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The Contraceptive Covenant:

Examining The Relationship Between State Religiosity and Contraceptive Policy for Insured Dependents

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August 2024

Abstract

Americans are engaged in and committed to their religious communities, with over seventy percent deeming religion an important part of their lives.[1] Involvement with religious institutions shapes individual perspectives on family planning matters, including contraceptive policy. This research examines state legislatures' responses to the Patient Protection and Affordable Care Act (ACA) raising the dependent maximum age to 26. This policy created a new class of older insured dependents facing confidentiality concerns when accessing contraceptive care under existing guidelines treating dependents as minor children of policyholders. Informed by rational choice and social control theory, this study evaluates whether rates of high and low religiosity in a state are related to the presence or absence of access-oriented contraceptive policy for insured dependents. A logistic regression analysis using STATA BE was performed on religious service attendance and state contraceptive policy data across 50 states and the District of Columbia pertaining to the confidentiality of insured dependents. The findings reveal that with every additional percentage point of low religiosity, states were 14.7% more likely to have access-oriented contraceptive policy ($p = .0034$). For every additional percentage point of high religiosity, states were 19.3% less likely to have any policy in place ($p = .018$). This study underscores the relationship between religiosity and family planning policy and highlights the need for policymakers to better assess religiosity's potential impact on policy outcomes since most reproductive health bills surface under state legislatures.[2]

Keywords: Contraception, Family Planning, Policy, Legislation, Religiosity, Religion

Topics: Religion in American Public Life, Affordable Care Act (ACA), State Policies on Contraception, Confidentiality for Insured Dependents, Rational Choice Theory, Social Control/Hellfire Theory

Background

Religion in American Public Life

Religion permeates public life for individuals living in the United States (US), with 70% of Americans* considering religion to be of importance and 41% attending religious services on a weekly or monthly basis.[1] Americans' commitment to their faith communities is underscored by the fact that a majority of churchgoers have attended their current congregation for over 10 years, while the average tenure an employee maintains with their employer is only 4.1 years.[3] Faith groups are often the foundation of the community, serving as one of the only settings where intergenerational community members meet regularly, engage in dialogue on relevant issues within and beyond the pulpit, and seek counsel on personal decisions.[4]

Citizens' engagement with their religious community, including interactions with religious organizations working with pregnant and parenting people, contribute to individual perspectives on these issues and shape beliefs surrounding related legislation.[5,6] As religious institutions foster community involvement, they create a social environment valuing and promoting political participation.[7,8] Increased engagement within the pulpit emerges in the form of heightened civic and political participation from congregants, especially among Black Protestant churches.[9] Individuals who attend religious services more frequently are far more likely to believe that abortion should be illegal in all or most cases.[10]

Insurance Coverage of Contraceptives

Contraception enables individuals to choose if and when to become pregnant, limiting

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* In this paper, the term "Americans" specifically refers to individuals in the United States. This usage distinguishes them from people residing in other countries within the Americas, which includes North, Central, and South America.

adverse maternal and infant health outcomes.[11] Access to contraceptives expands access to higher education, augments career outcomes and earnings, and narrows the gender pay gap.[12] Hormonal contraceptives are utilized not only for family planning, but also for treating various medical conditions, including dysmenorrhea, endometriosis, and polycystic ovary syndrome.[13] Still, persons seeking contraceptive care — especially Black, Indigenous, and Hispanic & Latina/x individuals—face barriers to safe, affordable access to care.[14]

Prior to 2012, contraceptive coverage in the US was inconsistent and often limited, largely dependent on the specific health insurance plan and the state in which a person resided. Many insurance plans, citing their own religious and moral objections and working with inconsistent state coverage policies, did not provide full or any coverage for contraceptive care.[15] Passed in 2010, the ACA drastically changed the landscape of federal contraceptive coverage in the US. It had a swift and substantial impact of eliminating the brunt of out-of-pocket costs[16] and also improved the uptake and utilization rates of contraceptives.[17,18] The ACA mandated that all non-grandfathered private health insurance plans—in short, most insurance-sponsored plans—provide coverage for all FDA-approved contraceptive methods, counseling, and related medical appointments.

