

**Medicaid Family Planning Programs and Contraceptive Autonomy: A Comparative
Analysis of Four U.S. States**

by

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Abstract

Contraception, otherwise known as birth control, is when individuals use a single contraceptive method, like a device or medication, or a combination of two or more methods to prevent pregnancy. In the United States, contraceptive methods are designed, improved, and perfected by private or public organizations. The U.S. Food and Drug Administration (FDA) approves methods to ensure efficacy and trustworthiness for consumer use. Contraceptive access is fundamental to healthcare to prevent or plan a pregnancy, which in turn may allow reproductive-aged men and women to achieve their desired level of socioeconomic and individual-level freedoms. Medicaid, a state-federal program for low-income individuals, is the largest single-payer for contraception, covering 75% of publicly funded family planning services. Federal law outlines the minimum standards for family planning services covered in state Medicaid programs, where each state allows a certain percentage of funding for contraception available to their respective Medicaid beneficiaries. Despite these federal baseline rules, state-by-state variation in contraceptive coverage and accessibility creates uncertainty around the options available, which can cause individuals to forgo treatment or make a suboptimal reproductive health decision. This paper discusses the [burden] variation in state contraceptive availability in Pennsylvania, West Virginia, Ohio, and Maryland Medicaid programs. The paper will provide evidence of the need for increased contraceptive autonomy for Medicaid beneficiaries and how may reduce

socioeconomic barriers. Recommendations to improve access to contraception to increase contraceptive autonomy will clarify the coverage mandates for contraception by the federal government and focus on the navigability of the state-regulated government website. The limitations of this analysis are also discussed.

Public Health Significance: State-by-state program implementation variations can lead to decreased access and knowledge when an individual seeks contraceptive services. In the United States more than thirty million females are enrolled in Medicaid and more than half are under 50. This policy brief will identify the different structural components of Medicaid Family Planning Services in Pennsylvania, Ohio, West Virginia, and Maryland. The future implementation recommendations will provide valuable references for policymakers and Medicaid beneficiaries for a safe and effective understanding of contraceptive options and how access to these services varies.

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1.0 Introduction

All individuals including men, women, and couples may discuss using contraception with their health care providers throughout their reproductive years. Common contraception methods include oral pills, implants, intrauterine devices, vaginal rings, and permanent methods like tubal sterilization and vasectomy. While many individuals will use contraceptives to prevent pregnancy, many individuals will seek out contraception to regulate their menstrual cycles, reduce the side effects associated with pre-menstrual pain and pain during menstruation, and potentially reduce the side effects of other medical conditions or diseases.¹ Access to equitable and adequate family planning is recognized globally, with the United Nations Population Fund citing “family planning is central to gender equality and women’s empowerment, and it is a key factor in reducing poverty.”² Family planning services, per the Centers for Disease Control and Prevention, are programs and services “so that individuals can achieve their desired number and spacing of children, increase the chances that a baby will be born healthy, and improve their health even if they choose to not have children.”³

Reproductive autonomy is “an individual’s ability to be fully empowered agents in their reproductive needs and decisions and to access reproductive health services without interference of coercion.”⁴ Contraceptive autonomy is one component of reproductive autonomy: it is the ability to have appropriate access to, information about, and the ability to choose one’s preferred method, while reproductive autonomy encompasses all aspects of reproductive health.⁵ Accessibility and use of the preferred contraceptive method are crucial to empower and allow women to make informed decisions about their reproductive health, including when or when not to become pregnant.

Contraceptive use is common in the United States. The 2022 Kaiser Family Foundation Women’s Health Survey, a nationally representative survey of individuals who identify as female or other genders between the ages of 18-64, found that 90% have used at least one form of contraception in their reproductive life.⁶ Despite the ubiquity of contraception in American adult life, individuals still face widespread barriers to accessing their desired form of contraception at the desired time. Barriers to access include individual-level factors, community norms and infrastructure, socioeconomic inequalities, geographical variance, and national and state policies.⁷ Financial concerns, like high out-of-pocket costs if someone chooses to see an out-of-network provider or chooses a contraceptive method that is not covered by their health insurance plan, are a common barrier to equitable contraceptive access.

Through the Affordable Care Act, individuals of reproductive age (15-49 years) can access a range of contraceptives at low or no cost, but 4 in 10 women do not know that most health insurance plans are required to cover the full cost of contraception.⁶ Lack of knowledge surrounding contraceptive coverage can also influence patients’ preferred method and choice. In the same 2022 Kaiser Family Foundation national health survey, 17% of women who live on lower incomes attribute their not using a preferred method to the cost of contraceptive care, and 1 in 5 women stopped using contraception due to the inability to afford the preferred method.⁶ The Guttmacher Institute’s Reproductive Health Study found that even with health insurance coverage individuals struggle to cover the remaining costs associated with reproductive health services, and lack of health insurance contributed significantly to delayed access or difficulty obtaining the preferred method of contraception.⁸ Financial barriers are not exclusive to the cost of care, but also include the loss of wages to attend the appointment, transportation fees, and if applicable childcare.⁷ For an individual to have contraceptive autonomy and reproductive autonomy, they

must have the ability to obtain their preferred contraceptive method while continuing to maintain financial stability in all areas of their life.

In addition to financial concerns, a person's geographic location can pose additional barriers to contraceptive use.⁷ Public and private health insurance plans cover a wide range of contraceptive methods, but failure to provide comprehensive coverage can lead to individuals lacking the reproductive autonomy necessary to make decisions about their health. In turn, contraceptive deserts can develop—areas where “the number of health centers offering the full range of methods is not enough to meet the needs of the county's estimated number of people eligible for publicly funded contraception.”⁷ Contraceptive deserts restrict the ability of an individual to have full reproductive and contraceptive autonomy. Provider shortages are expected to rise over the next decade, with the Association of American Medical Colleges predicting shortages of providers by 2032, with an estimated decline of 46,900-121,900.⁷ Of particular concern is a decline in specialty providers like obstetricians/gynecologists, corresponding with increased demand for reproductive health care providers and services, by 2030.⁷ In addition to provider shortages, the Health Resources and Services Administration (an agency of the Department of Health and Human Services) predict deficits among registered nurses and licensed practical nurses.⁷ Healthcare provider shortages will impact the access to care, and the ability for an individual to freely choose their preferred contraceptive method.

The lack of availability of a preferred contraceptive method or licensed healthcare provider can be attributed to the variability in state and federal reproductive health legislation. The American College of Obstetricians and Gynecologists reported in 2023, twenty states have restrictions for certain groups of minors to consent for contraceptive services.⁹ Regulations on contraceptive access may decrease an individual's ability to obtain contraceptive autonomy.

Burwell v Hobby Lobby Stores Inc., 2014, the United States Supreme Court heard arguments surrounding the viability of the Religious Freedom Restoration Act of 1993. The Supreme Court ruled that closely held [religious] organizations are not required to include “preventative care and screenings” through employer-sponsored health insurance.¹⁰ The precedent set forth in the 2014 ruling created an avenue allowing closely held religious organizations to exclude reproductive health screenings and preventative care coverage to their employers. Allowing someone to choose their preferred method of contraception must include access to an available health center and provider offering a range of method options, and an ability to afford care.

In the current analysis, I explore reproductive and contraceptive autonomy by evaluating state-level Family Planning Medicaid contraception policies and state-level government websites in Maryland, Ohio, Pennsylvania, and West Virginia. Specifically, I ask and answer these questions:

1. How do state-level Medicaid Family Planning contraceptive policies support or hinder reproductive and contraceptive autonomy?
2. How do state-government websites on Medicaid Family Planning contraceptive policies support or hinder reproductive and contraceptive autonomy?

2.0 Methods

For this thesis project, I first conducted a narrative literature review of contraceptive and reproductive autonomy as they intersect with Medicaid contraception policy. I chose Maryland, Ohio, Pennsylvania, and West Virginia to analyze the Medicaid policies due to the difference in eligibility requirements and policy variation for accessibility of contraceptive methods within the same geographic region. I conducted a series of PubMed and Ovid searches for relevant manuscripts published between 2000-2023 using the following terms: “contraception,” “Medicaid and contraception,” “reproductive autonomy,” “reproductive autonomy and Medicaid,” “Medicaid programs and contraception,” “state Medicaid and contraception,” and “unintended pregnancy.” The literature included research conducted both in the United States and internationally. Through an exhaustive review of the manuscripts obtained from these search terms, I read the abstracts to initially understand if the article contained relevant information for this examination. After this initial review, I outlined the relevant resources necessary to provide a comprehensive overview of federal and state Medicaid programs that pertain to reproductive and contraceptive health.

To extract data from each state Medicaid website and/or policy, along with several private or public organizations, I created a data abstraction form that included the following variables of interest: Medicaid expansion and the date of incorporated expanded eligibility policies, the Federal Poverty Level (FPL) for eligibility, FPL eligibility for pregnant women, enrollment increase for Medicaid and Children’s Health Insurance Program (CHIP) (as a percentage), FPL for Family Planning Program(s), eligibility criteria for state Family Planning Programs, contraceptive and services covered by Family Planning Program(s), and dispensing and/or prescribing authority for nurses/pharmacists.

To examine data from each state Medicaid and/or Children’s Health Insurance Program (CHIP) website and/or policy, I documented the Modified Adjusted Gross Income (MAGI) as of July 1, 2022, for CHIP in all age groupings, MAGI for children if separate CHIP was available, MAGI if pregnant women CHIP was offered, and if the state offered CHIP reproductive coverage.

The Modified Adjusted Gross Income, MAGI, is a metric used by the federal government “to determine the eligibility for premium tax credits and other savings for Marketplace health insurance plans and for Medicaid and the Children’s Health Insurance Program (CHIP).”¹¹ To determine MAGI, the amount of a family or individual’s adjusted gross income (AGI), untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest are added together to calculate MAGI. Medicaid and CHIP are both means-tested programs, which rely on MAGI to determine if a family and/or individual are eligible compared to the FPL of the state eligibility criteria. The Federal Poverty Level, FPL, is an annually assessed and adjusted for inflation measure of economic stability regarding family and/or individual income and if the income earned is suitable to provide the minimum necessities (food, clothing, shelter, etc.). A family and/or individual is eligible for Medicaid when their FPL is equal to or less than the state-set percentage. States determine the FPL eligibility criteria for Medicaid, which creates variability for individuals that qualify for assistance. As eligibility varies across state borders, the variation in coverage causes barriers to accessing equitable healthcare coverage.

