Key State Policies at a Glance

As of July 1, 2017[1]

The policies below help expand access to and information about contraception, but none of them alone is a panacea. Taken together these policies can serve to ensure that all women have access to all methods of contraception, giving women the power to decide if, when, and under what circumstances to become pregnant. [2] 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, and reduced public spending.

Medicaid Expansion

Thirty-two states (including Washington D.C.) have decided to expand Medicaid coverage to childless adults with income up to 138% of the Federal Poverty Level (FPL), as the Affordable Care Act allows and encourages.[3,4] Expanding access to health insurance coverage can help more women access the most effective methods of contraception by removing cost barriers. In 2017, the Kansas legislature passed Medicaid expansion legislation, but the governor vetoed it.

Medicaid Family Planning Expansion Waiver or State Plan Amendment

Twenty-six states have federal approval either through a waiver or state plan amendment to expand Medicaid coverage only for family planning services and family planning related services, to individuals who would otherwise not be eligible for Medicaid coverage.[5] Texas and Missouri operate similar programs that are entirely state-funded. Income eligibility tends to be more generous for family planning expansions than for full scope Medicaid, whether under traditional Medicaid or the Medicaid expansion allowed under ACA (see eligibility levels for parents and childless adults).[6] In 2017, legislation failed in Utah that would have directed the state to seek a federal waiver for family planning.

Medicaid Reimbursement for Postpartum Long-Acting Reversible Contraception (LARC)

At least 27 states (including Washington, D.C.) have issued guidance to make it possible for Medicaid to reimburse for the insertion of LARC devices (IUDs and the Implant), separate from the reimbursement for labor and delivery.[7] Traditionally, fee-for-service Medicaid has issued global payments for labor and delivery, meaning that providers are not reimbursed for insertion of the devices and/or the devices themselves. This is a disincentive to providers and has been a barrier for women who want to receive postpartum LARC.

Pharmacy Access to Contraception

As of 2016, California, Oregon, and Tennessee had enacted legislation to allow pharmacists to prescribe and dispense self-administered hormonal contraceptives. In 2017, Maryland and Hawaii became the fourth and fifth states to do so, while New Hampshire passed a law establishing a commission to study the matter. At least eight other states introduced similar legislation in 2017. In addition, New Mexico instituted regulations to give pharmacists this authority. The specifics of these laws vary by state, but the goal is to provide another way for women to access some forms of contraception.

Extended Supply of Prescription Contraceptives

As of 2016, six states (California, Hawaii, Illinois, Maryland, Oregon, Vermont) and Washington, D.C enacted legislation requiring insurers to increase the number of months for which they cover prescription contraceptives at one time. Thus far in 2017, five states (Colorado, Maine, Nevada, Virginia and Washington) followed suit. Also, the New Jersey legislature passed a bill that is awaiting approval by the governor. Most of these states have mandated 12 months of coverage for prescription contraceptives at one time, in contrast to the 30- to 90-day supplies that insurance plans traditionally covered, in order to increase timely access to contraception and reduce gaps in contraceptive use.

Educating College Students About Unplanned Pregnancy

Arkansas and Mississippi have enacted legislation to educate college students about preventing unplanned pregnancy.[8] 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, as a way to reduce high teen birth rates among 18- and 19-year-olds and to improve college completion.

During the 2017 session, similar legislation was introduced in Tennessee and Texas, and a bill in Louisiana became law. The Tennessee bill passed the Senate but failed in the House, while the Texas bills had hearings in both chambers—though they did not move forward this session.

Codifying and Strengthening 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 without out-of-pocket (OOP) costs, and reduce administrative barriers for patients. In 2014, California was the first state to enact such a law; followed by Maryland, Illinois, and Vermont in 2016; and Maine and Nevada in 2017.

Illinois, Maryland, and Vermont have expanded upon the contraceptive coverage protections in the ACA. California prohibits OOP costs for vasectomies. Maryland prohibits OOP costs for vasectomies, over-the-counter prescription contraceptives available without a prescription (currently, only emergency contraception) and prior authorization for LARCs. Illinois prohibits OOP costs for vasectomies and over-the-counter methods (except male condoms).

At least 10 other states introduced legislation in 2017 to codify or expand upon the federal contraceptive coverage provision, which is not surprising given the uncertainty of the federal protections, and the future of the ACA itself.

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[1] Please note that about half of states are still in the midst of their legislative sessions.

[2] U.S. Food and Drug Administration. Birth Control Guide. Retrieved June 1, 2017 from www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM517406.pdf.

[3] Kaiser Family Foundation. (2017). *Current Status of State Medicaid Expansion Decisions*. Retrieved June 1, 2017 from http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.

[4] States that expanded Medicaid are able to receive an increased federal matching rate for services provided to "newly eligible" individuals. The federal matching rates are as follows: 100% for 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and after.

[5] Guttmacher Institute. (2017). *Medicaid Family Planning Eligibility Expansions*. Retrieved June 1, 2017 from www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions.

[6] States receive an enhanced federal match of 90% for family planning services and supplies provided to Medicaid beneficiaries enrolled in traditional full-scope Medicaid or a Medicaid family planning expansion program. For more background, see Ranji, U., Bair Y., and Salganicoff A. (2016). *Medicaid and Family Planning: Background and*

Implications of the ACA. Kaiser Family Foundation. Retrieved June 1, 2017 from http://kff.org/womens-health-policy/issue-brief/medicaid-and-family-planning-background-and-implications-of-the-aca/.

[7] American Congress of Obstetricians and Gynecologists. (2017). *Medicaid Reimbursement for Postpartum LARC by State*. Retrieved June 1, 2017 from www.acog.org/About-ACOG/ACOG-Departments/Long-Acting-Reversible-Contraception/Immediate-Postpartum-LARC-Medicaid-Reimbursement.

[8] Quinton, S. (2016, February 1). Some States Help College Students Avoid Unplanned Pregnancies. *Stateline.* Retrieved June 1, 2017 from www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/02/01/some-states-help-college-students-avoid-unplanned-pregnancies.