The ACA's contraceptive policy has evolved significantly since taking effect on January 1, 2012, due to numerous judicial and administrative challenges. The first major challenge, *Burwell v. Hobby Lobby Stores* (2014)[19] successfully challenged the contraceptive coverage mandate on the grounds of violating the Religious Freedom Restoration Act of 1993, resulting in an exemption for for-profit organizations on religious/moral grounds. The exemption was upheld and expanded in *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania* (2020), permitting more employers, including non-profits, to opt out of contraceptive coverage.[20] In the

context of these federal loopholes, state legislation became the metric by which policyholders receive contraceptive coverage, not federally as was intended.

Confidentiality and Contraceptive Access

Privacy concerns are important for individuals of all genders; however, 27% of women/people with the capacity for pregnancy of reproductive age are insured as dependents, compared with only 20% of men of the same age.[21] Young adults and minors seeking contraceptive care may be subject to social and familial consequences if the pursuit or receipt of such care is disclosed to parents/guardians (namely, policyholders). Contraceptive confidentiality laws provide an avenue for individuals to receive care without concern over their health information shared.

In Carey v. Population Services International (1977), the US Supreme Court recognized that minors' constitutional right to privacy includes access to contraceptives.[22] Although contraceptive care is considered to be a "sensitive" health care service, there is a range of federal (see Appendix *Table 1*) and state variability in legislation dictating adolescent confidentiality in the provision of care.[23,24] Before the ACA, most health insurance plans terminated dependent coverage at age 19 or upon completion of full-time education (typically around age 22). However, the ACA raised this limit to 26 years old, allowing many young adults to remain on their parents' plan, irrespective of marital, financial, student, or employment status.[25] While this change expanded access to many young adults who might have otherwise faced barriers to obtaining contraception, this policy inadvertently generated complications concerning the privacy of dependents. Pre-ACA state laws often treated insured dependents, particularly minor children, in a manner that presumed a level of parental involvement in their healthcare decisions.

When the age limit was extended to 26, a new class of older dependents emerged who, while legally adults, were still classified as dependents under their parents' health insurance policies.

This expansion created tension between young adults seeking confidential contraceptive care and the traditional methods insurers used to contract the policyholder, often the parent. For instance, explanation of benefits forms (EOBs) are documents sent by insurers to policyholders after anyone covered under their policy obtains medical care. These documents usually include the name of the individual receiving care, the healthcare provider, and the type of care obtained, essentially making it impossible for dependents to obtain confidential access to sexual and reproductive healthcare services.[26] Still, insurers maintain the near-universal practice of sending EOB forms, even when the ACA's no-cost contraceptive mandate means the policyholder will, in most circumstances, not experience financial burden. In response, several state legislatures have passed policies that aim to address confidentiality concerns for dependents seeking contraceptive care. Other legislation aimed at safeguarding dependent confidentiality requires minor's consent for disclosure, which is the default practice at Title X clinics and one reason patients choose to seek family planning care at these sites.[27]

Religiosity, Attitudes Towards Contraception, and Contraceptive Policy

Critically, religious socialization serves as one of the few institutions that promotes child rearing among men, whereas women bear pressure to do so from a multitude of sources (family members, media, casual social circles, etc). Though most religious traditions espouse pronatalist values, their theologies provide varied perspectives on the role of contraception in family planning (see Appendix *Religious Groups and Family Planning Beliefs* for a breakdown across different traditions*)*. In addition to patriarchal views, Christian nationalism is a leading predicting factor in support for nationalist pronatalism.[28]

Looking at religiosity through a demographic lens reveals associations between religious affiliation and contraceptive choice and utilization. Almost all people with the capacity for pregnancy who identify as religious—99% of evangelical Protestants, mainline Protestants, and Catholics, and 96% of those with other religious affiliations—have used a contraceptive drug or device at some point.[29] Low and moderately religious women are at least twice as likely as their highly religious counterparts to use non-ad hoc hormonal contraceptive methods.[30] Highly religious women are far more likely to use coital methods, namely condoms, compared to low and moderately religious women.[31]

Theoretical Framework

Rational choice theory (RCT) asserts that individuals make choices using a cost-benefit analysis, seeking to maximize personal gain while minimizing drawbacks. When the costs are excessively high and/or the benefits are insufficient, the likelihood of a behavior occurring diminishes. Within this context, RCT provides a framework for understanding the role of religious beliefs, institutional ideology, and socio-cultural influences in shaping individual behaviors, namely voting, and resulting policy. Under the promise of heaven and the threat of damnation— theologically and socially—RCT submits that individuals' self-imposed sanctions (eg., feelings of guilt, shame, or spiritual distress) are correlated with their degree of religious commitment when contemplating or engaging in contraceptive use.[32]

