I. Access to Contraception

A. Definitions of Contraception

1. Contraception is generally defined as the use of medicines, devices, or surgery to prevent pregnancy.
2. Varying methods may be utilized to help women plan or space their pregnancies, prevent unplanned pregnancies, or to regulate hormonal imbalances that may lead to a wide range of health concerns (NCSL 2023).

B. General Use Statistics (NCSL 2023)

1. Approximately 65% of females aged 16 to 49 use some form of contraception.
2. The most common form of birth control is female sterilization (18.1% of females), closely followed by oral pill contraceptives (14.0%), long-acting reversible contraceptives including injections, implants, and IUDs (10.4%), and male condoms (8.4%).
3. Contraceptives vary in efficacy.
    a) Female sterilization, IUDs, and implantable rods are the most effective, resulting in less than 1 pregnancy per 100 women.
    b) Patches, contraceptive rings and oral contraceptives have efficacy rates of nine pregnancies per 100 women.
4. The IUD and implantable rod must be inserted by a health care professional and last up to five years and three years, respectively. The patch and ring each last three weeks and then are removed for the fourth week.
5. Emergency contraception is a form of backup birth control that can be used up to several days after unprotected intercourse or contraceptive failure to prevent pregnancy.
    a) Emergency contraception is not intended to be used as a regular form of birth control, and these forms of birth control are not the same as medications used to end an early pregnancy (abortifacients).
    b) The Affordable Care Act requires coverage for two forms of emergency contraception if they are prescribed by a health care provider. Pharmacies may also offer over-the-counter emergency contraception.

**Common Forms of Contraception**

| Barrier Contraception | Hormonal Contraception | Long-Acting Reversible Contraception | Permanent Contraception |
|---|---|---|---|
| Male and female condoms | The pill | Intrauterine device | Vasectomy |
| Spermicide | Progestogen-only mini pill | Contraceptive implant | Tubal ligation |
| Diaphragm | Contraceptive patch | | |
| | Contraceptive injection | | |

Figure 1: NCSL 2023

C. Financial Barriers & Awareness (Frederiksen et. al 2023)
    1. Although the ACA has required contraceptive coverage for over a decade, many still do not know about the policy and some privately insured females are still paying for their contraceptives.
        a) 41% of females at reproductive age do not know that most insurance plans are required to pay the full cost of their birth control.
    2. While most females (70%) with private insurance say their insurance covered the full cost of their most recent birth control method, a quarter say they paid at least part of the cost out-of-pocket.
        a) 16% say they paid out of pocket because they wanted a certain brand of contraception that was not covered by their plan (even though their plan should cover it if their provider recommends it for them).
        b) Others note that their prescribing provider (10%) or pharmacy (5%) was out of network.
        c) Half did not know why they had to pay.
    3. Cost can be a barrier to contraceptive use for some.
        a) One in five uninsured females of reproductive age say they had to stop using a contraceptive method because they couldn't afford it.
        b) A smaller share of those on Medicaid (6%) or with private coverage (3%) cited cost as a barrier to continued use.
        c) For low-income women, 17% said cost was the leading reason they weren't using their preferred method.

D. Contraceptive Preferences and Side Effects (Frederiksen et. al 2023)
    1. Overall, one quarter of females who are using contraception are not using their preferred method.
        a) The leading reason for this is concern about side effects, a theme that comes up in many aspects of contraceptive care.

b) Almost one-third of contraceptive users (31%) say they are experiencing side effects from their current method, and just over half (52%) say the side effects are more severe than they expected.

2. Just 30% of females say they received all the information they needed before choosing their birth control method.
    a) This is even lower among Asian/Pacific Islander females, just 12% of whom say they had all the information they needed before choosing a method, compared to more than a quarter of Hispanic (26%) and Black (28%) females and one-third of White females (34%).
    b) Person-centered contraceptive counseling is a key element to assuring people can select the contraceptive method that suits them.
    c) Only 40% of those receiving contraceptive care rate their most recent contraceptive counseling as "excellent."

