Top Ten List: Reproductive and Sexual Health Care Access in the Time of COVID-19

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The COVID-19 pandemic is exposing and exacerbating pervasive obstacles to sexual health, family planning, prenatal, labor and delivery, postpartum, and abortion care in the U.S. It is also illuminating how overlapping systems of oppression unjustly mar the health and wellbeing of people with disabilities, LGBTQ individuals, and people of color, including Black, Latinx, Asian American, Indigenous/Tribal, and undocumented immigrant communities. Some efforts to halt the spread of COVID-19 and facilitate treatment have inadvertently disrupted and diverted resources away from essential and urgently needed reproductive and sexual health services. Anti-choice policymakers have also exploited the crisis, building on existing systemic barriers to further restrict and effectively ban access. Together, these challenges undermine reproductive and sexual health, rights, and justice, especially for marginalized communities. These injustices produce and compound gaps in and hurdles to crucial and time-sensitive health services. Fortunately, states have numerous opportunities to ensure all individuals can access comprehensive and quality reproductive and sexual health care during and after the pandemic.

1. **States should center reproductive justice[1] in COVID-19 responses.** COVID-19 responses should promote reproductive and sexual health for all. This requires dismantling social and economic obstacles to health and wellbeing. States should begin by actively engaging reproductive justice leaders to shape policy responses and elevating and centering the leadership of people of color, LGBTQ people, and people with disabilities in the process.

2. **States should promote reproductive and sexual health care access during and after the pandemic by expanding coverage for people who are pregnant, postpartum and/or uninsured.** From 2015–2017, one in three women experienced a disruption in health

[1] Reproductive justice is an intersectional movement rooted in the principle that all individuals and communities should have the resources and power they need to make their own decisions about their bodies, genders, sexualities, families, and lives. This means that all people have the means and ability to direct their own reproductive and sexual and health decisions, including the rights to have a child, the right to not have a child, and the right to parent the children they already have with dignity.

insurance during pregnancy or postpartum.[2] The postpartum uninsurance rate in Medicaid non-expansion states was three times as high as in expansion states. Absent immediate policy reforms, the COVID-19 pandemic has the potential to significantly magnify these inequities. States can seek an emergency waiver or leverage state funds to extend continuous postpartum coverage from the federal minimum—the end of the month in which the 60-day postpartum period falls—to the end of the month in which the 365-day postpartum period falls. They can also provide coverage to pregnant people who are ineligible for Medicaid based on income or immigration status under the state's CHIP program. Fourteen states could promote reproductive and sexual health for many uninsured adults and save lives by expanding Medicaid.

3. **States should expedite reproductive and sexual health service program enrollment.** States should use presumptive eligibility (P.E.) to allow pregnant individuals, certain breast or cervical cancer patients, patients seeking family planning or hospital services, and others to immediately enroll in Medicaid or CHIP without verifying certain eligibility criteria. States should allow qualified providers to utilize telephonic signatures for immediate enrollment via P.E. (*see, e.g.*, CA). States should also clearly establish that P.E. applies to Medicaid-covered abortion care (*see, e.g.*, CA, NY).

4. **States should streamline reproductive and sexual health service program enrollment and renewal.** States should allow telephonic and online enrollment and recertifications for individuals seeking enrollment or recertification in traditional Medicaid, CHIP, family planning expansion waivers (*see, e.g.* CA), state Breast and Cervical Cancer Treatment Programs (*see, e.g.*, CA), the National Breast and Cervical Cancer Early Detection Program (*see, e.g.*, CA), the Ryan White HIV/AIDS program (*see, e.g.*, Palm Beach County, FL), and other programs that provide vital reproductive and sexual health services to low-income people, people of color, young people, people with disabilities, LGBTQ people, and others.

5. **States should strengthen access to contraceptives, anti-retroviral therapy, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP).** They should expand over-the-counter coverage (*see, e.g.*, DE, DC) of, authorize pharmacists to prescribe and dispense, and offer home delivery options for hormonal and injectable contraceptives. They should also waive quantity, frequency, and duration limits (*see, e.g.*, DC) and prior-authorization requirements for contraceptives, anti-retroviral therapy, PrEP, and PEP.