Finally, I used qualitative content analysis to open code information to analyze the state Medicaid websites, along with several private or public organizations.¹² For each state Medicaid website, I documented if the website was written with plain language, the literacy level of the written context according to the Flesch-Kincaid Scale, visual accessibility compliance, availability

of disability accommodations, clearly linked resources and if linked were the resources reputable, and additional language options.¹³⁻¹⁷

3.0 Literature Review

The federal government sets the minimum standards for family planning coverage. Federal minimums for Medicaid family planning services include but are not limited to, contraception, testing/screening, and education/counseling. Many states will meet the minimum guidelines for contraceptive coverage, but some states have gone beyond these guidelines.¹⁸ Variation in reproductive health coverage can range from contraceptive methods offered, counseling services, screening/treatment, state mandates for refusal of coverage for religiously affiliated organizations/institutions, emergency contraception, abortion services, or preventative services offered.¹⁸ Variability in reproductive services includes not only the availability of services, but also state variation is present in prescribing and dispensing authority for licensed health providers. To ensure contraceptive autonomy, a state must provide a comprehensive list of contraception and have a range of providers who can provide services and contraceptive method(s). The following sections will review peer-reviewed and gray literature on reproductive and contraceptive autonomy, state plan amendments, waiver programs, the federal Title X program, Children's Health Insurance Program (CHIP), prescribing and dispensing authority of contraceptives, federal Medicaid family planning programs, and state-regulated Medicaid programs to illuminate the variation of state-to-state contraceptive access and state-level government website accessibility.

3.1 Reproductive and Contraceptive Autonomy

Reproductive autonomy is the ability to freely choose how and when to use contraceptives and, if wanted, to become pregnant.⁴ Contraceptive autonomy encompasses three components: informed choice, full choice, and free choice.⁵ Informed choice is when someone can decide on their contraceptive care, through unbiased information about the risk and benefits of methods or methods available.⁷ Full choice is when there is a full range of available methods that someone can choose from.⁷ Free choice is the ability to decide whether to use contraception or not, and a decision was made voluntarily without coercion or barriers to access.⁷

When making informed decisions about reproductive health care, an individual must understand what methods are available and choose their preferred method; in many instances the preferred method may not be available, leading someone to choose an option that may not support their lifestyle, a method that is not optimal for their health, or no method at all.¹⁹

Barriers to accessing reproductive health care can be due to insurance, providers, or contraceptive method(s) offered.⁴ When an individual encounters barriers to accessing reproductive healthcare, they may feel less empowered to making decisions or less confident in their contraceptive autonomy. One frequently-cite consequence of inadequate access to contraception is unintended pregnancy. Unintended pregnancy is a pregnancy that occurred when the person wanted to become pregnant in the future and not in the present, or when a woman did not want to become pregnant in the present or at any time in the future.²⁰ Pregnancy may not always be wanted for a woman and can have a devastating impact on their life if they must carry out a pregnancy.

For an individual to achieve reproductive autonomy, they must have access to providers licensed to prescribe and trained with the appropriate skills to provide various contraceptive

options. Geographic barriers cause a lack of understanding and access to a full range of contraceptives. A telephone survey study of providers in Hawaii identified geography as the main barrier to contraceptives.²¹ In this analysis, the study team interviewed provider offices across the state to determine how providers licensed to provide contraceptive care varied and what contraceptives were available to eligible individuals. In the state of Hawaii, Title X programs provided reproductive care for individuals.²¹ Title X grant funding is a competitive award process, with funding to nonprofit private and public community-based clinics.²² In 2019, Hawaii was one of six states to end Title X programs and thus decrease of funding for reproductive health care services.²¹ Through the series of telephone interviews, the study inquired about the types of contraceptives offered and if at least one method of Medicaid was accepted. The Hawaii study highlights why geography is a barrier to access and use of contraceptives. The most common forms prescribed were the pill/patch/ring, but these may not align with the preferred method of the individual receiving the care.²¹ With the lack of licensed or trained providers to provide reproductive care, the patient-centered approach to reproductive health was a failure. Individuals may choose a method that is not preferred, leading to a lack of contraceptive autonomy.

3.2 State Plan Amendments and Waiver Programs

One-way states can support reproductive, or contraceptive, autonomy through expanding access to contraceptive coverage in Medicaid via State Plan Amendments (SPA) or waiver programs. SPAs and waiver programs allow a state to receive federal funding and expand coverage at a quicker rate, than if the state waited for Medicaid expansion to implement new coverage guidelines. Through waiver programs or a SPA, states could expand access to contraceptive

coverage in Medicaid.²³ States were not required to expand access, through traditional Medicaid, SPAs, or waiver programs. Waiver programs are state-dependent and funded through the federal government.²³ Waiver programs are implemented with a designed end date and required Centers for Medicare and Medicaid Services (CMS) approval but could be re-implemented if there was value gained.²³

Waiver programs require states to collect, interpret, and analyze data on the impact the program had. As a function of the federal government, waiver programs are designed to allow states to implement or improve new programs. States that implemented waiver programs provided examples and data on the decreased rates of unintended pregnancy, improved the timing of [wanted] pregnancies, increased effectiveness of contraceptive method(s), and cost-effectiveness of the program for state budgets.²³ Data from states with waiver programs implemented recorded \$159 million in annual cost savings.²³ State waiver programs can help increase the number of individuals who are eligible for coverage and increase the accessibility of contraception. When a waiver program was proven a success, a SPA could be implemented to formally adopt the program.²³ SPAs and waiver programs differ for several reasons, but permanence is the main factor. State legislation would permanently enact the use of the waiver program expansion for contraception, but state variation created differences in eligibility.

3.3 Title X Family Planning Program

The Title X Family Planning Program was established in 1970 through the federal government, as a provision of the Public Health Service (PHS) Act.²² The Department of Health and Human Services (HHS) administers grants through the Office of Population Affairs (OPA)

and operates as the only federal funding [domestic] specifically for family planning and related health services.²⁴ Title X clinics may use federal funding to offer a broad range of reproductive and family planning services including 1) screening and testing for infection, disease, cancer, pregnancy, or other non-reproductive health issues; 2) reproductive health examinations; 3) counseling and administration of contraception; 4) abortion counseling or referral for services (upon request); and 4) performing basic lab tests.^{24,25} Title X family planning services have strict funding guidelines, where no funds cannot be allocated to clinics where abortion is offered as a family planning services (42 U.S.C. §300a-6).²⁶ Funding for abortion services has been a long-standing prohibition for Title X grantees, yet clinics were operational and compliant with the regulations to provide counseling or referral for their patients.²⁷

In 2019 the Trump administration issued a final rule, *Compliance with Statutory Program Integrity Requirements*, which reversed nearly a decade-long regulation that ensured protections for providers and patients.²⁷ The 2019 final rule required abortion-related activities and all other activities to have complete financial separation.²⁷ Federal Title X funds were prohibited for abortion referral, irrespective of a patient's request, and must be referred to prenatal care.²⁷ In addition to financial separation of abortion-related services, "pregnancy options counseling" were eliminated and authorized only advanced practice providers to offer "nondirective counseling."²⁷ Prior to the 2019 final rule all patient records remained confidential, but under new regulations adolescent patient's records must include detailed information on "the age of their sexual partners and specific actions taken to encourage family participation."²⁷ Ramifications of the 2019 final affected providers and patients, with an estimated 981 clinics exiting the Title X program and six states lost all remaining Title X health care providers.²⁸ From 2018-2020 there were 6.5 million

family planning visits and 3.9 million individuals who received care, which decreased significantly to 2.7 million visits and 1.5 million individuals receiving care.²⁹

To combat the devastating effects of the 2019 final rule the Biden administration promulgated a final rule in 2021, *Ensuring Access to Equitable, Affordable, Client-Center, Quality Family Planning Services*.³⁰ The 2021 final rule has three categories where changes were made: quality, access, and equity.³⁰ These three areas have newly implemented regulations to ensure that individuals who visit Title X clinics can receive a higher standard of reproductive care. Quality access to care is essential to providing family planning services, and the 2021 final rule integrated a client-centered approach and “a comprehensive definition of family planning that is aligned with the Providing Family Planning Services Recommendations (QFP).”³⁰

QFP recommendations are established by the CDC for providers and health care professionals to ensure that individuals can achieve reproductive and contraceptive autonomy, no matter their pregnancy intentions.³ The 2021 final rule removed the barriers for providers to maintain separation of abortion and all other family planning services.³⁰ To ensure adequate access to contraception, all sites that were not offering on-site availability of broad range of contraceptives must “provide a prescription to the client for their method of choice or referrals, as requested.”³⁰ Regulatory protections for adolescence re-established confidentiality of their protected health information.³⁰ Equitable access to family planning services is essential for all individuals and reaffirms the goal of providing care to any person regardless of their socioeconomic standing. Under the newly re-established contingencies of Title X programs and incorporation of comprehensive regulatory guidance, individuals may be able to access their preferred method of contraception.

Although the 2021 final rule established regulations regarding abortion care and services, the preamble states “objecting individuals and grantees will not be required to counsel or refer for abortions in the Title X program in accordance with applicable federal law.”²⁴ Health care providers have longstanding protections for refusal to provide care “on religious or moral grounds.” Providers who refuse to provide care based on conscience rights cannot impede or infringe on the health care services another provider continues to deliver. Medication and procedural abortions are still prohibited, but counseling and referrals are available to Title X clients.

