# Expanded Prescription Contraceptive Supply

## Executive Summary

Prescription contraceptives (e.g., oral pill, rings, patches, and shots) are the most widely used form of contraceptive. Currently, the majority of health insurance plans cover only a 1–3 month supply of prescription contraceptives at a time. When individuals have difficulty obtaining their prescription refills due to various financial and insurance barriers, they may experience gaps in use, stop using contraceptives altogether, and may have increased risk for unintended pregnancies. Senate Bill 641 would require health insurance carriers that include coverage for contraceptives to increase the quantity covered in a prescription to a yearlong supply.

### Highlights

- In the United States, approximately 27% of women in their reproductive years live in a "contraceptive desert," meaning they lack access to all forms of birth control.
- In 2019, 14.8% of Missouri women between the ages of 19-44 years old did not have private or public health insurance coverage.
- Increasing supply of contraceptives to one year's worth has been shown to be cost-effective, increase contraceptive adherence, and reduce unintended pregnancies and abortions.
- Twenty-two states and Washington, D.C. have varying policies expanding contraceptive distribution and supply.

### Limitations

- The number of women residing in "contraceptive deserts" within Missouri is unknown.
- Increased contraceptive supply does not guarantee use and may lead to increased contraceptive waste.
- More research is needed to identify effective strategies to reduce disparities in unintended pregnancy and contraception access.

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## Research Background

### Access to Contraceptives

Several types of contraceptive drugs and devices, available both over-the-counter and by prescription, delay ovulation and prevent the fertilization of an egg before pregnancy is established, in addition to treating other health conditions. For more detailed information about

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the mechanisms of contraceptive drugs and devices, please see the previously published Science Note: Contraceptive Accessibility.

In the United States, it is estimated that approximately 27% of women in their reproductive years live in a "contraceptive desert," meaning they lack access to all forms of birth control.[1] There are a variety of social determinants that can create barriers to oral contraceptive access. One national survey of 1,385 women reported that among the 68% of individuals who had ever tried to obtain a prescription for hormonal contraception, 29% had problems accessing the initial prescription or refills.[2] Other challenges included cost barriers or lack of insurance (14%); challenges in obtaining an appointment or getting to a clinic (13%); the health care provider requiring a clinic visit, examination, or Pap test (13%); not having a regular physician or clinic (10%); difficulty accessing a pharmacy (4%); and other reasons (4%).[2]

Poverty in Missouri

Poverty disproportionately affects women and racial/ethnic minority populations.[3] Missouri-specific data indicated 14% of women had incomes below the poverty line compared to 11% of men in 2018.[3] Twenty-six percent of the African-American population were living in poverty compared to 11% of the White population; the unemployment rate for African American women was 4.9% compared to 3.1% for White women.[3,4] Most Missourians have access to health care with employer-provided insurance, but those at the lowest levels of income are often not provided employer health benefits. In fact, 32.7% of insured Missourians have public health insurance.[3] In 2019, 14.8% % of Missouri women between the ages of 19–44 years old did not have private or public health insurance coverage.[5]

During the COVID-19 pandemic, women were 1.3 times more likely than men to consider leaving the workforce, with Black women and women with children most likely to leave the workforce.[4] In Missouri from March to June of 2020, 30,000 more women became unemployed compared to men.[4] This number decreased by September, but 6,000 more women than men were still unemployed. Job loss, irregular job schedules, and hourly wages can decrease financial stability and create barriers to short- and long-term financial wellbeing.[3]

**Contraceptives and Insurance Coverage**

Insurance coverage may create unintentional barriers to accessing contraceptives.[6] Currently, the majority of insurance plans cover only 1–3 months' worth of prescription contraceptives at time.[6] One of the cited barriers for prescription contraceptive accessibility is related to accessing the initial prescription or refills.[1] When individuals have difficulty obtaining their prescription refills, they may experience gaps in use or stop using oral contraceptives altogether.[6] This may disrupt the mechanism of action for these drugs or devices and may lead to unintended pregnancies.

