



## Advancing Health Equity Through Improved Access to Patient-Centered Contraceptive Care

### Introduction

Marginalized individuals — including women<sup>1</sup> of color,<sup>1</sup> undocumented people,<sup>2</sup> women with disabilities<sup>3</sup> and women with low incomes<sup>4</sup> — face higher rates of unintended pregnancies and poorer reproductive health outcomes than other women. These disparities are frequently linked to lack of health coverage, limited access to reproductive health providers and services, high out-of-pocket costs, and low-quality care.<sup>5</sup> Since March 2020, inequities in access to contraceptive care have been exacerbated due to the COVID-19 pandemic and its devastating economic consequences. Currently, more than 19 million women of reproductive age are in need of contraception, but they live in a “contraceptive desert,” an area or county that lacks adequate access to a health center that offers the full range of contraceptive methods.<sup>6</sup>

Important evidence from the Patient-Centered Outcomes Research Institute (PCORI) offers critical insights into how best to tackle inequities in reproductive care. PCORI research suggests that patient-centered contraceptive care promotes equity and improved patient outcomes, especially

<sup>1</sup> Much of the research on contraceptive care and access presumes cisgender identities and does not include people who are transgender, gender expansive or nonbinary. While we have chosen to use the term “women” in this paper due to our heavy reliance on current research, we acknowledge that individuals seeking access to contraceptive care do not solely identify as women or with the sex assigned to them at birth.

*33% of women of reproductive age cannot afford to pay more than \$10 for contraception.*

for women with low incomes, women with disabilities and women of color who have experienced historic and ongoing harms stemming from programs of forced or incentivized sterilization<sup>7</sup> along with commonplace biases in contraceptive care.<sup>8</sup> As detailed below, the growing evidence base from PCORI demonstrates a need for women to have access to all methods of contraception, removing barriers to care (for example, cost, insurance policies and health system requirements), implementing patient-centered contraceptive counseling and prioritizing patient autonomy rather than a one-size-fits-all approach that steers women to a “most effective” method of contraception.<sup>9</sup>

In 2016, there were 68 million U.S. women of reproductive age, and 21 million of them were in need of publicly funded services due to their income level (below 250% of the federal poverty level) or their age (younger than 20).<sup>10</sup> Additionally, a recent national survey of women of reproductive age reported that 33% of all respondents, and nearly half (46%) of Black respondents, cannot afford to pay more than \$10 for contraception.<sup>11</sup> Given the significant unaddressed contraceptive need<sup>ii</sup> in the U.S. and the negative impact this has on women’s ability to control their reproductive health outcomes, there is an urgent and important opportunity for policymakers, advocates and health systems to take action to increase access to patient-centered contraceptive care and coverage. The provision of accessible and affordable reproductive health care services is especially important for women with low incomes and women of color, who face higher rates of adverse reproductive health outcomes and disproportionately live in contraceptive deserts.<sup>12,13</sup> While the majority of attacks on reproductive health care at the state and federal level are focused on restricting access to abortions, state legislatures have also sharply reduced access to contraceptive care by limiting funds and access to family planning providers that discuss or provide abortion services.<sup>14</sup>

In this report, we bring the latest and most relevant patient-centered outcomes research to bear on the issue of patient-centered contraceptive care. We seek to elevate these research findings to help inform state decision-makers who seek to create effective ways to improve contraceptive access, decrease rates of unintended pregnancies, better address personal contraceptive needs and improve women’s overall health. The recommendations offered below are focused on both reducing reproductive health inequities and improving health outcomes for women who are disproportionately affected by barriers to contraceptive care.

<sup>ii</sup> Contraceptive need is defined as the gap between a person’s contraceptive desires and that person’s contraceptive behavior.

Research findings, which are discussed in greater detail below, center on the following themes:

- » Increasing affordability of contraceptive methods.
- » Reducing provider barriers.
- » Improving patient-centeredness of contraceptive care.

In each area, we highlight possible solutions that decision-makers at the state level might consider that would result in improvements in patient outcomes and health equity.

