

BEYOND THE BELTWAY

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 wellbeing, 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.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,¹ 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,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 (81%) of the public also agrees that birth control is a basic part of women's health care (including 70% of Republicans and 90% of Democrats). While there is broad 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, nearly 20 million women in need of publicly funded contraception live in contraceptive deserts.⁶ This policy brief describes a number of emerging state policy trends, including legislative and executive/ administrative actions grouped into six categories:

- 1) Insurance coverage for an extended supply of contraception;
- 2) Pharmacy access to 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) Other better birth control policies; and
- 6) Expanding access to information for college students.

Insurance Coverage for an Extended Supply of Contraception

Insurance plans have typically covered 30- to 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

¹ This brief covers legislation introduced and/or enacted as of July 1, 2017 unless otherwise noted.

by 30%, 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%. Recognizing this opportunity, 11 states (including D.C.) 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; only Maryland mandates six months of coverage. The New Jersey legislature also passed a bill in 2017, which is currently pending approval by the governor. At least 11 other states introduced similar legislation in the 2017 legislative session.

Pharmacy Access to Contraception

Six states (California, Hawaii, Maryland, New Mexico, Oregon, and Tennessee) allow pharmacists to prescribe and dispense some hormonal contraceptives, typically self-administered methods (the pill, patch, ring, and shot).ⁱⁱ The goal is to provide a convenient way for women to access some forms of contraception. It could be particularly useful for women without ready access to a doctor from whom they can get a prescription—but not a cure-all.

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.⁹

Tennessee’s law, which is currently going through the rulemaking stage differs from others in that it requires pharmacists to have a “valid collaborative pharmacy practice agreement.”¹⁰ Similarly, Washington State has allowed pharmacists to enter into practice agreements with physicians for some time, and a small number of pharmacists have agreements allowing them to prescribe contraceptives. In 2016, legislation was introduced to allow pharmacists to independently prescribe birth control, but as enacted the law is much narrower.ⁱⁱⁱ

There is a good deal of interest in extending prescribing rights to pharmacists—at least eight other states, ranging from Missouri to Massachusetts introduced similar legislation in the 2017 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. The law in Hawaii explicitly states that pharmacists should be reimbursed. There is no reimbursement for pharmacists in California, although they are currently working to address this. In Oregon, there is a one-time fee that ranges from \$35-45, which customers must currently pay for out of pocket. The Tennessee legislation states that pharmacists may charge an annual administrative fee; however, those who have coverage for contraceptive prescription are not required to pay it. The law in Maryland does not require reimbursement for pharmacists or coverage for enrollees in private plans. 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.

ⁱⁱ 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.

ⁱⁱⁱ It calls for the development of a special sticker that can be placed in pharmacy storefront windows to call attention to pharmacists who have practice agreements to prescribe and dispense birth control. The approved sticker can be viewed at: <http://www.doh.wa.gov/Portals/1/Documents/Pubs/690309.pdf>.

Medicaid Reimbursement for Postpartum Long Acting Reversible Contraception (LARC)

A diverse range of states—at least 27 including D.C.—have issued guidance to make it possible for Medicaid to reimburse providers for the insertion of LARC devices (IUDs and the Implant) 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

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

Currently, six 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; and Maine and Nevada in 2017.¹⁴ Oregon passed legislation in July 2017, which the governor is expected to sign.

Four of these states have built upon the gains of the ACA by requiring additional coverage protections, without OOP costs.

- Beginning in 2018, Maryland will require coverage for vasectomies and contraceptive methods available by prescription and over-the-counter, regardless of whether one has a prescription (currently, only emergency contraception). It also prohibits both public and private plans from requiring prior authorization for LARCs.¹⁵
- Similarly, Illinois updated its contraceptive equity law to require coverage for over-the-counter methods (except male condoms).¹⁶
- Among a broad set of protections, Oregon’s law will require private insurers to cover the services under the federal Women’s Preventive Services Guidelines (as of January 1, 2017),¹⁷ including all contraceptive methods available over the counter. It will also appropriate state funds to provide coverage for the aforementioned to women who are of reproductive age but are disqualified from Medicaid due to their immigration status.¹⁸
- Vermont’s law requires all plans to cover vasectomies.¹⁹ Vermont also directed the state’s Department of Health Access to establish and implement value-based payments^{iv} for LARC insertion and removal, and appropriated funds to do so.

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.

^{iv} Value-based payments reward providers for the value of the care they deliver, rather than then the quantity of visits or services (known as fee-for service), which is the way health care payments have traditionally been made. Therefore, value-based payments for LARC insertion and removal should take into account the value of preventing unintended pregnancy.