3.4 Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program (CHIP), formally Separate Children’s Health Insurance Program (SCHIP), was enacted in 1997 through the Balanced Budget Act of 1997.³¹ The creation of CHIP was implemented to increase the number of children who would be covered by state health insurance programs, where the program established a mechanism for families with children whose income is greater than the Medicaid eligibility requirements to qualify or could not otherwise obtain health insurance via private or employer-sponsored coverage.³¹ Funding and coverage for CHIP beneficiaries can be implemented using funds specifically allocated for CHIP, by expanding Medicaid coverage, or through a combination of the two.³¹

CHIP is a federally regulated program, which utilizes state and federal funding for coverage. Unlike the infrastructure requirements for State Medicaid, CHIP programs were designed to create more flexibility in the state level policy enactment.³² To encourage states to implement CHIP programs, the federal government increased the allocation of federal funds and

state-by-state adaptation.³² The differences in program structure created uncertainty surrounding the establishment of CHIP programs state-to-state, but as of January 1, 2000 every state or territory (including Washington, D.C.) in the United States had an approved CHIP program with enrolled, eligible beneficiaries utilizing coverage.³¹

3.5 Federal Medicaid Family Planning Programs

The Social Security Amendment of 1965 established the joint state-federal Medicaid program, as an expansion of the Kerr-Mills program, which initiated coverage for “families with children, the blind and the disabled.”³¹ As of 1972 state Medicaid programs are required to cover family planning services, including reproductive planning, and care for males and females.³³ Prior to the ACA, the federal government allocated federal funds to states for contraceptive services.²³ Using federal funds, 89% of states in 2002 offered state insurance coverage for contraception.²³ Under the ACA, the federal match for expansion states started at 100% funding for expansion state, with the rate dropping to 90% in 2020.³⁴ Non-expansion states must bear the majority of the financial burden for state Medicaid programs, causing the federal government to further incentivize expansion which could create a fiscal benefit for all Medicaid state-run programs.³⁵ Funding from the federal government for Medicaid and Family Planning Programs varies due to state discretion of coverage implementation of family planning services, which can lead to an inability for medical professionals to provide patient-centered care and have downstream impacts both the providers and patients.

Although coverage of contraceptives in Medicaid and CHIP (and most commercial health plans) is required now under the ACA, a national survey found that four in ten (41%) of women

or individuals who identify as female, did not know that the majority of health insurance plans covered contraception⁶. Expanded access to contraception and reproductive health includes preventative care, screenings for sexually transmitted diseases and infections (STD/Is), and counseling. Abortion coverage and financing has been a long-contested issue at the state and federal level. In 1978 the Hyde Amendment prohibited the use of federal funds by Medicaid programs for abortion care or services, where Medicaid funds for abortion could only be used when the life of a woman would be endangered through continuing the pregnancy.

The Affordable Care Act enacted policy regulations to ensure that individuals who were not previously eligible for Medicaid now have equitable health care coverage. The ACA initially attempted to enact an individual mandate and the Medicaid expansion provision. The individual mandate required most Americans to have health insurance or pay a penalty, while the expansion provision created conditional funding for states where they must expand their Medicaid programs, or they would lose a significant portion of federal Medicaid funding. The Supreme Court (*National Federation of Independent Business v Sebelius, 2012*) established that the individual mandate was allowable under federal taxing power, and the Medicaid expansion provision is unconstitutional.³⁶ The individual mandate was upheld by the Supreme Court as a valid use of the Congress' power to tax, while the expansion mandate is unconstitutional and prohibited the Secretary of Health and Human Services from withholding federal funding. This ruling established that states do not have to expand coverage for newly eligible or otherwise ineligible populations beyond federal Medicaid eligibility requirements. Currently there are forty states (including Maryland, Ohio, Pennsylvania, and West Virginia) with expanded Medicaid programs, eleven without Medicaid expansion, and one with planned Medicaid expansion program (implementation July 1, 2023).

Even with the federal mandate, contraceptives are not as widely available as legislators hoped for with newly implemented Medicaid expansion. The expansion of family planning programs must undergo federal approval, with the federal government funding a portion of the cost. Since the implementation of the ACA, numerous federal and state legal challenges have been heard. Religious and religious-affiliated organizations fought against the contraceptive mandate and the requirement that contraception be offered through employer-sponsored health insurance. HHS adopted new rules for non-profit and for-profit religiously held organizations. Under the adopted rules, religious institutions (houses of worship) could be exempt from providing contraception to their employees; non-profit and for-profit organizations are presented with the same accommodations as corporations with closely held religious objections.²³ Under the new precedent, these religious organizations or corporations must submit to the federal government reasoning and explanation for an accommodation for exemption of contraceptive coverage; while organizations and institutions can apply for an accommodation, they are reviewed individually and approved if the standards are met.

With the passage of the ACA in 2010, any individual 19-64 years of age and with an income of less than or equal to 138% of the federal poverty level (FPL) could be eligible for Medicaid in participating expansion states.³⁷ Income eligibility for Medicaid, CHIP, and the health insurance marketplace was established through the ACA, using MAGI in an attempt to create consistency across states and federally regulated state programs.³⁸ Expanded coverage for contraception created inconsistencies and barriers to care across states. Attempting to combat inconsistencies, HHS had the Institute of Medicine (IOM) establish which services should be covered as preventative services, which include “[a] full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.”²³ IOM

created the list of preventative services in 2011, which was adopted through HHS in August 2012.²³ While the federal mandate sets the minimum standards for contraceptive coverage (including 18 available methods designated by the U.S. FDA, contraceptive counseling, and other related services), state legislation varies on what methods are available for use.¹⁸

3.6 State-Regulated Medicaid Programs

Family planning programs are a limited benefits program within state Medicaid programs; this allows people who may not be eligible for full Medicaid coverage in their state to apply for the family planning program and receive family planning specific care through this service. Ninety percent of Medicaid family planning services paid by the federal government with states contributing the remaining ten percent and no patient cost-sharing.^{37,39} Funding for the federal match program is state-dependent, where the size of the state population can influence how much funding will be awarded.³⁹ Inconsistencies in funding and allocation of available contraceptive methods can cause confusion among Medicaid beneficiaries. Even with the federal match program to increase funding for Medicaid services, not all states are required to expand the eligibility of the program.⁴⁰

At a minimum federal law pertaining to family planning outlines that states' providers cannot charge copayments of any form of patient cost sharing for eligible beneficiaries, federal funding of 90% and state funding of 10%, and establishes that beneficiaries can obtain family planning services from any Medicaid provider (free choice of provider).⁴¹ Each state that expands access to reproductive health care will individually regulate and maintain what services are offered to those that are eligible. Variability in states' programs will dictate when/how/what/who can

receive coverage through the Family Planning Programs.⁴⁰ Discretion of states' implementation of expanded Medicaid programs creates four pathways of coverage⁴¹:

1. ACA Medicaid Expansion and Family Planning (only SPA/Waiver), 19 states
2. ACA Medicaid Expansion and no Family Planning (only SPA/Waiver), 18 states and Washington, D.C.
3. No ACA Medicaid Expansion and Family Planning (only SPA/Waiver), 9 states
4. No ACA Medicaid Expansion and no Family Planning (only SPA/Waiver), 4 states

An analysis of Georgia's Medicaid Family Planning Waiver provides evidence that waiver programs can positively influence the effectiveness of contraceptive usage and increase the rate at which individuals use contraception when no method was previously used.⁴² Georgia's state bill P4HB, Georgia Planning for Healthy Babies Program, expanded access to reproductive health counseling, and family planning services for uninsured women.⁴² The Georgia waiver program was implemented in conjunction with the use of Title X clinics. Data from the assessment of the Georgia program shows that the implementation of a waiver program can reduce the number of individuals who use Title X programs.⁴² Title X programs serve the population(s) who may not otherwise be eligible for a state's Medicaid Family Planning Program.

A similar analysis of Medicaid-enrolled women in South Carolina reviewed the use of contraceptives, pregnancy outcomes, and the rate of pregnancy. In South Carolina, State Medicaid Family Planning Services provide a full range of benefits for contraception, while a family planning waiver or SPA may offer limited benefits.⁴³ Through Medicaid coverage, beneficiaries in South Carolina, could visit both public and private clinics, but there was variation of covered methods.⁴³ Oral contraceptives were most used, but data on the use of this method shows lower effectiveness due to the inconsistent or improper use.⁴³ Contraceptives like an intrauterine device

or implant (long-acting reversible contraception, LACR) are more effective and have a higher satisfaction for use among individuals⁴³. This retrospective cohort analysis found that women who used LARCs had a lower incidence of pregnancy than those who use short-acting reversible contraception.⁴³ The availability of resources and contraceptive methods can impact pregnancy rates among reproductive-age women and expanded services may lower the rates of unintended pregnancies.

3.7 Thesis Setting and Context

Variation in public-sector funding for family planning services (education, sex education, reproductive health counseling) and the associated policies for these programs have been correlated with the socioeconomic conditions of women and the rates of unintended pregnancy.⁴⁴ In 2011 around 2.8 of 6.1 million pregnancies were unintended, and this trend may continue to increase as the availability of a wide range of contraceptives vary from state-to-state.²⁰ Unintended [unplanned, unwanted] pregnancy rates as of 2020 for Maryland, Pennsylvania, and West Virginia are respectively 27.9%, 25.9%, and 22.0%.⁴⁵ These data did not report on the percentage of unintended pregnancies in Ohio, but historical data report 55% of pregnancies were unintended in 2010.⁴⁶ Nationally 28.5% of all pregnancies are unintended, unplanned, or unwanted.⁴⁵

To date, there are 26 states with expanded eligibility for family planning services for individuals who may not otherwise qualify for Medicaid reproductive health coverage.⁴⁷ Expanded eligibility for family planning services remains inconsistent with the availability and accessibility of contraceptives. Maryland, Ohio, Pennsylvania, and West Virginia are ACA Medicaid expansion states, like many states in the region, but these four states vary drastically with their sociopolitical

landscapes. Maryland and Pennsylvania expanded Medicaid eligibility and increased population covered by Medicaid Family Planning programs with the ACA, while Ohio and West Virginia only instituted ACA Medicaid Expansion. Data recorded nationally from October 2022 report 88, 978, 791 individuals enrolled in Medicaid, with 21% covered by Medicaid or CHIP and 16% are women of reproductive age (15-49 years of age).⁴⁸ State-level Medicaid enrollments of October 2022:⁴⁸

- Maryland: 1, 625, 457; 20% Medicaid/CHIP; 15% women of reproductive age (15-
- Ohio: 3, 242, 826; 22% Medicaid/CHIP; 20% women of reproductive age (15-49
- Pennsylvania:3,554,516; 21% Medicaid/CHIP; 16% women of reproductive age
- West Virginia: 622, 788; 28% Medicaid/CHIP; 23% women of reproductive age

Ohio and West Virginia report the highest percentages for women of reproductive age enrolled in the state-Medicaid programs, however, neither state expanded their family planning programs but continued to provide coverage through Title X programs. Ohio and West Virginia operate family planning services through Title X, implemented restrictive policies for access to abortion services and provide significantly fewer reproductive health care services than Pennsylvania and Maryland.

