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Policy Options to Improve Insurance Coverage of Vasectomy

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CONTENTS

KEY TAKEAWAYS

- Vasectomy is an effective, safe, and cost-effective contraceptive method, but it is the chosen contraceptive method for only a third as many couples as female sterilization (9% versus 28%).
- While most private U.S. health plans must cover other types of contraception without out-of-pocket costs for patients, there is no similar nationwide requirement for vasectomy.
- High deductibles and coinsurance for outpatient procedures could result in couples spending upwards of $1,000 for a vasectomy, creating a financial disincentive to choose this method over methods like female sterilization.
- There are several potential pathways to a federal requirement to cover vasectomy without cost-sharing, but progress has been stymied by obstacles in how the current federal law was designed and by gridlock in Congress.
- Eight states have enacted requirements for the health insurance plans they regulate to cover vasectomy without cost-sharing; this is a promising direction for additional states, but states do not have the authority to regulate self-funded health plans, which dominate the current landscape.
- There may be opportunities to improve vasectomy coverage by influencing the voluntary practices of health insurance companies and large employers, either directly or through health plan and business associations.

INTRODUCTION

Vasectomy is a highly effective and highly safe method of contraception, and one of the few that can be used by men. Unlike other male-controlled options such as external ("male") condoms and withdrawal ("pulling out"), vasectomy is permanent and does not require ongoing awareness and action to use correctly and effectively. Despite these qualities, vasectomy is underutilized in the United States and abroad, particularly by comparison to female surgical sterilization and intrauterine devices (IUDs)—methods that are similar in their effectiveness and "set and forget" nature.

There are multiple barriers to vasectomy use that may contribute to this disparity, including cultural attitudes about who should take responsibility for contraception and wider disparities affecting men's access to and use of healthcare in the United States. But one clear hurdle is economic: Under current U.S. law, most privately insured women have coverage for contraception without any out-of-pocket costs, such as copayments, co-insurance, or deductibles. By contrast, these protections do not extend to privately insured men for vasectomy. This disparity in coverage sets up a clear economic incentive for couples to choose other contraceptive options over vasectomy, even when vasectomy might otherwise better fit their needs and preferences.

Unfortunately, there is no clear path to fixing this coverage disparity under current U.S. law, as established by the Affordable Care Act (ACA) of 2010 and as interpreted by three successive presidential administrations. Instead, advocates are faced with options that are daunting or limited, including attempting to revise U.S. law through a divided Congress, passing new state-level requirements that will only affect a subset of health plans, or working to directly influence the practices of insurance companies and large employers. Despite their flaws, these options all have the potential to improve vasectomy coverage for millions of men and their partners.

FIVE REASONS WHY INSURANCE SHOULD COVER VASECTOMY WITHOUT COST-SHARING

1. Vasectomy is highly effective

Vasectomy is one of the most effective forms of contraception. Only 15 out of 10,000 women (0.15%) who rely on their partner's vasectomy as their primary method of birth control will become pregnant during the first year of use, a figure that surpasses the effectiveness of female surgical sterilization (0.5%) and rivals contraceptive implants (0.1%) and hormonal IUDs (0.1% to 0.4%).[1] Vasectomy—like those other permanent or long-term methods—is also about as effective in practice (what researchers call "typical use") as it is in theory in ideal situations ("perfect use"). By contrast, methods like birth control pills and condoms are considerably less effective in the real world (with failure rates of 7% and 13%, respectively, in typical use), because of the potential for user error, such as forgetting to take a pill every day or allowing a condom to slip or tear.

2. Vasectomy has health benefits

What this means in practice is that couples who use vasectomy are extremely unlikely to experience an unwanted pregnancy. Preventing pregnancy is the primary reason people use contraception (85% of women say they use it partially or entirely for that reason[2]), and it is therefore an important health benefit in its own right. Beyond that, pregnancy prevention has other major health benefits for women: It protects them against the inherent risks of pregnancy up to and including maternal mortality and is especially important for the health of women with serious medical conditions, such as diabetes or hypertension, that can be complicated by a pregnancy.[3] Therefore, even though vasectomy is a medical procedure for men, it has direct health benefits for their female partners.

3. Vasectomy is safe, simple, and minimally invasive

Vasectomy is an outpatient procedure conducted with local anesthesia, in which a clinician cuts or seals off the tubes (vas deferens) that transport sperm.[4] The procedure has a quick recovery time (several days of limited activity and about one week of avoiding sexual activity). Moreover, vasectomy is a common and safe procedure, with a low risk (1-2%) of complications or side effects.[5] Contrary to some men's fears, it has no effect on sexual performance, and severe or chronic pain is very rare.

