December 13, 2022 | Web Event Transcript

What is the future of contraceptive care in a post-Roe world?

Hello.

I'd like to welcome you to the KFF Web briefing
on the future of contraception in a post Roe world.

I'm Alina Salganicoff director of Women's
Health Policy and a senior VP at KFF,

and I'll be your moderator of the webinar today.

I know that many of you are here today
because you want to learn about the implications

of the recent Supreme Court decision
overturning Roe v Wade on contraceptive access.

The ruling was followed
by rapid actions of many states

to ban abortion and of others
to reaffirm the right to abortion,

but in particular in states
where abortion is no longer legal,

the need to strengthen and support
contraceptive access has taken on new urgency.

It's important
to recognize that there are several forces at work

that are shaping access to contraception
as well as contraceptive use.

On one hand, legal challenges
to contraceptive access persist

with a recent challenge to Texas, in Texas,
to the longstanding federal requirement

that a Title X services to teens be provided
without parental consent.

Some feel that even the right to contraception

is at stake

in light of Justice Thomas's concurrence on Dobbs
suggesting that the court

revisit Griswold,
which granted the right to abortion.

In addition,
there are concerns about the implications

of abortion bans that grant personhood
at the moment of fertilization, not to mention

broad scale misinformation about the mechanism
of action of many commonly used contraceptives.

But there have been many promising new developments
over the past decade

that offer opportunities
to expand contraceptive options and access.

Starting with the ACA's contraceptive coverage
mandate and the coverage expansions,

the FDA is currently reviewing an application
for a progestin only over-the-counter oral

contraceptive pill and new contraceptive products
have come to the market.

There is also increased awareness
and calls for broad scale response

to the structural racism and other challenges
that have limited access to health care services.

And we are seeing expanded avenues
for obtaining contraception online.

There's enough here to fill several webinars.

We'll start off today's webinar
with a short overview of contraceptive access

and experiences based on findings from a recent KFF
survey to be presented by my colleague Dr.

Brittni Fredrickson as an Associate
director of Women's Health Policy here at KFF.

Her presentation will be followed
by a panel discussion

with leading experts on contraceptive access
and care.

We're fortunate today to be joined by Dr.

Sonia Guerrero, who's an OB-GYN
and the director of the University

of Pittsburgh's Center
for Innovative Research on Gender Health Equity.

Dr. Borrero is also a professor of medicine
and will be spending the next year

as the Chief Medical
and Scientific Advisor to the U.S.

HHS Office of Population Affairs,
which is the agency

that operates the federal Title
ten Family Planning program.

We're also joined by Victoria Nichols,
who's the project director of Free the Pill,

which is a national campaign operated
under the auspices of IBIS Reproductive Health.

The Free the Pill campaign was developed
to support education and public engagement

regarding an over-the-counter oral contraceptive

or birth control pill in the US.

Amy Fan is also with us.

Amy is the co-founder, president and Chief Product
Officer at 28 Health, which is a telecontraceptive

platform that has prioritized
improving access to online contraception.

And Kami Geoffray is here with us today,
and she's the president of Geoffray Strategies.

For five years before that, before she became
a consultant, Kami was the CEO of Everybody Texas,

which is the Title X agency for the state of Texas.

Next slide, please.

But before we get started, a few logistics.

This web briefing briefing is being recorded
and the archived recording

and the slides will be posted online later today.

And everyone who RSVP will receive notification
when it's posted.

In addition to live transcriptions,

we also have ASL interpretation available
to access it

Please click on the Globe Icon on your Zoom
control panel and select American Sign Language.

The screen will appear
and you will be able to view the interpreter.

We will leave some time at the end of the panel
discussion to take a few questions,

and I encourage you to submit questions
for speakers at any time

during the web briefing
using the Zoom Q&A function.

With that now,
I'm going to turn to Brittni to share with us

some of the contraception
highlights from the 2022 KFF Women's Health Survey.

Next slide, please.

Thank you, Alina.

And thank you to everyone joining today.

I'll be presenting some key findings
from two briefs that were recently published

on KFF’s website around experiences, preferences
and coverage of contraception,

as well as interest in over-the-counter
oral contraceptive pills.

Next slide, please.

The KFF Women's Health Survey is a survey that
KFF has been conducting periodically since 2001.

It's a nationally representative survey
of over 5000 females, ages

The data presented today are among people
who reported their sex assigned

at birth was female,
the majority of whom identified as women.

But transgender men and non-binary
individuals are also included

to account for reproductive
health needs and capacity.

And while we attempted

to be as inclusive as possible and recognize
the importance of better understanding the health

of non-cisgender people as is common in many
nationally representative surveys,

we did not have sufficient sample to report
breakouts for the non-cisgender population.

The fieldwork for this survey was conducted by SSRS

via the SSRS opinion panel and supplemented
with a sample from Ipsos' knowledge panel.

The survey was conducted in English and Spanish,
primarily online with a smaller sample

by telephone,
and we wanted to ensure we had adequate sample

of female subpopulations of interest,
including those who are Asian.

Black. Hispanic.

Medicaid enrollees.

Those with low incomes
and those living in rural areas.

We feel that this survey earlier this year in
May and June, prior

to the Supreme Court decision
that overturned Roe v Wade.

