

BEYOND THE BELTWAY



State Policies to Increase Information About and Access to Contraception August 2019

When women have the power to decide if, when, and under what circumstances to get pregnant, they have the opportunity to pursue the future they want for themselves. This not only benefits women, but also supports shared goals around workforce readiness, family well-being, and maternal and infant health—while also producing significant savings in publicly funded programs.

Today, not all women have this power. However, policymakers can take proactive measures that help give women access to high-quality contraceptive services. In fact, over the last five years, states have worked to increase information about and access to contraception. Much of this occurred prior to 2017, as states sought to improve health and build on federal policies. Since 2017, Congress and the Trump Administration have acted to undo federal protections for contraceptive coverage and access, which has likely served as a catalyst for the increase in state action.

Notably, most of these policies have bi-partisan support. Sometimes this means bi-partisan support for a specific bill or for a specific policy option within the state; other times it means support for a policy in red and blue states.¹

In addition to the important steps that many states have taken to expand coverage through Medicaid for childless adults and for family planning services, the policies below can each expand information about or access to contraception. Alone, none is a panacea. Importantly, taken together, these policies can help move states in a direction where all women are able to choose from all methods of birth control,¹ giving women the power to decide if, when, and under what circumstances to become pregnant. The public understands that when women have this ability, it affects their educational and economic opportunities.²

The majority (85%) of the public, regardless of race/ethnicity or region of the country, agrees that birth control is a basic part of women's health care. While there is broad, bi-partisan public support for birth control,³ not everyone has access to it, nor does everyone have the same amount of information about the full range of contraceptive methods.⁴ While there has been progress in reducing unplanned pregnancies, disparities remain. In fact, more than 19 million women in need of publicly funded contraception live in contraceptive deserts.⁵ This policy brief describes a number of state policy trends, including legislative and executive or administrative actions grouped into six categories:

¹ This brief covers legislation introduced and/or enacted as of July 15, 2019, unless otherwise noted.

- 1) Insurance coverage for an extended supply of contraception.
- 2) Authorizing pharmacists to prescribe contraception.
- 3) Medicaid reimbursement for postpartum long-acting reversible contraception (LARC).
- 4) Policies that codify or go beyond the Affordable Care Act's contraceptive coverage.
- 5) Expanding access to information for college students.
- 6) Other better birth control policies.

Insurance Coverage for an Extended Supply of Contraception

Insurance plans have typically covered 30- to 90-day supplies of prescription contraceptives at one time. Limiting the supply of prescription contraceptives to these short intervals reduces timely access to contraception and can create gaps in use. Removing this barrier can reduce unplanned pregnancies that result from a delay in accessing contraception. In fact, one study found that a 12-month supply of birth control decreased unplanned pregnancies by 30%, compared with a supply of just one or three months.⁶ That study also found that giving women a one-year supply of birth control reduced the odds of an abortion by 46%. The Centers for Disease Control have found that “the more pill packs given up to 13 cycles, the higher the continuation rates” and has included this in its Select Practice Recommendations.⁷ Additionally, a 2019 analysis from researchers at the University of Pittsburgh and the US Department of Veterans Affairs showed that adoption of 12-month dispensing would result in substantial cost savings and reduction of unplanned pregnancy.⁸

Most of these states enacted legislation requiring insurers to cover 12 months of prescription contraceptives at one time. New Jersey and New Mexico are the exceptions, mandating coverage for six months at one time. The New Jersey legislature originally passed a bill requiring 12 months coverage, but it was reduced after Governor Chris Christie issued a conditional veto stating he would not sign the bill unless it reduced the required coverage to six months. Maryland passed a law in 2016 requiring six months of coverage, but then in 2018 enacted a law requiring 12 months of coverage, effective July 1, 2018 for Medicaid and CHIP, and January 2020 for commercial plans.

