State Policies to Increase Information About and Access to Contraception
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The ability to plan pregnancies is directly linked to a wide array of benefits to women, men, children, and society—including fewer unplanned pregnancies, more educational and economic opportunities for young women and men, improved maternal and infant health, greater family well-being, as well as reduced public spending and fewer abortions.

With this in mind, many states are taking positive policy actions to increase information about and access to contraception. 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.[i]

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.[1] 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,[2] 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.[3]

The majority (85 percent) 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, bipartisan public support for birth control,[4] not everyone has access to it, nor does everyone have the same amount of information about the full range of contraceptive methods.[5] 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 desserts.[6] This policy brief describes a number of emerging state policy trends, including legislative and executive or administrative actions grouped into six categories:

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).

[i] This brief covers legislation introduced and/or enacted as of June 30, 2018, unless otherwise noted.

4) Policies that codify or go beyond the Affordable Care Act's contraceptive coverage.
5) Other better birth control policies.
6) Expanding access to information for college students.

Insurance Coverage for an Extended Supply of Contraception

Insurance plans have typically covered 30–90-day supplies of prescription contraceptives at one time. However, these policies can reduce timely access, creating gaps in contraceptive use. In fact, one study found that a 12-month supply of birth control decreased unplanned pregnancies by 30 percent, compared with a supply of just one or three months.[7] The same study also found that giving women a one-year supply of birth control reduced the odds of an abortion by 46 percent. Recognizing this opportunity, 19 states (including DC) have enacted legislation requiring insurers to increase the number of months for which they cover prescription contraceptives at one time.[8]

Most of these states enacted legislation requiring insurers to cover 12 months of prescription contraceptives at one time; New Jersey is the exception, mandating coverage for six months. 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.

At least 10 other states introduced or considered similar legislation in the 2018 legislative session.

Authorizing Pharmacists to Prescribe Contraception

With the addition of New Hampshire, Utah, and Washington, DC, 10 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,iii] 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—but not a cure-all.

[ii] The other states are California, Colorado, Hawaii, Maryland, New Mexico, Oregon, and Tennessee.
[iii] Not to be confused with over-the-counter (OTC) access. The following report from the Center for Reproductive Rights provides more detail on OTC access and pharmacy access: www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_OCOTC_Report_Final_Web_2.16.compressed.pdf.

Extending prescribing authority for pharmacists does not mean that all pharmacists will participate.

There is not a singular model for delegating prescribing authority to pharmacists. New Hampshire, Tennessee, and Washington[iv] 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]

There is a good deal of interest in extending prescribing rights to pharmacists—at least eight other states introduced or considered similar legislation in the 2018 legislative session. As states consider this policy option, there are a number of factors to consider. 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 Postpartum LARC

A diverse range of states—at least 36 including DC—have issued guidance to make it possible for Medicaid to reimburse providers for the insertion of LARC devices (IUDs and implants) in the hospital immediately postpartum, for women who choose them. 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]

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 recent federal guidance, a number of states are seeking changes to their Medicaid programs through Section 1115 Medicaid Demonstration

[iv] Washington state (excluded from the count above) has allowed pharmacists to enter into practice agreements with physicians for some time, but only a small number of pharmacists have agreements allowing them to prescribe contraceptives.

Waivers, including work requirements. Given the complex documentation and administrative processes these entail, some eligible women could lose Medicaid and with it, coverage for contraception.[15]

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

Currently, 12 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. California was the first state to enact such a law in 2014; followed by Maryland, Illinois, and Vermont in 2016; Maine, Massachusetts, Nevada, New York (via regulation), and Oregon in 2017; and Connecticut, Delaware, and Washington in 2018.[16]

Five of these states (Connecticut, Illinois, Maryland, 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.[17]

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[18] and Arkansas followed in 2015.[19,20] It is evident other states in the region are taking note, as Texas and Tennessee pursued similar legislation in 2017.[21,22] 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 18- and 19-year-olds, these initiatives contribute to improving college completion. Louisiana passed a narrower bill in 2017.[23]

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.[v] 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, the campaign to prevent unplanned pregnancy.[24]

[v] 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.

Other Better Birth Control Policies

This 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.[vi]

Using federal funds
New Jersey and Utah passed legislation directing the states to expand Medicaid family planning services—a smart investment considering the federal government covers 90 percent 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's Medicaid State Plan Amendment (SPA) proposes to cover people with income up to 200 percent of the federal poverty level (FPL). Utah passed a bill directing the state to apply for a Medicaid family planning waiver to cover people with income up to 95 percent FPL. If approved by CMS, Utah plans to start providing the coverage on January 1, 2019, unless CMS approves full Medicaid expansion for adults first, since family planning services would be included.[25]

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.[26] 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 percent 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.[27]

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

[vi] New Jersey appropriated $7.45 million from the state general fund in FY 2018 for family planning grants. This supplemental appropriation was made after Governor Murphy came into office; both Gov. Murphy and the legislature are committed to continuing state funding for those grants.

care providers, the elimination of state agency policy barriers, a consumer-facing public awareness campaign, and a rigorous evaluation.[28]

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.[29]

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 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.

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.[vii] Ensuring that everyone has full information about and access to all methods of birth control so they can choose what is 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.[30]

[vii] 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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