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The Center for Innovative Research on Gender Health Equity

POLICY BRIEF

JANUARY 2025

12-MONTH DISPENSING OF SELF-ADMINISTERED CONTRACEPTION IN PENNSYLVANIA

BOTTOM LINE

Offering 12-month contraceptive dispensing in Pennsylvania expands contraceptive access, honors people's reproductive autonomy, and is economically feasible and sustainable for payers.

BACKGROUND

Autonomy over reproduction and reproductive decision-making has been globally recognized as a fundamental human right and is critical to individual and population health and well-being. [1] The ability to access and use contraception is essential to supporting people's reproductive autonomy and helping them to actualize reproductive decisions related to if, when, and under what circumstances to get pregnant and/or have children. In recognition of the important role of contraception in supporting health and wellbeing, the Affordable Care Act (ACA) has mandated most private insurance plans nationwide to cover the full range of FDA-approved contraception without patient cost-sharing.

While the ACA marked a significant gain in contraceptive access in the US, opportunities remain to further advance equitable and meaningful access to contraception. [2] One such opportunity is allowing for an extended supply of short-acting prescription contraception (e.g., pills, patches, vaginal rings) to be dispensed at a single fill. One-year contraceptive supplies have been associated with decreased gaps in contraceptive use, increased contraception continuation, and reductions in unintended pregnancy and abortion. [3, 4, 5] Based on this body of evidence and cost analyses demonstrating that extended supplies are cost-effective and even cost-saving, the Pennsylvania Department of Human Services (DHS) recently implemented a policy change allowing Medicaid Managed Care Organizations (MCOs) to cover 12-month fills of oral contraception. However, many MCOs across Pennsylvania have not implemented this change. Further state legislation would necessitate that payers adopt this evidence-based strategy.

THE EVIDENCE

Typically, prescription contraception is dispensed in 1-month or 3-month supplies in compliance with insurance stipulations, necessitating multiple timely refills annually. Because short-acting contraceptive methods require strict adherence to be effective in preventing pregnancy, gaps between refills are a common cause of contraceptive failure and resultant undesired pregnancy. [3, 5] Research examining the effect of having an extended supply of contraception on hand has demonstrated decreased gaps in use as well as increased continuation, compared to having only three-month or one-month supplies. [3, 5] In one study from California, new users of a one-year supply of oral contraception were 0.5 times as likely to experience a pregnancy-related outcome compared to users with less than a 12-month supply. [4]

Although the potential for wastage is increased with

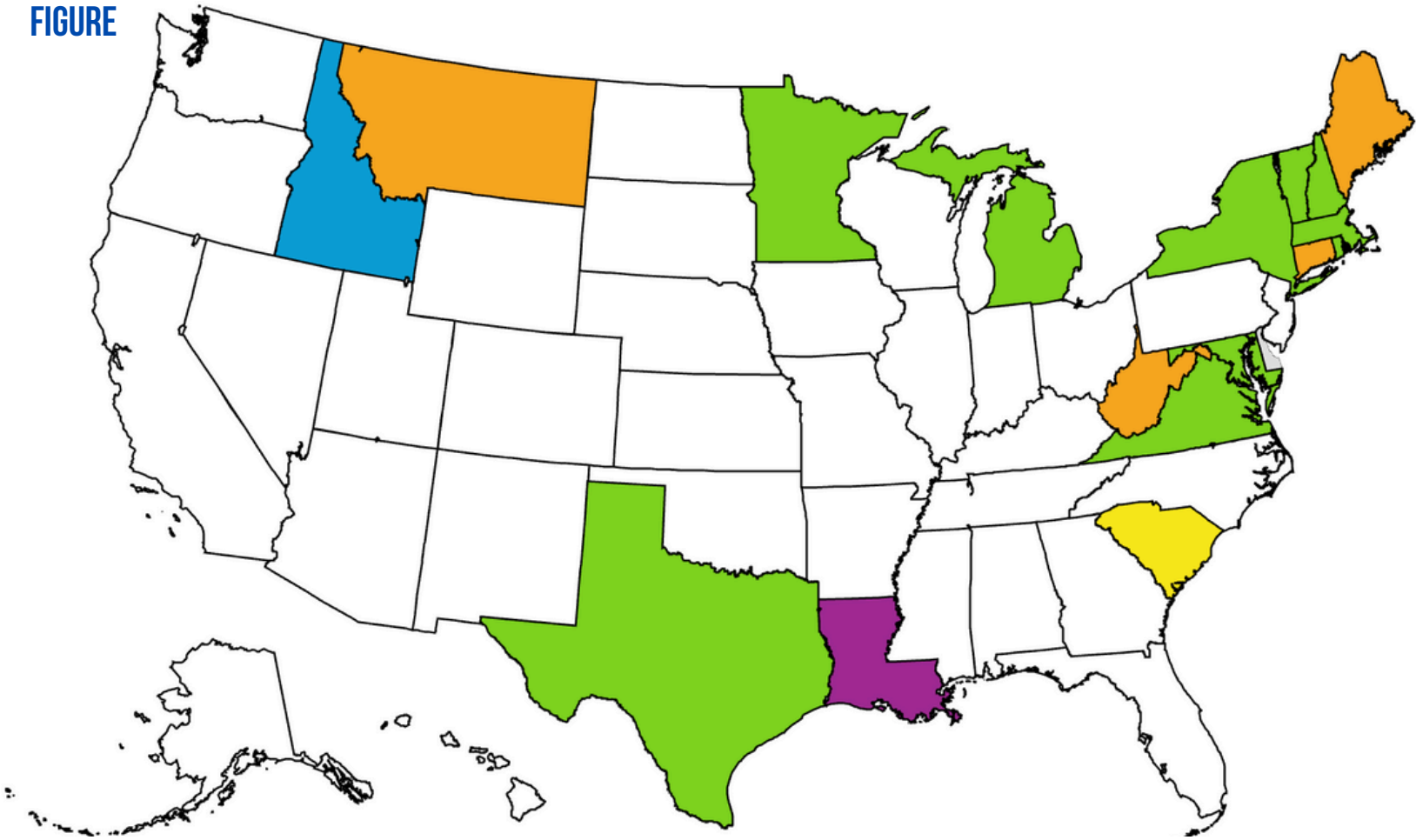
extended supplies, cost analyses consistently show that the savings resulting from averted undesired pregnancies outweigh costs related to any wastage. [7, 8] Thus, offering 12-month contraceptive dispensing could support people's reproductive health and autonomy and is economically sustainable for payers. [6, 7]