The Guttmacher Institute in 2019 published a report on state-level estimated contraceptive usage (using the Behavioral Risk Factor Surveillance System (BRFSS) data) on all women of reproductive age (18-49 years old).⁴⁹ West Virginian women at risk of pregnancy reported the use of highly effective permanent contraception, female or male sterilization, at the highest rate of 29% compared to 7% in New York.⁴⁹ In Ohio and Pennsylvania women at risk of pregnancy reported the use of moderately effective contraception at increased rates, like short-acting reversible methods, i.e., pills, injectables, patches, and vaginal rings, of 20.1% and 20.6%.⁴⁹ Women at risk of pregnancy in Maryland reported an elevated rate of use for the least effective

contraception (condoms, the withdrawal method, diaphragm, cervical caps, sponge, rhythm method, spermicide(s), natural family planning, and emergency contraception) of 23.7%.⁴⁹ These data represent the proportion of women who 1) completed the BRFSS self-reported survey; 2) actually and honestly reported their contraceptive history; 3) range from no health insurance coverage, employer-sponsored coverage, to public coverage.

Due to the variation in contraceptive use and the availability of FDA-approved methods through state-level Medicaid family planning programs or Title X-funded programs, Maryland, Ohio, Pennsylvania, and West Virginia were chosen to examine the status of Medicaid Family Planning or Title X program contraceptive policies.

4.0 Results

As outlined above, federal Medicaid regulations mandate that each state must offer some form of family planning services, which cover contraception, treatment(s), testing, and education/counseling services. While the federal regulation sets a floor for coverage, the family planning services offered are not uniform among states who have expanded family planning services. State regulations of family planning programs differ depending on funding sources and state regulations for what services are offered and who is eligible. In the following sections, I will (1) analyze the variation in funding sources for family planning programs in Maryland, Ohio, Pennsylvania, and West Virginia; (2) compare Child Health Insurance Programs (CHIP) among the four states mentioned above to examine the difference in care for children under 19 years of age and the availability of reproductive health services for those that qualify; (3) review the current availability of contraception to individuals who meet the four states' requirements for family planning programs; and (4) review the state level government websites in Maryland, Ohio, Pennsylvania, and West Virginia. Recommendations to increase the accessibility of the state websites are also provided.

4.1 Medicaid Expansion and Funding for Family Planning Services

The ACA created an avenue for states to expand Medicaid eligibility for population(s) that would not otherwise have access to comprehensive health services. Family planning services required through Medicaid date back the early 1970s, but the ACA allowed for expanded coverage

for individuals who did not meet FPL eligibility criteria through the state Medicaid programs.³³ Currently in the United States, as of October 2022, there are 84,374,871 individuals enrolled in the Federal Medicaid Program.⁵⁰ With federal oversight, there are several mechanisms to expand family planning services (Table 2). The differences across funding mechanisms will impact where someone can receive care and the availability of resources to an eligible beneficiary.

4.1.1 Medicaid Expansion in Maryland, Ohio, Pennsylvania, and West Virginia

ACA regulations changed the FPL eligibility to up to or less than 138% for any individual, and their children up to age 26 if applicable. Prior to the enactment of the ACA, states instituted FPL guidelines for eligibility and were not uniform across all states (Table 1). The increase in FPL allowed for an increase in Medicaid eligibility. In the four states examined in this paper, a 50% or higher increase in enrollment for Medicaid and CHIP occurred after the state expanded (Table 1). Maryland, Ohio, and West Virginia expanded Medicaid eligibility and services on Wednesday, January 1, 2014, while Pennsylvania expanded on Thursday, January 1, 2015. Maryland has increased enrollment in Medicaid/CHIP by 94.4%, Ohio 55.7%, Pennsylvania 52.8%, and West Virginia 80.12%. All four states increase the FPL eligibility to 133%, but each state has different FPL eligibility for pregnant women. Maryland increased to 259% FPL, Ohio to 200% FPL, Pennsylvania to 215%, and West Virginia to 185%.

Table 1 Comparison of Medicaid Eligibility Across Four States

<i>State</i>	<i>Medicaid FPL Eligibility</i>	<i>Medicaid FPL Pregnant Women</i>	<i>Medicaid Expansion Date</i>	<i>Medicaid/CHIP Enrollment Increase**</i>
<i>Maryland</i> ⁵¹	138%	264%	Wednesday, January 1, 2014	94.40%
<i>Ohio</i> ⁵¹	138%	205%	Wednesday, January 1, 2014	55.77%
<i>Pennsylvania</i> ⁵¹	138%	220%	Thursday, January 1, 2015	52.28%
<i>West Virginia</i> ⁵¹	138%	185%	Wednesday, January 1, 2014	80.12%
<i>**Expansion beneficiaries are as of October 2022- numbers may be inflated due to COVID-19</i>				

4.1.2 Section 1115 Demonstration Waiver

Expanded family planning programs were initially instituted as Section 1115 waivers. Approvals for Section 1115 waivers typically expire after five years, but a state can submit evidence to expand the program for a three-to-five-year period.⁵² Section 1115 waivers are approved through CMS and allow states to provide evidence and data about the different strategies, programs, or policy changes that were enacted to expand family planning services. The federal government requires that the Section 1115 initiatives are “budget neutral” for the Federal Medicaid.⁵² Family planning programs in Maryland, Ohio, Pennsylvania, and West Virginia do not operate under Section 1115 Waivers (Table 2).

4.1.3 State Plan Amendments

Authority granted through the ACA in 2010 created a second mechanism to expand services including but not limited to family planning services and other Medicaid services.⁵³ A State Plan Amendment (SPA) creates permanent changes to the state Medicaid programs. Expanded access to family planning services with a SPA requires a state to offer services to men and women, through income-based eligibility.⁵³ While Section 1115 waivers and can be similar, the one main difference is the permanence of the SPA; this will allow the state to operate, implement, and expand family planning services without applying for renewal of the expansion. Maryland and Pennsylvania have created expanded access to family planning programs through SPAs (Table 2). Maryland’s SPA was approved by CMS on March 15, 2019, and enacted July 1, 2019. Pennsylvania’s SPA was approved on August 21, 2015, with an effective date of July 1, 2015. Maryland and Pennsylvania state regulations on contraception establish a more

comprehensive list of covered services and methods for eligible individuals. Ohio and West Virginia do not operate using SPAs family planning services.

4.1.4 Title X Program

Ohio and West Virginia family planning programs operate with federal Title X funding, while Maryland and Pennsylvania do not (Table 2). The 2021 final rule re-established that clinics must provide information about abortion services or counseling on abortion(s). The Office of Population Affairs 2021 final rule preamble wording establishes that in states where abortion care and services are restricted, Title X clinics will not be required to provide information or referrals. 42 U.S.C. §300a-6 prohibits Title X funding for the use of abortion as a family planning method. West Virginia has made abortion and abortion services illegal, with few exceptions. While abortion is still legal under Ohio state regulations, there are regulations created to stop abortion or abortion services after 22 weeks. Due to the legalities for abortion in the state of West Virginia, under the 2021 final rule clinics do not have to provide information or counseling for abortions/services for any individual who is seeking reproductive health care from a Title X funded clinic.

Table 2 Funding for State Family Planning Programs

<i>State</i>	<i>Waiver Programs</i>	<i>State Plan Amendment</i>	<i>Title X</i>
<i>Maryland</i> ⁵⁴	No	Yes	No
<i>Ohio</i> ⁵⁵	No	No	Yes
<i>Pennsylvania</i> ⁵⁶	No	Yes	No
<i>West Virginia</i> ⁵⁷	No	No	Yes

4.2 Children's Health Insurance Program (CHIP) Coverage

Like other state regulated health insurance coverage, variation exists in income eligibility requirements and covered populations. Federal law establishes guidelines for CHIP coverage for targeted low-income children and targeted low-income pregnant women utilizing a separate CHIP.³⁸ Eligibility for targeted low-income children included anyone who is 19 years of age or younger, not eligible for Medicaid or currently insured through another coverage plan, a state resident and U.S. citizen or immigrant, eligible for the state CHIP dependent income, and meets state level regulations for CHIP.³⁸ The ACA created different coverage groups for states, wherein they could expand CHIP through (1) Medicaid expansion, (2) separate CHIP (utilizing federally allocated funds for coverage), or (3) utilize Medicaid expansion and separate CHIP. State CHIP Medicaid expansion operates through federal funds, with the Social Security Act of 2013, Section 2103, with expanded Medicaid eligibility requirements necessary for targeted low-income children.⁵⁸ State Separate CHIP utilizes federal funding for low-income children who meet the eligibility requirements outlined in Social Security Act of 2013, Section 2103.⁵⁸

Pennsylvania (314% MAGI) and West Virginia (300% MAGI) provide coverage for children from birth to 19 years of age, through Separate CHIP (Table 3). Pennsylvania and West Virginia provide coverage for uninsured children through CHIP Medicaid expansion and separate CHIP, while Maryland and Ohio provide coverage through CHIP Medicaid expansion. Maryland and Ohio provide coverage for children and pregnant women who meet the state eligibility requirements through expanded Medicaid services, and state-run CHIP- Maryland Children's Health Program (MCHIP) and Ohio Healthy Start. Table 3 provides MAGI eligibility ranges for three age groups- 0-1 years old, 1-5 years old, and 6-18 years old. MAGI in Maryland (317%) and Ohio (206%) do not fluctuate through the three age ranges. MAGI in Pennsylvania and West

Virginia decrease the MAGI eligibility through the three age ranges. In Maryland, Ohio, and Pennsylvania pregnant women are covered through the states' Medicaid program, while West Virginia covers pregnant women CHIP up to 300% MAGI (Table 3).

