Leveraging State Contraceptive Access Policies to Prevent Maltreatment Among Infants and Toddlers

Executive Summary

Research suggests that adequate access to contraception—allowing families to control family size and timing—is one beneficial component of a holistic approach to preventing child maltreatment and child welfare system involvement among families with very young children. This guide highlights promising state-level contraceptive access policies indicated by nonpartisan research to help lower rates of child maltreatment and welfare system involvement.

Promising contraceptive access policies include:

- **Supporting expanded prescribing and dispensing authority** by expanding prescribing and dispensing authority to non-physician health care providers and adjusting insurance coverage for pharmacist-led contraceptive consultations.
- **Offering and subsidizing long-acting reversible contraceptives following childbirth** for individuals who want to pursue that option—without coercing or pressuring.
- **Expanding contraceptive medications and supplies covered by Medicaid** to improve access for individuals from lower socioeconomic backgrounds.
- **Expanding eligibility for Medicaid-funded family planning services** even if general Medicaid expansion is not adopted.
- **Expanding public awareness and education** about pregnancy prevention and contraceptive access.
- **Ensuring confidentiality and access to minors and insured dependents** seeking reproductive health care.

Take action! State policymakers and their partners can use this information to develop goals and action plans and implement state policies aimed at strengthening contraceptive access with the explicit goal of impacting child welfare outcomes. These actions may benefit families of very young children and have the potential to reduce rates of child maltreatment in your state.

Need more information? See the rest of this Primer and Action Guide for more details on the research behind these ideas and visit the Measuring Up website for more resources (https://www.childtrends.org/project/measuring-up).

Primer and Action Guide

Research indicates that allowing families to choose the size and timing of their families is important for promoting positive family outcomes. Evidence suggests that expanding access to contraception may be a useful component of a comprehensive approach to preventing child maltreatment.

Through these connections, state leaders across the two systems can explore together how state policies related to contraception access might ultimately influence child welfare system involvement among very young children. Advocates and partners promoting family well-being in these areas may also use this resource to support conversations with policymakers and program administrators.

This resource was created to support the work of:

- **Interagency collaborations** between state child welfare program administrators and state administrators responsible for implementing contraception access policies and programs to examine the intersection between access to contraceptive care and child maltreatment
- **State policymakers** interested in promoting child and family well-being and preventing maltreatment through family planning-related policymaking
- **Advocates and partners** working with state legislative and agency policymakers and administrators

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This document contains:

1. An **overview** of the research evidence on the intersection of child maltreatment and contraception access.
2. A summary of **state-level contraception access policy options** and research on the effect of these policies on child maltreatment rates.
3. **Discussion prompts** for use as part of intra- or inter-agency discussions, as well as dialogue with child welfare partners and advocates.

Part I: Overview

This overview provides high-level overview of nonpartisan research evidence on child welfare system involvement, child maltreatment, and links between contraception access on family well-being.

Maltreatment and child welfare system involvement among infants and toddlers

- In the United States, risk of maltreatment and child welfare system involvement is highest among infants and toddlers. In 2022, ~28 percent of child maltreatment victims were under 3 years old, and ~15 percent were under 1 year of age.[1]
- Importantly, reports to the child welfare system do not equate to child maltreatment victimization. In 2021, about half of reports did not receive a formal investigation after initial screening. Of the ~three million children who received an investigation or "alternative response" (e.g., resource provision), nearly two and a half million children were determined not to be victims of maltreatment,[2] but perhaps in need of other resources or erroneously reported.
- Experts increasingly advocate for a holistic public health approach to ***preventing*** child maltreatment[3] and promoting family well-being.[4] This approach acknowledges the complex needs and challenges of parents and families.[5]