Research investigating contraceptive adherence with monthly refills found a low level of adherence, which is associated with higher odds for unintended pregnancy. In a St. Louis area study of 619 women, approximately 30% (187 women) obtained all their monthly refills on time

and the remaining 70% of study participants were at an increased risk for an unintended pregnancy.[7] However, an increased supply of contraceptives to 1-year was found to improve adherence and contraceptive effectiveness.[8,9] In a study of 82,000 women who received contraceptives from the California Family PACT program, women who received a 1-year supply of contraceptives were 28% more likely to adhere and continue their contraceptive plan compared to women who received a 3-month plan.[8] In a similar large study (84,000 women), those who receive a 1-year supply of contraceptives had a 30% reduction in the odds of having an unintended pregnancy and 46% reduction in the odds of having an abortion.[9]

Research suggests that increased supply of contraceptives to 1-year may be cost effective.[8,10] A nationwide study investigating financial implications of 1-year supply of contraceptives in 24,300 female veterans found savings of $87.12 per woman compared with the cost of four 3-month supplies ($700.60 vs. $787.72).[10] It is suggested the majority of cost savings is from the reduction of unintended pregnancies; over the course of one year, there was a reduction of 24 unintended pregnancies per 1000 women per year.[10]

Providing both over-the-counter and prescription contraceptive methods without a prescription via a pharmacist has the potential to improve contraceptive use and reduce unintended pregnancy rates. However not all insurance plans cover pharmacy-prescribed contraceptives. For more information about pharmacy access to contraceptives, please see the previously published Science Note: Contraceptive Accessibility.

**State Legislation**

Twenty-two states and Washington, D.C. have policies expanding contraceptive coverage and availability **(Figure 1)**.[11] Twenty states and Washington D.C. have policies that have expanded contraceptive insurance coverage to one year, whereas two states (NM & NE) have expanded contraceptive coverage to 6 months.[10] New Jersey most recently signed a law extending 6-month coverage to 12-month supply prescriptions of contraceptives (December 2021). There are slight variations between state policies. For example, Oregon, Colorado, and Massachusetts must initially prescribe a 3-month supply of contraceptives before permitting a 12-month supply. [11] Lastly, South Carolina law extends year-long contraceptive

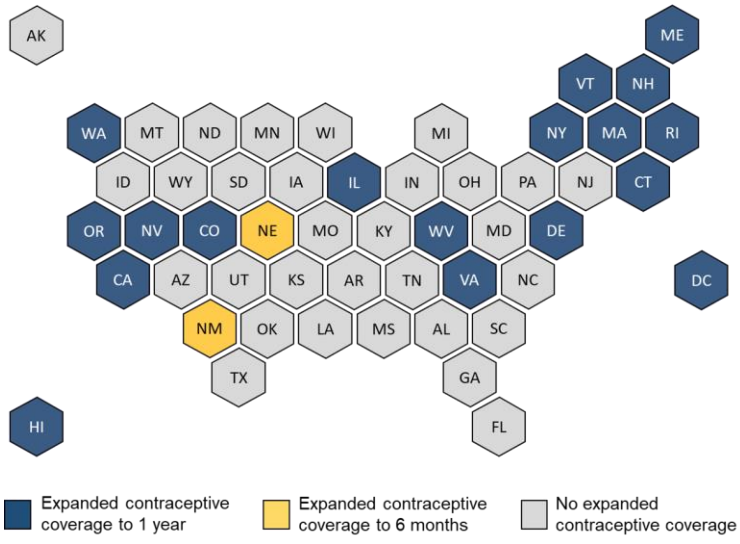


**Figure 1.** States with expanded contraceptive coverage policies.[11]

supply coverage to Medicaid participants only, whereas most state policies extend to both state and private insurance plans or only private insurance plans. [11]

Missouri Legislation

According to the MO HealthNet Pharmacy Manual, oral contraceptive prescriptions are exempted from the 31-day supply limit and are permitted to be provided as a one-year supply from one prescription dispensed in 3-month quantities (RSMo 338.202). RSMo 338.202 states that Missouri pharmacists can make the determination to dispense varying quantities of certain medications per refill, up to the total number of dosage units as authorized by the prescriber on the original prescription at a maximum of a 3-month supply.

RSMo 376.1199 requires health carriers that provide pharmaceutical coverage to include coverage for contraceptives, excluding drugs and devices that are intended to induce an abortion. Senate Bill 641 amends Chapter 376 to add a new section that requires health carriers that include coverage for contraceptives to increase the quantity covered in a prescription to a yearlong supply with no changes to deductibles and copayments.

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