Vasectomy has relatively few drawbacks, compared to other contraceptive methods. One short-term issue is that it can take several months before a vasectomy is fully effective and a clinician can confirm that sperm has been cleared from the patient's semen, meaning that couples must use another method of contraception in the meantime. Another potential drawback is the possibility that a patient may later experience regret over their decision.[6] (Vasectomy can in some cases be reversed, but it is intended to be a permanent procedure.)

The safety profile of vasectomy combined with its limited set of complications, side-effects, and drawbacks make it a safer and less invasive option than female sterilization procedures (which, to be clear, themselves have few complications).[7] Vasectomy also compares favorably in many ways to the reversible hormonal contraceptives that most women rely on, which have a longer list of contraindications and potential side-effects.[8]

4. Vasectomy is highly cost-effective

Generally speaking, a vasectomy procedure can cost upwards of $1,000, although insurance coverage can cover most of that amount.[9] For example, one study found that in 2015, the procedure cost an average of $938, although (like all medical procedures) that varied widely by region and setting.[10] That is comparable to the cost of an IUD and its insertion, and generally lower than the cost of female sterilization.

Notably, despite its fairly high one-time cost, vasectomy is among the most cost-effective contraceptive methods, because of its high effectiveness and the lack of ongoing costs.[11] One study found that vasectomy was the single most cost-effective method by the third year of use: slightly better than IUDs and contraceptive implants and roughly four times as cost-effective as female sterilization procedures.[12]

It makes no financial sense for the U.S. healthcare system to favor female sterilization over vasectomy. However, as discussed below, most U.S. insurance plans are not required to cover vasectomy or to cover it on the same terms as they must cover other contraceptive methods, free of patient cost-sharing. So, in practice for many couples, vasectomy may have sizable costs that they would not face with any other contraceptive option.

5. Covering vasectomy would promote gender equity

According to the most recent national survey data from 2018, about 4.1 million women, amounting to less than 9% of women aged 15-49 who use contraception, rely on their partner's vasectomy as their primary method of contraception (see Fig 1).[13] By comparison, 28% rely on female sterilization, 21% on oral contraception, and 16% on IUDs or implants.