Educating College Students About Unplanned Pregnancy

In 2014, Mississippi was the first state to enact legislation to educate college students about preventing unplanned pregnancy²⁰ and Arkansas followed in 2015.²¹ 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 18- and 19-year-olds, 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.^v Although funding is beneficial, colleges can begin to address unplanned pregnancy using free resources, such as online lessons and other resources available through The National Campaign.²⁵

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. This can range from filling gaps so that clinics and providers are able to stock the full range of methods to ensuring that providers are trained on insertion of LARC devices. Below are a few examples:

Arkansas passed legislation allowing the Department of Health to transfer \$3.7 million in carry forward funds to be used in FY 2017 at the discretion of the Department Director. The funds are intended to carry out two initiatives—one of which is to provide LARCs through services provided at the Department of Health’s local health units.

For the second year in a row, the Colorado legislature increased the state’s family planning budget to build upon the successful efforts of the Colorado Initiative to Reduce Unintended Pregnancy, which was initially supported by private funds.²⁶ The Colorado Initiative famously helped to reduce the rate of teen births and abortions by nearly half, as well as the abortion rate for women age 20-24 by 18%.²⁷ In addition, the initiative is responsible for reducing racial and ethnic disparities in the teen birth rate.²⁸

In Delaware, Governor Jack Markell used his 2016 State of the State address to announce the launch of the Delaware Contraceptive Access Now (CAN) initiative. The public-private partnership includes customized training and technical assistance to healthcare providers, the elimination of state agency policy barriers, a consumer-facing public awareness campaign, and a rigorous evaluation.²⁹

In 2017, Nevada passed legislation to set aside state general funds in order to provide family planning grants for which there is a great need in some areas of the state.³⁰

^v The Department of Human Services has 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.

Texas passed a provision in the FY 2016-17 budget directing the Department of State Health Services to expeditiously implement program policies to increase access to long acting contraceptives and develop provider education and training to increase access to the most effective forms of contraception, including vasectomy.³¹

Conclusion

States are approaching the goal of expanding information about and access to contraception in a variety of ways. It will be 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. In the coming months, The National Campaign will launch a Better Birth Control best practices framework to assist states and localities that are interested in increasing equitable access to birth control. 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.³²

¹ For states that have expanded Medicaid for childless adults see: Kaiser Family Foundation. (2017) Status of State Action on the Medicaid Expansion Decision. Washington, DC: Author. Retrieved from kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0. For states that have expanded Medicaid coverage for family planning services, see: Guttmacher Institute. Medicaid Family Planning Eligibility Expansions. Washington, DC: Author. Retrieved from www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

² U.S. Food and Drug Administration. Birth Control Guide. Washington, DC: Author. Retrieved from www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM517406.pdf.

³ The National Campaign to Prevent Teen and Unplanned Pregnancy. (2016). Survey Says: April 2016: Our Story + Yours. Washington, DC: Author. Retrieved from <https://thenationalcampaign.org/resource/survey-says-april-2016>.

⁴ The National Campaign to Prevent Teen and Unplanned Pregnancy. (2016). Everyone Loves Birth Control. Washington, DC: Author. Retrieved from <https://thenationalcampaign.org/resource/everyone-loves-birth-control>.

⁵ Shartzter, A., Courtot, B., McMorrow, S., Benatar, S., and Kenney, G.M. (2016). Beyond Birth Control: Family Planning and Women's Lives, Knowledge Gaps and Misinformation about Birth Control Persist in 2016. Washington, DC. Urban Institute. Retrieved from www.urban.org/sites/default/files/alfresco/publication-pdfs/2000918-Knowledge-Gaps-and-Misinformation-about-Birth-Control-Methods-Persist-in-2016.pdf.

⁶ The National Campaign to Prevent Teen and Unplanned Pregnancy. (2016). Birth Control Access Map. Washington, DC: Author. Retrieved from <https://thenationalcampaign.org/resource/accessmap>.

⁷ Foster, D.G., Hulett, D., Bradsberry, M., Darney, P., and Policar, M. (2011). Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies. *Obstetrics & Gynecology*, 117(3):566-572. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/21343759>.

⁸ The National Campaign. Extended Supply of Contraception. (June 2016). Retrieved from <https://thenationalcampaign.org/sites/default/files/resource-primary-download/extended-supply-of-contraception.pdf>

⁹ O'Mara, K. (2016, May 26). It's still hard to get birth control pills in California without a Prescription. *NPR*. Retrieved from www.npr.org/sections/health-shots/2016/05/26/478878991/its-still-hard-to-get-birth-control-pills-in-california-without-a-prescription. Also, see: (2016, March 28). *Science Daily*. Oregon's new birth control law increases access, but more still to be done. Author. Retrieved from www.sciencedaily.com/releases/2016/03/160328114634.htm.