Individuals motivated by an intrinsic feeling of religiosity are more likely to be swayed by shame, while extrinsic religious socialization acts as an influence of embarrassment.[32] For religious individuals, the perceived costs of contraceptive use might include spiritual distress and shame due to misalignment with doctrine. In tightly-knit communities, congregants are subject to

an inescapable stream of social monitoring—and applicable sanctions—from faith leaders and community members for noncompliance with norms.[33] This extrinsic pressure compliments pre-existing intrinsic beliefs, further deterring voting for access-oriented contraceptive policy. For people with the capacity to become pregnant, the risks of sexual activity are even greater.

Social Control Theory (SCT), also termed "Hellfire Theory," complements this understanding by emphasizing the role of religious congregations in regulating behavior. Even if people in the pews do not hold the same views as faith leaders, SCT holds that those who are strongly bonded to their religious community can internalize ideology as morality and are thus still less likely to engage in behaviors that contradict their community's norms.[34,35] These social bonds create a network of accountability and reinforce adherence to communal values, thus influencing voting behavior and policy preferences. Informed by these frameworks, the purpose of this study is to evaluate the relationship between religious service attendance and the presence or absence of access-oriented contraceptive policy for insured dependents.

Methodology

Definition of Variables

Religiosity refers to the extent of an individual's religious beliefs, practices, and commitment. Religious service attendance (RSA) was chosen as a robust, quantitative measure that reflects both the personal and communal aspects of religious engagement. Unlike belief systems (e.g., belief in God and feelings of spirituality) that are subject to individual interpretation and can be difficult to define, RSA is a tangible commitment found across many religious traditions. As opposed to other quantifiable metrics such as frequency of prayer, RSA not only measures individual commitment and belief but also includes religious socialization

from leaders and congregation members. Moreover, higher rates of RSA reflect stronger internalized religious beliefs.[36]

Datasets for Analysis

The dataset for RSA was obtained from the Centers for Disease Control National Center for Health Statistics and US Census Household Pulse Survey, Phase 4.0 Cycle 2, conducted from February 6, 2024, to March 4, 2024, and administered online.[37] Only households in the Census Bureau Master Address File with a cell phone number and/or email address for contact were included in final eligibility for the survey. During the response period, the Census Bureau sent invitations to 1,055,602 households and received 71,152 responses across all 50 states and the District of Columbia, for a weighted response rate of 6.8%. The survey centered around household social connection and contained variables relevant to this study, adapting questions from the Berkman-Syme Social Network Index. Respondents were asked "How often do you attend religious services?" and given the following ordinal, Likert-style options: never or less than once a year, 1 to 3 times per year, 4 to 11 times per year, and 12 or more times per year. Raw sample sizes were then divided by the total number of respondents per state.

Data from the Guttmacher Institute[38] was used to evaluate which states had legislation that protected the confidentiality of insured dependents seeking contraceptive care as of August 31, 2023. Three types of laws were considered: confidential dissemination of information to dependents from health insurance companies, confidentiality protections pertaining to EOBs, and broader protections for dependents applicable to contraceptive coverage. State contraceptive policy specific to the confidentiality of insured dependents was coded as present (1) or not present (0). See Appendix *Table 1* for a comprehensive chart with policies and coding for 50 states and the District of Columbia. The dataset comprised three variables for 51 participants

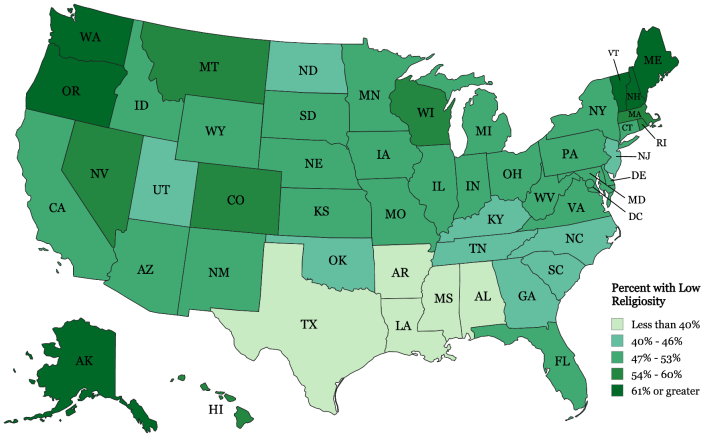
(representing 50 states and the District of Columbia). The variables were as follows: *Policy*, coded as 1 (policy present) or 0 (policy absent); *religiosity_high*, a decimal value reflecting the proportion of survey respondents in each state who reported attending religious services 12 or more times per year; and *religiosity_low*, a decimal value representing the proportion of survey respondents in each state who reported attending religious services never or less than once a year.