Authorizing Pharmacists to Prescribe Contraception

Ten states have enacted legislation or passed regulations allowing pharmacists to prescribe and dispense some hormonal contraceptives, typically self-administered methods (the pill, patch, ring, and shot).ⁱⁱ The idea of having pharmacists prescribe is not new, and not particular to contraception. Many states provide pharmacists with varying levels of prescribing authority.⁹

Pharmacists with prescribing authority can increase access to some forms of contraception for some women. It could be especially useful for women without ready access to a doctor from whom they can get a prescription. This does not make pharmacist prescription a cure-all. Extending prescribing authority does not mean that all pharmacists will participate.

ⁱⁱ Not to be confused with over-the-counter (OTC) access. A report from the Center for Reproductive Rights provides more detail on OTC and pharmacy access

www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_OCOTC_Report_Final_Web_2.16.compressed.pdf

There is not a singular model for delegating prescribing authority to pharmacists. New Hampshire, Tennessee, and Washington have collaborative practice agreements, which require pharmacists to have a supervising physician, whereas, California, Colorado, and Oregon have statewide protocols specifically for prescribing hormonal contraception (among other drugs). Statewide protocols do not require agreements with physicians, as the authority comes directly from the state.

As with any law, implementation is key. California and Oregon, the first two states to enact and begin implementing these laws, have had different experiences with the roll-out lessons from which other states can learn.¹⁰

As other states consider this policy option, there are several factors to weigh. For example, there are some concerns about whether pharmacies will be able to provide a private space for patient counseling and how to handle reimbursement for pharmacists who provide counseling services. Other states considering a policy to increase pharmacy access should bear in mind whether customers can be reimbursed for counseling fees, and the financial burden this may add to uninsured customers.

Medicaid Reimbursement for Immediate Postpartum LARC

Most states have issued guidance allowing Medicaid to reimburse hospitals or other providers for providing LARC immediately postpartum to women who chose them. This could mean reimbursement for the devices (IUDs and implants), their insertion, or sometimes both. This payment is separate from the reimbursement for labor and delivery.^{11,12} Traditionally, fee-for-service Medicaid has made a single global payment for labor and delivery, meaning that providers are not reimbursed for additional costs for insertion of the devices and/or the devices themselves. This created a disincentive for providers to insert LARC devices immediately postpartum and acted as a barrier for women, since the insertion would often be scheduled for a follow-up visit. However, this can often lead to a missed opportunity. Research has shown that nearly one-third of women with Medicaid coverage do not make it back for their postpartum visit.¹³

More generally, it is important to keep in mind that Medicaid is a major financing source for contraception, covering 20% of women of reproductive age, or 13 million people, in 2015.¹⁴ In response to federal guidance issued in January 2018, a number of states have sought changes to their Medicaid programs through Section 1115 Medicaid Demonstration Waivers, including work requirements.¹⁵ Given the complex documentation and administrative processes these entail, some eligible women could lose Medicaid and with it, coverage for contraception.¹⁶

States Codifying or Going Beyond the Affordable Care Act's Contraceptive Coverage Provision

Currently, 15 states have codified the contraceptive coverage provision of the ACA, which requires all non-grandfathered plans to cover all [18 distinct method categories](#), as prescribed, without out-of-pocket (OOP) costs, and reduce administrative barriers for patients.¹⁷

Six of these states (Connecticut, Illinois, Maryland, New Mexico, Oregon, and Washington) have built upon the gains of the ACA by requiring additional coverage

protections, without OOP costs. This ranges from coverage for over-the-counter methods to coverage for vasectomies.¹⁸

Given the uncertainty of protections offered by the ACA, and the future of the law itself, more action at the state level seems likely to both codify the provisions of the ACA's contraceptive coverage provision and expand upon it.