Table 3 CHIP Coverage Across Four States

State	CHIP MAGI ⁵⁹ Eligibility, Age Range:			Children Separate CHIP MAGI ⁵⁹	Pregnant Women CHIP MAGI ⁵⁹	CHIP Eligibility ⁶⁰⁻⁶³	CHIP Reproductive Coverage ⁶⁰⁻⁶³
	0-1	1-5	6-18				
Maryland***	317%	317%	317%	N/A	N/A	MD resident ≤ 19 years of age U.S. resident/qualified alien State income requirements met	All health services available via Maryland Medicaid Managed Care Program
Ohio**	206%	206%	206%	N/A	N/A	OH resident ≤ 19 years of age State income requirement(s) met	Prenatal and associated health care services
Pennsylvania	215%	157%	133%	314%	N/A	PA resident ≤ 19 years of age U.S citizen/qualified alien Uninsured and not otherwise eligible for Medical Assistance	Maternity care Reproductive Health Counseling Short-Acting Reversible Contraception (pill/patch/implant) LARC (IUD) Voluntary Sterilization
West Virginia	158%	141%	133%	300%	300%	WV resident ≤ 19 years of age Otherwise not eligible for WV Medicaid Income/family size within state requirements U.S. citizen or qualified aliens [if not U.S. citizen, must provide verification of alien status]	Maternity care Short-Acting Reversible Contraception (pill/patch/implant) LARC (IUD/IUCD) Barrier contraceptive(s) [diaphragm/cervical cap] Emergency contraceptive
<p>*MAGI- Modified Adjusted Gross Income as of July 1, 2022 **Ohio Healthy Start ***Maryland Children's Health Program (MCHP)</p>							

4.3 Contraceptive Coverage for Family Planning Services

Federal Medicaid regulations require family planning services to be available and included as a mandatory benefit, but state authority grants discretion over which specific services are ultimately covered. As stated above (**Page 18**) there are four pathways for coverage to newly eligible populations through Medicaid expansion and family planning program implementation. Due to state regulatory authority for family planning expansion, different eligibility criteria are established for ACA Medicaid expanded programs. Eligibility hinges on if a state created a family planning program or if these services would be provided via the states' Medicaid expansion program.

States with a newly established limited scope family planning program (Maryland and Pennsylvania) extend the population(s) who are not eligible for Medicaid (through expansion) but are still unable to acquire health insurance coverage for certain services, i.e., family planning.⁴¹ State regulatory authority in Maryland and Pennsylvania, through either an approved SPA or Waiver, expanded FPL eligibility to $\leq 264\%$ and $\leq 215\%$ respectively (Table 4). Eligibility criteria specifically state that the individual must not otherwise be eligible for Medicaid/MCHP (Maryland) or Medical Assistance (Pennsylvania). Pennsylvania includes eligibility language regarding pregnancy status; to be eligible the individual cannot be pregnant (Table 4).

State-to-state variation is apparent in family planning coverage in expansion states. Ohio and West Virginia both expanded Medicaid under ACA regulations, but neither state created a newly established limited scope family planning program. In states where there is not a formal family planning program, services for “essential health benefits” must be covered; these services include a variety of family planning or related services.⁴¹ FPL eligibility criteria in Ohio ($\leq 215\%$) and West Virginia ($\leq 250\%$) are similar to states with a limited scope family planning program

(Maryland and Pennsylvania), but there are significant differences in requirements that must be met for eligibility (Table 4). Ohio and West Virginia vary from one state to another for eligibility standards, with Ohio providing these services for all Medicaid beneficiaries, pregnant women, infants, and children, older adults, and individuals with a disability(s) (Table 4). In West Virginia any individual who is unemployed, employed (with specific standards for pay), a student, uninsured, insured (coverage does not include contraception or other related family planning services), or cannot otherwise afford contraception after their basic needs are met (Table 4).

While these two states vary in eligibility criteria, both Ohio and West Virginia include male, female, and adolescent individuals in the population that could be covered by these services (Table 4). Ohio and West Virginia offer alternative services like natural family planning, Fertility Awareness-Based Method (FABM), abstinence counseling, or sexual risk avoidance (Table 4). Natural family planning and FABMs encourage an individual to track their ovulation schedules to prevent pregnancies, while abstinence counseling and sexual risk avoidance provide education surrounding the prevention of sexual encounters. While these options are not widely used, the effectiveness of these methods may not enable individuals to obtain the most effective form of contraception.

FDA-approved contraceptives include both “name-brand” and generic options for surgical/permanent sterilization, implant(s), intrauterine devices, injection, oral contraceptives, patch, ring, diaphragms contraceptive sponges, cervical caps, female condoms, spermicides, and emergency contraception.⁶⁴ The variation in availability and type of contraception stems from policies for utilization control (limit spending/promote quality).⁴¹ Utilization control creates significant barriers to accessing preferred contraceptive type, because the state can limit who can obtain these contraceptives. Maryland, Ohio, Pennsylvania, and West Virginia all vary in their

contraceptive coverage, but all four states abide by the federal regulation for coverage of nearly all FDA-approved contraceptives (Table 4).⁴¹ Maryland, Ohio, Pennsylvania, and West Virginia provide long-acting reversible contraceptives (LARCs), such as implants or IUDs, and are the most effective forms contraceptives (Table 4). Currently there are six FDA-approved LARCs. West Virginia limits the options for IUDs and implant (two IUDs and one implant), while Ohio guidelines outline that “at least one” form of a LARC should be offered at every site, and available to be inserted on the same day.⁵⁵

Maryland, Ohio, Pennsylvania, West Virginia offer surgical sterilization, with Maryland restricting sterilization to individuals ≥ 21 years of age and older (Table 4) Maryland, Ohio, Pennsylvania, and West Virginia all provide coverage for oral contraceptives, patch, and emergency contraception (Table 4). Ohio and West Virginia, both funded by Title X, provide abstinence counseling and natural family planning as methods of contraception; as stated above **(Page 27)** Title X regulations prohibit providing counseling, information, or performing abortions for beneficiaries (Table 4). Ohio state regulations indicate that a fertility awareness-based method (FABM) (Table 4). The services covered by Maryland, Ohio, Pennsylvania, and West Virginia are similar with each state providing coverage for counseling, screening and testing for sexually transmitted infections/disease, office visits, and screening or specified services (Table 4).

Protocols for pharmacist provisioning of medication, including contraceptives, are state dependent and authorize different levels of authority. The variation in authorization of medications include statewide standing orders, collaborative practice agreements, and authority to dispense defined medications without the requirement of a prescription.⁶⁵ A difference in the option for a state to adopt pharmacist provisioning for contraception can be explained with Pennsylvania and West Virginia. Pennsylvania invoked standing orders for naloxone, a medication that can be

dispensed to reverse or stop the effects of opioids, but the state does not currently allow pharmacist provision of contraceptives. West Virginia statewide standing orders allow for pharmacist provisioning of several medications, including both contraceptives and naloxone.^{66,67} Statewide standing orders and collaborative practice agreements are more commonly used opposed to state-based laws or regulations.⁶⁵ Advanced Practice Registered Nurses (APRN) discretion to dispense or prescribe medications is also contingent upon state regulations. APRNs are individuals with advanced training and education, which include “nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists.”⁶⁸ Most states authorize APRNs with the authority to dispense or prescribe at least one medication.

Dispensing authority for contraceptives in Maryland include nurse practitioners, nurse midwives, registered nurses (samples, with state pharmacists authority), and clinical nurse specialists; prescribing authority for self-administered hormonal contraceptives is granted to nurse practitioners, nurse midwives, and pharmacists who have a collaborative practice agreement with a physician (Table 4). West Virginia also grants prescribing authority to pharmacists for self-administered hormonal contraceptives and nurse practitioners, nurse midwives, and clinical nurse specialists who have a collaborative practice agreement with a physician; there is no dispensing authority granted to advanced practice registered nurses (Table 4). Pennsylvania and Ohio do not grant prescribing authority to pharmacists (Table 4). Pennsylvania grants authority for dispensing (samples, with state regulatory authority) and prescribing to nurse practitioners, nurse midwives, and clinical nurse specialists (Table 4). Ohio grants authority for dispensing and prescribing to nurse practitioners, nurse midwives (Table 4).