E. Accessing Contraception (Frederiksen et. al 2023)
    1. The majority of reproductive age females get their birth control care at a doctor's office (77%) and prefer to get their care there, despite a growing number of online providers.
        a) Many also rely on clinics and health centers for their care, particularly those who are low-income, uninsured, Black or Hispanic.
        b) Just 7% have received a prescription or obtained a health care service from an online company in the prior 12 months.
        c) Most who get their birth control care from an online company cite convenience as the primary reason for their preference.
    2. Emergency contraceptive pills (EC) are an effective form of back up birth control, but a sizable minority of people who might benefit from them don't know where to get them or that they're available over the counter.
        a) Emergency contraceptive pills, which can be taken to prevent pregnancy after a contraceptive failure or unprotected sex, have been available over the counter for more than 15 years.
        b) 27% of reproductive age females either don't know EC pills are available over the counter or have never heard of them.
        c) Among those who have heard of EC pills and could become pregnant, 31% don't know where they could get it.
    3. Not only was there a lack of awareness about where to get emergency contraceptive pills, but even before the Supreme Court overturned *Roe v. Wade*, few knew where they could get an abortion if they needed one.
        a) Prior to the ruling in *Dobbs*, only 26% of females ages 18-49 said they knew what clinic or health care provider they could go to for an abortion if they wanted or needed one.

b) For those living in rural areas, where services are more limited, even fewer knew where they could go to get an abortion compared to females living in more urban areas (16% vs. 28%).

F. Contraception Deserts (Parker Waichman LLP 2024 via Power to Decide)

1. It's estimated that 19 million women in the U.S. live in what are known as "contraceptive deserts," defined as areas where women who are eligible for publicly funded birth control do not have reasonable access to the full range of methods available.
    a) This means that these women may have to travel more than an hour each way to obtain the method of birth control that works best for them.
    b) They may have to take time off of work or school to travel and may incur additional transportation costs to get there.

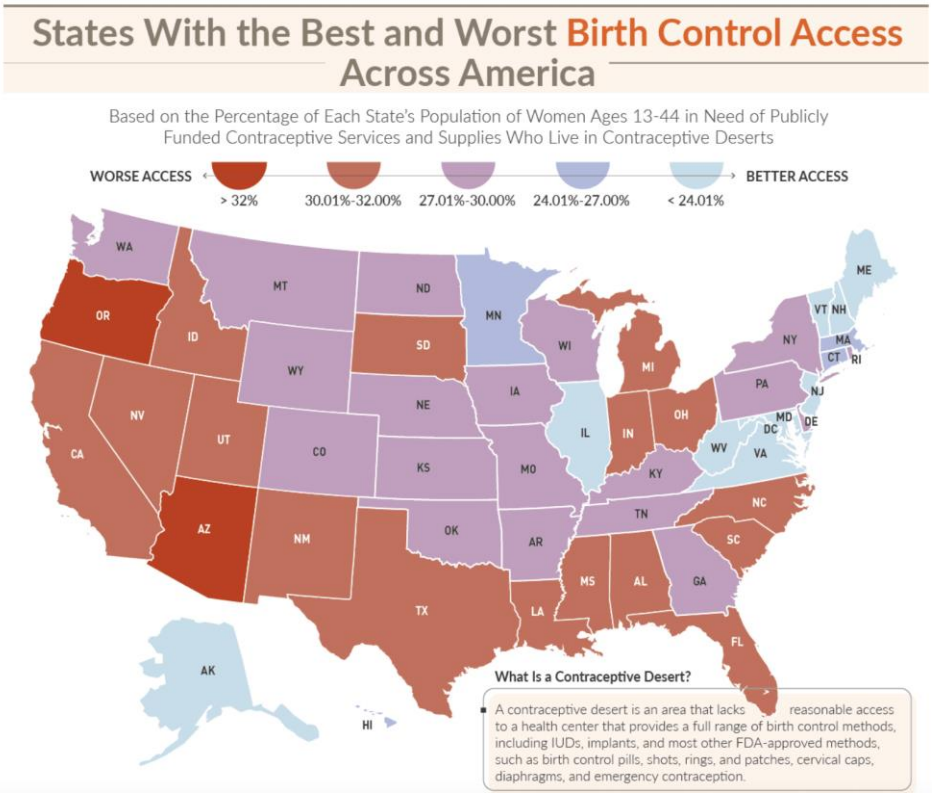


Figure 2. Parker Waichman LLP 2024, via Power to Decide

II. Birth Control Insurance Coverage

A. Coverage Mandates

1. 30 states and D.C. currently regulate health insurance plans in a manner that requires insurance companies to cover contraception (Guttmacher 2023a)
2. Under the Affordable Care Act of 2010, federal law expands on state mandates.

