STATE TELEHEALTH POLICIES RELEVANT TO CONTRACEPTIVE ACCESS

As of September 10, 2021

Telehealth has greatly expanded in the US since the beginning of the COVID-19 pandemic[1] and has proven itself a viable option for folks to obtain contraception. Power to Decide's polling data found that 77% of respondents agree that telehealth is a useful method to get birth control when in-person visits are not possible.

Power to Decide embarked on a project to synthesize, analyze, and visualize state-level telehealth policies pre-COVID and during COVID (the latter of which are temporary unless otherwise noted), with a focus on those that can have an impact on contraceptive access. Our data is largely collected from the Center for Connected Health Policy, and in some cases, directly from state executive orders and regulations.[2] Since these sources are not specific to contraceptive access, we focused on the elements that are necessary to obtain contraception. We created two types of visualizations depicting the telehealth landscape for Medicaid[3] and private payor[4] insurance: maps that, when a specific state is selected, show high-level information; and interactive tables that allow you to compare pre-COVID and during COVID data within and between states. The data presented within our maps and tables answer the following three questions: how is it delivered, who can provide it, and what services are provided? The following provides background on each of the categories, as well as some state trends.

How is it delivered?

Telehealth can be delivered through multiple modalities, or the ways in which a provider and patient can communicate. Our telehealth information includes telephonic, live video, store and forward, and email. For more specific definitions, please read our FAQs and Key Terms.

- Medicaid laws are more expansive than private payor laws in that they are more specific as to what is required to be covered. Many private payor laws will allow coverage of certain modalities but do not require it.
- **There has been a significant increase in coverage of telephonic telehealth during COVID under Medicaid – jumping from two to 49 states and DC. Moreover, five of these states have made this coverage permanent.**
- Under private payor insurance, the number of states requiring coverage increased for all aforementioned modalities during COVID. An exception to this increase is email-based telehealth, which remains at zero.

1 Galewitz P. Telemedicine surges, fueled by coronavirus fears and shift in payment rules. Kaiser Health News. 2020. https://khn.org/news/telemedicine-surges-fueled-by-coronavirus-fears-and-shift-in-payment-rules/. Accessed January 21, 2021.

2 In addition to the Center for Connected Health Policy, we also utilized resources from eVisit, VisuWell, and multiple specific state policies.

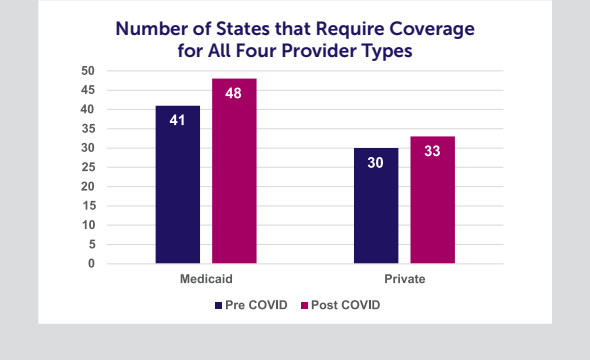
3 Please note that unless we specifically mention Medicaid managed care organizations (MCOs), this data refers to Medicaid fee-for-service plans.

4 While our research focused on state policies regarding private payor coverage of telehealth, it is possible that your insurance company has taken measures beyond what is required by law. Please read this report from the CCHP for an overview of private payor telehealth changes during the COVID-19 pandemic.

Who can provide it?

While there are multiple types of providers who are eligible to provide telehealth, we focused on four that are often involved in providing contraception: physicians, nurse practitioners, physician assistants, and nurse-midwives.

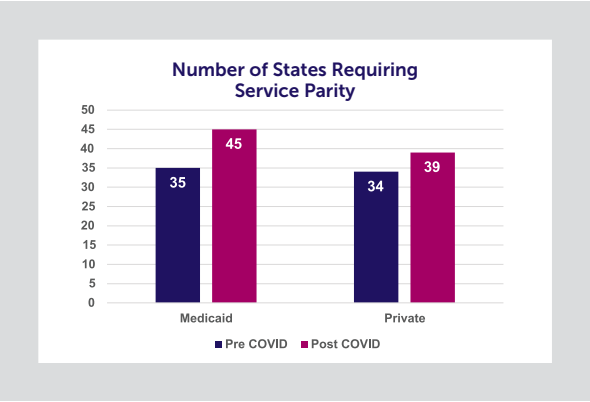
- Under Medicaid, most states (41 including DC) required coverage for all four types pre-COVID. During COVID this increased to 48 states and DC.
- Private payor laws are less clear about providers. Pre-COVID, 30 states (including DC) required coverage for all four types pre-COVID. During the pandemic this has increased by three states, two of which have made this permanent.



What services are provided?

Since most policies and executive orders do not include specific language on services related to contraception, we sought out language about service parity (meaning any services covered for patients in-person must be covered for patients when delivered via telehealth) and online prescribing.

- About two-thirds of states and DC required service parity pre-COVID under Medicaid and private payor laws.
- During COVID, about 90% of states and DC require service parity under Medicaid and three-quarters under private payor insurance.



- A handful of states only require service parity for "medically necessary" services pre- and during COVID, for both Medicaid and private payor insurance.
- Under Medicaid, about two-thirds of states allow online prescribing pre- and during COVID without a prior provider-patient relationship, while about one-sixth do require a prior provider-patient relationship.
- Under private insurance, the number of states allowing online prescribing with no prior provider-patient relationship increased from 26 pre-COVID to 33 during COVID. The number of states requiring a prior provider-patient relationship increased from seven to 12.

Overall, these resources simplify complicated policies so that advocates, public health officials, elected officials, and everyday health care users can more easily understand the telehealth policies that have the potential to affect access to contraception in their states.

Telehealth moving forward

While telehealth shows great promise in increasing access to health care, including contraception, there are also cautions. Power to Decide's polling data revealed gaps in access and knowledge for women with lower income, with 67% of respondents with annual household incomes over $50,000 reporting understanding what telehealth is, compared to only 21% of respondents with annual household incomes under $50,000. Additionally, there are concerns over quality of care, payment parity, HIPAA compliance, individual privacy, and internet access. Ultimately, these issues need to be properly addressed to ensure that telehealth is not only beneficial but also equitable. These are important considerations as states decide whether and in what form to continue temporary telehealth expansions past the COVID-19 pandemic.