Table 4 Contraceptive Coverage for Family Planning Services

<i>State</i>	<i>Family Planning State Poverty Level Eligibility</i>	<i>Eligibility Criteria</i>	<i>Contraception Covered</i>	<i>Services Covered</i>	<i>APRN Dispensing Option⁶⁹</i>	<i>APRN Prescribing Option⁶⁹</i>	<i>Pharmacist Provision Option⁶⁹</i>
<i>Maryland⁷⁰</i>	≤ 264%	Maryland resident U.S. citizen/qualified alien FPL standard met Not otherwise eligible for Medicaid or MCHP Male/female	FDA-approved contraction/contraceptives LARCs (IUDs/implants) Oral Contraceptives Emergency Contraception Diaphragms/cervical caps Contraceptive rings/patches Permanent sterilization (≥ 21)	Advice about contraception Physical exams (pelvic/breast) Screenings (STIs) Contraception Emergency contraception Permanent sterilization (≥ 21)	NP Nurse Midwife Registered Nurse ^o CNS	NP** Nurse Midwife**	Self-administered hormonal contraception
<i>Ohio⁵⁵</i>	≤ 215%	Male/female/adolescent All Medicaid beneficiaries Ohio resident U.S. citizen/non-citizen requirement Social Security Number FPL standard met Pregnant women/infants/children Older adults Individuals with disability(ies)	Combined oral contraceptives Hormonal contraceptives Condoms LARCs FABM Implant/injection Diaphragm/cervical cap Emergency Contraception Permanent Contraception Natural family planning Abstinence/sexual risk avoidance	Broad-range family planning methods Contraceptive services Preventative health services Screening services Physical exams Laboratory testing Basic infertility services Preconception health services STD/I services Pregnancy diagnosis/counseling Achieving desired pregnancy (fertility awareness) Adolescent-friendly health services	NP* Nurse Midwife* CNS*	NP Nurse Midwife CNS	N/A
	<i>Family Planning State Poverty Level Eligibility</i>	<i>Eligibility Criteria</i>	<i>Contraception Covered</i>	<i>Services Covered</i>	<i>APRN Dispensing Option</i>	<i>APRN Prescribing Option</i>	<i>Pharmacist Provision Option</i>

Pennsylvania ⁵⁶	≤ 215%	Not otherwise eligible for Medical Assistance (MA) FPL standard met Must not be pregnant Male/female	Oral contraceptives LARCs (IUDs/implants) Hormonal/nonhormonal contraceptives 28-Day Extended Cycle 3-Month Extended Cycle Patch/ring/injection Condoms Diaphragm/cervical cap/ Emergency Contraceptive(s) Male/female sterilization	Office visits Counseling (smoking cessation /pregnancy) Prescription coverage (contraceptives/vaccines/antibiotics) Screenings/laboratory services /treatment Sterilization (male/female) Cancer screening/education	NP Nurse Midwife	NP Nurse Midwife	N/A
West Virginia ^{57,71,72}	≤ 250%	Unemployed Employed (entry-level/temporary/minimum wage/other low-pay employment) Student Uninsured Cannot afford contraception after basic met Insured, coverage does not include contraception/other family planning services Male/female/adolescents of reproductive age	Oral IUD [2] Implant [1] Ring [1] Patch [1] Foams/condoms/diaphragm /vaginal contraceptive film Emergency contraception [1] Natural family planning Abstinence counseling Surgical sterilization (tubal ligation/vasectomy)	Clinical exams (breast/testicular) Screening/treatment (STDs) Testing/examination (Pap smears/pelvic) Pregnancy test Education/counseling (pregnancy/contraception/HIV/STD) Contraception Permanent sterilization Reproductive health counseling	N/A	NP** Nurse Midwife** CNS**	Self-administered hormonal contraception

*Dispensing of samples as regulated by state

** APRN required by state to have a collaborative practice agreement with physician explicitly for prescriptive authority

°Dispensing of specified prescription drugs regulated by state (typically in outpatient setting)

4.4 State(s) Government Website Comparisons

State and federal government websites have information available for people to search an array of topics, including family planning programs and what services may be available under their health insurance coverage. The Federal Plain Writing Act was signed into law on October 13, 2010, established clear and concise standards that must be met when creating, implementing, and adapting state and federal government websites. Per this Act, all federal agencies must “use clear government communication that the public can understand and use.”¹⁴ Through a series of Executive Orders, government websites must follow the Federal Plain Language Guidelines, OMB’s Guidance on Implementing the Plain Writing Act, and include a plain writing section.¹⁴ The Federal Plain Language Guidelines outline that users of government facing websites must be able to find, understand, and use what they are looking for or need.¹⁵ Maryland, Pennsylvania, Ohio, and West Virginia are all in compliance with the Plain Writing Act of 2012 (Table 5).

The Flesch-Kincaid Grade Level is a metric used in the United States to interpret a passage and translate the information into the reading level required to comprehend the material. The Moraine Park Technical College created an infographic to easily understand and view where a passage of text would score on the Flesch-Kincaid scale. The Flesch Reading Ease score ranges from 0-100 (Figure 1), with the higher scores ranking easier to read and understand.¹³ By inputting passages available on the state government website’s into Microsoft Word, I was able to determine a Flesch Reading Ease score for each state’s website; Maryland, Pennsylvania, Ohio, and West Virginia sites all scored between a fifth and sixth grade reading level (Table 5). The only government website that was unable to be scored was the Department of Medicaid in Ohio.

Score	School level (US)	Notes
100.00–90.00	5th grade	Very easy to read. Easily understood by an average 11-year-old student.
90.0–80.0	6th grade	Easy to read. Conversational English for consumers.
80.0–70.0	7th grade	Fairly easy to read.
70.0–60.0	8th & 9th grade	Plain English. Easily understood by 13- to 15-year-old students.
60.0–50.0	10th to 12th grade	Fairly difficult to read.
50.0–30.0	College	Difficult to read.
30.0–10.0	College graduate	Very difficult to read. Best understood by university graduates.
10.0–0.0	Professional	Extremely difficult to read. Best understood by university graduates.

Figure 1 Flesch Reading Ease Moraine Park Technical College, located in Fond du Lac, Wisconsin published the Flesch Reading Ease chart. The chart was published on April 19, 2021 by Enterprise Systems.

Visual compliance standards varied for each of the four states websites of interest. Although the World Wide Web Consortium (W3C) created and established international standards for website accessibility, Pennsylvania and Ohio are the only state government websites that clearly identifies the W3C Web Accessibility Initiative (WAI). The Pennsylvania Department of Human Resources website hosts a clickable “Accessibility” link, where users can review the Information Technology Policy (ITP-ACC001) and the incorporated use of W3C (Table 5). The Ohio Department of Health website also hosts a clickable “Accessibility” link, where users are directed the “Accessibility Policy” page which incorporates the use of the WAI Web Content Accessibility Guidelines (WCAG 2.0) into the State of Ohio IT Policy Web Site Accessibility (IT-09) (Table 5).

Maryland and West Virginia regulate visual compliance through guidance and regulations established individually for these states. The Maryland Department of Health website hosts a clickable “Accessibility” link, directing users to the “Accessibility Policy.” The “Accessibility

Policy” webpage hosts another clickable link for the “Maryland Information Technology Nonvisual Access Website.” Users are directed to the Department of Information Technology webpage hosting the Nonvisual Access guidance, which outlines that the state of Maryland regulates visual compliance through Maryland Information Technology Nonvisual Access (MD IT NVA). Under the state regulations for visual compliance, government websites must be compliant with COMAR 14.33.02.01 (Table 5). Application for the Family Planning Program in Maryland is hosted via the Maryland Health Connection webpage, which offers individuals resources for interpreter services in sixteen languages at no cost (Table 5). The West Virginia Department of Health and Human Resources website hosts a clickable “Privacy, security, and Accessibility” link, where users are directed to the “Policies” webpage. On the “Policies” webpage there is another hosts a clickable “Accessibility Policy” link, with an external link for the Section 508 Rehabilitation Act (Table 5). The U.S. Access Board, a federal agency regulating accessible access for individuals with physical, sensory, and cognitive impairments or disabilities via Information and Community Technology (ITC).⁷³

Individuals with disabilities may navigate and/or view webpage content differently from able-bodied individuals, and per the Americans with Disabilities Act (ADA) services available online for absentee ballot applications, paying tickets/fees, police report filing, virtual town hall attendance, tax documentation filing, school/school program registration, and state benefit program applications, including state Medicaid applications pages and external websites, must be compliant.¹⁶ The Ohio Department of Medicaid includes disability accommodations of qualified sign language interpreters, assistive listening device(s), availability of documents in Braille, and other services, as applicable (Table 5). The West Virginia Department of Health and Human Resources through the above mentioned “Accessibility Policy” link informs users on how to resize

text for their browsers (Table 5). Also listed on this webpage are additional accommodations that include auxiliary aids and other applicable services necessary to obtain information from the government webpages (Table 5).

Pennsylvania Family Planning Program applications are housed through the state website COMPASS. On the COMPASS webpage, there are no disability accommodations clearly listed or readily accessible (Table 5). When a user is directed to the COMPASS webpage, the “Accessibility” link is shown again with no additional information other than contact information. Contact information is provided for an individual to email about validation and assistive technology tools.⁷⁴ Even with the use of the search functionality on the Pennsylvania Department of Health home page, no clear and apparent disability accommodations appear for navigating the state government website(s) or online application. Although there is no clear and explicit notice of disability accommodations for users, ITP-AC00 (Information Technology Digital Accessibility Policy) establishes that all Commonwealth Agencies:

“Respond to requests from individuals with a Disability, to make agency Digital Content and Services available in an accessible, alternative format, or provide an effective accommodation, within a reasonable time-period, that is consistent with pertinent federal or state regulations.”⁷⁵

Maryland, Ohio, and Pennsylvania include additional language options for viewing website content; Maryland and Pennsylvania include numerous language options offered through Google Translate, while Ohio provides directions on how to change the language preference through Safari, Google Chrome, Mozilla Firefox, and Microsoft Edge (Table 5). West Virginia does not offer any additional languages for website users. Maryland, Ohio, Pennsylvania, and West Virginia

all provide several clearly linked and reputable resources for users to move about the state facilitated government website and externally hosted webpages (Table 5).