a) The federal contraceptive coverage guarantee applies to most private health plans nationwide, whether sold to employers, schools or individuals, or whether offered by employers that self-insure.
b) An employer that self-insures shoulders the financial risks for health care costs for its employees. Further, state laws cannot regulate self-insured employers, which cover about 60% of insured workers nationwide (Guttmacher 2023a)

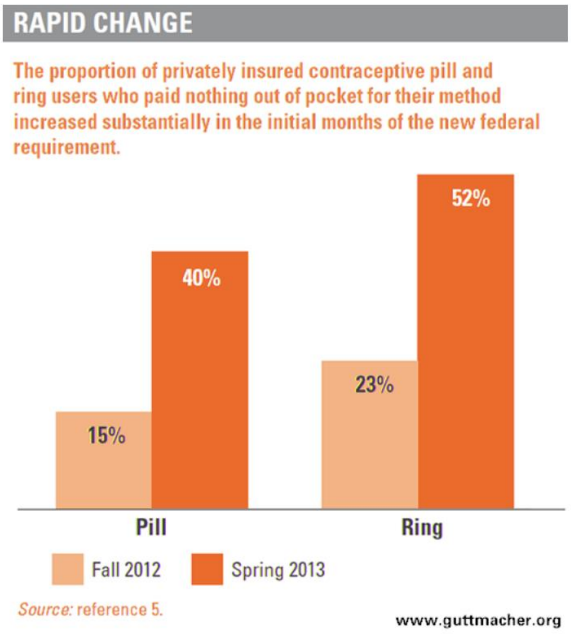


Figure 3. Guttmacher 2013.

3. Federal regulations specify coverage requirements for 18 forms of "female-controlled" contraception, including female sterilization.
    a) The federal guarantee also requires these forms to be available without any out-of-pocket costs to the patient, such as co-pays or deductibles.
    b) This does not, however, apply to male-controlled forms of birth control, such as vasectomies or condoms (Guttmacher 2023a).
4. "Under the guarantee, health plans may apply formularies, prior authorization requirements and similar restrictions within a method category (e.g., to encourage patients to choose one hormonal IUD over another), but they may not favor one type of method over another (e.g., oral contraceptives over contraceptive rings)" (Guttmacher 2023a).
5. Some states have amended/expanded their requirements to match the standard set in the federal guarantee, requiring coverage for the full range of contraceptive methods, counseling and services used by women,

eliminating out-of-pocket costs, and limiting other health plan restrictions (Guttmacher 2023a).

6. Some of these new state provisions go beyond the federal guarantee by requiring coverage for contraceptive methods that are available over the counter without requiring the patient to first obtain a prescription, ensuring that people may receive an extended supply of a method at one time (usually a one-year supply, rather than a typical one- or three-month supply), or requiring coverage of vasectomy without out-of-pocket costs (Guttmacher 2023a).

B. Conscience Clauses
   1. Conscience clauses are guidelines included within coverage mandates that exempt individuals or groups with religious and/or moral objections to contraception from requirements to cover BC with company/entity insurance
   2. Conscience clauses do 3 things:
      a) Identify entities entitled to claim an exemption
      b) Define the grounds that form the basis of exemption
      c) Identify measures exempt individuals/groups can take to mitigate the adverse effects of non-provision to those who need BC
   3. Some states' conscience clauses are broader than others, while some are very specific. Broader language applies to a greater number of entities, leaving more women without coverage as companies claim exemption.
   4. As of 9/1/2023, states with conscience clause language included in their statutes are classified by the Guttmacher Institute as Expansive, Broad, or Limited; some states with coverage mandates do not include these exemption guidelines.
      a) EXPANSIVE: Arizona, Connecticut, Delaware, Hawaii, Illinois, Maryland, Missouri, Nevada, New Mexico, Texas, Virginia, West Virginia, Washington D.C.
      b) BROAD: Arkansas, Maine, Massachusetts, New Jersey, North Carolina, Rhode Island
      c) LIMITED: California, New York, Oregon
      d) NONE: Colorado, Georgia, Iowa, New Hampshire, Vermont, Washington, Wisconsin, Montana, Tennessee, Ohio

C. Trump Era Expansion of Exemptions
   1. In 2017, the Trump Administration substantially expanded employers' ability to exclude some or all forms of birth control from provision in their healthcare plans.
   2. One regulation allows any employer—nonprofit or for-profit—to exclude some or all contraceptive methods and services from the health plans it sponsors if the employer has religious objections.