Unintended pregnancy, family stress, and child maltreatment risk

- The United States has one of the highest rates of unintended pregnancy among industrialized nations.[6]
- Due to a variety of complex factors, unintended pregnancy is sometimes linked with greater risks for maltreatment of very young children.[7]
- Researchers find that parents experiencing unintended pregnancies often face higher levels of depression and other mental health distress—during pregnancy and through their child's infancy.[8,9,10] Some individuals who experience an "unwanted birth" experience more mental health distress compared with individuals who experience a "wanted birth," adoption, or abortion.[11]
- Unexpected (or "sooner than expected") births can also put significant strain on parents and families, having been linked to increased risks of experiencing significant financial distress,[12] debt, bankruptcy, eviction,[13] unemployment,[14] and intimate partner violence[15]—compounding economic and familial risk factors for child maltreatment[16] and child welfare system involvement.[17]
- Importantly, research does not suggest that all or even most individuals who experience unexpected (or sooner-than-expected) pregnancies are likely to mistreat their children. Many pregnancies in the United States are unexpected or unplanned, and most of those children are welcome additions to their family and are never harmed by their parents. Rather, research suggests that unexpected pregnancies and the restriction of options and choices related to family planning may contribute to family stress, parental mental health challenges, and economic hardships that are sometimes associated with risks for child maltreatment and child welfare system involvement.

Expansive contraceptive access as a tool for preventing child maltreatment and child welfare system involvement

- Given the links between unexpected pregnancies and child maltreatment risk—and the benefits of contraception for allowing individuals to prevent, plan, and time their pregnancies—there is reason to believe that expanding access to, and use of, contraception may be a promising component of a holistic approach to preventing child maltreatment.
- Analyses of national data on child maltreatment and state-level contraceptive access policy changes from 2006-2019[18] found that each additional policy expanding contraceptive access was associated with a decrease in maltreatment reports and in substantiated or confirmed reports.[19]

Key contexts and considerations

Access to contraception is a rapidly changing landscape.[20] The contextual information below may be helpful for state-level policymakers and administrators working collaboratively policies and initiatives related to contraception access.

Rural communities

- Over 46 million U.S. residents live in rural areas—with many rural areas having few or no local health care providers.[21]
- About 19 million women live in counties without a clinic offering full-range contraceptive care—also known as "contraceptive deserts."[22]
- Evidence suggests that publicly funded clinics offering family planning services in rural areas may not provide the same access to highly effective forms of contraception known as long-acting reversible contraception (LARC; e.g., implants, intrauterine devices, or IUDs).[23]
- As such, individuals living in rural areas may not benefit from policies simply authorizing expanding access to contraceptives or even making contraception more affordable.

Racial inequities

- Racial and ethnic disparities in access to reproductive health care and reproductive health outcomes persist for several reasons.[24,25]
- Young Black women are more likely than other women to have negative experiences seeking and obtaining health care of all types.[26]
- Evidence suggests that some people of color may be less likely to readily trust medical professionals, given prior negative experiences and discrimination,[27] as well as historical events involving medical harm perpetuated against people and communities of color.[28]
- In the 25 states with the highest proportions of Black residents, only 11 states require reproductive/sexual health education in schools, and only three of those states have policies requiring that information disseminated be medically accurate.[29]

Part II: State-Level Contraception Policy Options and Effects on Child Maltreatment

This section summarizes various policy levers for increasing access to contraception, which evidence suggests as an important part of a holistic approach to preventing maltreatment and child welfare system involvement among families with very young children. This section can support policymakers in understanding how contraception-related policy variations may intersect with child welfare outcomes.

Supporting expanded prescribing and dispensing authority

Expanding prescribing and dispensing authority to non-physician health care providers