Analysis

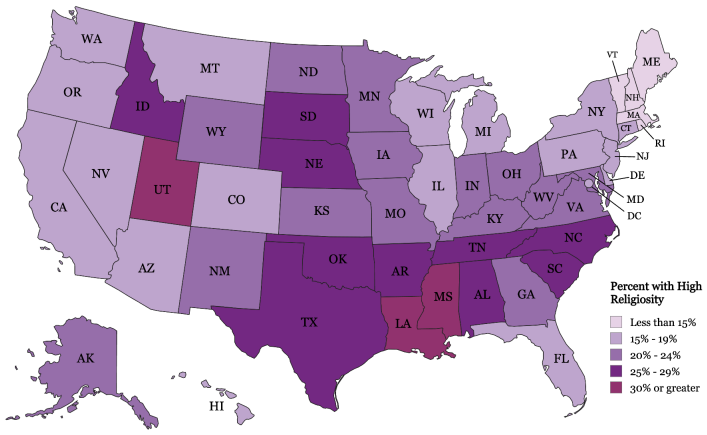
Statistical analysis was conducted using STATA BE version 18.0 (Stata Corporation, College Station, Texas). A logistic regression analysis with nominal variables was performed to obtain an odds ratio.[39] Chi-square tests of independence compared state religiosity with and without contraceptive policy present. Statistical significance was set at the 95% level ($p < .05$). The proportion of respondents reporting RSA as "never or less than once a year" was coded as the dummy variable *religiosity_low* for 50 states and the District of Columbia. The same procedure was repeated to evaluate high religiosity, using the number of respondents who reported "12 or more times per year" and coding proportions as *religiosity_high*. States were sorted based on the variables *religiosity_high* using the commands "sort religiosity_high" and "list State Policy religiosity_high." A T-test against *policy* was conducted using the command "ttest religiosity_high, by(Policy)." After confirming $p < .05$, a new variable, named *high*, was generated which converted *religiosity_high* from a proportion to a percentage using the command "gen high = religiosity_high*100." Subsequently, a logistic regression analysis using the newly generated variable in conjunction with the *policy* variable was performed using the command "logistic Policy high." The process was then repeated using *religiosity_low* and *low*.

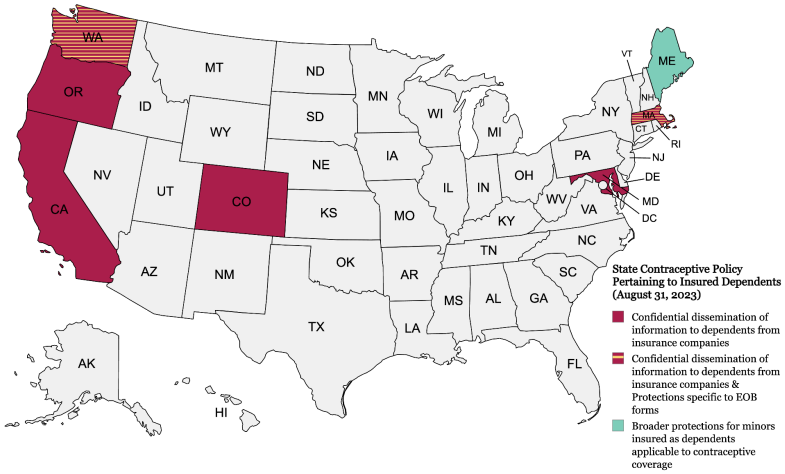
Results

The results indicate that states in the northeastern region, such as Maine and New Hampshire, and western states like Oregon and Washington, exhibit the highest percentages of low religiosity. The second map reveals a pronounced concentration of high religiosity in the southeastern US and Utah.