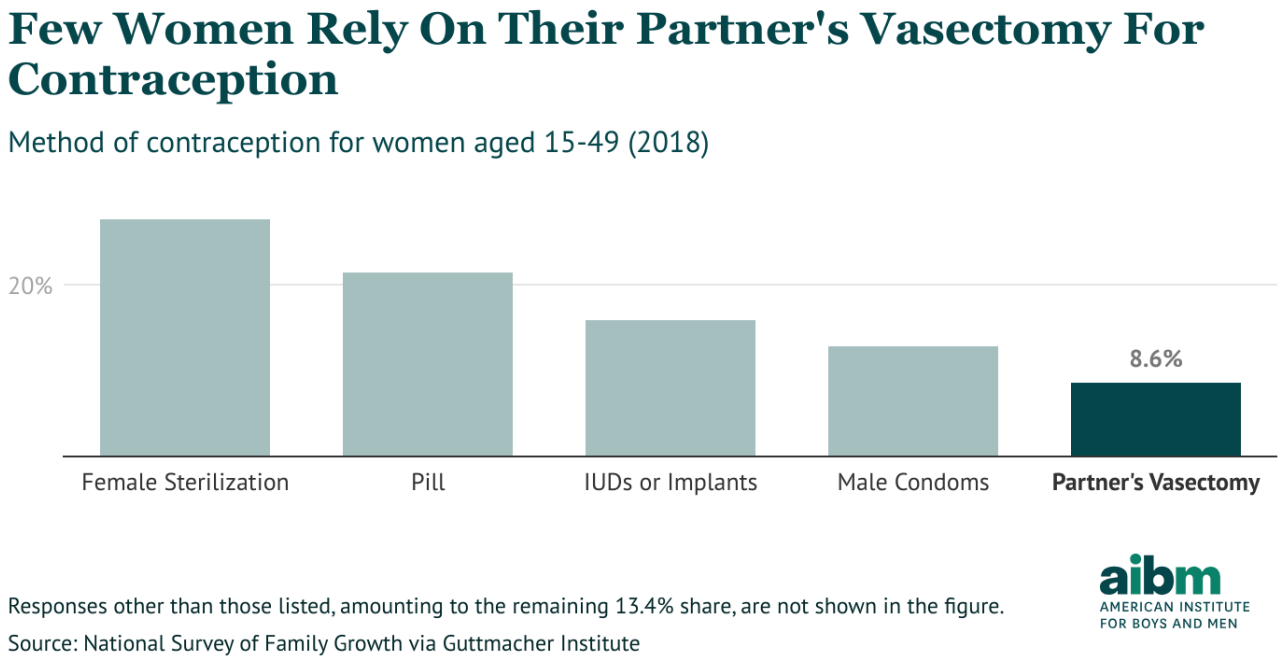

Figure 1

This low level of vasectomy use is not inevitable. In several other industrialized countries, including Canada, Ireland, South Korea, and the United Kingdom, more couples rely on vasectomy than female sterilization, as Figure 2 shows.[14]

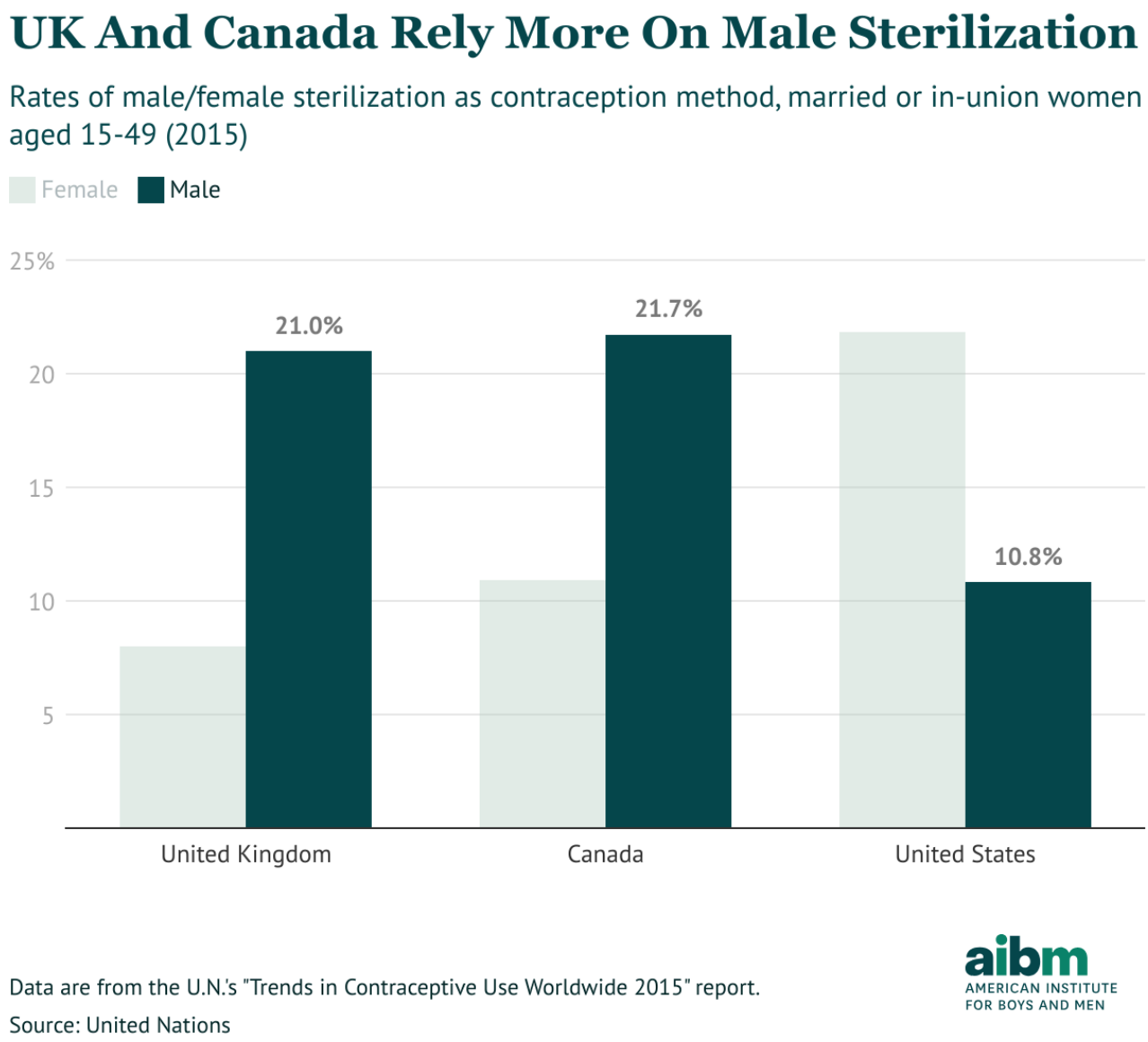

Figure 2

WHO GETS A VASECTOMY?