- Allowing providers such as pharmacists,[30] advanced practice nurses (or nurse practitioners),[31] and midwives[32] to prescribe and dispense a variety of birth control methods can expand access to contraception and help prevent unintended pregnancies.[33]
- For example, Hawaii extended contraceptive prescribing authority to pharmacists in 2017 (Act 067, S.B. 513). However, by 2020, only 31 percent of 175 surveyed pharmacies offered this service.[34] Pharmacies reported that the low uptake was due to a lack of knowledge of the policy and gaps in training related to implementation.
- As of 2023, 25 states have passed some form of policy allowing contraceptive prescribing by pharmacists,[35] though 5 states have not finalized regulations (AZ, AR, DE, NV, and NH).[36]
- Policies granting pharmacists the ability to prescribe contraception do not *require* pharmacists to participate. Evidence suggests some pharmacists may have concerns about liability or other issues related to prescribing contraception.[37] Policymakers should explore barriers to pharmacist participation in these efforts.[38]
- There is also evidence that man young people do not feel comfortable approaching pharmacists about obtaining contraception in a pharmacy setting.[39] Policymakers should engage young people when designing initiatives to promote participation in these programs.
- States may also find success with other pharmacist-centered approaches, including allowing pharmacists to:
    - Sell emergency contraception in vending machines (e.g., ME).[40]
    - Prescribe contraception via telehealth (e.g., VA).[41]
    - Administer injectable hormonal contraception (e.g., SC).[42]

Adjusting insurance coverage for pharmacist-led contraceptive consultations

- While the Affordable Care Act (ACA) requires insurance coverage for prescription contraception, prescribing pharmacies often charge “consultation fees” that may not be covered by insurers.
- Policymakers in states with expanded prescribing for pharmacists should consider these barriers and potential solutions.[43] For instance, Maryland and California have enacted legislation creating billing protocols so that pharmacist consultations can be covered by Medicaid.[44,45] In 2023, Indiana passed legislation making the way for reimbursement of pharmacists’ contraception-related services. The legislation also provided protection for pharmacists who refuse to participate in contraception disbursement on moral or religious grounds.[46]

Expanding contraceptive medications covered by Medicaid

- While the ACA requires private insurance to cover contraception without cost-sharing (e.g., co-pays), many individuals rely on state Medicaid programs for health insurance.
- Medicaid is required to cover "family planning services and supplies." However, states are given significant discretion to define what contraceptive supplies and services qualify.[47] States are responsible for 10 percent of these costs, while the federal government covers 90 percent, making this cost effective for states.
    - Examples of state policies that can expand the definition of contraceptive services or supplies covered by Medicaid[48] include requiring Medicaid to cover six months' worth of contraceptive medications at a time (e.g., LA) and requiring coverage of over-the-counter contraception.

Expanding eligibility for Medicaid-funded family planning services

- States can apply for waivers from the Offices of Medicare and Medicaid to expand eligibility for family planning services to individuals who may not otherwise qualify for Medicaid.[49]
- As of 2024, 26 states have received federal approval under this program, and 24 of these states use this mechanism to provide family planning benefits to individuals with incomes of up to 200 percent of the federal poverty line.

Expanding public awareness and education

- Public knowledge of contraception varies widely. For instance, research has found that young people without health insurance have questions or misconceptions about various forms of contraception.[50,51]
- Research points to health care providers as trusted sources of information about contraceptives among young people.[52] Policymakers should consider health care practitioners as key partners in promoting contraceptive knowledge and access.

Ensuring confidentiality to minors and insured dependents seeking reproductive health care

- While teenage birth rates are at historic lows in recent years, 13.5 in every 1,000 females in the United States will give birth between ages 15-19.[53,54]
- State policies vary widely in terms of minors' access to various forms of sexual and reproductive health care.[55] Many states have laws requiring parental permission for minors seeking contraception, or requiring providers to notify parents, guardians, or health insurance subscribers of insured dependents seeking reproductive health care.[56]
- Even young people over age 18 have expressed concerns about seeking contraceptive care due to worries about privacy and insurance company disclosures.[57]
- Policy options that can promote access to contraceptive health care for minors and insured dependents include allowing minors and insured dependents to obtain contraception without permission from guardians or health insurance subscribers,[58] and expanding funding alternatives to private insurance for contraceptive services.