There was a statistically significant difference in the mean religiosity between rates of low and high religiosity and state policy. States with absent policy had a mean rate of high religiosity of 0.217 [95% CI: 0.199 to 0.234], while states with present policy had a mean rate of 0.165 [95% CI: 0.137 to 0.192] (p = .0114). States with absent policy had a mean rate of low religiosity of 0.492 [95% CI: 0.468 to 0.516], while states with present policy had a mean rate of 0.579 [95% CI: 0.524 to 0.634] (p = .0036).





Logistic regression analysis revealed that the odds of having a policy in place increased by 14.7% with every additional percentage point of low religiosity [OR 1.147, 95% CI: 1.024 to

1.284 (p = .0034)]. The chi-square test for independence found a significant relationship between higher rates of low religiosity and the presence of policy [LR $chi^2(1) = 6.89$ (p = .0087)]. Conversely, states with high religiosity were 19.3% less likely to have a policy in place with every percentage increase in high religiosity [OR 0.807 (95% CI: 0.662 to 0.984) (p = .018)]. The chi-square test for independence found a significant relationship between increased rates of high religiosity and the absence of policy [LR $chi^2(1) = 6.02$ (p = .0141)].

Discussion

Key Findings

The results of this study affirm that states with higher rates of low religiosity are more likely to have policies that safeguard the confidentiality of insured dependents seeking contraceptive care, whereas states with higher rates of high religiosity are more likely to have an absence of access-oriented policy. These differences highlight the role of strong religious constituencies as a contributing factor to contraceptive policy.

The self-imposed sanctions that come with strong intrinsic and extrinsic religiosity, as well as social consequences if the pursuit or receipt of such care is disclosed, may possibly dissuade individuals from both publicly and privately supporting access-oriented policies. They may be more likely to consider religious teachings and socialization in not only their use of contraceptives but also the need to elect officials who do not support access-oriented policies for insured dependents. Similarly, individuals with low religiosity may be more likely to disregard religious teachings and socialization in their decision-making, thus being more likely to vote for candidates who support access-oriented contraceptive policy. At a state demographic level, this variance may translate to differences in policy.

Moreover, RCT and SCT provide valuable reasoning behind why confidential contraceptive coverage and access is so critical for insured dependents. Young adults and minors seeking contraceptive care may be subject to social and familial consequences if the pursuit or receipt of such care is disclosed to parents/guardians (namely, policyholders). Contraceptive confidentiality laws provide an avenue for individuals to receive care without concern over the privacy of their health information.

Implications for Policy and Practice

Higher levels of religiosity are associated with certain favorable reproductive health outcomes, including reduced instances of unintended pregnancies.[40,41] However, this study suggests that increased religiosity is also correlated with less access-oriented contraceptive policy. As such, while religiosity can positively influence certain health behaviors, its impact on policy may contradictingly simultaneously create barriers to contraceptive access. Understanding the influence of religiosity on contraceptive policy can also help in designing targeted interventions and advocacy strategies. For instance, in states with high religiosity, efforts to increase policy support might focus on reframing the benefits of contraceptive access in ways that resonate with religious values, such as emphasizing family health and well-being.

Limitations

US Census Bureau data is self-reported, and thus subject to recall bias and participants potentially not fully understanding questions and/or options given. Despite the census' extensive reach, certain populations can remain underrepresented, especially with surveys conducted outside of the 10-year interval. The Household Pulse Survey was developed rapidly by the US Census Bureau and National Center for Health Statistics to measure social and economic

response to the Coronavirus pandemic. The survey's entirely online administration risks excluding those with limited internet access, including older adults, low-income, and rural households.

Survey participants may also misapprehend questions to be as much about their public and self-image as actual attendance (eg., *How often do you attend services?* → "*Are you a good Christian?"*). This potential bias is compounded on surveys about religious behaviors since religious service attendance is generally regarded as a positive, prosocial behavior, which individuals tend to over-report.[42,43] Notably, however, over-reporting bias is mitigated when online surveys are used in place of live or telephone interviews, the former of which is the instrument employed in the dataset used.