In the United States, vasectomy use increases with age, as individuals and couples decide they do not want any or any more children, and is also more common among higher-income people and those with college degrees. There also appears to have been a spike in interest in vasectomy after the Supreme Court's 2022 decision eliminating U.S. abortion rights, indicating that societal attitudes can shift.[15]

One recent study identified an increase in the vasectomy rate among privately insured U.S. men between 2014 and 2021.[16] It noted that among other potential reasons for the increase, providers may have been influenced by December 2012 guidelines from the American Urological Association, which stated that "vasectomy should be considered for permanent contraception much more frequently than is the current practice in the United States and most nations of the world."[17]

However, there are clear, long-standing cultural and societal factors that place the burden of contraception primarily on the shoulders of women. Some of that comes from serious threats of reproductive coercion, which means that some women do require contraception that they can fully control and possibly conceal from their partners.[18] However, many women would prefer for their partners to share the responsibility for contraception and would trust them to do so. Covering vasectomy under health insurance on equal terms as female-controlled contraceptive methods would be an important step toward encouraging a more equitable balance of this responsibility.

INSURANCE COVERAGE FOR VASECTOMY

Affordable Care Act requirements

The ACA expanded coverage for contraception nationwide, by requiring most private health plans in the United States to cover the full range of contraceptive methods used by women, without copayments, coinsurance, or deductibles.[19] This requirement generally applies to health plans purchased by an employer or school for their employees or students, and those purchased by individuals and families, including on the ACA's health insurance marketplaces.

However, as noted above, the ACA treats vasectomy differently from other forms of contraception: As interpreted by the federal government under the Obama, Trump, and Biden Administrations, the ACA's requirement does not apply to sterilization surgery for men.[20] Therefore, there is no nationwide requirement for health plans to cover vasectomy, and plans are generally free to impose cost-sharing on vasectomy if they do cover it.

This disparity in coverage is essentially an oversight by Congress in crafting the ACA. The drafters of the law knew they wanted health plans to cover a wide range of preventive care services and to do so without cost-sharing. That is because a wealth of research had found that even small copayments reduced people's use of necessary preventive care, particularly among lower-income patients.[21] Rather than including a long list of specific preventive services in the law, Congress wanted to defer to outside experts, who could update that list regularly according to the latest medical science.

To this end, the ACA required health plans to cover every preventive service included in four sets of recommendations.[22] Two of them apply to patients broadly: preventive services given an A or B recommendation by the U.S. Preventive Services Task Force (USPSTF)[23] and vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.[24] Another long-standing set of recommendations was designed for children: the Bright Futures guidelines led by the American Academy of Pediatrics, with support from the federal government.[25]

The fourth set of recommendations is for preventive care and screenings specifically for women, as supported by the Health Resources and Services Administration (HRSA), a branch of the Department of Health and Human Services (HHS). Because these recommendations had not been developed prior to the ACA, HRSA has commissioned groups of outside experts to develop them, most recently through the Women's Preventive Services Initiative (WPSI).[26] It is those recommendations that included contraceptive services and supplies, triggering the nationwide contraceptive coverage requirement. Yet, because that provision of the ACA covers services "with respect to women," HRSA has determined it does not extend to vasectomy, as a sterilization procedure for men.

Congress included the women-specific recommendations in the ACA in response to clear evidence that health plans had excluded or restricted coverage for many services that are needed primarily or exclusively by women, including contraception and maternity care. State and federal policymakers and healthcare advocates had been working for decades to address these problems. Those same policymakers and stakeholders had not identified similar gaps in coverage for services used by men.[27]

Coverage before and after the Affordable Care Act

Several national surveys from the decades prior to the ACA found that both female and male sterilization procedures were routinely covered by private insurance plans in the United States, most recently by 89% of employment-based health insurance plans in 2002.[28] These findings reflected broader trends in U.S. health insurance plans, which routinely covered surgical procedures but were less consistent in their coverage of prescription drugs and devices, including many reversible contraceptives.

