

Rights Without Means Are Not Rights:
Operationalizing Insurance Coverage
at the Retail Counter for
Over-The-Counter Contraceptives in
Maryland

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Problem & Background

Implementation Problem with SB848 (2016)- The Contraceptive Equity Act

- Requires insurance carriers in Maryland to cover FDA-approved contraceptives available over-the-counter or by prescription
- Statutory requirements for coverage are a vital first step in providing healthcare access for Marylanders
- Coverage exists on paper, but the infrastructure is lacking
 - *Pharmacies don't know how to bill for non-prescription items, and consumers don't know that coverage is an option*
- HB939 established The Maryland Collaborative to Advance Implementation of Coverage of Over-the-Counter Birth Control to implement coverage that has been required since 2016

Background

The Historical, Political, and Social Dimensions

Contraceptive access is (1) essential and (2) precarious. Despite the social, economic, and health benefits, federal legal code and political attitude presents risk to access.

Retail Counter Coverage Strategies

Coverage can be operationalized through cards (like SNAP or HSAs), apps, mobile wallets, or digital kiosks. States also have the ability to wield soft power to negotiate with providers and PBMS. Universalized healthcare models guarantee accessibility for all.

OTC Contraceptive Coverage: Theory and Foundation

Contraceptive access is common in developing nations, and ten states have enacted OTC coverage policy in the US. This is operationalized at the retail counter or pharmacy, with the former considered more accessible.

Implementation Challenges and Literature Gaps

Uptake of policy is generally poor. Lack of statutory clarity, resource-scarcity, and information access all pose challenges at the retail counter. The literature on retail counter coverage implementation lacks depth.

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Methodology

Methodological Strategies

Literature Review & Analysis

Focused on: OTC drug policy, contraceptive access, insurance policy, pharmaceutical policy, and the sociological dimension of birth control access.

Document Analysis & System Mapping

Analyze industry manuals and documentation to create system maps of payment transaction structures.

State Case Studies

Assess conditions for implementation. Included: MD, DE, WI, NM, MA, NJ, NY, PA, and Washington, D.C., and was designed to capture variation across demographic, religious, political, and policy contexts.

Geospatial Analysis & Mapping

Analyze spatial data on retail access and population need to generate geospatial maps and overlap measures.

Supplementary Expert Interviews

Conduct supplementary interviews to gain a better understanding of implementation successes and challenges.

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Analysis

State Policy Landscape & Uptake

- ❖ Maryland (2016) + 9 states enacted OTC contraceptive coverage mandates
- ❖ Comparative case study across peer states shows consistent outcomes:
 - Uptake is minimal to nonexistent across all states examined
- ❖ No clear examples of successful retail-counter implementation
- ❖ Shared barriers across states:
 - Unclear legislation
 - Confusion among providers and retailers; low consumer awareness
 - Lack of billing mechanisms
- ❖ Key takeaway:
 - Failure is not demographical, political, or religious, but appears structural and infrastructural

Payment Rails Comparative Analysis

What is a payment rail?

- ❖ Payment rails = systems that process transactions
- ❖ Connect:
 - Retailers
 - Payment processors
 - Financial institutions
 - Insurers / benefit administrators

Payment Rail Infrastructure

- ❖ Coverage at the retail counter requires transaction infrastructure
- ❖ Must support:
 - Real-time authorization
 - Product eligibility restrictions
 - Connection between retailer and insurer

Rail 1 — Prepaid Card Model

Summary: Uses existing card networks to enable real-time retail transactions with minimal POS integration

Tradeoff:

- ❖ Simple and scalable
- ❖ Limited ability to restrict purchases to eligible products

Rail 2 — WIC

Summary: Uses an Authorized Product List (APL) to enforce real-time SKU-level product eligibility at checkout

Tradeoff:

- ❖ High precision control
- ❖ Requires complex, state-managed infrastructure

Rail 3 — PBM Auto-Adjudication

Summary: Processes claims in real time using patient-specific eligibility and clinical rules through PBM systems

Tradeoff:

- ❖ Maximum precision and control
- ❖ Not compatible with retail POS environments

Comparative Assessment

Prepaid Cards

- ✓ Easy integration
- ✓ Low burden
- ✗ Weak product control

WIC-Style Systems

- ✓ Strong SKU-level restriction
- ✓ High oversight
- ✗ High infrastructure + state burden

PBM Adjudication

- ✓ Highest precision + clinical safeguards
- ✓ Established claims system
- ✗ Not compatible with retail POS

Takeaway: Systems trade simplicity for control. No model achieves ease of integration, product restriction, and claims processing.