Educating College Students About Unplanned Pregnancy

In 2014, Mississippi was the first state to enact legislation to educate college students about preventing unplanned pregnancy,¹⁹ Arkansas followed in 2015.^{20,21} It is evident other states in the region are taking note, as Texas and Tennessee pursued similar legislation in 2017.^{22,23} These bi-partisan laws direct state higher education entities to work with public universities and community colleges to develop action plans to address the issue. In addition to reducing high teen birth rates among those age 18-19, these initiatives contribute to improving college completion. Louisiana passed a narrower bill in 2017.²⁴

One major difference between the laws in Mississippi and Arkansas is that the former was able to fund community colleges to implement the plans they had developed, providing grants between \$7,000 and \$40,000 for the 2015–2016 academic year. While proposed funding for the 2016–2017 academic year did not make it into the state budget, the state identified other funds to support the activities in 2017.ⁱⁱⁱ Although funding is beneficial, colleges can begin to address unplanned pregnancy using free resources, such as online lessons and other resources available through Power to Decide.²⁵

Other Better Birth Control Policies

This is a broad category we use to describe a variety of policies that aim to increase access to birth control methods, aside from those already mentioned above. Below are a few examples:

Using state funds

Though state budgets are often strained, a number of states have appropriated state funds to increase access to birth control because they understand it is cost-effective to do so. This ranges from one-time supplemental allocations made by Arkansas, Nevada, and Texas, to increasing or restoring annual appropriations for family planning services in Colorado and New Jersey.^{iv}

In 2019, Maryland and Massachusetts passed laws to mitigate the loss of federal funds from the Title X Family Planning Program, after a final rule commonly referred to as the

ⁱⁱⁱ The Department of Human Services provided \$250,000 in available Temporary Assistance for Needy Families (TANF) funds to the Mississippi Community College Board to allocate to community colleges in 2017; funding didn't continue for 2018 but some colleges are continuing their activities.

^{iv} New Jersey appropriated \$7.45 million from the state general fund in FY 2018 for family planning grants. Governor Murphy and the legislature have expressed their commitment to continuing state funding for those grants.

“domestic gag rule” went into effect.^v Massachusetts made an \$8 million supplemental appropriation to be used over the 2019 and 2020 fiscal years.²⁶ Maryland’s law requires the state to stop taking federal Title X funds in fiscal year 2020 and offset federal dollars with state funds. Specifically, the law requires the Maryland Department of Health’s Family Planning Program to continue to be funded at the same overall level it received in fiscal year 2019.²⁷

Using federal funds

In 2018, New Jersey passed legislation directing the states to expand Medicaid family planning services—a smart investment considering the federal government covers 90% of family planning services in Medicaid. This requires the state to submit a proposal to the Centers for Medicare and Medicaid Services (CMS). New Jersey is proposing a Medicaid State Plan Amendment (SPA) to cover people with income up to 200% of the federal poverty level (FPL).²⁸

Some states have directed their health departments to use federal funding to increase access to contraception. For example, Virginia’s 2018–2019 biennial budget includes a pilot program to increase education about and access to LARC.²⁹ The two-year [pilot program](#), funded at \$3 million annually, will use federal TANF funds. It will reimburse providers for the provision of LARCs to patients whose income is below 250% of FPL. The pilot also calls for a plan to improve awareness and utilization of Virginia’s Medicaid Family Planning Program, Plan First, including women who have a diagnosis of substance use disorder who are seeking family planning services. The Virginia Department of Health is tasked with evaluating the effectiveness of the pilot project. Tennessee passed a bill requiring the Department of Health to administer a program to improve information about and access to contraception, with a focus on Voluntary Reversible Long-Acting Contraception, which they call VLARC, using available federal funds.³⁰

Public-private partnerships

In 2016, Delaware launched the Contraceptive Access Now (CAN) initiative with Upstream USA. It includes customized training and technical assistance to health care providers, the elimination of state agency policy barriers, [a consumer-facing public awareness campaign](#), and a rigorous evaluation.^{31,32,33}