3. Another regulation allows employers with moral objections to do the same, although it applies to a slightly narrower set of employers (any employer that is not a publicly traded company).
    a) Enforcement of these regulations has been blocked by the courts.
4. Previous federal regulations are in effect that offer an exemption for a much narrower set of explicitly religious employers and provide an "accommodation" for other nonprofit and closely held for-profit employers with religious objections that allows them to avoid paying or arranging for contraceptive coverage, while still ensuring that employees and dependents receive coverage seamlessly from the same insurance company.
5. Most of the state laws that expand contraceptive coverage offer exemptions as well, although few of them are as broad as the blocked federal exemption (Guttmacher 2023a).

D. Policy Summary - Guttmacher Institute (2023a)
1. Federal law requires health insurance coverage for the full range of "female-controlled" contraceptive methods, including counseling and related services, without out-of-pocket costs.
    a) This mandate applies to 18 methods delineated by the U.S. Food and Drug Administration (FDA), which includes female sterilization and methods available over the counter (when obtained with a prescription).
    b) Federal law allows for a "broader" refusal clause that allows churches, associations of churches, religiously affiliated elementary and secondary schools, and, potentially, some religious charities and universities to refuse; hospitals are not allowed to refuse.
2. 30 states and the District of Columbia require insurers that cover prescription drugs to provide coverage of FDA-approved prescription contraceptive drugs and devices.
    a) 12 states and DC require coverage of methods received over the counter; the insurer may still require the enrollee to obtain a prescription.
    b) 21 states and DC require insurers to cover an extended supply of contraceptives at one time.
    c) 9 states require coverage of male sterilization, and 14 states and DC require coverage of female sterilization.
3. 17 states and DC prohibit cost sharing for contraceptives.
4. 9 states and DC prohibit restrictions and delays by insurers, or the use of medical management techniques that restrict access to contraceptives.

5. 20 states and DC allow certain employers and insurers to refuse to comply with the contraceptive coverage mandate; 8 states do not permit refusal by any employers or insurers.
    a) 3 states include a limited refusal clause that allows only churches and church associations to refuse to provide coverage and does not permit hospitals or other entities to do so.
    b) 7 states include a broader refusal clause that allows churches, associations of churches, religiously affiliated elementary and secondary schools, and, potentially, some religious charities and universities to refuse; hospitals are not allowed to refuse.
    c) 7 states and DC include an expansive refusal clause that allows religious organizations, including at least some hospitals, to refuse to provide coverage. (An additional state, Nevada, does not exempt any employers but allows religious insurers to refuse to provide coverage; two other states exempt both insurers and employers.)
    d) 2 states include an almost unlimited refusal clause that allows religious and secular organizations to refuse to provide coverage.
    e) 15 of the 20 states with exemptions and DC require employees to be notified if their health plan does not cover contraceptives.