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Recommendations

Recommendation 1:

Hybrid Infrastructure Model

- ❖ Develop a hybrid payment system integrating:
 - Prepaid card payment rails (ease of use)
 - WIC-style product eligibility controls (SKU-level restriction)
 - PBM-style insurer connectivity (eligibility + coverage rules)
- ❖ Core system components:
 - Payment layer: Restricted-use card operating on existing card networks
 - Product restriction layer: Approved Product List (APL) integrated with POS
 - Connectivity layer: Rules engine to verify eligibility, coverage, and limits
 - *Transaction*: Product scanned → POS checks eligibility → card processed
→ coverage verified, rules applied → payment approved
- ❖ Leverage existing POS infrastructure to minimize retailer burden
- ❖ Contract with third-party payment processors or program administrators
- ❖ Insurers define coverage rules; system handles execution

Recommendation 2: Oversight Mechanisms

- ❖ Establish multi-agency oversight structure:
 - *Maryland Insurance Administration (MIA)*: Regulates insurers
 - *Maryland Department of Health (MDH)*: Coordinate and oversee program
 - *Third-party administrator (TPA)*: System management
- ❖ Tie participation to regulatory requirements:
 - Require insurer participation in approved system
 - Establish data reporting by retailers as a condition of compliance
- ❖ Enforcement mechanisms:
 - Tax subsidies for participating retailers during early adoption period
 - Corrective action plans for noncompliance
 - Financial penalties or sanctions
- ❖ Implementation strategy:
 - Pilot program with select retailers and insurers
 - Phased statewide rollout based on performance

Recommendation 3: Legislative Action

- ❖ Amend SB848 to include explicit enforcement mechanisms
 - Grant MIA authority to issue penalties for noncompliance
 - Require insurer participation in approved coverage system
- ❖ Mandate reporting requirements
 - Standardized data submission on coverage, claims, and access
 - Tie reporting to regulatory compliance
 - Transaction volume
 - Denial rates and coverage gaps
 - Consumer complaints and insurer responses
- ❖ Designate a lead implementing agency
 - Assign Maryland Department of Health (MDH) responsibility for program coordination
 - Clarify roles across agencies
- ❖ Authorize system implementation
 - Enable state to contract with third-party administrators and vendors
 - Support pilot programs and phased rollout

Supplementary Elements

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Performance Evaluation Framework

Early implementation evaluated across...

Uptake:

Indicates the ability for merchants and insurers to provide coverage for OTC contraceptives at the retail counter.

- ❖ # of covered contraceptive transactions
- ❖ % of eligible transactions covered versus paid out-of-pocket
- ❖ # of eligible transactions forgone due to coverage barriers

Access

Represents the availability of OTC contraceptives at a breadth of retailers without cost to consumers.

- ❖ # of unique users purchasing contraceptives with coverage
- ❖ % of eligible users age 15-44 utilizing coverage
- ❖ % of retailers providing coverage
- ❖ Time of program adoption by retailers from onboarding date

Equity

Signifies the distribution of program access across populations by income, race, age, and geography.

