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All Methods for All: Funding comprehensive contraceptive programs for everyone

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Due to interlocking systems of structural oppression such as racism, bias, and discrimination, many people who desire contraceptive information and services are not able to obtain them. In 2018, about 73 million people in the United States were of reproductive age, and about 63 percent did not desire to become pregnant.[1] Researchers estimate that nearly all women will use a method of contraception to achieve their reproductive desires and manage their reproductive health during their reproductive life course.[2]* Of these contraception users, about one-third will require public assistance to access contraception-related information and services.[3] Regardless of insurance status and income, barriers in access to contraception persist. The need for contraception among people with the ability to give birth highlights how these services are essential for sexual and reproductive health and well-being and are of great public health importance.

CONTRACEPTIVE COERCION

Currently, people desiring contraception-related information and services face systemic and structural barriers to contraception access. As the American Public Health Association states, "contraceptive coercion refers to any attempt to influence or control someone's access or ability to use or not use contraception as they wish."[4] Much of the contraceptive literature on coercion has focused on the role of sexual partners, but more attention is needed for how healthcare providers, institutions, and structural barriers limit people's reproductive autonomy. Qualitative public health research describes coercion at each of these levels, which may be explicit, such as a provider pressuring an individual to initiate contraception use, or implicit, such as a provider's refusal in helping people discontinue or switch contraceptive methods or healthcare facilities (i.e., religiously affiliated hospitals and clinics), limiting which contraceptive options are available.[5,6,7] Other research has highlighted how public health programs may limit people's contraceptive options by exclusively offering highly effective forms of contraception, such as long-acting reversible contraception (LARCs), with no cost-sharing while maintaining costs for other methods.[8,9] Offering the full range of contraceptive options and related information with limited financial barriers and constraints in an affirming manner can help address ongoing structural inequities in contraception access.

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>
> — *American Public Health Association*

COST DEFINITIONS

Cost-Sharing: insurance companies pay part of the cost and the individual with the insurance needs to pay out-of-pocket for the rest

No Cost or No Cost-Sharing: full share of costs covered with no out-of-pocket costs for the individual

* Population Institute (PI) intentionally uses women in statements where the data do not include nonbinary people or trans men in the research. Otherwise, PI uses gender-inclusive language to represent all individuals who may seek contraceptive information and services.

THE NEED FOR NO COST CONTRACEPTION

Ensuring that people have access to the full range of contraceptive options is critical for achieving health equity and promoting reproductive justice and autonomy. From a health equity stance, public health practitioners, healthcare providers, federal and state governments, and healthcare and medical insurance payors should work to dismantle barriers in access to care that may take the form of a lack of transportation, method unavailability, insufficient insurance coverage, and other financial constraints. Increasing access can be achieved through less cost-sharing, fewer restrictions on preferred methods, increasing self-managed methods or telehealth options, enabling people to discontinue methods when they desire, and government assistance in paying for all contraceptive methods, including those that are non-hormonal.

CONTRACEPTIVE METHODS	
Hormonal: A type of contraception that uses hormones, such as estrogen and/or progesterone, to prevent pregnancy	**Non-Hormonal:** A type of contraception that does not impact the user's hormones
Birth Control Pills	Cervical Cap
Hormonal IUD	Condoms, including internal condoms
Implant	Copper IUD
Patch	Diaphragm
Shots	Spermicide
Vaginal Ring	Sponge
	Vaginal Gel
	Fertility Awareness
	Basal Body Thermometer
	Sterilization

Furthermore, people's access to contraception is also impacted by structural factors such as capitalism, racism, gender-based discrimination, and other forms of sociopolitical and reproductive oppression. The needs of those the health system has excluded or harmed in the past must be centered when focusing attention on expanding access to contraception; however, everyone who desires access to contraception should be able to obtain the method(s) they prefer without cost and coercion.[10] For example, while the *Patient Protection and Affordable Care Act* (ACA) added protections to expand contraception access, people continue to experience difficulty accessing contraception through changes in policies, such as exemptions on religious and moral grounds and states' refusal to expand Medicaid eligibility to cover more low-income Americans.[11,12]