**INSURANCE COVERAGE OF CONTRACEPTIVES**

| Jurisdiction | Coverage required for: | | | | | Prohibits cost sharing | Prohibits restrictions and delays | Refusal provisions | |
|---|---|---|---|---|---|---|---|---|---|
| | Prescription methods | Over-the-counter methods | Extended supply | Male sterilization | Female sterilization | | | Scope | Enrollees notified by: |
| Federal | X | X | | | X | X | | Broader§ | |
| Arizona | X | | | | | | | Expansive | Employer |
| Arkansas | X | | | | | | | Broader | |
| California | X[β] | X | X | X | X | X | X | Limited | Employer |
| Colorado | X[β] | | X | | | | | | |
| Connecticut | X | X | X | | X | X | | Expansive*,† | Insurer |
| Delaware | X | X (excludes external condoms) | X | | X | X | X | Expansive | Employer |
| District of Columbia | X[β] | X | X | | X | X | X | Expansive[£] | Employer[£] |
| Georgia | X | | | | | | | | |
| Hawaii | X[Θ] | | X | | | | | Expansive† | Employer |
| Illinois | X | X (excludes external condoms) | X | X | X | X | X | Almost unlimited‡ | |
| Iowa | X | | | | | | | | |
| Maine | X | | X | | X | X | | Broader | Employer |
| Maryland | X[β] | X (drugs only) | X | X | | X | | Expansive | Employer |
| Massachusetts | X | X (excludes external condoms) | X | | X | X | | Broader | Employer |
| Michigan | X | | | | | | | Broader | |
| Missouri | X | | | | | | | Almost unlimited†,‡ | Insurer |
| Montana | X | | | | | | | | |
| Nevada | X | X (only EC) | X | | X | X | X | Expansive‡ | Insurer |
| New Hampshire | X[Θ] | | X | | | X | | | |
| New Jersey | X | X (excludes condoms) | X | X | X | X | | Broader | Employer |
| New Mexico | X[β] | X | X | X | X | X | X | Expansive | |
| New York | X | X | X | X | X | X | X | Limited† | Employer/ insurer |
| North Carolina | X | | | | | | | Broader | Insurer |
| Ohio | | | € | | | | | | |
| Oregon | X[Θ] | X (excludes condoms) | X | X | X | X | X | Limited | |
| Rhode Island | X | | X | | | | | Broader | Employer |
| South Carolina | X | | | | | X | | | |
| Tennessee[Θ] | | | | | | | | | |
| Texas** | | | X | | | | | | |
| Utah | β | | | | | | | | |
| Vermont | X | | X | X | X | X | X | | |
| Virginia | X | | X | | X | X | | | |
| Washington | X[β] | X | X | X | X | X | X | | |
| West Virginia[Θ] | X | | X | | | | | Expansive† | Insurer |
| Wisconsin | X | | | | | | | | |
| TOTAL | 30 + DC | 12 + DC | 21 + DC | 9 | 14 + DC | 17 + DC | 9 + DC | 20 + DC | 15 + DC |

*Note:* EC=emergency contraception.

§ Regulations that offered an almost unlimited religious and moral exemption are currently blocked by the courts.

‡ Refusal clause applies to insurers.

β The state allows pharmacists to prescribe and dispense contraceptives, but insurance coverage of these services is not explicitly included in the law.

Θ The state explicitly includes coverage for contraception that is prescribed and dispensed by a pharmacist.

* Religious insurers are not exempt from the mandate but may provide contraceptive coverage through a subcontract with another insurer or third-party entity.

† Enrollees have the option of obtaining coverage directly from insurer.

€ The state's law allows pharmacists to dispense the full amount of a prescription at one time, including contraception, but there is no requirement that health insurance plans cover the cost of accessing a year's worth of contraceptives at one time.

** Employers must be offered the option to include coverage of contraceptives within the health plan.

Figure 4. Guttmacher 2023a.

III. Restrictions on Abortion Access, Dobbs, the Right to Privacy

A. Dobbs Decision

1. The Supreme Court's *Dobbs* ruling has heightened interest in affirming the right to contraception.
    a) While the Court's majority opinion stated that the *Dobbs* decision does not "cast doubt on precedents that do not concern abortion," Justice Thomas argued in his concurring opinion that in future cases, the Court should reconsider precedent that relied on the same principles as *Roe* – including *Griswold v. Connecticut*, the Court's 1965 landmark decision that recognized the right of married people to obtain contraceptives – and overturn those decisions.
2. The prospect of the Court overturning *Griswold* moved some in Congress to introduce federal legislation that would protect the right to

contraception, though that legislation is unlikely to advance in the current divided Congress.

    a) Similarly, some state legislators have recently introduced measures to protect the right to obtain contraceptives.