Part III: Discussion Guide

This section offers prompts to help child welfare program administrators partner with other policymakers, program administrators, partners, and advocates around promoting access to contraception, which may in turn reduce incidences of child maltreatment (largely neglect) and child welfare system involvement among families of very young children in your state. Questions are intended to spur inquiry, dialog, and reflection to ensure that everyone has a common understanding of the scope and shape of any problems, and to help inform action planning and next steps for increasing alignment between child welfare and public health leadership. This guide is designed to be flexible, so users can choose to focus on selected subtopics and question prompts, or the full guide, depending on the needs and priorities in your state. Child welfare leaders may also choose to work through the guide internally to support their own goal setting and planning. To access data, resources, and other information that may help you think about answers to the questions below, see our Annotated Resource Compilation.

Step 1: Gather information.

Infant and toddler maltreatment data

- What are the reasons that young children are being reported to our child welfare system?
- Who are the key actors and partners influencing policy and programming related to maltreatment of infants and toddlers in our state, and what are their perspectives and priorities?
- Are state legislators aware of child abuse and neglect trends and issues in our state?
- What are the trends in reported and confirmed abuse and neglect among infants and toddlers?
- Among young children being reported to Child Protective Services, what is the rate of "unsubstantiated" or unconfirmed allegations?

The intersection: Child maltreatment and barriers to contraception

- What do child welfare professionals observe related to contraceptive access, knowledge, values, barriers, and use among the parents and families they serve?

Contraception access policies and practices

- What challenges exist for accessing contraception in our state?
    - Are there any equity issues? For example, are challenges universal, or do they vary across regions or communities within our state?
- What, if any, contraception-related policy changes are being considered or implemented?
- Who are key partners on this issue, and what are their positions on contraception access?
- What is the status of Title X funding utilization in our state? *Title X funding is federal funding provided to states for family planning services for low-income individuals, often through publicly funded clinics.*[59]
- What is the role of Title X-funded clinics in providing contraception in our state?
    - Are there enough Title X-funded clinics to meet family planning needs in our state?

Step 2: Reflect on nuances, challenges, and policy opportunities.

This section lists specific aspects of contraception-related policies and local contextual information, followed by topic-specific questions for identifying areas of opportunity in your community. Some questions below may offer opportunities to think about opportunities for improvement and potential barriers (e.g., *Is there room for improvement? If yes, what barriers and opportunities exist?*).

Public awareness and education

- To what extent are leaders and agencies in our state working with health care providers to educate young people about their contraceptive access options?
- Do uninsured people have accessible ways to learn about our state's contraceptive access policies?
- Do young people have accessible ways to learn about contraceptive access options in our state?

Rural communities

- To what extent does our state promote contraceptive access among rural communities?
- What partnerships (existing or potential) could help rural health care providers learn about options for promoting contraceptive access?
- What mechanisms exist for us to learn more about what rural providers perceive as barriers to contraceptive access for the individuals they care for?

Minors and insured dependents

- Is there variation in teen birth rates across communities or demographics in our state? If so, where is it high (and low)?
- What are the policies determining contraceptive access among minors and insured dependents in our state? How well are these policies working? Is there evidence that policy changes are needed?
- Who should we engage to learn more about contraception needs and barriers among young people?

Racial disparities in contraceptive access

- What racial and ethnic disparities exist in our state regarding access to reproductive and sexual health care, including contraceptive access?
- What actions has our state taken to build trust among residents of color who may be skeptical or fearful of seeking medical care? What additional actions can be taken?
- What efforts has our state engaged in to promote equitable reproductive health care in our state?[60]
- What are we doing to attract health care workers of color (e.g., physicians, pharmacists, nurses) to our state?
- Do health care workers get the training and support needed to provide equitable care to all patients?
- Who are the key partners in addressing racial and ethnic inequities in contraceptive access and reproductive health care in our state?

Medicaid coverage

- What forms of contraception are covered by Medicaid?
- Does our state have any policies expanding family planning coverage through the Medicaid program?

- If no, why?
- If yes, how well are those policies working?

Expanded prescribing authority

- Does our state allow contraceptive prescriptions to be written by pharmacists?
  - If no, why?
  - If yes, how well is that working?
- Does our state allow contraceptive prescriptions to be written by non-physician health care professionals?
- What, if any, legislation is being considered related to expanding contraception prescribing authority in our state?
- Who can we engage in efforts to make young people feel comfortable asking pharmacists about contraception?[61]

Step 3: Take action! Move from understanding to impact.

