stated that, if elected, he would issue an executive order turning Medicaid into a block grant system, arguing that block grants would save the federal government \$200 billion per year.³³ Texas Governor and Republican presidential candidate Rick Perry has called for a block grant program and a lifetime benefit cap for Texas residents – something that the administration of President George W. Bush rejected for being too restrictive.³⁴ Former Utah Governor and Republican presidential candidate Jon Huntsman would also advocate a block grant program.³⁵

As the Guttmacher Institute points out, evolving Medicaid into a block grant could have deep implications for reproductive health care access for low income women. Medicaid is the financial support system for low income women and men's reproductive health services. Medicaid is a resource that gives teeth to state and federal contraceptive coverage mandates. The state of the economy makes Medicaid accessibility even more critical for lowincome and/or unemployed Americans. If Medicaid undergoes the reform Republicans propose, then the future of Medicaid and the reproductive health services it supports would be in danger.

Lawsuits: In addition to the proposed policy reforms, 26 states have brought Constitutional challenges arguing that the ACA is unconstitutionally forcing states to pay for costs associated with the Medicaid expansion. On November 14, 2011, the Supreme Court announced it will hear oral arguments on the state of Florida's challenge to the ACA -- Florida's challenge being the "largest and broadest" of the 26 challenges. Though it is just one of four challenges to the ACA, the Court's decision to hear the Medicaid challenge is significant and somewhat surprising.³⁶ The Court will address whether mandating states to cover the costs of Medicaid expansion are so coercive as to constitute impermissible commandeering.

In the event that the Court rules in favor of Florida, or if Medicaid is evolved into block grants, states could choose to roll back their Medicaid benefits – including reproductive health care. It is in this regard that the state-level contraceptive coverage activism of the past many years reveals its relevance. As described further below, reproductive health advocates have strategies and historical data that they can utilize to ensure that state leaders sustain and expand Medicaid's family planning expenditures.

Strategies for the Future: Action in the States: While the political threats are real, there are strategies that reproductive health advocates have been and can continue to implement in order to protect both Medicaid's current structure under the ACA as well as its coverage of contraceptives. Just as the pro-contraceptive coverage activism of the last twenty years took place at the state level, safeguarding Medicaid is something that state leadership can help accomplish. During the next many months, reproductive health advocates should focus on educating state legislators and Governors on the need to protect contraceptive coverage under both private and public plans. Reproductive health advocates can utilize the arguments that helped them achieve state legislative successes between 1998 and 2010 to continue influencing state-level leaders about why contraceptive coverage is so critical to women and families. The following arguments can be utilized:

³³ "Romney plan calls for Medicaid block grants, repeal of Obama health law." *The Hill*, (September 6, 2011). Available at <http://thehill.com/blogs/healthwatch/politics-elections/179725-romney-plan-calls-for-medicaid-block-grants-repeal-of-obama-health-law>

³⁴ Ben Adler, "What Rick Perry Would Do to Medicaid." *The Nation* (September 26, 2011).

³⁵ Daniel Henninger, "A Conservative Problem Solver." *The Wall Street Journal Weekend Review* (June 25, 2011).

³⁶ Ashby Jones, "Nearly everything you need to know about the health care decision." *Wall Street Journal Law Blog* (Nov. 14, 2011), available at blogs.wsj.com/law/2011/11/14/nearly-everything-you-need-to-know-about-the-health-care-decision/

- Contraceptive coverage results in long term cost savings. Research over the past decades has revealed that contraceptive coverage does not increase insurance premiums and can result in long term cost savings by preventing unplanned pregnancies.³⁷ This fact is particularly critical given the focus on budget cuts and shaving government spending.

- There is a deep historical trend of states using Medicaid for contraceptives and related reproductive health services. Since 1980, states have initiated Medicaid expansions of family planning for their residents.³⁸ Twenty-one states have broadened Medicaid eligibility requirements to provide coverage for family planning under the program to individuals based solely on their income. States who have done so have been able to serve more women in need.

- Advocates can utilize data that demonstrates the long term cash influx Medicaid expansion can provide to the states. As the Center for American Progress explained in its 2010 report, “States Lose When they Push Aside Health Reform,” states that reject the ACA reforms would be losing billions in federal funds from Medicaid alone.³⁹

- Advocates can point to the majority of states’ having contraceptive coverage mandates on the books as evidence of the continued need as well as the paucity of controversy surrounding contraceptive coverage.

Encouragingly, some Governors have already begun to push back on a Medicaid block grant approach. In October, Democratic Governors Association Chair, Maryland Governor Martin O’Malley, and Washington Governor Christine Gregoire, Minnesota Governor Mark Dayton and Massachusetts Governor Deval Patrick held meetings with the Chairs of the Congressional Super Committee to discuss the importance of preserving critical entitlement programs, including Medicaid. Advocates throughout the country should focus on convincing their respective state leaders of the benefits of the Medicaid expansion for the states’ bottom lines, and that reproductive health coverage should not be compromised.

Conclusion: State-based activism of the past two decades has resulted in robust statutory support for insurance coverage of contraceptives at both the state and federal levels. Since the contraceptive equity movement began in earnest over twenty years ago, 28 states have enacted contraceptive coverage mandates. The *Affordable Care Act (ACA)*’s inclusion of contraceptives within its preventive care provisions and its Medicaid expansion are significant policy developments that recognize the importance of both contraceptive coverage and the accessibility of health care to lower income Americans.

The challenges for the future of contraceptive coverage laws are primarily rooted in political shifts, as well as divisiveness and anger over Government spending. If the Republicans’ goal to reform Medicaid into block grants prevails, or if the states’ suit against the Medicaid expansion succeeds at the Supreme Court, states could choose to drastically cut reproductive health services, impacting the poorest women and families in the United States. Meanwhile, economic challenges continue to demonstrate the importance of systemic access to reproductive health care. As economic woes continue, so should state and federal support of programs that can ease the burdens that American women and their families face.

From the perspective of the movement for contraceptive coverage, state mandates have proven to be durable strategies that are appealing across party lines and, thus far, relatively inoculate from repeal.

³⁷ Cynthia Dailard, “The Cost of Contraceptive Insurance Coverage.” *The Guttmacher Institute* (March 2003).

³⁸ Adam Sonfield, Casey Ulrich, and Rachel Benson Gold, “Public Funding for Family Planning, Sterilization, and Abortion Services: 1980-2006.” *The Guttmacher Institute* (January 2008).

³⁹ Emma Sandoe, “States lose when they push aside health reform.” *Center for American Progress* (March 2010), available at www.americanprogress.org.

The ACA serves as a federal endorsement of these many state mandates, and its Medicaid expansion can help expand reproductive health care for more American women. Helping the ACA's Medicaid expansion withstand the coming political season and legal challenges is the immediate next crisis that reproductive health advocates in the United States must now face. To this end, sustained state-level activism continues to be necessary to preserve contraceptive access for American women.