3. However, even with the current constitutional protections of *Griswold* in place, uncertainty has emerged around people's ability to access certain contraceptive methods, such as IUDs and emergency contraceptive pills (often confused with medication abortion), which are believed by many to be abortifacients. (See Section B)
4. If the Supreme Court's basis for their reasoning hinges on whether "potential life" is involved in a law, the conflation of contraception with abortifacients could be the reasoning in a future case or in the application of certain laws.
5. Currently, *Griswold v. Connecticut* and *Eisenstadt v. Baird* protect access to contraception on the federal level. (Felix et. al 2023)

B. Early Misconceptions about IUDs, Emergency Contraceptives

1. As many as 73% of individuals believe that ECs work by ending pregnancy in its early stages, but this is a false conception, as EC (Plan B) pills actually work by preventing ovulation and/or making it more difficult for sperm to reach an egg (Felix et. al 2023).
2. Similarly, many believe that IUDs prevent implantation of a fertilized embryo on the uterine wall.
    a) The device does not prevent implantation, terminate pregnancy, or affect a developing embryo. (Felix et. al 2023)
3. Several scientists and doctors said in interviews that common misconceptions regarding EC and IUDs, which far predate the Dobbs decision, do not reflect the way the birth control methods actually work.
    a) "There's so much evidence for how these things work prior to fertilization," said Diana L. Blithe, director of contraceptive development for the National Institute of Child Health and Human Development. "And there's no evidence that they work beyond fertilization." (Belluck and Eckholm, 2012)
    b) Blithe and other experts said these methods are incredibly effective in preventing fertilization, and as such, the chance of an egg and sperm uniting is slim.
    c) If fertilization does occur, the embryo is unlikely to implant for "natural reasons".
    d) While several medical sites, including some from government agencies, raise the possibility that the morning-after pill could affect implantation, Dr. Blithe and others said it had not been scientifically verified that the drugs work that way. (Belluck and Eckholm, 2012)

4. Dr. Anita Nelson, a professor of obstetrics and gynecology at the David Geffen School of Medicine at the University of California, Los Angeles, says that the morning-after pill, Plan B, contains a synthetic progesterone that blocks ovulation.
    a) Recent studies have indicated that women who take Plan B after ovulation have a normal chance of becoming pregnant, and that Plan B does not prevent their fertilized eggs from implanting.
    b) Ella, the other morning-after pill, delays ovulation by blocking the body's progesterone. (Belluck and Eckholm, 2012)
5. Ella is a hormonal cousin of the drug used in an acknowledged abortifacient, RU-486, which is given to women who are up to about seven weeks pregnant and stops the development of an already-implanted embryo.
    a) But the RU-486 hormone is a very high dose, between 200 to 600 milligrams, whereas the Ella hormone is 30 milligrams, Dr. Nelson said.
    b) She said that Ella had not been tested to see if it prevented implantation, but added that the RU-486 hormone at low doses acts only to prevent ovulation. (Belluck and Eckholm, 2012)

C. ECs and IUDs - Recent Medical Research
1. Major gynecologic, pediatric, and primary care organizations recommend counseling women at risk of unintended pregnancy about EC (Batur et. al 2016).
    a) In the United States, 4 methods are available, including the copper intrauterine device (IUD) and 3 oral methods: levonorgestrel (LNG) 1.5 mg (a progestin-only pill), ulipristal acetate (UPA) 30 mg (a selective progestin receptor modulator), and the Yuzpe regimen (high-dose combined estrogen and progestin oral contraceptives).
    b) All EC options can be used within 5 days of intercourse with varying efficacy.
2. The largest barrier to use for EC is a lack of knowledge among users and providers regarding its availability, efficacy, and function (Batur et. al 2016).
    a) In a 2016 study of providers practicing at larger academic institutions, only 13% of emergency medicine, 17% of internal medicine, 23% of pediatric, 26% of family medicine, and 52% of reproductive health care providers reported awareness of UPA as EC.
    b) The percentage of providers across specialties who prescribed UPA was even lower: 3% in internal medicine and emergency

medicine, 4% to 5% in pediatrics and family medicine, and 14% in reproductive health.

c) The most effective methods, the copper IUD and UPA, can be obtained only via a clinician, and some women may not feel comfortable requesting EC.

