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 percent, compared with a supply of just one or three months. The same study also found that giving women a one-year supply of birth control reduced the odds of an abortion by 46 percent. The Centers for Disease Control finds that “the more pill packs given up to 13 cycles, the higher the continuation rates” and has included this in its Select Practice Recommendations.

To improve access to contraception, twelve states (including D.C.) have enacted legislation requiring insurers to increase the number of months for which they cover prescription contraceptives at one time. Half of these bills had bi-partisan sponsors and more than half of the bills passed with bi-partisan support. Except for Maryland, which enacted legislation requiring insurers to cover 6-months of a prescription at once, all other states require insurers to cover 12-months at a time.

Similar to most insurance mandates, these modest proposals have had some push back from insurers. As a result, some states have a requirement that the insured person first receives a smaller supply of the contraceptive before receiving an extended supply. Importantly, none of these laws require providers to prescribe an extended supply of contraception at one time—only that insurers cover the quantity of contraceptives dispensed in accordance with a prescription.

These laws are mostly new and their implementation is ongoing. As states issue guidance and gain experience, we will learn more about how each works in practice. The table that follows offers more details on each state’s bill, which may be helpful as other states move forward on similar measures.
<table>
<thead>
<tr>
<th>State</th>
<th>Law/Guidance</th>
<th>Year Passed</th>
<th>Date By Which Plans Must Comply</th>
<th>Length of Initial Prescription (if required)</th>
<th>Applies to Medicaid?</th>
<th>Other Limits or Features</th>
</tr>
</thead>
</table>
| California | SB 999 (Guidance) | 2016 | January 1, 2017 | N/A | Yes: Medi-Cal Managed Care Plans | • Provides authority to both providers and pharmacists.  
• The state Medicaid Family Planning Expansion, Family PACT, has allowed an extended supply of oral contraceptives for over 25 years, when dispensed at a clinic.  
• The state began requiring Medi-Cal managed care plans to do the same on May 1, 2016, and has since updated the requirements.  
• Does not exclude coverage for contraceptives prescribed for reasons other than a contraceptive purpose. |
| Colorado | HB 1186 | 2017 | January 1, 2019 | 3 months | No | • Applies to CHIP  
• The maximum amount of cycles that can be dispensed at once for the contraceptive ring (Nuvaring) is 3 months.  
• The state already allows a 6-month supply of oral contraceptives for Medicaid beneficiaries. |
| D.C. | B21-0020 (Guidance) | 2015 | January 1, 2017 | N/A | Yes | N/A |
| Hawaii | SB 2319 (private plans) | 2016 | January 1, 2017 | N/A | Yes: Medicaid Managed Care | N/A |
| Illinois* | HB 5576 | 2016 | January 1, 2017 | N/A | No | • The state already allows a 3-month supply of oral contraceptives for Medicaid beneficiaries. |
| Maine* | LD 1237 | 2017 | January 1, 2019 | N/A | No | N/A |
| Maryland* | HB 1005 | 2016 | January 1, 2018 | 2 months | Yes | • Also applies to CHIP |
| Nevada* | AB249(SB 233) | 2017 | January 1, 2018 | 3 months | Yes | • Requires a second dispensing of up to 9 months in the first year, then allows a refill of up to 12 months in subsequent year if insured by the same plan.  
• Also applies to student health insurance policies.  
• The state Medicaid Family Planning Expansion, CCare Program, already requires this. |
<p>| Oregon | HB 3343 | 2016 | January 1, 2016 | 3 months | No | N/A |</p>
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</thead>
<tbody>
<tr>
<td>Vermont</td>
<td>H 620</td>
<td>2016</td>
<td>October 1, 2016 (Medicaid)</td>
<td>N/A</td>
<td>Yes, and any other public insurance plans</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No later than October 1, 2017 (private plans)</td>
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</tr>
</tbody>
</table>
| Virginia  | H 2267       | 2017        | January 1, 2018                 | N/A                                         | No                   | • Does not exclude coverage for hormonal contraceptive when used for reasons other than a contraception.  
• The state already allows 12-months dispensing of oral contraceptives for Medicaid beneficiaries at clinics. |
| Washington| H 1234       | 2017        | January 1, 2018                 | N/A                                         | No                   | • The plan may limit refills obtained in the last quarter of the plan year if a 12-month supply of the contraceptive has already been dispensed during the plan year.  
• The state already allows 12-months dispensing of oral contraceptives for Medicaid beneficiaries. |

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3 Some states, such as Oregon, require the patient to first have an “initial dispensing” of a few months’ worth of a given contraceptive, before receiving a subsequent larger quantity of the same method or therapeutic equivalent. Laws in Colorado and Oregon specify that the covered person can receive the larger quantity, whether or not they were enrolled in the same plan when they received the initial dispensing. While an initial dispensing is not a required practice from the medical community, it is a balance some states have struck in order to assuage insurer concerns.
7 Ibid.
8 Ibid.
9 Ibid.
10 Ibid.