Coverage for both female and male sterilization have also been standard in state Medicaid plans for many decades. Every state that responded to a 2021 survey of state Medicaid policies reported that they were covering these procedures, and as required under federal Medicaid law, they were doing so without any out-of-pocket costs for patients.[29]

There have been no nationwide studies looking at coverage of specific contraceptive methods since the ACA's requirement was implemented. Given that coverage of vasectomy was already routine in private health plans before the ACA, it seems likely that plans continue to cover the service at high rates. One sign of continued coverage is the recent trend data described above that shows a growing use of vasectomy among privately insured men.[30]

However, in the absence of a federal requirement to eliminate cost-sharing for vasectomy, it also seems likely that plans continue to charge copays and/or coinsurance for the procedure and to apply it to an enrollee's deductible. That assumption is supported by anecdotal evidence from media reports and publicly available health plan documents. In addition, one study found that in 2015, privately-insured vasectomy patients paid an average of $173 in out-of-pocket costs at an office setting and $356 at an ambulatory surgical center.[31] However, additional research on the subject would be helpful to confirm health plan practices and cost-sharing levels.

Cost-sharing can be a major expense. As of 2024, 87% of covered workers in employer-sponsored health plans had a deductible, at an average of nearly $1,800 for single coverage and roughly double that for family coverage.[32] If an enrollee has had few other healthcare expenses that year, the entire cost of a vasectomy could be applied to the deductible, meaning they would pay for the procedure fully out of pocket. Even if an enrollee has met a deductible, they would likely be faced with a sizable amount of coinsurance. More than 70% of covered workers had to pay coinsurance for outpatient surgery in 2024, at an average rate of 20% of the procedure's cost. That would translate into $200 for a $1,000 procedure. The average copay for an outpatient procedure is similar ($216).

State-level requirements

State-level policymakers and advocates have worked in recent years to expand on the ACA's contraceptive coverage requirements, including by requiring coverage of vasectomy without cost- sharing. As of 2024, at least eight states specifically require state-regulated insurance plans to cover male sterilization without cost-sharing (see Figure 3): California,[33] Illinois,[34] Maryland,[35] New Jersey,[36] New Mexico,[37] Oregon,[38] Vermont,[39] and Washington.[40]

