

State Options Addressing Access to Contraception

BY KENDALL SPEER

The [majority](#) of females 18 to 64 have used contraception at some point in their reproductive years. The ability to plan pregnancies is directly linked to a wide array of benefits—including fewer unintended pregnancies, more educational and economic opportunities for young women and men, improved [maternal](#) and [infant](#) health, and greater family well-being.

Certain forms of contraception reduce the spread of sexually transmitted diseases (STDs), and contraceptive access may [reduce rates of abortion](#). There are [cost savings](#) for individuals and states associated with reducing unintended pregnancy rates.

Barriers to Accessing Contraception

While the Affordable Care Act increased access to contraception and reduced the cost for patients, some barriers exist. [One in six](#) sexually active women who say they are not trying to get pregnant yet, are not using contraception. [Twenty-five percent](#) of women who are currently using contraceptives report they are not using their preferred method because of one or multiple barriers.

Financial resources and insurance coverage may limit access to certain contraceptive methods. Costs vary between different forms, ranging from approximately \$1 for [condoms](#), \$25 to \$50 per month for [oral contraceptives](#), \$1,000 to \$1,300 every five to 10 years for [intrauterine devices \(IUDs\)](#), to \$6,000 for [surgical sterilization](#). These costs can be higher when doctor's visits, follow-up care and any insertion/removal of devices are included. Research shows removing out-of-pocket costs for contraception is associated with [increased](#) consistent use and reduced income disparities in unintended pregnancy rates.

Geographic barriers in [rural areas](#) include a shortage of practicing physicians, leading to health care shortage areas, as well as patient



transportation issues. [One study](#) found that across the 14 states studied, 17% to 53% of the state population lived in areas without enough facilities offering contraceptive methods to cover the number of eligible women in a county.

Federal Action

Section 2713 of the Patient Protection and Affordable Care Act (ACA), codified as 42 USC 300gg-13C 300gg-13, requires all non-[grandfathered](#) group health and individual health insurance plans to cover certain preventive health services with no cost sharing (e.g., copayment, coinsurance or deductible). This includes coverage for all [contraceptive methods approved by the U.S. Food and Drug Administration \(FDA\)](#), except for [religious exemptions and accommodations for certain employers](#). Over-the-counter (OTC) formulations are only required to be covered by insurance if they were prescribed.

Under the federal [Health Center Program](#), federally qualified health centers (FQHCs) play an integral role in providing contraception to low-income and uninsured individuals.

The [Title X](#) National Family Planning Program is the only federal program specifically dedicated to supporting the delivery of family planning care. The program funds organizations in each state to distribute federal dollars to safety net clinics to provide family planning services to low-income, uninsured and underserved clients. FQHCs may also enroll in the [340B Drug Pricing Program](#), entitling them to purchase contraception at a discounted price.

State Policy Options

States play a role in addressing access to contraception by considering barriers such as cost, insurance coverage and provider shortages.