¹⁰ American Pharmacists Association. (2014, July 1). *Pharmacists, prescribers team up for collaborative practice in TN*. Washington, DC: Author. Retrieved from www.pharmacist.com/pharmacists-prescribers-team-collaborative-practice-tn.

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- ¹¹ American College of Gynecologists. (n.d.). Immediate Postpartum LARC Medicaid Reimbursement. www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC-Medicaid-Reimbursement.
- ¹² In April 2016, CMS released an informational bulletin summarizing the payment strategies that states had implemented through 2015 to optimize LARC utilization, including postpartum LARC. See: Centers for Medicare and Medicaid Services. (2016). *State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception*. Retrieved from www.medicaid.gov/federal-policy-guidance/downloads/cib040816.pdf.
- ¹³ John Hopkins Medicine. (2014, February 5). *Fewer than half of women attend recommended doctors visits after childbirth*. www.hopkinsmedicine.org/news/media/releases/fewer_than_half_of_women_attend_recommended_doctors_visits_after_childbirth.
- ¹⁴ Sobel, L., Beamesderfer, A., and Salganicoff, A. (2016). *Private Insurance Coverage of Contraception*. Washington, DC: Kaiser Family Foundation <http://kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception/>.
- ¹⁵ Contraceptive Equity Act, Md. Assemb. H. 1005 (2016) Chapter 437 (Md. Stat. 2018). Retrieved from http://mgaleg.maryland.gov/2016RS/Chapters_noln/CH_437_hb1005t.pdf.
- ¹⁶ Il. § 356z.4. (2016). Retrieved from www.ilga.gov/legislation/ilcs/ilcs4.asp?ActID=1249&ChapterID=22&SeqStart=94000000&SeqEnd=106400000.
- ¹⁷ US Human Resources Services Administration. (2015). Women’s Preventive Services Guidelines. Retrieved from <https://www.hrsa.gov/womensguidelines/>.
- ¹⁸ An act relating to reproductive health care; and declaring an emergency. Or. House. H.B. 3391 (2017). Retrieved from <https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB3391/Enrolled>.
- ¹⁹ An act relating to health insurance and Medicaid coverage for contraceptives. Vt. House. H. 620 (2016) (Vt. Stat. 2016-2017). Retrieved from <http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT120/ACT120%20As%20Enacted.pdf>.
- ²⁰ Mississippi Senate SB 2563. (2014). Retrieved from <http://billstatus.ls.state.ms.us/documents/2014/pdf/SB/2500-2599/SB2563SG.pdf>.
- ²¹ Arkansas House HB 1534 (2015). Retrieved from www.arkleg.state.ar.us/assembly/2015/2015R/Bills/HB1534.pdf.
- ²² Tennessee Senate SB 521 (2017). Retrieved from <http://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=SB0521&GA=110>.
- ²³ Texas Senate SB 2109 (2017). www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=85R&Bill=SB2109.
- ²⁴ Act 321. Louisiana Senate SB 106 (2017). Retrieved from www.legis.la.gov/Legis/ViewDocument.aspx?d=1052203. Note that the bill restricts information about and referrals to certain providers.
- ²⁵ Bedsider.org. Student Sex Life, includes online lessons for college students. Retrieved from www.bedsider.org/studentsexlife.
- ²⁶ In FY 2017, the legislature appropriated \$2.5 million in family planning funds, and \$4 million in the FY 2018 budget. See: <https://rewire.news/article/2017/05/26/colorado-gop-stops-fighting-teen-pregnancy-prevention-program/>.
- ²⁷ Colorado Department of Public Health and Environment. (2017). Taking the Unintended out of Pregnancy: Colorado’s Success with Long-Acting Reversible Contraception. Denver, CO: Author. Retrieved from www.colorado.gov/cdphe/cfpi-report.
- ²⁸ Colorado Initiative to Reduce Unintended Pregnancy. (n.d.) Overview.
- ²⁹ National Institute for Child Health Quality and National Academy for State Health Policy. (2017). State Strategies to Increase Access to LARC in Medicaid: “Contraceptive Access Now and the Expansion of LARC in Delaware”. Retrieved from http://www.nashp.org/wp-content/uploads/2017/04/NASHP_LARC_Delaware-updated.pdf
- ³⁰ Nevada Senate Bill SB 122 (2017). Retrieved from https://www.leg.state.nv.us/Session/79th2017/Bills/SB/SB122_EN.pdf
- ³¹ General Appropriations Act. TX. House HB 1 (2015). Retrieved from www.capitol.state.tx.us/tlodocs/84R/billtext/pdf/HB00001F.pdf#navpanes=0.
- ³² Kaye, K., Gootman, J.A., Ng, A.S., & Finley, C. (2014). *The Benefits of Birth Control in America: Getting the Facts Straight*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy. Retrieved from <https://thenationalcampaign.org/resource/benefits-birth-control>.