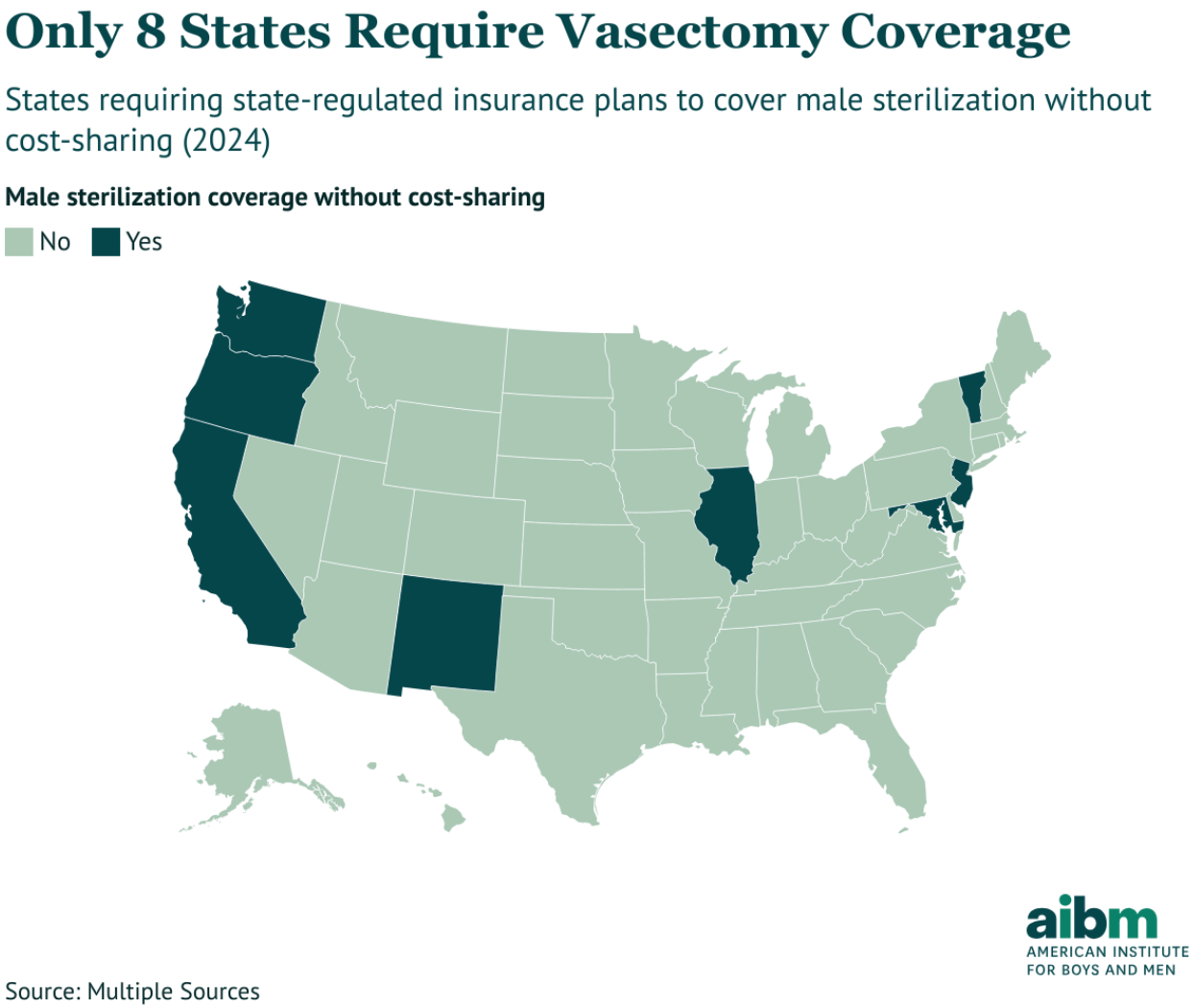

Figure 3

These requirements apply to millions of state residents, and they set an important precedent for other states and for the nation. However, they do have several major limitations, and there has not yet been any published research to determine whether they have been effective.

First, states only have the authority to regulate fully insured private health plans. They cannot regulate so-called self-funded health plans, under which an employer pays directly for some or all of the enrollees' healthcare expenses, rather than purchasing coverage from an insurance company. As of 2024, 63% of covered workers are in self-funded plans, which can only be regulated by the federal government.[41]

Second, the state vasectomy coverage requirements have run afoul of another quirk in federal law that governs High-Deductible Health Plans (HDHPs). These plans allow enrollees and their employers to contribute money to a tax-free Health Savings Account (HSA) that they can use for healthcare expenses, but the plan must maintain a high deductible. Preventive care is exempt from the deductible requirement, but the Internal Revenue Service (IRS) ruled in 2018 that vasectomy did not count as preventive care for this purpose.[42] This ruling has effectively required states to carve HDHPs out from their vasectomy coverage requirements, thereby further limiting their scope. As of 2024, 21% of covered workers were in HDHPs with HSAs.[43] (That percentage overlaps with the percentage in self-funded plans, who would be exempt from state regulation anyway.)

POLICY OPTIONS

There are strong reasons why health plans should cover vasectomy on the same terms as other forms of contraception, without any out-of-pocket costs for patients. As described above, the current disparity in what is required under the ACA has set up an economic incentive for couples to choose female sterilization and other contraceptive options instead of vasectomy, even when vasectomy might otherwise be a better fit for that couple's needs and preferences and might be more cost-effective for the healthcare system.

What is less clear is how to achieve this goal on a universal basis in the United States. There are potential options at the federal, state, and private-sector levels, but all have significant pros and cons, as described below.

Federal Options

Option 1: Reinterpreting the ACA Requirements

There are at least two major lines of reasoning for arguing that the ACA's contraceptive coverage requirement should extend to vasectomy (as well as any forms of male-controlled contraceptives developed in the future).

First, vasectomy can be rightfully designated as preventive care for women. Despite it being a procedure performed on a man, the benefits of preventing unwanted pregnancies accrue to both halves of a couple, and the additional health benefits accrue only to the woman. By that logic, vasectomy can indeed be classified by HRSA as preventive care "with respect to women."

Second, the federal administration could decide that coverage of a male-controlled contraceptive method like vasectomy is required under the ACA as a matter of gender equality and nondiscrimination, because health plans are required to cover female-controlled contraceptive methods. Notably, another provision of the ACA (Section 1557) bars discrimination on the basis of sex and pregnancy (among other characteristics) in many healthcare programs and activities.[44]

Pros: Reinterpreting the ACA in this manner would affect private plans nationwide, including self-funded plans that states cannot regulate. In addition, it would not require legislation, so this could be done without the need for Congress to act.

Cons: Three successive presidential administrations have consistently staked out the opposite position, that the ACA contraceptive coverage requirement excludes vasectomy. The Biden Administration did reverse an earlier position on coverage of male condoms, which is a precedent for change. Nevertheless, it has been 13 years since the contraceptive coverage requirement was established, and advocates' arguments have not been convincing in all that time, even under presidential administrations supportive of sexual and reproductive health and rights.