After reflecting on the key topics and questions above, child welfare administrators and their partners can use this information to develop goals, action plans, and policies aimed at maintaining or strengthening contraception access, use, and operations with the explicit goal of impacting child welfare outcomes. These actions may benefit families of very young children and have the potential to reduce rates of child maltreatment in your state. Users of this resource are encouraged to collect and monitor data on policy impacts over time to assess their success.

Action planning prompts

- How do we define "successful" policymaking related to contraceptive access in our state?
- What data are collected that could be used to evaluate the impact of changes to contraceptive access policy in our state? What pieces of information or data are needed?
- Who in our state should collect and analyze the necessary data? Do they have appropriate authorizations and resources?
- How can we pivot if assessments indicate that changes are needed in our state?
- What questions remain about the status of contraceptive access in our state?

For more information on our work and original analyses of contraceptive access policies and child welfare system data, see: https://www.childtrends.org/project/measuring-up

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References

[1] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2024). Child Maltreatment 2022. https://www.acf.hhs.gov/cb/data-research/child-maltreatment

[2] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2024). Child Maltreatment 2022. https://www.acf.hhs.gov/cb/data-research/child-maltreatment

[3] Herrenkohl, T. I., Leeb, R. T. & Higgins, D. (2016). The public health model of child maltreatment prevention. *Trauma Violence Abuse,* 17(4), 363-365. https://doi.org/10.1177/1524838016661034

[4] Child Welfare Information Gateway. (n.d.). Well-being. *U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.* https://www.childwelfare.gov/topics/preventing/promoting/

[5] Child Welfare Information Gateway. (n.d.) Prevention. *U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.* https://www.childwelfare.gov/topics/prevention/

[6] Singh, S., Sedgh, G., & Hussain, R. (2010). Unintended pregnancy: Worldwide levels, trends and outcomes. *Studies in Family Planning, 41*(4), 241–250.

[7] Guterman, K. (2015). Unintended pregnancy as a predictor of child maltreatment. *Child Abuse & Neglect, 24,* 160-169. https://doi.org/10.1016/j.chiabu.2015.05.014

[8] Muskens, L., Boekhorst, M. G. B. M., Kop, W. J., van del Heuvel, M. I., Pop, V. J. M. & Beerthuizen, A. (2022). The association of unplanned pregnancy with perinatal depression: A longitudinal cohort study. *Archives of Women's Mental Health, 25*, 611-620. https://link.springer.com/article/10.1007/s00737-022-01225-9

[9] Barton, K., Redshaw, M., Quigley, M.A., & Carson, C. (2017). Unplanned pregnancy and subsequent psychological distress in partnered women: a cross-sectional study of the role of relationship quality and wider social support. *BMC Pregnancy and Childbirth*, *17*, 44, https://doi.org/10.1186/s12884-017-1223-x

[10] Abajobir, A. A., Maravilla, J. C., Alati, R. & Najman, J. M. (2016). A systematic review and meta-analysis of the association between unintended pregnancy and perinatal depression. *Journal of Affective Disorders,* 192, 56-63. https://doi.org/10.1016/j.jad.2015.12.008

[11] Sasaki, N., Ikeda, M. & Nishi, D. (2022). Long-term influence of unintended pregnancy on psychological distress: A large sample retrospective cross-sectional study. *Archive of Women's Mental Health*, 25, 1119–1127. https://doi.org/10.1007/s00737-022-01273-1

[12] Boden, J. M., Fergusson, D. M. & Horwood, L. J. (2015). Outcomes for children and families following unplanned pregnancy: Findings from a longitudinal birth cohort. *Child Indicators Research,* 8, 389–402. https://doi.org/10.1007/s12187-014-9241-y