3. Another barrier to EC access and use is the misconception that EC methods are abortifacients (Batur et. al 2016).
    a) Oral EC can only prevent or inhibit ovulation, while the copper IUD prevents fertilization by affecting sperm viability and function.
    b) No studies have reported that EC negatively affects implantation or an established pregnancy (Batur et. al 2016).
4. Meglin and Isaacs (2022) provide further detail on ECs, specifically the FDA approved Plan B and Ella pills, which work by preventing ovulation.
5. An interesting article on the safety of ECs, including adverse effects and experiences of women who did end up pregnant and gave birth despite UPA use: https://www.contraceptionjournal.org/article/S0010-7824(14)00011-0/pdf

D. Interpretations of State Abortion Bans
1. Definitions utilized by some states, in combination with the misconceptions that IUDs and ECs are abortifacients, may lead to abortion bans being utilized to limit access to contraceptives.
    a) While leading medical organizations define pregnancy to begin at the implantation of a fertilized egg (American College of Obstetricians and Gynecologists 2024), a number of abortion bans define pregnancy to begin at fertilization and "fetus" and "unborn children" as living humans from fertilization until birth.
2. Tennessee's total abortion ban defines pregnancy as the "reproductive condition of having a living unborn child within [the pregnant person's] body throughout the entire embryonic and fetal stages of the unborn child from fertilization until birth."
    a) Abortion bans that establish that a pregnancy exists from the moment of fertilization could lead to complications, interpreting the prevention of the implantation of a fertilized egg as terminating a pregnancy.
3. In Missouri, abortion is defined by outlawing "[the] termination of the pregnancy of a mother by using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth or to remove a dead unborn child".

a) The ban also defines “unborn child” as “the offspring of human beings from the moment of conception” — which they define as fertilization — “until birth.”
b) The ban does not provide a definition for pregnancy, but instead establishes personhood for fertilized eggs, which could be interpreted as banning anything that prevents the implantation of a fertilized egg on the uterine lining, a possibility the state’s governor did not firmly deny after the *Dob*bs decision.
c) As a result, when the state’s abortion ban went into effect, a major hospital system in Missouri immediately stopped providing Plan B out of fear of charges that could have resulted from a prosecutor’s misunderstanding of how Plan B works.
d) The hospital system resumed providing emergency contraceptives after the Attorney General’s office and the governor clarified that the ban did not affect Plan B.
e) However, this situation demonstrates how the definitions included in abortion bans, which imply pregnancy starts at fertilization, coupled with misunderstandings of how contraceptives work, could limit access to the full range of contraceptive methods.

4. Currently, most other abortion bans that define pregnancy to begin at fertilization also limit the definition of abortion to providing procedures or medication to people “known to be pregnant” or with “clinically diagnosable pregnancies”.
    a) This definition of abortion would preclude these bans from being used to limit contraceptives. This is because contraceptives – emergency or otherwise – do not end an existing pregnancy and emergency contraceptives are only effective up to 5 days after intercourse, while the earliest a pregnancy can be clinically confirmed is approximately 10 to 11 days after fertilization.
    b) Even with a misunderstanding of how contraceptives work, these bans do not affect conduct prior to the time when a pregnancy can be confirmed.
5. Additionally, the abortion bans in a few states explicitly clarify that they do not prevent the prescription, sale, or transfer of birth control devices and oral contraceptives. See table below for more details.