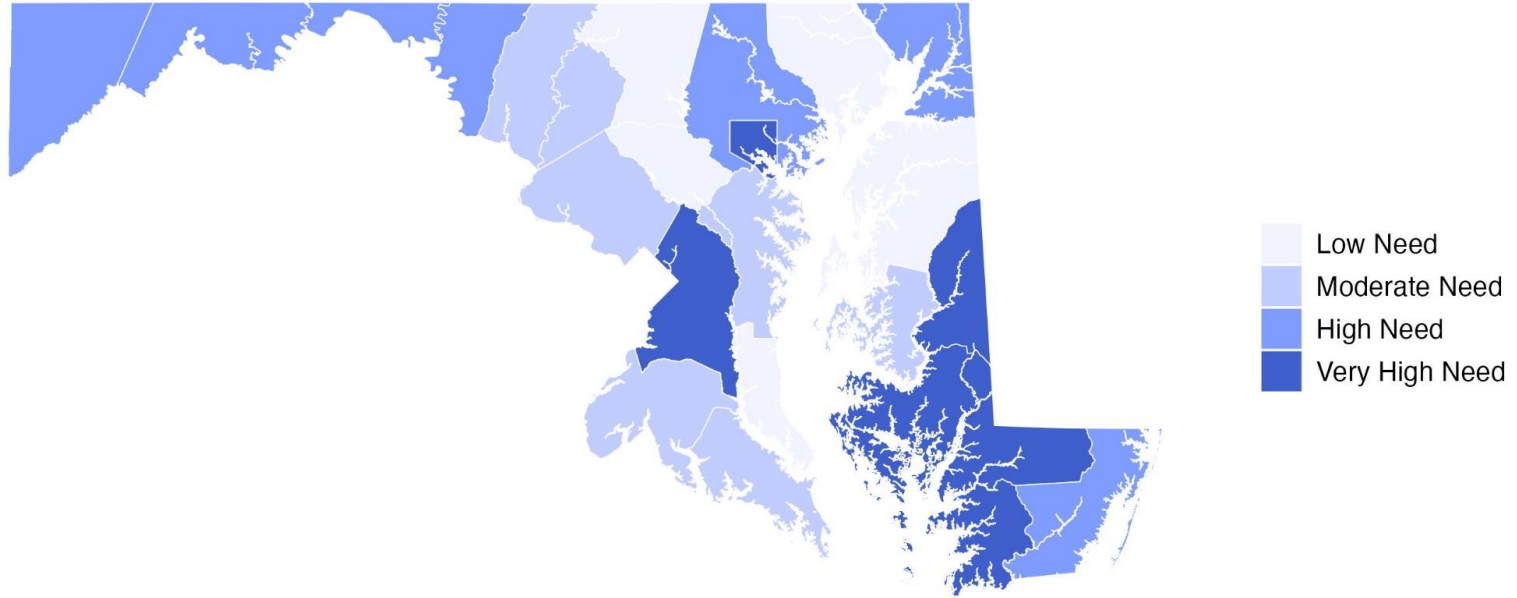
- ❖ % of participants that are non-white, low-income, or under age 25
- ❖ % of eligible users per county utilizing coverage
- ❖ % of transactions occurring within a defined geographic radius from user's residence (ZIP code)

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Geospatial Evaluation & Anticipated Behavioral Trends

Reproductive need concentrates geographically

Combined indicators reveal clusters of high need in rural and low-income urban areas.