## 1. Increase affordability of contraceptive methods

In the U.S., people with low incomes and other vulnerable populations, such as women of color, undocumented people and minors, face significant barriers to contraceptive access.<sup>15</sup> Unfortunately, contraceptive access has worsened during the pandemic.<sup>16</sup> Insurance coverage is a large determinant of contraceptive use, and uninsured women are 30% less likely to use prescription contraception.<sup>17</sup> Yet when cost is removed as a barrier, women are more likely to use their method of choice and have their contraceptive preferences met.<sup>18</sup> In fact, 22% of women at risk of an unplanned pregnancy reported that, if cost were not an issue, they would want to use a different birth control method.<sup>19</sup> Removing out-of-pocket costs for contraception is also associated with increased consistent use, which is important for preventing unintended pregnancies.<sup>20</sup> Improving the affordability of contraceptives improves health outcomes, reduces health disparities and increases people's ability to exercise reproductive autonomy.<sup>21</sup> State decision-makers should be aware that making free or low-cost contraceptive care accessible to women would be beneficial to advancing health equity and promoting improved patient outcomes, as the evidence suggests. The following approaches and actions may be considered:

- » **Require insurance coverage for the full range of contraceptive methods, including traditionally “male” methods, with no cost-sharing for state-regulated plans.** The federal contraceptive coverage guarantee passed as part of the Affordable Care Act (ACA) requires private plans to provide coverage for 18 “female-controlled” contraceptive methods and related services without any out-of-pocket costs.<sup>22</sup> State decision-makers should consider approaches that go beyond the federal standard established in the ACA and require coverage of all contraceptive methods, including traditionally “male-controlled” methods, to expand access to a wider range of contraceptive methods and encourage contraceptive responsibility for all partners engaged in sexual intimacy.<sup>23</sup> While the ACA's contraceptive coverage requirement mandates that there be an “exceptions process” for people to obtain specific birth control products within a covered category, many states violate this provision.<sup>24</sup> To ensure patients can access the method that works best for them, we urge states to put in place and enforce exception policies in an expedited process for birth control brands that are not covered by insurance without cost-sharing.<sup>25</sup>

- » **Require coverage of all over-the-counter contraceptive drugs and devices approved by the Food and Drug Administration (FDA) in marketplace and Medicaid plans.** Research shows that distributing birth control over the counter leads to greater use of effective birth control and lower rates of unintended pregnancy.<sup>26</sup> While emergency contraception and condoms are the only FDA-approved birth control methods that are distributed over the counter, it is likely that more contraceptive methods will be approved for over-the-counter distribution soon. As of October 2021, 12 states and the District of Columbia require marketplace insurance coverage of over-the-counter birth control methods.<sup>27</sup> However, most of these 12 states exclude coverage of the external “male” condom, and insurers may require enrollees to obtain a prescription in order to receive coverage.<sup>28</sup> To ensure easy access to both current and future FDA-approved contraceptives, states should consider requiring marketplace and Medicaid coverage of all FDA-approved over-the-counter contraceptive methods without a prescription and at no cost. Additionally, states should consider removing age requirements for emergency contraception, which disproportionately harm young people and those without necessary identification.
- » **Pass legislation mandating Medicaid and private payer coverage of a 12-month supply of birth control, and enforce accountability and monitoring of compliance.** Allowing women to obtain a 12-month supply of birth control at once, rather than every one to three months, can help prevent unintended pregnancies and save significant health care costs.<sup>29</sup> A study from the University of California—San Francisco found that a 12-month supply of birth control decreased unplanned pregnancies by 30%, compared with a supply of just one or three months.<sup>30</sup> Massachusetts’ state ACCESS law (Advancing Contraceptive Coverage and Economic Security in our State), for example, enables patients to obtain a 12-month supply of prescription birth control at once, prior to completing a three-month trial of the prescription.<sup>31</sup> Unfortunately, even in states that require insurers to cover a 12-month supply of birth control, it is sometimes difficult for patients to get a year’s supply because insurance companies refuse to pay upfront for a full year of contraceptives.<sup>32</sup> In turn, in addition to passing legislation requiring Medicaid and private insurers to cover a 12-month supply of birth control, states must consider providing a mechanism to enforce such coverage mandates through state Medicaid agencies, insurance departments or actions by the attorney general’s office.<sup>33</sup>
- » **Ensure free access to family planning services and birth control for uninsured residents, including undocumented people.** Programs should be developed that connect uninsured women to federally funded family planning programs or utilize separate state dollars to fund reproductive health programs for uninsured and undocumented women. For example, Oregon established a program through the Reproductive Health Equity Act to provide reproductive health care services to people who do not qualify for Medicaid due to their citizenship or immigration status.<sup>34</sup>

## 2. Reduce provider barriers

For women with low incomes, reproductive health care providers are often their sole source of medical care.<sup>35</sup> Thus, state decision-makers may consider approaches that proactively improve access to care by loosening practice restrictions and adjusting reimbursement guidance to allow more providers and direct support professionals to prescribe birth control or provide contraception counseling services. To improve access to contraceptive care, particularly for women with low incomes and rural residents, states may consider the following approaches:

### » **Expand scope-of-practice laws to allow pharmacists to prescribe birth control.**

Pharmacist prescribing is a growing state trend that creates more access points to prescription contraceptives for patients, particularly Black women and people living in rural areas.<sup>36</sup> Currently, 23 states and the District of Columbia have enacted policies that allow pharmacists to prescribe and dispense self-administered hormonal methods of contraception (for example, the pill, patch, ring and shot).<sup>37</sup> State legislation authorizing pharmacist prescribing of contraceptives usually takes one of three forms: statewide protocol laws, statewide standing orders or collaborative practice agreements.<sup>38</sup> When implementing pharmacist prescribing laws, states should also consider payment for pharmacist services, authorized contraceptives, training requirements, implementation, data collection and analysis, liability protections, and confidentiality of services.<sup>39</sup> To reduce inequities in access, states should ensure that pharmacists are able to prescribe contraception without additional costs to consumers and without age restrictions, which create barriers for young people and those without necessary identification.<sup>40</sup>


### » **Expand Medicaid billing codes to allow alternative providers and direct support professionals to bill Medicaid for contraceptive counseling.**

The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the Centers for Disease Control and Prevention recommend evidence-based contraceptive counseling to all female patients of reproductive age.<sup>41</sup> However, time-limited patient interactions can inhibit providers' ability to provide counseling services.<sup>42</sup> In a PCORI study on improving contraceptive care at three federally qualified health centers in the Midwest, nonclinicians were trained to provide contraceptive education to patients, decreasing the time health care providers were required to spend on counseling.<sup>43</sup> Allowing more professionals to bill for contraceptive counseling would help to expand patient-centered reproductive health services at publicly-funded centers running on tight profit margins.<sup>44</sup>

### » **Eliminate restrictions on Medicaid reimbursement and the allocation of state family planning funds to include all reproductive health providers, even those that provide counseling or referrals for abortions or provide abortion services.**

Over the past several years, state legislatures have limited access to contraceptive care by restricting the types of providers eligible to receive Title X and state family planning funds.<sup>45</sup> For example, some states bar distributing federal block grant funds to providers that offer abortion counseling.<sup>46</sup>





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In addition, Arkansas has barred Planned Parenthood from its Medicaid programs.<sup>47</sup> Many family planning providers are underfunded, and placing limits on public funds to providers of abortion services limits access to the broader range of reproductive health care services for those who need it most.<sup>48</sup> According to the Kaiser Family Foundation, 1 in 3 low-income women in the U.S. relies on a health center, Planned Parenthood or other publicly funded clinic to get contraception.<sup>49</sup> Attacks on reproductive rights and access over the years have eroded access to essential sexual and reproductive health care by reducing the number of family planning providers and services, particularly for people living in rural regions and communities of color.<sup>50</sup>

» **Utilize flexibilities in telehealth policy to expand access to remote reproductive health care.** Women who live in rural areas face a shortage of reproductive health care providers, and some must drive over 200 miles to see an OB-GYN.<sup>51</sup> States may address disparities in access to reproductive health care by building on telehealth flexibilities made available during the COVID-19 public health emergency. Options include: removing licensing barriers by adopting the Interstate Medical Licensure Compact; expanding the list of providers permitted to offer telehealth care to include midwives, doulas and advanced practice clinicians; allowing online prescribing without a prior provider-patient relationship; and allowing for permanent reimbursement of audio-only telehealth services for contraceptive care appointments and mandating payment parity for these services.<sup>52</sup>

### **3. Improve patient-centeredness of contraceptive care**

Patient-centered contraceptive care is highly valued by women.<sup>53</sup> However, many women report a lack of choice in contraception, a lack of sufficient information about contraceptive options and an inability to discuss concerns with health care providers, fostering dissatisfaction with the patient-centeredness and quality of contraceptive counseling overall.<sup>54</sup> Research suggests that patients who feel their contraceptive choices are undervalued or underprioritized by providers are less likely to access reproductive health care in both the short and long term, and less likely to trust their health care providers.<sup>55</sup>

Taking a patient-centered approach requires a true partnership between providers and their patients wherein providers respect patients' needs, values and preferences and patients' values guide clinical decisions.<sup>56</sup> In an effort to reduce inequities in contraceptive use and access, decision-makers should consider approaches prioritizing patient-centered frameworks that center on reproductive autonomy. These approaches include the following:

- » **Integrate the person-centered contraceptive counseling (PCCC) measure into Medicaid and health plan quality measurement to encourage and incentivize health care organizations, facilities and providers to utilize the PCCC measure in addition to common contraceptive provision measures.** The Person-Centered Contraceptive Counseling (PCCC) measure is a four-item scale used to evaluate quality of care and person-centeredness of contraceptive counseling in a family planning or primary care setting. This simple assessment is administered to patients immediately following a contraceptive visit to evaluate provider performance regarding respect for the patient, provision of information, and eliciting and honoring patient preferences for birth control.<sup>57</sup> The PCCC, which was endorsed by the National Quality Forum in 2020, offers a patient-centered complement to common measures that tend to favor contraceptive options deemed to be “highly effective” to the detriment of patient autonomy.<sup>58</sup> A statewide, person-centered reproductive health care metric, such as the PCCC measure, has the potential to improve the quality of care by identifying areas for improvement at both the health system and provider level.
- » **Require ongoing training for providers and staff related to the provision of contraceptive services. Training topics may include person-centered counseling and contraceptive care, teen-friendly clinical practices, reproductive coercion, the importance of contraceptive access, implicit bias, and health equity.**<sup>59</sup> Health care providers report barriers to providing contraceptive counseling in the primary care setting, including lack of knowledge and training on contraceptive counseling.<sup>60</sup> Additionally, many providers lack formal medical training on contraceptive coercion,<sup>61</sup> implicit bias<sup>62</sup> and gender-affirming care,<sup>63</sup> which leads to marginalized communities disproportionately receiving lower-quality reproductive health care and, in turn, facing poor reproductive health outcomes. Person-centered trainings on these topics may improve health care system delivery and equip providers with tools to develop a more inclusive approach to contraceptive care that centers on patients' needs, reproductive equity and improved health outcomes for marginalized communities.
- » **Work with managed care organizations to incentivize the use of decision support tools in clinical settings to increase patient autonomy in contraceptive appointments.** Decision support tools inform patients of the range of contraceptive options, determine what factors are most important to them when seeking contraceptive care, and support shared decision-making between patients and providers during visits.<sup>64</sup> Utilizing decision

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support tools helps to address challenges posed by short clinic visits<sup>65</sup> by offering patients individualized information about contraceptive options that suit their needs and values, sharing these preferences with their providers, and establishing effective, patient-centered communication between patients and providers.<sup>66</sup>

In a PCORI-funded study, researchers tested an interactive web-based decision support tool called *My Birth Control*. Results indicated that patients who used the tool had higher levels of counseling quality and increased knowledge of contraception options and side effects, and they felt more empowered to ask questions of their provider than patients in the control group.<sup>67</sup> *My Birth Control* has since been adapted to a mobile app, *Decide + Be Ready*, which is distributed via TRICARE among servicewomen to reduce rates of unintended pregnancy.<sup>68</sup>

- » **Have Medicaid agencies work with provider associations to encourage the adoption and implementation of an electronic health record measure that tracks the delivery of evidence-based, patient-centered resources on contraception options.** To increase contraceptive knowledge, self-efficacy and use of contraception, patients must have easy access to contraceptive information.<sup>69</sup> For example, participants in a PCORI-funded research study spoke about how gaps in knowledge and contraceptive myths had impacted their contraceptive use.<sup>70</sup> Implementation of a new electronic health record measure has the potential to increase contraceptive knowledge by ensuring providers are offering patient-centered and evidence-based resources on a consistent basis. Providers may use decision support tools, which should be culturally and linguistically appropriate, to deliver this information.
- » **Allow all minors to consent to confidential contraceptive services without parental involvement, regardless of their marital status, pregnancy status or health concerns.** Confidentiality in seeking reproductive health care services is key to ensuring minors have access to necessary contraceptive and sexual health care services, as parental contact requirements have been shown to discourage teens from seeking care.<sup>71</sup> Currently, many states have limits on the age or categories of individuals who can consent to contraceptive care services, such as minors who are married or are a parent.<sup>72</sup> Ensuring confidential access to treatment for all sexually active minors may improve safe sex practices and reduce sexually transmitted infections and unintended pregnancies.<sup>73</sup> States may protect sensitive personal



health information of minors and dependents by refusing to disclose information about services obtained unless patients specifically authorize permission to do so in writing,<sup>74</sup> or create protections specific to explanation of benefit forms.<sup>75</sup>

## Conclusion

Reproductive health care services and access to contraception are essential components of quality health care. Unfortunately, people who identify as women of color, disabled women, LGBTQ+, women with low incomes, and women with limited English proficiency continue to face serious health inequities in contraceptive care due to provider bias, discrimination and systemic barriers. Evidence suggests that reducing cost barriers and utilizing a patient-centered framework in contraceptive care services would not only reduce unintended pregnancies and improve women's health outcomes, but also help to address systemic health inequities by putting patients' needs, values and preferences at the center of decision-making. We encourage state advocates and policymakers alike to prioritize a proactive, patient-centered approach to improving contraceptive access and coverage for all.

## Endnotes

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