Option 2: Securing a USPSTF recommendation

Even if HRSA continues to opt against reinterpreting the ACA's women's preventive services requirement, there is another potential avenue for vasectomy coverage under the current ACA statute: an A or B recommendation by the USPSTF. If that expert body were to issue a positive recommendation on vasectomy as a preventive service, it would trigger a nationwide requirement to cover vasectomy without cost-sharing.

In fact, the USPSTF has taken action before to address gender equality in a preventive services recommendation: In 2011, HRSA's new women's preventive services recommendations included routine HIV screening for women; in 2013, the USPSTF updated its own recommendations to include routine HIV screening for adolescents and adults of any gender, thereby extending the recommendation—and the ACA coverage requirement—to men.[45]

Pros: A USPSTF recommendation would trigger a requirement that would affect private plans nationwide, including self-funded plans that states cannot regulate. This path would not require Congress to act, and a presidential administration hostile to contraceptive rights would have difficulty eliminating coverage required because of a USPSTF recommendation.

Cons: The USPSTF has not made a recommendation related to contraception since the 1990s (when it had a recommendation related to contraceptive counseling) and has shown no interest in addressing the topic. The USPSTF also appears resistant to making recommendations specifically for the purpose of triggering a coverage requirement under the ACA, instead preferring its pre-ACA mission of making recommendations to primary care providers about clinical preventive services.

The task force's standards would make it difficult to secure a recommendation for vasectomy in particular.[46] The USPSTF has traditionally focused on screenings, preventive medications, and counseling, and vasectomy procedures do not fit under these categories. Moreover, the panel would want to see strong evidence that vasectomy specifically has health benefits (as opposed to contraception in general), and it would need to accept the concept of health benefits for someone other than the patient receiving the recommended service (although there is precedent there with maternal health services, which benefit infants).

In addition to these other barriers, an ongoing court case, Braidwood Management v. Becerra, is threatening to eliminate the ACA's requirement to cover USPSTF- recommended preventive services.[47]

Option 3: Correcting the IRS ruling on HDHPs

Even without reinterpreting the ACA's preventive services requirement, the federal government could address the narrower issue of vasectomy coverage under HDHPs that has tripped up state lawmakers. When the IRS issued its notice in 2018 that vasectomy did not count as preventive care, its explanation was sparse.[48] It simply said that under federal law governing HDHPs, the exception for "preventive care" applies to preventive care as defined in Medicare law (which does not include male contraceptives) and to preventive care "as otherwise provided for by the Treasury Department and the IRS"—and the IRS has not issued any specific guidance saying that male contraceptives count as preventive care.

However, the existing IRS guidance on what constitutes preventive care seems written broadly enough to encompass male contraceptives. Its pre-ACA guidance says preventive care "includes, but is not limited to" a specific list of preventive items, and that it "does not generally include any service or benefit intended to treat an existing illness, injury, or condition."[49] Post-ACA guidance says that any ACA-required preventive care also counts for the HDHP exception.[50] Neither guidance would preclude classifying vasectomy and other male contraceptives as preventive care for the purposes of HDHPs. The IRS could issue guidance to make that explicit.

Pros: The IRS would need only to issue a notice changing its ruling and explaining its reasoning. It would have an impact in the eight states with current vasectomy coverage requirements and potentially in HDHPs issued in other states that want to voluntarily cover vasectomy without cost-sharing.

Cons: This action would not have a direct nationwide impact and would not actually require any plans to cover vasectomy without cost-sharing.

Option 4: Enacting new federal legislative requirements

The most secure approach to requiring vasectomy coverage without cost-sharing nationwide would be through new federal legislation. Congress could take multiple approaches here: It could simply amend the ACA's preventive services requirement to specifically add male sterilization and other male contraceptive methods. It could instead amend federal law to explicitly require every method of female and male contraception (rather than leaving coverage of contraception up to HRSA-supported guidelines). Alternatively, it could change the ACA to add a fifth set of recommendations on preventive services for men or for all people (one that is not tied to the USPSTF, with its limited scope and resources).

Pros: Congress has the authority to require coverage for private health plans nationwide, including those self-funded plans that are beyond state regulation. A statutory requirement would be difficult for a hostile federal administration to undermine or eliminate. It would also be more difficult for courts to overturn, if the law explicitly required coverage of specific contraceptive services and methods (as opposed to delegating that decision to a federal agency or an expert panel, which has been at issue in the Braidwood lawsuit and other recent court cases).