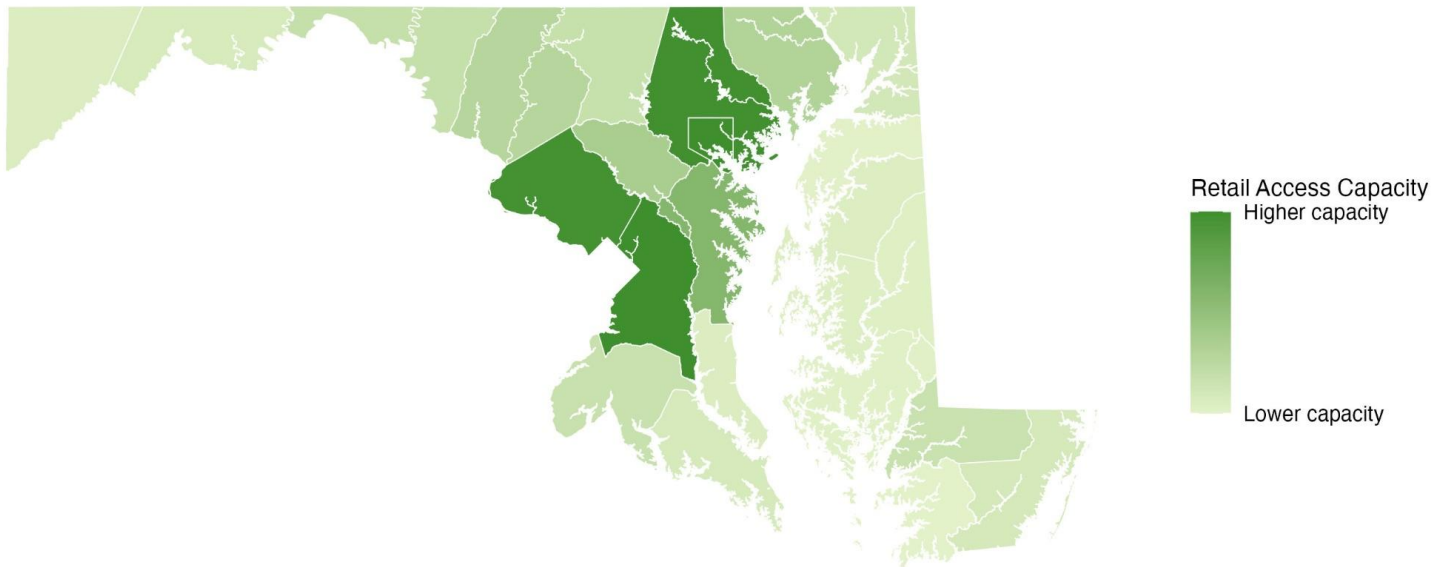


Source: Maryland PRAMS; NCHS; US Census; ALICE dataset.
Economic vulnerability combines poverty and ALICE households.

Concentration of reproductive need by county in Maryland.

Retail presence does not translate evenly into capacity

Aggregating retailer types reveals meaningful differences in counties' ability to support point-of-sale contraceptive coverage.