[13] Miller, S., Wherry, L. R., & Foster, D. G. (2023). The economic consequences of being denied an abortion. *American Economic Journal: Economic Policy*, *15*(1), 394-437. https://www.nber.org/system/files/working_papers/w26662/w26662.pdf

[14] Nuevo-Chiquero, A. (2014). The labor force effects of unplanned childbearing. *Labour Economics*, *29*, 91-101. https://doi.org/10.1016/j.labeco.2014.07.006

[15] Nelson, H. D., Darney, B. G., Ahrens, K., Burgess, A., Jungbauer, R. M., Cantor, A., ... & Fu, R. (2022). Associations of unintended pregnancy with maternal and infant health outcomes: a systematic review and meta-analysis. *JAMA, 328*(17), 1714-1729. https://doi.org/10.1001/jama.2022.19097

[16] CDC. (2024). Child Abuse and Neglect Prevention: Risk and Protective Factors. https://www.cdc.gov/child-abuse-neglect/risk-factors/index.html

[17] Dubowitz, H., Kim, J., Black, M. M., Weisbart, C., Semiatin, J., & Magder, L. S. (2011). Identifying children at high risk for a child maltreatment report. *Child Abuse & Neglect*, *35*(2), 96-104. https://doi.org/10.1016/j.chiabu.2010.09.003

[18] Rice, W. S., Redd, S. K., Luke, A. A., Komro, K., Arriola, K. J. & Hall, K. S. (2022). Dispersion of contraceptive access policies across the United States from 2006 to 2021. *Preventive Medicine Reports,* 27. https://doi.org/10.1016/j.pmedr.2022.101827

[19] Piña, G., Moore, K., Mihalec-Adkins, B., Darling, K., Abdi, F. & Liehr, A. (2024). Preventing child maltreatment in infants and toddlers: Gaps and evidence from state-level policies. *Child Maltreatment*, 10775595241267236. https://doi.org/10.1177/10775595241267236

[20] National Conference of State Legislatures. (2024). *State contraception policies.* https://www.ncsl.org/health/state-contraception-policies

[21] CDC. (2023). *About rural health*. Centers for Disease Control and Prevention. https://www.cdc.gov/ruralhealth/about.html

[22] Kreitzer, R. J., Smith, C. W., Kane, K. A. & Saunders, T. M. (2021) Affordable but inaccessible? Contraception deserts in the US states. *Journal of Health Politics, Policy and Law, 46*(2), 277-304. https://doi.org/10.1215/03616878-8802186

[23] Bornstein, M., Carter, M., Zapata, L., Gavin, L., & Moskosky, S. (2018). Access to long-acting reversible contraception among US publicly funded health centers. *Contraception*, 97(5), 405–410. https://doi.org/10.1016/j.contraception.2017.12.010

[24] Sutton, M. Y., Anachebe, N. F., Lee, R., & Skanes, H. (2021). Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020. *Obstetrics and Gynecology*, 137(2), 225–233. https://doi.org/10.1097/AOG.0000000000004224

[25] Troutman, M., Rafique, S. & Plowden, T.C. (2020). Are higher unintended pregnancy rates among minorities a result of disparate access to contraception?. *Contraception and Reproductive Medicine,* 5(16). https://doi.org/10.1186/s40834-020-00118-5

[26] Pew Research Center. (2022). *Black Americans' views of and engagement with science.* Pew Research Center. https://www.pewresearch.org/science/2022/04/07/black-americans-views-of-and-engagement-with-science/#:~:text=The%20legacy%20of%20egregious%20medical,symptoms%20among%20those%20study%20participants

[27] Bazargan, M., Cobb, S. & Assari, S. (2021). Discrimination and medical mistrust in a racially and ethnically diverse sample of California adults. *The Annals of Family Medicine, 19*(1), 4-15. https://doi.org/10.1370/afm.2632

[28] CDC. (2023). *The U.S public health service untreated syphilis study at Tuskegee.* Centers for Disease Control and Prevention. https://www.cdc.gov/tuskegee/index.html