IMPLEMENTATION ACROSS THE U.S.

Given the body of evidence in support of extended contraceptive supplies, clinical guidelines published by the Centers for Disease Control and Prevention's Selected Practice Recommendations (SPR) and The American College of Obstetricians and Gynecologists (ACOG) recommend that, at initial and return visits, healthcare providers should offer and prescribe up to a one-year supply of self-administered hormonal contraception. [9, 10] These recommendations have spurred states to implement strategies to allow dispensing of up to twelve months of contraception to patients at a single fill.

Currently, 20 states as well as Washington DC allow 12-month dispensing of hormonal contraception in non-ERISA exempt commercial plans; of those, 15 codify the federal ACA requirement of no patient cost-sharing for these services (Figure). It should also be noted that 23 states allow a 12-month contraceptive option in Medicaid programs. [11]

FIGURE



COMMON QUESTIONS AND CONCERNS

Will patients forgo routine health screens because they are able to receive 12-month supply of contraception?

Prior research has demonstrated that patients are not more likely to forgo routine health care when receiving extended contraceptive supplies. [3] Although patients were seen to have a reduction in number of clinic visits, during those visits 74% of women received cervical cancer screenings (pap smears) compared to only 57% of women who had received one or three months of oral contraceptive pills and also had higher rates of chlamydia screening (69% vs 56%). [3, 8] These findings suggest that patient appointments for those receiving extended contraceptive supplies may accomplish more comprehensive sexual and reproductive health care.

What if patients switch insurance plans? Won't payers lose money on the 12-month supply since the projected savings will not accrue to the original insurance plan?

A state-wide mandate requiring all plans to cover a 12-month supply will eliminate this potential risk. Self-administered contraception is inexpensive and holds minimal financial risks for payers. When looking at the state of California's 12 month dispensing law, the California Health Benefits Review Program saw a decrease in total net health care expenditures by .03% ($43 million) in 2016 due to the avoidance of undesired pregnancies and related costs. [6]

Even if insurers are mandated to allow extended contraceptive supplies, how do we change provider behavior?

State policies of this nature are critical but not sufficient to ensure access to extended contraceptive supplies. In a Massachusetts study exploring clinician perspectives on 12-month dispensing, they found that 58% of the clinician participants were unaware of the expanded access law. [17] This means that awareness and behavior needs to be addressed during the implementation phase. Implementation strategies could include public awareness campaigns, education outreach for prescribing, allowing pharmacists to authorize changes in supply amounts, and creating 12 month supply defaults in EMR ordering systems. [12, 13] In one implementation study, providers in Massachusetts felt that having a multifaceted educational outreach campaign could successfully change prescribing behaviors and address barriers on the patient, clinician, organizational, and environmental levels. [14]

Our plan authorizes 3-month dispensing with four automatic refills. Isn't that the same as 12-month dispensing?

Receiving 3-month supplies still requires patients to go to the pharmacy for four additional fills over the year. Unlike most other medications, contraception requires strict adherence to be effective and avoid an undesired outcome. For example, missing more than 2 consecutive pills puts people at significant risk for contraceptive failure and subsequent undesired pregnancy. Moreover, difficulty obtaining hormonal contraception, such as picking up a prescription, doubles an individual's likelihood to discontinue that method. [15] While mail order services exist, only 9.8% of Americans have ever used mail order prescriptions, and delays in mail delivery are of significant current concern and can lead to negative reproductive outcomes [16]. Moreover, for individuals impacted by housing insecurity (25% of American adults) and those for whom discretion regarding contraceptive use is important (including dependents or those in abusive relationship), mail order prescriptions are not an option.

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