Religious traditions that count membership upon or soon after birth, such as Catholicism, Judaism, and Islam, tend to have less frequent service attendance than groups where members achieve their status later in life, such as Mormons and Christian Evangelical sects. Correspondingly, some states, based on high populations of religious affiliations with regular service attendance, might have data that more so reflects their affiliation, a sociological category, versus religiosity, a behavior. For instance, from 2021-2023, 67% of Mormons/Latter Day Saints (LDS) attended services at least almost every week, compared to 44% of Protestant Christians, 38% of Muslims, 33% of Catholics, and 22% of Jews.[44] Therefore, Utah and Idaho, which have a larger percentage of residents who are members of the LDS Church than other states, might have higher rates of service attendance on a purely denominational basis.

Future Research Directions

Reproductive health policy is a highly contentious, rapidly evolving legislative issue in the US. Future research employing a longitudinal lens to explore changes in religiosity and

policy over time is needed. The same lens of state religiosity may also be applied to examine the relationship with other family planning policies, particularly in the aftermath of the *Dobbs v. Jackson* (2022) decision handing abortion policy back to the states. Further investigation may also illuminate how these factors intersect to shape maternal health outcomes.

VII. Acknowledgements

I extend tremendous gratitude and thanks to my mentor, Dr. Roxanne Mirabal-Beltran, whose expertise as a researcher and clinician has proven invaluable to this project. Thank you to Colleen Dougherty and the dedicated staff at the Center for Research and Fellowships for their support throughout the research process, as well as fellow members of this year's fellowship cohort. I would also like to thank Megan Hunt, Data and Public Policy Librarian at Lauinger Memorial Library, as well as Dr. Nancy Crowell from Georgetown University Medical Center, for her expert statistics guidance. Finally, I would like to extend my gratitude to the Laidlaw Foundation, whose funding has provided me with the dedicated time and resources to pursue the fellowship this summer.

VIII. Appendices

Appendix I. Religious Groups and Family Planning Beliefs

Catholic catechism opposes nearly all contraceptive methods, guided by the belief that they interfere with the procreative purpose of sex.[45] Evangelical Protestants—theologically and socially conservative—are the only major religious group opposed to a federal no-cost contraceptive guarantee.[46] On the other hand, mainline Protestant and Methodist theology leans in support of family planning and contraceptive use among married couples, and in some cases for all couples.[47] The Southern Baptist Convention passed a resolution in favor of legalizing abortion in 1971, and twice again in 1974 and 1976. It wasn't until the 1980s that their stance on reproductive politics—spurred by concern over the great replacement theory—changed.[48] Judaism serves as a rare example of a theology that is decidedly pronatalist yet also overwhelmingly in support of reproductive freedom, championing access to contraception and prioritizing the life of the mother. And though the political interpretation of Islamic law varies, Islam similarly permits family planning alongside its encouragement of childbearing.[49]

Appendix II. Table 1: Federal Confidentiality Legislation

Legislation or Program	Scope		Federal Code
	Minors	Young Adults	
Health Insurance Portability and Accountability Act (HIPAA)[50]	● Protects privacy of individually identifiable health information ● Minor's health information may be kept confidential from parents/guardians under the following circumstances ○ The minor, as an individual, consents to care, OR ○ Care is court-directed or ordered, OR ○ Parent agrees to confidentiality ● Parent/guardian access to information may be denied if a health care professional determines it would cause substantial harm to the minor or another individual	● Covered entities—including healthcare providers and insurers—must implement safeguards to protect the confidentiality of protected health information (PHI) ● Individuals have access to their own PHI ● Individuals may request additional restrictions on the disclosure of PHI and that communications regarding their PHI occur through an alternative means or to another address	45 C.F.R. § 164.502(g)(3) and (5) 45 C.F.R. §§ 164.524(a)(3)(iii)
Title X Family Planning Program	● Information about family planning services, including contraceptives, received at Title X-funded sites is confidential and may only be disclosed under the following circumstances: ○ Minor's permission, OR ○ If required by law	● Information about family planning services, including contraceptives, received at Title X-funded sites is confidential and may only be disclosed under the following circumstances: ○ Patient's permission, OR ○ If required by law	Public Health Service Act, Section 1001 (42 U.S.C. § 300)
Medicaid	● Ensures confidentiality for minors receiving Medicaid-covered	● State Medicaid plans are required to protect applicant and enrollee	Social Security Act, Section

	services, including those related to sexual and reproductive health	confidentiality	1902(a)(7) (42 U.S.C. § 1396a(a)(7))
Family Educational Rights and Privacy Act (FERPA)	● Parents/guardians have access to minor's education records ● Information regarding health services provided by a school may be included in educational records, thus subject to FERPA, not HIPAA	● Parents/guardians do not have access to education records of non-minor children aged 18 and older ● Information regarding health services provided by a school may be included in educational records, thus subject to FERPA, not HIPAA	20 U.S.C §1232g, 34 C.F.R. Part 99; 45 C.F.R. § 160.103
Federally Qualified Health Centers	● Adhere to strict confidentiality requirements that allow minors to receive care, including reproductive health services, without parental consent	● Adhere to HIPAA and state confidentiality requirements, ensuring confidentiality of PHI and reproductive health services	Section 330 of the Public Health Service Act (42 U.S.C. § 254b)

