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Expanding Contraceptive Access: Developing and Implementing State-based Approaches

March 16, 2017
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- Injury prevention
- Immunizations
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  - Contraceptive Care
  - Preventive Reproductive Health
Presenter

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Presenter

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  - Grant and advocacy programs
  - Mississippi Access to Justice
Expanding Contraceptive Access: Developing and Implementing State-Based Approaches

Legislative Policy Landscape
Legislative Policy Landscape: Overview

- Pre-ACA Approaches
  - Parity for contraceptive coverage

- ACA Requirements
  - Preventative Health Services

- Post-ACA Trends
  - Coverage and cost-sharing mandates
  - Continuing LARC promotion
  - Pharmacist dispensing
States with contraceptive parity laws

States with contraceptive parity laws and religious exclusions
Legislative Policy Landscape: ACA Contraceptive Requirements

- 42 USC § 300 gg-12 (a)(4):
  - In general a group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—
    - with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

- 2011: HRSA adopted Women’s Preventative Services Recommended by IOM to be Covered under the Affordable Care Act
Legislative Policy Landscape: Post-ACA Trends
Coverage for 12-month supply

- **States that require coverage for 12 months of contraceptives**
- **States proposing coverage for 12 months of contraceptives**
Legislative Policy Landscape: Post-ACA Trends
Contraceptive Coverage Mandates

States that require coverage for all forms of contraceptives
States proposing coverage for all forms of contraceptives
Legislative Policy Landscape: Post-ACA Trends
Allowing Pharmacists to Dispense Contraceptives

- **States that allow pharmacists to dispense contraceptives**
- **States proposing to allow pharmacists to dispense contraceptives**
Legislative Policy Landscape: Post-ACA Trends
Other state approaches identified in 2017

- Reimbursing for immediate post-partum LARC
  - Oregon and Vermont

- Promoting or expanding family planning programs
  - Connecticut, Georgia, Minnesota, Nevada, Texas, Tennessee, and Wyoming

- Allowing LARC prescribed to one patient to be used by another
  - Missouri

- Medicaid reimbursement for Zika prevention measures
  - New Jersey
Expanding Access to Contraception in Oregon

Network for Public Health Law
March 16, 2017

Emily Elman, MPH
Reproductive Health Program
Outline for Today’s Presentation

- Oregon’s health system transformation efforts
- Effective contraceptive use (ECU) incentive metric
- Metrics and messaging
- Recommendations for use
- State legislative efforts to expand access to contraception
Health System Transformation in Oregon

- Implementation of the coordinated care model in Oregon’s Medicaid program - the Oregon Health Plan (OHP) in 2012

- 16 Coordinated Care Organizations (CCOs) across the state, covering approximately 850,000 lives (or 85% of total OHP enrollment)
C CO I ncentive Metrics

• OHA established a financial pool, or “quality pool” as part of its agreement with CMS to reward CCOs for the quality of care provided to Medicaid members.
• Quality pool dollars are allocated to CCOs based on performance on established metrics.
• In 2017, 17 incentive metrics, including:
  – Childhood immunization status
  – Colorectal cancer screening
  – Emergency department utilization
  – Controlling high blood pressure
  – Effective contraceptive use
Why is this Important?

Nearly half of U.S. pregnancies were unintended in 2011.

- Intended: 55%
- Mistimed: 27%
- Unwanted: 18%
Disparities Exist

Between 1981 and 2011, unintended pregnancy has become increasingly concentrated among poor and low-income women.

Rate (per 1,000 women aged 15-44)

140
120
100
80
60
40
20
0


<100% of poverty
100-199% of poverty
All women
≥200% of poverty

GUTTMACHER INSTITUTE
Contraception Works

In 2008, the two-thirds of U.S. women at risk of pregnancy who used contraceptives consistently accounted for only 5% of unintended pregnancies.

- Women at Risk (43 Million):
  - 14% Nonuse or long gaps in use
  - 18% Inconsistent use
  - 68% Consistent use

- Unintended Pregnancies (3.1 Million):
  - 5% Consistent use
  - 54% Nonuse
  - 41% Inconsistent use

By consistency of method use:
- All year
- During month of conception

NOTES: “Nonuse” includes women who were sexually active, but did not use any method of contraception. “Long gaps in use” includes women who did use a contraceptive during the year, but had gaps in use of a month or longer when they were sexually active. “Inconsistent use” includes women who used a method in all months that they were sexually active, but missed taking some pills, or skipped use or incorrectly used their barrier method or condom during some acts of intercourse. “Consistent use” includes women without any gaps in use who used their method consistently and correctly during all months when they were sexually active, including those who used a long-acting or permanent method.

www.guttmacher.org
What is the Effective Contraceptive Use Metric?