Cons: Congress has been in perpetual gridlock for many years now, and reproductive health-related issues —including not only abortion, but also contraception— have become increasingly partisan and contentious. A legislative fix for requiring vasectomy coverage specifically seems unlikely to pass without a major shift in Congress as well as a supportive Executive branch.

State Options

Enacting new state level requirements

As described above, eight states have already passed laws requiring state-regulated health plans to cover vasectomy without patient cost-sharing. That is a promising start, and many other states could and should follow their example.

Pros: State laws can affect millions of state residents with private insurance, as well as state employees and their families. State laws can also serve as examples for other states, potentially leading to a cascade of new laws in a short few years. In fact, there is evidence from earlier state contraceptive coverage requirements in the late 1990s and early 2000s that state mandates have spillover effects for other states, because of companies that offer coverage nationwide and generally prefer to standardize their offerings.[51] These spillover effects might also affect self- funded plans, because the same insurance companies affected by state requirements also often serve as the third-party administrators (TPAs) used by self-funded employers to manage their health plans.

Cons: One downside of a state legislative approach is that advocates must work state by state. This can be a slow process even in favorable political situations, and some states (such as those run by anti-contraception conservatives) will not want to pass these laws at all. One option for mitigating this problem would be securing the assistance of one or more multi-state associations, such as the National Association of Insurance Commissioners,[52] the National Conference of State Legislatures,[53] the National Governors Association[54], or the Reproductive Freedom Alliance[55]. Political groups such as the governors association for each party are another potential avenue.

In addition, as discussed above, state laws can only affect insured plans, and not the self-funded plans that account for most of the market. And unless the IRS policy discussed above is addressed, states will need to carve out HDHPs from vasectomy coverage without cost-sharing, further limiting the direct impact of their laws.

Private Sector Options

Voluntary action by insurance companies and health plans

Legal requirements are not necessary for health plans to change their practices. Insurance companies and TPAs are always working to update and modernize their health plans, looking for financial and competitive edges. And there is a business case (as well as a healthcare case) for covering vasectomy without cost-sharing, just as there is for covering other forms of contraception.

Business consultants and associations have repeatedly argued, as far back as 2000, for the financial benefits of contraceptive coverage, as well as indirect benefits from averting problems like employee absence and reduced productivity.[56] For example, a 2007 guide on maternal and child health benefits from the National Business Group on Health recommended that employer health plans cover the full range of contraceptive methods—specifically including vasectomy—and to do so with "zero cost-sharing…to avoid real or perceived financial barriers, and to increase utilization."[57] The report cited actuarial estimates by PricewaterhouseCoopers as evidence for the cost-effectiveness of this approach. The Business Group on Health (as it is now known) is a membership association for large employers that focuses on healthcare policy.[58]

Pros: Pursuing change through persuasion can be effective even when federal or state action is stalled. And it would not necessarily require working one health plan at a time. Rather, changing the practices of a few nationwide insurance companies, TPAs, and employers could have wide influence both directly and possibly indirectly, if their competitors decide they need to match their actions. Another tactic would be to partner with associations of health plans or businesses —like the Business Group on Health or the insurer trade group AHIP—encouraging them to influence their members' health coverage policies.

Cons: Despite the possibilities of influencing large companies and associations, this would still result in a patchwork of coverage policies that would leave out many people. Moreover, without an actual legal requirement, this coverage would be unenforceable, potentially leaving enrollees without recourse if denied the coverage they need. In addition, some insurers and businesses might be difficult to persuade, because of ideology or doubts about the financial costs and benefits.

CONCLUSION

None of these policy options are ideal, given their limitations and the barriers to making them happen. In addition, further research is needed to examine health plans' current coverage and cost-sharing policies and to study the implementation and impact of state vasectomy coverage requirements. Nevertheless, it is clear that the current lack of a national coverage requirement for vasectomy is bad for both women and men, and progress on vasectomy coverage is long overdue.

The best approach is likely a multi-pronged one. National-level policymakers and advocates should work to achieve whatever is currently possible, starting with the straightforward but limited correction to the IRS's policy on vasectomy as preventive care in HDHPs. Federal legislation might be valuable as a messaging tool, even if it cannot get through today's Congress. State policymakers and advocates should continue to pursue state-level requirements, where the political environment is favorable. And advocates should seek out opportunities to influence the voluntary practices of health insurers, TPAs, and employers.

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