In June 2018, the Washington State Department of Health announced [Upstream Washington](#), a statewide partnership with Upstream USA to provide training and technical centers to health centers. The goal is to ensure all women have access to the full range of contraceptive method in a single visit.³⁴

Addressing infant mortality

In working to address their high rates of infant mortality, Ohio passed a bill to implement recommendations from their Commission on Infant Mortality. Among other provisions, the law calls for medical, nursing, and physician assistant programs to train

^v The Domestic Gag rule disallows Title X funding to provide high-quality, affordable contraceptive services in health centers that also offer abortion services, unless those services are offered at a physically separate site. In addition, the rule prohibits health providers at sites that receive Title funds from providing information about abortion alongside other pregnancy options. See more here: <https://powertodecide.org/about-us/newsroom/domestic-gag-rule-challenged-courts-millions-stripped-access-quality-family>

providers on patient contraceptive counseling for patients. It also provides grants for technical assistance to Federally Qualified Health Centers (FQHCs) and FQHC lookalikes interested in promoting awareness and use of LARC and provides for access to LARC at freestanding birthing centers and hospitals.³⁵

Conclusion

States are approaching the goal of expanding information about and access to contraception in a variety of ways. It remains important for states to learn from one another. This is true not just as it pertains to legislation or guidance, but also to the lessons learned from implementation, which can make all the difference when it comes to expanding access.^{vi} Ensuring that everyone has full information about and access to all methods of birth control so they can make the choice best for them will contribute to decreasing unplanned pregnancy, and in turn support broadly shared goals. When women have power to decide if, when, and under what circumstances to become pregnant, we all—women, men, children, and society—stand to benefit.³⁶

^{vi} For example, see ASTHO's Increasing Access to Contraception Learning Community, which convened 25 states and territories to disseminate strategies and best practices to implement policies and programs that increase access to the full range of contraceptive options.

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State	Coverage for an extended supply of Rx contraception ¹	Codifying/ Expanding ACA contraceptive coverage ²	Allowing pharmacists to prescribe contraception	Educating College Students ³	Separate Medicaid Reimbursement for IPP LARC *	Full Medicaid expansion ⁴	Medicaid expansion - family planning services only ⁵
Total	20	15	11	3	44	36	26
Alabama					X		X
Alaska					X	X	
Arkansas				X	X	X	
Arizona					X	X	
California	X	X	X		X	X	X
Colorado	X		X		X	X	
Connecticut	X	X			X	X	X
D.C.	X	X	X			X	
Delaware	X	X			X	X	
Florida					X		X
Georgia					X		X
Hawaii	X		X		X	X	
Idaho					X	X	
Illinois	X	X			X	X	
Indiana					X	X	X
Iowa					X	X	
Kansas					X		
Kentucky						X	
Louisiana				X	X	X	X
Maine	X	X			X	X	X
Maryland	X	X	X		X	X	X
Massachusetts	X	X			X	X	
Michigan					X	X	
Minnesota						X	X
Missouri					X		

Mississippi				X	X		X
Montana					X	X	X
Nebraska					X		
Nevada	X	X			X	X	
New Hampshire	X	X	X		X	X	X
New Jersey	X					X	X
New Mexico	X	X	X		X	X	X
New York	X	X			X	X	X
North Carolina					X		X
North Dakota						X	
Ohio					X	X	
Oklahoma					X		X
Oregon	X	X	X		X	X	X
Pennsylvania						X	X
Rhode Island	X				X	X	X
South Carolina					X		X
South Dakota					X		
Tennessee			X		X		
Texas					X		
Utah			X			X	
Vermont	X	X			X	X	
Virginia	X				X	X	X
Washington	X	X	#		X	X	X
Wisconsin					X		X
West Virginia			X		X	X	
Wyoming					X		X

* This could mean reimbursing hospitals or other providers for the devices (IUDs and implants), for the insertion procedure, or sometimes both. For specific state guidance, see <https://www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC-Medicaid-Reimbursement>

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