Appendix III. Table 2: State Contraceptive Policy Pertaining to Insured Dependents

State	Contraceptive Policies for Insured Dependents			Final Policy Code
	Requires confidential dissemination of information to dependents from insurance companies	Confidentiality protections specific to EOB forms	Broader protections for minors insured as dependents applicable to contraceptive coverage	
Alabama	-	-	-	Not Present (0)
Alaska	-	-	-	Not Present (0)
Arizona	-	-	-	Not Present (0)
Arkansas	-	-	-	Not Present (0)
California	X	-	-	Present (1)
Colorado	X	-	-	Present (1)
Connecticut	-	-	-	Not Present (0)
Delaware	-	-	-	Not Present (0)
District of Columbia	-	-	-	Not Present (0)
Florida	-	-	-	Not Present (0)
Georgia	-	-	-	Not Present (0)
Hawaii	-	-	‡	Not Present (0)
Illinois	§	-	-	Not Present (0)
Indiana	-	-	-	Not Present (0)
Iowa	-	-	-	Not Present (0)
Kansas	-	-	-	Not Present (0)
Kentucky	-	-	-	Not Present (0)
Louisiana	-	-	-	Not Present (0)
Maine	-	-	X	Present (1)
Maryland	X	-	-	Present (1)
Massachusetts	X	X	-	Present (1)
Michigan	-	-	-	Not Present (0)
Minnesota	-	-	-	Not Present (0)
Mississippi	-	-	-	Not Present (0)

Missouri	-	-	-	Not Present (0)
Montana	-	-	-	Not Present (0)
Nebraska	-	-	-	Not Present (0)
Nevada	-	-	-	Not Present (0)
New Hampshire	-	-	-	Not Present (0)
New Jersey	-	-	-	Not Present (0)
New Mexico	-	-	-	Not Present (0)
New York	-	**	-	Not Present (0)
North Carolina	-	-	-	Not Present (0)
North Dakota	-	-	-	Not Present (0)
Ohio	-	-	-	Not Present (0)
Oklahoma	-	-	-	Not Present (0)
Oregon	X	-	-	Present (1)
Pennsylvania	-	-	-	Not Present (0)
Rhode Island	-	-	-	Not Present (0)
South Carolina	-	-	-	Not Present (0)
South Dakota	-	-	-	Not Present (0)
Tennessee	-	-	-	Not Present (0)
Texas	-	-	-	Not Present (0)
Utah	-	-	-	Not Present (0)
Vermont	-	-	-	Not Present (0)
Virginia	-	-	-	Not Present (0)
Washington	X	X	X	Present (1)
West Virginia	-	-	-	Not Present (0)
Wisconsin	-	**	-	Not Present (0)
Wyoming	-	-	-	Not Present (0)

[§] Illinois state law includes the same requirement, but exclusively for Medicaid participants, which accounts for 16.4% of those with health insurance in the state.[51] Given that the large majority of insured dependents are unaffected, Illinois was coded as not present.

[**] Insurance providers in New York and Wisconsin are not required to send policyholders EOBs if there is no balance due. However, this legislation more accurately closely reflects one's financial status versus dependent status because if there is an unpaid balance, there is no avenue for dependents to request confidential communication. As such, both states were coded as not having relevant legislation.

[‡] Hawaii requires health care providers to inform insurers when “minors without support” (eg., emancipated minors living independently) request confidentiality. Since the large majority of insured dependents are unaffected by this policy, it was coded as not present.

Maine state law permits any minor to refuse a parent/guardian’s request to access EOBs, including any claims made to the insurance company and the corresponding denials—for all services, including contraceptive care. Since the law affords expansive privacy protections to a non-insubstantial portion of dependents in the state, it was coded as present.

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