[29] Brinkman, B. G., Garth, J., Horowitz, K. R., Marino, S. & Lockwood, K. N. (2019). *Black girls and sexuality education: Access, equity, justice.* Gwen's Girls, Gwendolyn J. Elliott Institute. https://www.gwensgirls.org/wp-content/uploads/2019/10/BGEA-Report2_v4.pdf

[30] National Conference of State Legislatures. (n.d.). *Prescription of hormonal contraception.* https://www.ncsl.org/scope-of-practice-policy/practitioners/pharmacists/prescription-of-hormonal-contraceptives

[31] Alaska Admin Code, 12 AAC 44.440. (2023). https://www.akleg.gov/basis/aac.asp#12.44.440

[32] National Academy for State Health Policy. (2023). State medicaid strategies for the contraceptive care workforce. *National Academy for State Health Policy.* https://nashp.org/state-medicaid-strategies-for-the-contraceptive-care-workforce/#:~:text=A%20range%20of%20clinical%20primary,Community%2DBased%20Providers

[33] Rodriguez, M. I., Hersh, A., Anderson, L. B., Hartung, D. M. & Edelman, A. B. (2019). Association of pharmacist prescription of hormonal contraception with unintended pregnancies and Medicaid costs. *Obstetrics & Gynecology, 133*(6), 1238-1246. https://doi.org/10.1097/AOG.0000000000003265

[34] Collins-Doijode, H., Oehlers, J., Tyson, J., Rodriguez, M. I., & Kaneshiro, B. (2022). Availability of Pharmacist-Prescribed Contraception in Hawai'i. *Hawai'i Journal of Health & Social Welfare, 81*(8), 218–222. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9344536/

[35] NCSL. (2023). *State contraception policies.* National Conference of State Legislatures. https://www.ncsl.org/health/state-contraception-policies

[36] California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Maine, Maryland, Minnesota, Montana, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia.

[37] Lio, I., Remines, J., Nadpara, P. A., Goode, J. R. (2017). Pharmacists' comfort level and knowledge about prescribing hormonal contraception in a supermarket chain pharmacy. *Journal of the American Pharmacists, 58*(4), 89-93. https://doi.org/10.1016/j.japh.2018.05.005

[38] Rafie, S., Cieri-Hutcherson, N.E, Frame, T.R., Griffin, B., Harris, J. B., Horlen, C., Shealy, K., Stein, A. B., Stone, R. H., Vest, K., Westberg, S. & Yancey, A. M. (2019). Pharmacists' perspectives on prescribing and expanding access to hormonal contraception in pharmacies in the United States. *Journal of Pharmacy Practice, 34*(2), 230-238. https://doi.org/10.1177/0897190019867601

[39] Zuniga, C., Wollum, A., Katcher, T., & Grindlay, K. (2019). Youth perspectives on pharmacists' provision of birth control: findings from a focus group study. *Journal of Adolescent Health*, *65*(4), 514-519. https://doi.org/10.1016/j.jadohealth.2019.05.013

[40] An Act to Allow for the Sale of Nonprescription Drugs Through Vending Machines, H. P. 38, L. D. 37. (2019). https://legislature.maine.gov/LawMakerWeb/summary.asp?ID=280070657

[41] Pharmacists; Initiation of treatment with and dispensing and administration of vaccines, SB 672 (2022). https://lis.virginia.gov/cgi-bin/legp604.exe?221+sum+SB672

[42] Pharmacy Access Act, A210, R238, S628 (2022). https://www.scstatehouse.gov/sess124_2021-2022/bills/628.htm

[43] Staren, D. (2024). State approaches to pharmacist prescribing of hormonal contraceptives. *National Academy for State Health Policy.* https://nashp.org/state-approaches-to-pharmacist-prescribing-of-hormonal-contraceptives/

[44] Gomez, A. M. (2017). Availability of pharmacy-prescribed contraception in California, 2017. *JAMA, 318*(22), 2253-2254. https://doi.org/10.1001/jama.2017.15674