Table 5 Comparison of Government Websites Across Four States

<i>State</i>	<i>Plain Language*</i>	<i>Literacy Level of Writing (Flesch-Kincaid Scale)</i>	<i>Visual Accessibility Compliance**</i>	<i>Disability Accommodations</i>	<i>Additional Language Options</i>	<i>Clearly Linked Resources</i>	<i>Reputable Resources</i>
<i>Maryland</i>	Yes	Department of Health: 79% Maryland Health Connection: 97%	Maryland Information Technology Nonvisual Access (MD IT NVA) (COMAR 14.33.02.01)	Deaf and Hearing Interpreter services (16 languages)	Yes (Google Translate)	Yes	Maryland Health Connection Local Health Department(s) Department of Social Services Enrollment Information Human Trafficking Fact Sheets for Family Planning Services Accessibility Policy
<i>Ohio</i>	Yes	Department of Health: 93% Department of Medicaid: -	State of Ohio IT Policy Web Site Accessibility (IT-09) WCGA 2.0	Upon Request: Qualified sign language interpreters Assistive listening device(s) Documents in Braille Other services, as applicable	Yes (not automatic, provides directions on how to change language in web browser)	Yes	Title X Clinical Services and Protocols Other Medicaid Programs OSAH Family Clinic Search Local Health Districts Presentations Accessibility Policy

	<i>Plain Language*</i>	<i>Literacy Level of Writing (Flesch-Kincaid Scale)</i>	<i>Visual Accessibility Compliance**</i>	<i>Disability Accommodations</i>	<i>Additional Language Options</i>	<i>Clearly Linked Resources</i>	<i>Reputable Resources</i>
<i>Pennsylvania</i>	Yes	Department of Health: 77% Department of Health and Human Services: 83% Department of Health and Human Services, Reproductive Autonomy: 95%	Information Technology Digital Accessibility Policy (ITPACC001) Revised February 2, 2023 W3C	Not readily accessible ITP-ACC001 explicit language	Yes (Google Translate)	Yes	Regional Family Health Councils FPL Guidelines Family Planning Services Guidelines Other Medicaid Programs Clinic Locations Covered Drugs/Devices Accessibility Policy
<i>West Virginia</i>	Yes	Family Planning Program: 100% Family Planning Program, Services: 87% Family Planning Program, Eligibility: 95%	U.S. Access Board- Information and Community Technology (ITC) Section 508 of the Rehabilitation Act	Text resizing Auxiliary aids Other services, as applicable	No	Yes	OSAH Family Clinic Search (due to Title X funding) Family Planning Services Family Planning Eligibility Clinic Information Other Programs

****Plain Language- guidelines from Plain Writing Act of 2010***

*****Visual Accessibility Compliance- standards/regulations based on state-state differences***

5.0 Discussion

Most individuals of reproductive age across the United States depend on contraceptive and family planning service availability in the United States, yet they face major barriers due to variability in health insurance coverage and accessibility of covered services. Maryland, Ohio, Pennsylvania, and West Virginia have all expanded Medicaid coverage per the ACA, but this does not necessarily provide contraceptive coverage for all state Medicaid beneficiaries. Using three funding mechanisms, states could expand Family Planning Programs to cover individuals who would historically be left uninsured. Maryland and Pennsylvania enacted State Plan Amendments to expand coverage for individuals, while Ohio and West Virginia continued to use Title X federally funded programs.

The Children's Health Insurance Program (CHIP) coverage was expanded through the ACA, where coverage groups could expand through three pathways: expand CHIP through Medicaid expansion, separate CHIP (utilizes federally allocated funds for coverage), or both CHIP Medicaid expansion and separate CHIP. Due to the regulatory authority for CHIP coverage declared to the states, there is irregularity for who and when someone may be eligible for coverage. Pennsylvania and West Virginia provide coverage for uninsured children through CHIP Medicaid expansion and separate CHIP, while Maryland and Ohio provide coverage through CHIP Medicaid expansion. Coverage for CHIP is also contingent upon meeting MAGI eligibility standards, which can transition from age groups of 0-1 years old, 1-5 years old, and 6-18 years old. Maryland and Ohio did not alter the MAGI eligibility across the three age groups, while Pennsylvania and West Virginia decreased the MAGI eligibility from the first to last age group.

While Family Planning Programs must be provided as a mandatory benefit for state Medicaid beneficiaries, discretion to the states for coverage groups and services creates barriers to accessing equitable contraceptive care. Through four coverage pathways, individuals in expansion states may have increased family planning resources but this is not a guarantee. Maryland and Pennsylvania both established limited scope family planning programs, which expanded coverage for those who do not qualify for traditional Medicaid but still lack health insurance coverage for specified family planning services. Expansion states like Ohio and West Virginia did not create limited scope family planning programs but maintained Title X funding to operate these clinics through traditional Medicaid. Ohio and West Virginia must provide “essential health benefits” that do include a variety of family planning services. While all four states provide family planning services there is variation in eligibility requirements and coverage areas. Contraception and related health services vary among Maryland, Ohio, Pennsylvania, and West Virginia with coverage for some services in one but not in another. Not only is availability of contraceptive coverage or options affected by regulatory differences in states, the mode in which an FDA-approved contraceptive is dispensed or prescribed is also affected.

Among all states website accessibility was available for any individual who has access to a computer, device, or smartphone. The ease of accessibility from one government website to the next creates another barrier for obtaining coverage and utilizing services. Maryland, Ohio, Pennsylvania, and West Virginia present online information in a way that is easy to read and understand, while also having availability of numerous reputable resources. Where some states achieved higher success than others were in the availability of disability accommodations. Pennsylvania is the only state that did not explicitly state how and where to obtain disability

accommodations, other than to obtain or continue employment. West Virginia was the only state that did not provide directions or directly link a user to additional language options.

5.1 Cost-Effect of Medicaid Expansion v Non-Expansion States

To date ten states still have not expanded access to Medicaid coverage, despite evidence showing increased contraceptive uptake in expansion states. Certain non-expansion states have implemented Section 1115 waivers or SPAs to increase the eligibility criteria for family planning services, even without implementing ACA Medicaid expansion. Increased utilization of preferred contraceptive method(s) can reduce the rate of unintended or unwanted pregnancy. When quantifying the comparison of the cost-savings in Medicaid expansion, states with expanded Medicaid have reported net savings due to the increase in revenues from taxes that certain states have imposed on health plans and providers. Regarding contraception Medicaid beneficiaries will pay no out-of-pocket costs for receiving family planning health care, while individuals of reproductive age, regardless of expansion status, are offered contraceptive coverage at low or no cost but thousands of people are unaware of this benefit.

In states that have not expanded Medicaid eligibility, there are nearly two-times as many uninsured individuals in the coverage gap when compared to expansion states.⁸⁰ States without expansion are heavily concentrated in the South, where the distribution of nonelderly adults without insurance live in Tennessee (7%), Alabama (7%), Georgia (13%), Florida (20%) and Texas (41%).⁸⁰ Of these five states, Tennessee is the only state to not implement a Section 1115 waiver or SPA to increase eligibility for family planning services.⁸¹ These five states also represent some of the most restrictive abortion policies post-*Dobbs*, with Texas, Tennessee, and Alabama

completely outlawing abortion, Georgia with a 6-week restrictive ban, and Florida with a 15-week restrictive ban. With the increased risk for unintended pregnancies and decreased abortion access, the cost of forced pregnancies will burden women and children. These individuals will likely have lower incomes due to the necessity to bear children and forego abortion, causing an influx of those who will need health insurance coverage through Medicaid in both expansion and non-expansion states.

5.1.1 Recommendations

Increasing the FPL eligibility in non-expansion states could decrease the federal and state financial burden of contraceptive access. While the ACA attempted to implement the Medicaid provision to incentivize states to expand, this stipulation was found unconstitutional by the Supreme Court. To further create equitable access to contraceptive and reproductive care in Medicaid Family Planning programs, the federal government may consider providing additional funding to states that have increased the FPL eligibility without ACA Medicaid Expansion. This would create an avenue for more individuals to access equitable reproductive care, without meeting the FPL limit for Medicaid in these states. Due to the legalities and state discretion for abortion access, there are fewer incentives or protections available for patients and providers. States have begun to rewrite protections for those who are providing care in states with changing state laws, and for individuals who may be traveling to receive care. The current socio-political climate in reproductive health does not provide a concise answer for increasing access while also protecting patients.

5.2 Contraceptive Access Variation

The ACA created different programs and funding mechanisms for people of reproductive age to access contraception and equitable reproductive health care services but variability in access and availability creates barriers to receiving patient-centered healthcare. Different funding mechanisms cause variation in access to covered family planning services. While Maryland, Ohio, Pennsylvania, and West Virginia all offer the minimum requirements for contraception through family planning services, Maryland and Pennsylvania provide coverage for significantly more options for those contraceptives than Ohio and West Virginia. In West Virginia there is only one form of an implant, ring, patch, or emergency contraceptive and two forms of IUDs. In Ohio regulatory policies indicate “at least one form” of LARCs, combined hormonal contraceptive, progestin-only contraceptive, and FABMs and only male condoms must be available. Providing inadequate and inequitable access to contraceptives may lead to individuals not using contraceptives or being forced to choose a less desirable method. Failure to provide accessible contraception can lead to an increase in unintended pregnancy rates. In 2011 the highest rates of unintended pregnancies were among those whose incomes were less than 100% FPL, with 112 of every 1,000 pregnancies reported as unintended.²⁰

5.2.1 Recommendations

Given the recent *Dobbs v Jackson Women’s Health Organization* decision to overturn *Roe v Wade*, state family planning programs may become inundated with demand for contraception. In states with expanded Medicaid coverage, like Ohio and West Virginia, but restricted or completely outlawed abortion services, individuals will need equitable access to contraceptive coverage.

Federal and state level regulatory changes must occur to enable equitable access to contraception for individuals using state Medicaid coverage for such services. At the federal level, the guidance for Title X funding must be amended. For providers to offer comprehensive contraceptive access, coverage of all FDA-approved contraception must be enacted. The Office of Population Affairs official government website provides information and resources on all FDA-approved contraceptive methods but not all Title X states provide these services. As noted above, **(Page 11)**, when a Title X clinic does not offer a patient's preferred method of contraception, the clinic must provide a perception or referral. To ensure access at state-levels for individuals with Medicaid coverage through Title X Family Planning Programs, federal oversight must mandate that all FDA-approved methods are available for use. Individuals utilizing Title X family planning services in expansion states are the highest proportion of women receiving the most effective forms of contraception.⁸² Increasing the availability of contraceptive methods mandated to be covered by federal guidelines could increase this number even more.