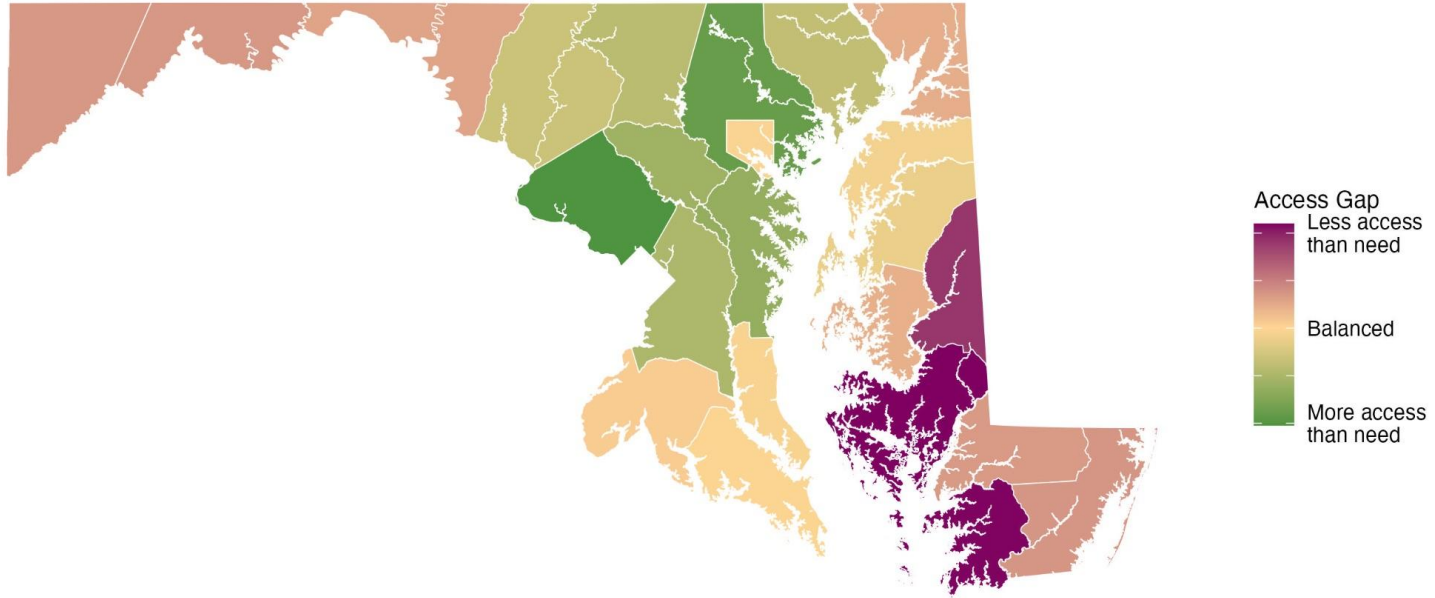


Source: SafeGraph retail POI data; author's classification.

Retail capacity by county, weighted for retailer capacity.

Access and need do not fully align

Even where retail infrastructure exists, gaps remain in high-need areas—indicating that availability alone may not ensure coverage.

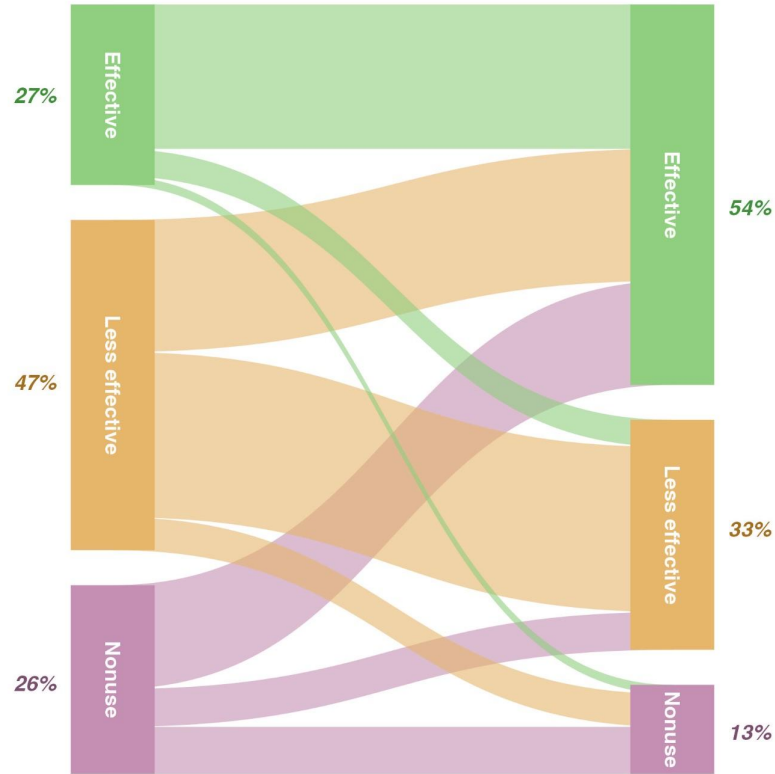


Source: Maryland PRAMS; NCHS; US Census; United Way; SafeGraph.

Gap between retail capacity and reproductive need.

When access improves, method effectiveness increases

Individuals shift toward more effective contraceptive methods when barriers to access are reduced.



Effective use more than doubles under modeled conditions.

Projected changes in
contraceptive use in
Maryland;
Population-weighted
scenario based on
Maryland baseline method
use and observed behavior

Conclusion

- ❖ Coverage mandates alone are insufficient without implementation infrastructure
- ❖ The core constraints are infrastructural— both in a technical and governance context—and this barrier reinforces secondary challenges
- ❖ Bridging this gap requires a hybrid system design, oversight, and policy support

Thank you!
Any questions?