THE ACA BIRTH CONTROL BENEFIT

The federal contraception coverage guarantee, commonly referred to as the Birth Control Benefit, is a provision under the ACA that requires most private health plans to cover the full range of FDA-approved contraceptive methods, services, and counseling without any out-of-pocket costs.[18] Plans, however, are not required to cover drugs to induce abortions and services for male-controlled methods, such as vasectomies. Additionally, 'grandfathered' plans purchased before March 2010, church plans, plans affiliated with a house of worship, and plans from employers and universities with moral objections are exempt from this requirement.[19] The National Women's Law Center estimates that as of 2017, 62.4 million individuals had insurance that covered contraception, saving an average of $255 per individual per year in out-of-pocket costs.[20, 21]

Moreover, providers who are unable to offer free and low-cost contraception through government programs may rely on non-profit or private funders that restrict which options are available to service users. National organizations, public health scholars, and reproductive justice advocates oppose programs that exclusively offer LARCs or other forms of highly effective contraception at significantly lower costs or for free over other methods, as this inherently limits people's options.[13,14,15] When the full range of contraceptive information and services are not offered to everyone at no cost, people have differential access to their preferred method(s) and experiences of care.[16,17] Therefore, to ensure that people have access to their preferred contraceptive method(s) with adequate education and any necessary support from trained health professionals, all contraceptive methods should be available at no cost.

RECOMMENDATIONS

To offer adequate and appropriate contraceptive information and services to a diverse group of service users, the federal government should mandate that all methods of contraception be made available to those who desire these services, including those who have previously been denied access based on their sexual or gender identity. Funding the provision of person-centered and comprehensive contraceptive counseling and related contraceptive supplies so that services can be provided at no cost is a crucial step in achieving equity. To do so, the federal government should:

Cover the cost of offering comprehensive education, counseling, and support from diverse healthcare providers (i.e., physicians, nurses, health educators)

Public health departments, Title X, the ACA Birth Control Benefit, Medicaid providers, and other federal and state-funded family planning providers, hereafter referred to as government programs, should diversify where people can obtain reputable and comprehensive information about their sexual and reproductive health, and enable people to obtain contraception inside and outside the formal healthcare system. They must also ensure that culturally responsive materials are available and include healthcare providers with diverse backgrounds, genders, racial and ethnic identities, sexual orientations, and physical abilities.

Broaden coverage to include all contraceptive methods, including non-hormonal methods

Government programs that only provide funding for "female-controlled" hormonal methods limit the support offered to people who would benefit from learning about and using the full range of contraceptive methods, including non-hormonal methods. Additionally, out-of-pocket costs for non-hormonal methods are common, further restricting people's options and making it potentially difficult to use multiple methods, such as a hormonal methods and condoms. Other preferred methods, such as spermicide, may be cost-prohibitive for those with and without insurance. Instead, a federal mandate should require all government programs to include the full range of contraceptive methods, hormonal and non-hormonal, in all contraceptive programing.

Ensure coverage for a robust method mix, including self-managed options

Healthcare and medical insurance payors are not required to cover multiple types of the same contraceptive method, which restricts people's options if they want to use a particular product such as a name brand versus generic or a different kind of hormonal option such as Kyleena rather than Mirena. Instead, a federal mandate should require all payors to cover several options per method category with differentiated profiles to ensure that people have access to more methods at no cost.

Fund ongoing innovations to increase access to contraception

Government programs need to build the health system's capacity to respond to service users' needs by ensuring access to a diverse range of contraceptive options through avenues like over the counter, telehealth, home delivery, pharmacy access, extended supply, and self-managed options. Making methods accessible, self-managed, and virtual at no cost to service users can facilitate equitable access to contraception. In addition, for those who may need assistance with non-hormonal methods, counseling and education should be available at no cost.

Support training in reproductive justice, anti-racist, person-centered, and healing-centered contraceptive counseling

In maintaining the equitable provision of contraceptive information and services that meet people's needs, those who prescribe hormonal methods and assist people in deciding what contraceptive options are right for them should be required to complete justice-focused training that centers people's needs in conversations, aligns their counseling and education practices with equity-oriented frames, and supports people in their reproductive decisions.

Endnotes

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