6. **States should waive burdensome provider licensing and scope of practice requirements that impede timely access to reproductive and sexual health care.** States can waive scope of practice limitations for midwifery services, birth center services, and home births. Likewise, they can waive licensing requirements for out-of-state providers to

[2] This fact sheet uses the term "women." This is not intended to be exclusionary. We recognize that different categories of people, including cisgender women and transgender men, are able to become pregnant, and we use the term "women" here in order to conform to the cited research.

provide family planning services, medication abortion, midwifery services, birth center services, and home birth via telehealth or other modalities.

7. **States should eliminate restrictions on abortion care.** Abortion is an essential and time-sensitive health care service. Some states tried to define abortions as "non-essential" or "elective" procedures and banned abortions until the end of the emergency, yet most of these bans have been successfully blocked in court. In addition, states should eliminate ultrasound requirements, mandatory waiting periods, and in-person counseling requirements.

8. **States should expand telehealth to connect people to the full range of comprehensive sexual and reproductive health services.** COVID-19 has elevated the importance of telehealth in facilitating access to care. States should enable providers to use telehealth to provide patients with family planning (*see, e.g.*, WA) as well as sexual health services, including PrEP, PEP, and routine HIV care. They should allow providers to conduct prenatal and postpartum care (including doula care) via telehealth (*see, e.g.*, NC). Likewise, they should eliminate state bans on abortion via telehealth. Medication abortion is a safe and effective method that can be easily prescribed through telehealth and mailed or delivered to patients. Post-abortion care should also be available via telehealth. Health care payers such as Medicaid and CHIP should reimburse reproductive and sexual health services, including related mental health services, delivered via telehealth at the same rate as comparable in-person services (*see, e.g.*, WA). Beyond COVID-19, telehealth should be integrated into a long-term strategy for improving access to vital reproductive and sexual health services.

9. **States should reduce the risk of maternal mortality and birth trauma by strengthening access to doula care before, during, and after birth.** Maternal mortality in the U.S. has long outpaced rates in similarly wealthy nations, particularly among people of color. COVID-19 could further exacerbate maternal health inequities, including those stemming from racism and racial bias endemic to the U.S. health care system. People who are pregnant or postpartum may encounter increased stress and anxiety due to COVID-19. Some providers are imposing bans on partners and other supporters accompanying a pregnant or birthing parent to prenatal visits, hospitals, and hospital delivery rooms as well as measures that immediately separate parents from their infants after birth. People are reporting clinical decisions that deprioritize patient autonomy. Even when well-intentioned, these measures may increase the risk of pregnancy and childbirth complications, birth trauma, pre- and postpartum depression, and maternal mortality. Doulas (especially community-based doulas) can help mitigate these risks. It is crucial that states work to ensure that all pregnant people enrolled in Medicaid who want access to a doula have one. Medicaid, CHIP, and private payers should cover doula care delivered in-person and virtually during and following the pandemic. States should permit one asymptomatic doula or other birth worker of the pregnant person's choice to be present to support the person in labor, in addition to at least one asymptomatic partner or support person of the pregnant person's choice to be present on the labor floor (*see, e.g.*, NY). States should also enable pregnant patients to access virtual doula support through the use of videoconferencing and related technologies in the hospital and during labor.

10. **States and municipalities should ensure that COVID-19 data surveillance efforts do not leave reproductive and sexual health and justice behind.** Emerging data show

disproportionate rates of COVID-19 infection and mortality among communities of color. Overlapping systems of oppression may place people seeking reproductive and sexual health services during the pandemic at particular risk for negative outcomes—especially pregnant, birthing, and postpartum people of color, young people, people with disabilities, and LGBTQ people. Data on the effects of COVID-19 infection during pregnancy are extremely limited. In addition to testing, incidence, and mortality data aggregated by race, sex, gender, socioeconomic status, and other factors, states and municipalities should collect, analyze, and publicly report health data about people who are pregnant and postpartum who have or had the virus. Policymakers and advocates need these data to understand COVID-19-related health risks and help ensure equitable responses.

Please email morcelle@healthlaw.org or huang@healthlaw.org if you would like to share outcomes, questions, or issues related to these policy opportunities.