The proportion of women at risk of unintended pregnancy who use a most or moderately effective method of contraception

**Denominator:** Women age 15-50 who are physiologically capable of pregnancy (18-50 will count for incentive, 15-17 will be monitored)

**Numerator:** Women with evidence of Tier 1 or 2 contraception during the measurement period (tubal ligation, IUD, implant, pills, patch, ring, shot, diaphragm)
What is the Metric Benchmark?

- **30%**
  - Women who are not currently sexually active,
  - Women who only partner with women,
  - Women who are trying to conceive or ok with conceiving

- **Effective Contraception Use Benchmark 50%**
  - Women who are physiologically capable of getting pregnant and are currently sexually active with men

- **70%**

Excluded:
- Women physiologically incapable of pregnancy
- Women who were pregnant in the measurement year who did not also receive contraception
2015 CCO Performance

Statewide, effective contraceptive use among adults increased slightly

- Statewide change since 2014: +9%
- Number of CCOs that improved: 14
- Number of CCOs achieving benchmark or improvement target: 9
Metrics & Messaging – Macro Level

The Philadelphia Inquirer

Poverty and Norplant: Can Contraception Reduce the Underclass?
– December 12, 1990

NOTE: The removal of an implant is only reimbursable by South Dakota Medicaid when due to infection, rejection or when determined medically necessary. South Dakota Medicaid will not reimburse for the removal of the implant if the intent is for the recipient to become pregnant.
Metrics & Messaging – Micro Level

Reproductive Health Program
PUBLIC HEALTH DIVISION
Recommendations for Use

• Focus on low, rather than high, rates of use (“red flags” versus “targets”)
• Where feasible, track other measures of access (e.g. patient satisfaction) in addition to method uptake
• Recognize that reproductive coercion is a present-day reality for many communities of color and low-income people
• Emphasize patient-centered counseling
Recommendations, Continued

• Screen women for pregnancy intentions on a routine basis
• Remove barriers to contraception
• Improve availability and uptake of LARCs
• Create quality improvement processes for contraceptive care
• Build provider awareness and capacity around effective contraceptive use
• Enhance partnerships with local family planning clinics
Oregon’s Recent Legislative Efforts

- HB 2789: Pharmacist prescribing of contraceptives
  - Permits pharmacists at retail pharmacies to prescribe and dispense OCs and the Patch

- HB 3343: 12-month coverage
  - Requires private health insurance plans to cover 12-month cycle of contraceptives

- HB 2758: Oregon confidential communication request law
  - Gives patients enrolled in a private health insurance policy the right to request that protected health information be sent directly to them instead of the person who pays for their health insurance (i.e., the primary account holder or policy holder).
Contact Information

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Reducing Unplanned Pregnancies in Young Adults: Mississippi’s SB 2563

Jamie Bardwell, MPP
Chief Operating Officer
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Mississippi State Department of Health
Background

- Mississippi Proportion of Teen Births by Age, 2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls Under 15</td>
<td>2%</td>
</tr>
<tr>
<td>Girls 15-17</td>
<td>27%</td>
</tr>
<tr>
<td>Girls 18-19</td>
<td>71%</td>
</tr>
</tbody>
</table>

- 18% of teen births in 2014 were subsequent pregnancies

- HB 999
Political Landscape

• Governor’s focus on teen pregnancy prevention

• Teen Pregnancy Prevention Legislation
  – Bipartisan
  – Unfunded
  – Workforce development focused
Senate Bill 2563

• Championed by Senator Sally Doty
• Effective July 1, 2014
• Requires community colleges and universities to develop a plan to address unplanned pregnancy
• Plans left up to discretion of individual institutions
• Some specific areas to address
  – Incorporate into orientation
  – Health center collaborations
  – Support student parents
SB 2563 Task Force

- Began meeting in Fall of 2014
- Institutes of Higher Education
- Community College Board
- State and Community Partners
  - Mississippi State Department of Health
  - Women’s Foundation of Mississippi
- Intended to help design plans for institutions
Successes

• Partnerships between clinics and institutions
  – Mississippi State Department of Health

• Partnerships to support institutions in making effective plans
  – National Campaign to Prevent Teen and Unplanned Pregnancy
  – Women’s Foundation of Mississippi

• Other states have passed similar legislation
  – Arkansas

• Highlights need for improved education in younger populations

• Expansion of Personal Responsibility and Education Program focus
Challenges

• Unfunded mandate
  – Year 2, some money was appropriated
  – Still inadequate funding formula

• Lack of oversight

• Limited access to services in rural areas

• Prevalence of abstinence only

• Sex education is controversial regardless of age group
Thank you!

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Q&A

Please type your questions in the Q&A panel.
Thank you for attending

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