5.3 Prescribing and Dispensing Regulations for Providers

Prescribing and dispensing authority varies from state-to-state, and at times medication to medication. Maryland, Ohio, Pennsylvania, and West Virginia allow some non-physician professionals to dispense or prescribe contraceptives, but there are strict regulations implemented on these providers. In most states, individuals must obtain a prescription from a provider before receiving and starting their preferred contraceptive method. This creates barriers to access, due to the time constraints for scheduling and traveling to an appointment for the prescription.

5.3.1 Recommendations

While pharmacists may not be able to provide contraception on a wide scale, implementing pharmacist provision of contraception can increase the rate at which these prescriptions are obtained and utilized. There are currently 27 states with pharmacist provisions for contraception, which may continue to increase. This new prescriptive mechanism decreases the barriers that many face when attempting to obtain contraception. While pharmacist provisions can help increase access, expanding the availability of 6-month or 1-year prescriptions can also positively impact the utilization of contraception. Over-the-counter availability of contraception has been long contested at the federal and state level, and in May 2023 the FDA ruled in favor of providing oral contraceptives without a prescription.⁸³ Providing oral contraceptives without a prescription may increase the likelihood of access to equitable preventative care to those with that an individual with no insurance or limited availability to attend an appointment, receive a prescription, and finally make their way to a pharmacy, compared to counterparts.

ACA requirements for contraception coverage is mandated for prescriptive use, not over-the-counter policies.⁸³ While there are concerns for misuse of the oral contraceptive medication, pharmaceutical companies continue to produce highly addictive medications that are misused. According to HHS data reported in 2022, 10.1 million individuals “misused prescription opioids in the past year.”⁸⁴ As stated above even those with health insurance, whether public or private, stated financing the cost of care or inability to afford their preferred method as a barrier to contraceptive use (**Page 1**). Providing individuals with the opportunity to achieve reproductive and contraceptive autonomy may decrease adverse socioeconomic barriers for low-income and insured or uninsured persons. The future landscape of contraceptive access moving toward

pharmacist provisioning and over-the-counter methods may decrease the unintended burdens of inequitable contraception availability for all reproductive-aged men and women.

5.4 Website Accessibility

Availability of information on the state and federal government websites for Family Planning Programs is not uniform and creates significant barriers to understanding and locating accurate information. The in-depth analysis of the state government websites for Maryland, Ohio, Pennsylvania, and West Virginia highlighted the need for uniformity across state agencies. Numerous studies regarding ease of access and readability all note the significant variation in content, layout, and structure which may inhibit individuals from accessing services or coverage on government-run websites.⁸⁵ In 2018, a study on website accessibility for all fifty states and the District of Columbia was conducted specifically regarding abortion care and services on state and local health department websites. While the study found that information and engagement of health departments for abortion related services or activities was available, the regionality of abortion stigma may be responsible for the lack of engagement by some state or local health department websites.⁸⁶

5.4.1 Recommendations

To allow individuals to easily search for contraceptive access and coverage on state-run government, these websites must present information in a clear and concise manner. The Maryland Department of Health, Maryland Medicaid Administration website provides factsheets specific to

reproductive health providers, including outlines what the family planning program is and separate factsheets describing coverage for LARCs, permanent sterilization, and abortion services. To improve the ease of access among all state government websites, the inclusion of bulleted and short informational fact sheets could decrease the amount of time searching for covered contraceptive services. Another area to improve upon is the availability of information pertaining to disability accommodation.

Through the examination of the state government websites, disability accommodations were not as easily accessible as they should be. For example, to find information a user must click through several pages or conduct various searches. While the Pennsylvania Department of Labor and Industry does offer disability accommodations through deaf and hard of hearing services, blindness and visual services, vocational rehabilitation services, and others (for employment purposes) the Department of Health website does not explicitly state that these services are available. The COMPASS website does offer chat functionality but can only respond to full sentences or fragments. Maryland and Pennsylvania are the only two examined state government websites that provided chat functionality, but the resources provided when asking questions is inadequate. Individuals with disabilities and their caretakers may be relying on these websites to provide information and additional accommodation information, but without an exhaustive search they may be encountering barriers to care. To improve the ease of identifying disability accommodations state-run government websites should improve or include the functionality of chats and increase content regarding the availability of disability accommodations.

6.0 Limitations

This paper has several limitations. Using the Flesch-Kincaid Reading Score provided through Microsoft Word, passages cannot be calculated under 100 words. Although all referenced statistics and information were obtained from credible online sources, there is no data included about the utilization and availability of Family Planning Services other than contraception. While contraception does include a broad range of topics, the availability and utilization of abortion access and services were not examined through the paper. While the use of reputable sources was cautiously examined and reviewed, there is no original data from the Center for Medicare and Medicaid Services regarding claims for contraception utilization or the Centers for Disease Control and Prevention for US Medical Eligibility Criteria for Contraceptive Use (MEC). Only examining the policies in four states with expanded Medicaid coverage could present barriers to understanding the breadth of contraceptive policies in Medicaid. Future studies could examine Medicaid Family Planning policies and contraception in non-expansion states, with differing contraceptive and Medicaid policy landscapes.

7.0 Conclusion

Maryland, Ohio, Pennsylvania, and West Virginia are all Medicaid expansion states with considerably diverse sociopolitical landscapes, but state-level variation in Medicaid contraception policies stratifies the availability to comprehensive family planning services. Ensuring equitable access to Medicaid Family Planning programs and services are essential to contraceptive and reproductive autonomy. Variation in expanded services may be attributed to varying funding mechanisms through three funding sources. Through SPAs Maryland and Pennsylvania expanded coverage for family planning services and increased the FPL eligibility threshold to increase the population with coverage, while Ohio and West Virginia expanded FPL eligibility, but continued as Title X grantees receiving federal funding.

Low-income pregnant women and children encounter irregularities for covered services through three coverage pathways a state could implement. CHIP Medicaid expansion and separate CHIP, utilized in Pennsylvania and West Virginia, provide coverage for uninsured children. Maryland and Ohio implemented coverage for pregnant women and children through CHIP Medicaid expansion. MAGI eligibility standards must be met in all four states for an individual to receive coverage across three age groups; Pennsylvania and West Virginia reduce the MAGI eligibility requirements through all three age groups, while Maryland and Ohio retained MAGI eligibility standards consistent.

States are federally mandated to provide the minimum standards of family planning coverage, creating state-to-state variation covered services. Maryland and Pennsylvania expanded traditional Medicaid by establishing limited scope family planning programs, leaving low-income individuals outside of the FPL eligibility limit without coverage for specified family planning

services. Ohio and West Virginia continued to provide family planning services through their pre-expansion established Title X programs. Across all four states contraception coverage is offered, but Maryland and Pennsylvania offer more FDA-approved methods than Ohio and West Virginia.

While all four state-run government websites are accessible through electronic devices, the ease of accessibility varied. All four states' websites are compliant with Federal Plain Language Guidelines and content was presented between a fifth and seventh grade reading level. Visual compliance in each state abided by their own states regulations or instituted the guidelines created by W3C Web Accessibility Initiative (WAI). Disability accommodations were provided, or were searchable and attainable, in Maryland, Ohio, and West Virginia for those who need accommodations, where Pennsylvania's disability accommodations were not explicitly stated or searchable through the online government webpage. Additional language options were provided in Maryland, Ohio, and Pennsylvania but not West Virginia.

To continue to increase equitable access to family planning and reproductive health services, an increase in federal funding for non-expansion states may increase the population of low-income individuals who are historically uninsured. If non-expansion states increased the FPL eligibility requirements, there may be a correlation with a decreased financial burden for the state and federal governments of funding contraceptive access. The availability of contraception is not widely available in all expansion states, where there are states that do not provide access to all FDA-approved methods. Through federal guidance and regulatory authority, mandating the coverage of all FDA-approved methods may allow for comprehensive access to contraception that is not currently available.

With more than half of reproductive-aged individuals using at least one form of contraception in their reproductive years, decreasing the barriers to accessing care could shift the

negative attitudes surrounding public health insurance coverage and increase the socioeconomic standing of low-income individuals. Increasing the availability of over-the-counter oral contraceptive methods could decrease the number of individuals who cannot afford the associated costs to obtain their preferred method, while simultaneously reducing barriers to achieving reproductive and contraceptive autonomy. The use of modern technology will continue to rise, and the content available to individuals searching state-government websites for health care services should present information in a clear and conscience manner. Individuals with disabilities are just as likely to need easily accessible family planning information as individuals without disabilities. Increasing the ease of searchability for necessary information and increasing the communication tools available through the chat functions can decrease the amount of time all individuals, disabled or not, spend searching government websites for accommodations that are available.

Contraceptive access is a fundamental component in family planning and reproductive health care services. Contention over reproductive rights has been a long-contested issue in the United States, and even through the enactment of the contraceptive mandate, individuals do not have comprehensive access to equitable and affordable care. The *Dobbs v Jackson Women's Health Organization* Supreme Court decision impacted the lives of every reproductive-aged male and female. More individuals are seeking permanent contraception, with more men receiving or inquiring about vasectomies.⁸⁷ The abortion landscape has drastically deteriorated since June 2022. States with a total ban or highly restrictive coverage on abortion, shifted the dynamic between patients and providers with newly codified legal ramifications for providers and conspirators of those receiving abortion care or services. Historically conservative states have enacted or will continue to enact abortion bans or restrictions. States with a total ban or highly restrictive abortion policy are more likely to be non-expansion states with extremely low FPL eligibility thresholds.

Strict abortion regulations and lack of adequate access to contraception may be linked to maternal morbidity and mortality, with few exceptions for even a medically necessary abortion. While Medicaid does not offer coverage for abortions, unless deemed medically necessary, the impact of the Supreme Court decision may increase the need for comprehensive contraceptive access. Achieving reproductive autonomy and contraceptive autonomy encompasses contraception, abortion, and pregnancy intentions where an individual must have the ability to choose their preferred method of contraceptives and the timeliness of their pregnancies.

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