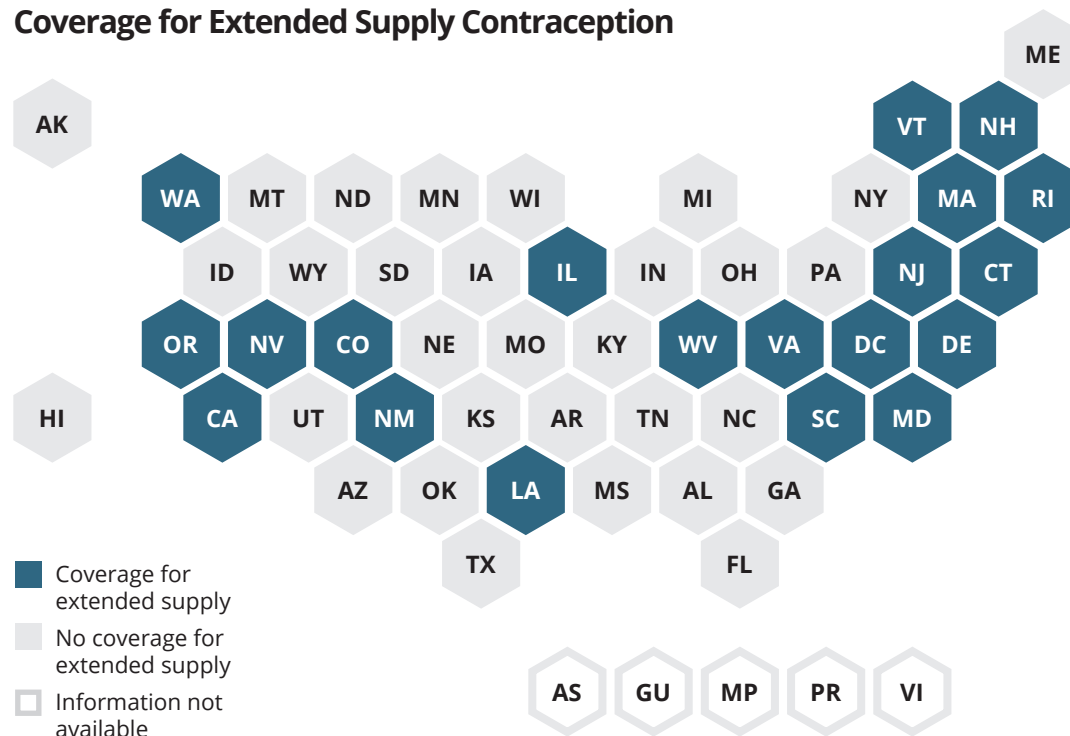
INSURANCE COVERAGE

The majority of women who are privately insured report their insurance covers the full cost of their contraceptive care, while one in five say they pay some out-of-pocket costs. This is in part due to exceptions for certain types or brands of contraception. Some states have codified or expanded their insurance coverage requirements for contraception. [Twelve states and the District of Columbia](#) require marketplace insurance coverage for certain OTC birth control methods, such as spermicide, sponges, emergency contraception or condoms. [Seven states and the District of Columbia](#) require private insurers to cover male condoms; insurers may require enrollees to obtain a prescription to receive coverage for these OTC birth control methods.

Traditionally, Medicaid fee-for-service has issued global payments for labor and delivery, meaning providers are not reimbursed for insertion of long-acting reversible contraception (LARCs) (i.e., IUDs and implants) and/or the devices themselves if provided immediately postpartum. States can increase access to contraception during the postpartum period by [unbundling](#) the cost of LARCs from other postpartum services. For example, [Utah](#) requires the Medicaid program to reimburse providers separately for the insertion of LARC immediately after childbirth. [Illinois](#) permits health plans to allow hospitals separate reimbursement for LARC devices provided immediately postpartum before hospital discharge.

Nearly [one-third](#) of hormonal contraceptive users say they have missed taking their birth control because they were not able to get their next supply of pills. Studies suggest a 12-month supply has been associated

Coverage for Extended Supply Contraception



Source: NCSL, 2023

with a [30% reduction](#) in the odds of having an unintended pregnancy when compared with women who are dispensed less than three months of coverage. [New Jersey](#) requires public and private health plans to allow enrollees to obtain a 12-month supply of their contraceptive method at one time. [Louisiana](#) requires Medicaid plans to dispense six-month supplies of contraceptives to patients at a time, unless the patient or provider requests otherwise.

Some states require insurance plans to cover contraception prescribed by practitioners other than physicians. For example, [Arizona](#) requires health insurance plans cover pharmacist prescribing of self-administered hormonal contraceptives. [Maryland](#) permits pharmacists to bill Medicaid for the patient assessment that is required before pharmacists can prescribe.

ADVANCED PRACTICE CLINICIANS AND PHARMACISTS

States may consider the scope of practice of advanced practice clinicians and pharmacists to increase the number of providers who can prescribe contraception. For example, in 2021, [Maryland](#) established certification requirements and the scope of practice for certified midwives, which include family planning, well-person reproductive care and contraception prescribing. [Washington](#) permits certified nurse-midwives to prescribe and administer contraception. [Utah](#) permits physician assistants who have practiced for at least 10,000 hours to provide services and prescribe medication, including contraceptives, without supervision from a physician.

“Pharmacy access” laws authorize pharmacists to prescribe contraceptives, which can make contraceptive care more accessible and affordable by eliminating the need for a separate visit to a health care provider. Pharmacists are more likely to have extended hours than clinics and do not require an appointment to be seen. In the United States, about [89%](#) of residents live within five miles of a pharmacy and people see their community pharmacist [12 times](#) more frequently than their primary care provider.

At least [20 states and the District of Columbia](#) allow pharmacists to prescribe—or dispense under a standing prescription order—hormonal contraceptives. For example, [Hawaii](#) allows pharmacists to prescribe self-administered hormonal contraceptives and [West Virginia](#) allows pharmacists to dispense self-administered hormonal contraceptives under a standing prescription order from the state health officer. In addition to prescribing and dispensing self-administered hormonal contraception, [South Carolina](#) permits pharmacists to also administer injectable hormonal contraceptives under a standing order. [Nevada](#) requires prescribing pharmacists to provide the patient with a risk assessment tool and contraceptive method counseling when prescribing and dispensing self-administered hormonal contraceptives. In 2022, [Virginia](#) expanded the ability of pharmacists to distribute contraceptives to patients through telehealth. [Seven states](#) require a patient to see a primary care provider after a specified period of time to continue receiving contraceptives from a pharmacist.

EMERGENCY CONTRACEPTIVE ACCESS IN EMERGENCY ROOMS

Emergency contraception, which significantly reduces the chance of pregnancy, is most effective the sooner it is taken. [Twenty states](#) and the District of Columbia require hospital emergency rooms to provide emergency contraception-related information or services to sexual assault victims. [Wisconsin](#) requires hospitals to provide survivors of sexual assault with medically accurate information about emergency contraception including its availability. [Nevada](#) requires any facility providing emergency care to a sexual assault survivor to give the patient information about emergency contraception—and to supply emergency contraceptive pills upon request.

Resources

- NCSL Website: [State Contraception Policies](#)

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