Table 1

## Definitions of Abortion, Pregnancy and Fetal Personhood in State Abortion Bans

| Statute | Definition of Abortion/Conduct Prohibited | Pregnancy Definition | Definitions Establishing Fetal Personhood |
|---|---|---|---|
| **Arkansas**<br><br>Ark. Code Ann. § 5-61-301 | "[T]he act of using, prescribing, administering, procuring, or selling of any instrument, medicine, drug, or any other substance, device, or means with the purpose to terminate the pregnancy of a woman" | | **"Unborn child"** defined as "an invididual organism of the species Homo sapiens from fertilization until life birth". |
| **Idaho**<br><br>Id. Code § 18-622 | "[T]he use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman" | "[T]he reproductive condition of having a developing fetus in the body and commences with fertilization." | "Fetus" and **"unborn child"** defined as "an individual organism of the species Homo sapiens from fertilization until live birth." |
| **Kentucky**<br><br>Ky. Rev. Stat. § 311.772 | "Administer to, prescribe for, procure for, or sell to any pregnant woman any medicine, drug, or other substance" or "Use or employ any instrument or procedure upon a pregnant woman with the specific intent of causing or abetting the termination of the life of an **unborn human being**" | "[T]he reproductive condition of having a living **unborn human being** within [the] body throughout the entire embryonic and fetal stages of the unborn child from fertilization to full gestation and childbirth" | **"Unborn human being"** defined as "an individual living member of the species homo sapiens throughout the entire embryonic and fetal stages of the unborn child from fertilization to full gestation and childbirth." |
| **Missouri**<br><br>Rev. Stat. Mo. § 188.017 | "The act of using or prescribing any instrument, device, medicine, drug, or any other means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb; or The intentional termination of the pregnancy of a mother by using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth or to remove a dead unborn child" | | **"Unborn child"** defined as "the offspring of human beings from the moment of conception until birth and at every stage of its biological development, including the human conceptus, zygote, morula, blastocyst, embryo, and fetus"<br>And "conception" defines as "the fertilization of the ovum of a female by a sperm of a male" |
| **Tennessee**<br><br>Tenn. Code Ann. § 39-15-213 | "[T]he use of any instrument, medicine, drug, or any other substance or device with intent to terminate the pregnancy of a woman known to be pregnant" | "[T]he human female reproductive condition of having a living **unborn child** within her body throughout the entire embryonic and fetal stages of the unborn child from fertilization until birth" | **"Unborn child"** defined as "an individual living member of the species, homo sapiens, throughout the entire embryonic and fetal stages of the unborn child from fertilization until birth" |
| **Wyoming**<br><br>Wyo. Stat. Ann. § 35-6-122 | "[T]he act of using or prescribing any instrument, medicine, drug or any other substance, device or means with the intent to terminate the clinically diagnosable pregnancy of a woman" | "[T]he condition of having a living **unborn baby or human being** within a human female's body throughout the entire embryonic and fetal stages of the unborn human being from fertilization, when a fertilized egg has implanted in the wall of the uterus, to full gestation and childbirth" | **"Unborn baby"** or **"unborn human being"** defined as "an individual living member of the species homo sapiens throughout the entire embryonic and fetal stages from fertilization to full gestation and childbirth" |

PNG

KFF

Figure 5. Frederiksen et. al, 2022.

**Exclusion of Emergency Contraceptives in State Programs**

Although Medicaid programs are required to cover family planning services, some states have attempted to exclude certain contraceptive methods from their state Medicaid programs. In 2020, **Texas** received permission from the Trump Administration to exclude emergency contraceptives from its Medicaid-funded family planning program, after requesting to exclude coverage in 2017. This waiver will remain in effect until December 2024. Similarly, in 2021 the **Missouri** senate voted on a bill that would have barred coverage of emergency contraceptives from the state's Medicaid program. This measure failed, and it is unclear whether Missouri had the authority to enforce this restriction without receiving authorization from the federal government. And earlier in 2023, **Iowa** stopped paying for Plan B for survivors of sexual assault through its Crime Victim Compensation Program. Although these measures affect coverage of emergency contraceptives – not their legality – they still constitute attempts to restrict access to certain contraceptive methods. Additionally, in 2021, the Idaho legislature enacted a law that bars "abortion-related activities" in school-based clinics, which prohibits health clinics at public schools, including higher education institutions, from dispensing emergency contraceptives, except in cases of rape.

E.

F. States with Protections for Contraception
    1. Thirteen states – **California**, **Colorado**, **Florida**, **Illinois**, **Massachusetts**, **Michigan**, **Minnesota**, **New Jersey**, **New Mexico**, **Oregon**, **Rhode Island**, **Vermont**, and **Washington** – and **D.C.** currently have legal or constitutional protections for the right to contraception.
    2. Many of these protections have been put into place since the Dobbs decision, but more than half were enacted prior to Dobbs.

IV. Guttmacher Institute Legislation Tracker
    A. This site tracks state legislation related to abortion, contraception, conscience clauses, and more. I anticipate this being a useful resource as legislation continues to move through state legislatures and state/federal courts.
        1. https://www.guttmacher.org/state-legislation-tracker

V. ACOG Gynecological Definitions Document
    A. https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions

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