[45] Maryland Department of Health. (n.d.). Maryland Medicaid Contraception Prescriber Enrollment. https://health.maryland.gov/pharmacy/Pages/Contraception-Prescribing.aspx#:~:text=Once%20enrolled%2C%20Pharmacist%20Prescribers%20may,via%20a%20CMS%2D1500%20form

[46] Prescription for Hormonal Contraceptives, Indiana House Bill 1568 (2023). https://iga.in.gov/legislative/2023/bills/house/1568/details

[47] KFF. (2022). *State requirements for insurance coverage of contraceptives.* https://www.kff.org/other/state-indicator/state-requirements-for-insurance-coverage-of contraceptives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[48] National Conference of State Legislatures. (2023). *Medicaid strategies to improve access to contraception.* https://www.ncsl.org/health/medicaid-strategies-to-improve-access-to-contraception

[49] KFF. (2024). States that have expanded eligibility for coverage of family planning services under Medicaid. https://www.kff.org/medicaid/state-indicator/family-planning-serviceswaivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[50] Yen, S., Parmar, D. D., Lin, E. L., & Ammerman, S. (2015). Emergency contraception pill awareness and knowledge in uninsured adolescents: high rates of misconceptions concerning indications for use, side effects, and access. *Journal of Pediatric and Adolescent Gynecology*, *28*(5), 337-342. https://doi.org/10.1016/j.jpag.2014.09.018

[51] Russo, J. A., Miller, E., & Gold, M. A. (2013). Myths and misconceptions about long-acting reversible contraception (LARC). *Journal of Adolescent Health*, *52*(4), S14-S21. https://doi.org/10.1016/j.jadohealth.2013.02.003

[52] Goodman, S. R., El Ayadi, A. M., Rocca, C. H., Kohn, J. E., Benedict, C. E., Dieseldorff, J. R., & Harper, C. C. (2018). The intrauterine device as emergency contraception: how much do young women know?. *Contraception*, *98*(2), 115-119. https://doi.org/10.1016/j.contraception.2018.04.009

[53] Hamilton, B. E., Martin, J. A., & Osterman, M. J. K. (2023). *Births: Provisional data for 2022. Vital Statistics Rapid Release, Report No. 28.* Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/data/vsrr/vsrr028.pdf

[54] Centers for Disease Control and Prevention. (2023). *U.S. teen birth rate reached another historic low in 2022.* Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2023/20230601.htm

[55] Centers for Disease Control and Prevention. (2022). *State laws that enable a minor to provide informed consent to receive HIV and STD services.* https://www.cdc.gov/hiv/policies/law/states/minors.html

[56] Congressional Research Service. (2023). *Title X Parental Consent for Contraceptive Services Litigation: Overview and Initial Observations*. https://crsreports.congress.gov/product/pdf/LSB/LSB10916

[57] Wilkinson, T. A., Miller, C., Rafie, S., Landau, S. C., & Rafie, S. (2018). Older teen attitudes toward birth control access in pharmacies: a qualitative study. *Contraception*, *97*(3), 249–255. https://doi.org/10.1016/j.contraception.2017.11.008

[58] KFF. (2024). Minors' authority to consent to contraceptive services. https://www.kff.org/womens-health-policy/state-indicator/minors-authority-to-consent-to-contraceptive services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[59] Congressional Research Service. (2023). *Title X Family Planning Program.* https://crsreports.congress.gov/product/pdf/IF/IF10051

[60] Holt, K., Reed, R., Crear-Perry, J., Scott, C., Wulf, S., & Dehlendorf, C. (2020). Beyond same-day long-acting reversible contraceptive access: a person-centered framework for advancing high-quality, equitable contraceptive care. *American Journal of Obstetrics and Gynecology*, *222*(4), S878-e1. https://doi.org/10.1016/j.ajog.2019.11.1279

[61] Zuniga, C., Wollum, A., Katcher, T., & Grindlay, K. (2019). Youth perspectives on pharmacists' provision of birth control: Findings from a focus group study. *Journal of Adolescent Health*, *65*(4), 514-519. https://doi.org/10.1016/j.jadohealth.2019.05.013