But the survey can serve
as a baseline of contraceptive

utilization needs and preferences
prior to that decision.

Next slide, please.

Among females who reported having sex
with the male in the past 12 months,

the majority used contraception.

and 9% said they were pregnant
or trying to conceive

of those who are able to conceive and not pregnant
or trying.

Next, please.

When asked about the reasons
for not using birth control,

of which they could select more than one response,
the largest share

that they just didn't want to use birth control,
which is a perfectly valid reason.

However, nearly a third said that they were worried
about or disliked the side effects

of birth control, which is a common theme
that we'll see throughout the survey findings.

Another one in five

said they didn't really mind if they got pregnant,
even though they weren't trying to conceive.

Which speaks to the ambivalence
women can have around becoming pregnant.

Many of these reasons could be discussed
through client centered counseling and providing

adequate evidence based counseling on side effects can help
build that trust between patients and providers.

It can also help people select a method
that works for them and lead to a continuation.

Next slide please

The types of contraception that females use change
over the course of their reproductive years.

The most commonly used methods among younger
women are oral contraception and condoms.

Well over a third of women ages 36 to 49 rely

on female sterilization
or their partner's vasectomy.

Over one in five females of all reproductive age

groups use long acting reversible contraception,
including IUD.

and implants and the higher share of users is ages

Fewer females report using short
acting hormonal methods like the patch ring

and injectable contraception,
and that about one in seven females across all age

groups reports using fertility awareness
based methods to avoid pregnancy.

It'll be interesting to see how these trends change
given the Roe v Wade decision.

Next slide, please.

On average, people use more than one contraceptive
method across their reproductive years

to find the best method
that works for them at that point in their life.

But we found that one in four females
saythat they're not using their preferred

method of contraception.

And as with significantly higher
among females with low incomes

compared to those with higher incomes.

Next please.

Among those not using their preferred
method concerned about side effects

is the most commonly cited reason, followed
by not being able to afford their preferred method.

About one in ten
say that their preferred method was not available.

Their partner didn't

want them to use their preferred method
or their provider recommended a different method,

which again speaks to the importance
of person-centered contraceptive counseling.

The really takes people's preferences
about their birth control method seriously.

Next slide, please.

We find that the majority of women
are still receiving their contraceptive care

from an office based physician, followed by 11%
who receive their care

at a clinic like a Planned Parenthood
or another family planning clinic.

And 8% report going to some other place
like a pharmacy or drugstore.

Even during the pandemic, only 3% say they got
their most recent contraceptive care online.

There were differences
by race, ethnicity and larger

shares of black and Hispanic women report
receiving care at a clinic.

And while we didn't present it here,
we also asked where people would prefer

to get their contraceptive care
if they could go anywhere.

And larger shares of black and Hispanic
women said that they would prefer to go to a clinic

which could be influenced by where they usually
receive care or where they can get affordable care.

Next slide, please.

As I've mentioned a number of times, contraceptive
counseling

is an important component of contraceptive care
and therefore dimensions of quality

contraceptive counseling that are part of a person
centered contraceptive counseling measure

developed by researchers at UCSF.

The measure asked people to rate their provider
on four dimensions of person-centered

contraceptive counseling, including respecting
the other person, letting me say what mattered

about my birth control, taking my preferences
about my birth control seriously,

and giving me enough information
to make the best decision about my birth control.

Only four in ten contraceptive users
rate their most recent contraceptive care

provider as excellent on all four dimensions,
which leaves a lot of room for improvement.

We also found that smaller
shares of those who received care at a clinic rate

their counseling is excellent compared to those
who receive their care at a doctor's office.

We also asked what additional information

contraceptive users would have liked before
starting their contraceptive method.

And again, side effects rose to the top,
including impact

on menstruation and bleeding,
as well as impact on sexual experience.

Next, please.

Only 30% of contraceptive users

say that they had all the information they needed

before choosing their birth control method.

Next slide, please.

One newer avenue of contraceptive care
that is gained momentum during the pandemic,

but still serves a smaller share of people
are these online contraception platforms

and apps like Nerax, The Pill Club, 28 Health
Roman, His and Hers.

Just 7% of reproductive age females
see that they've ever received

a prescription or a health care service
through one of these platforms.

But the majority of those who say that
they received the services received birth control

among those who have access

to prescription or a health care service
through an online prescribing platform.

Three in ten were younger than age 25,
but the largest share between the ages of 26 and 35

half were white, with almost a quarter Hispanic
and nearly two thirds had higher incomes,

which is likely because people
are using these platforms for convenience

and many are paying out of pocket
where a credit or debit card is required.

However, there are some platforms like 28 Health

that are focused on reaching these underserved
communities.

Next slide.

As new avenues for obtaining contraception
have attempted to increase access,

research has shown that the best practices to offer
oral contraceptive users an extended supply.

And some states
now require their state regulated plans

to cover a 12 month supply of contraceptives.

However, few females
actually get a 12 month supply.

You see here only 3% receive 12 packs at a time.

Furthermore, only

that have used birth control in the past 12 months

that their health care provider or pharmacist
talked to them

about receiving a 12 month
or 12 pack supply of pills at one time.

Next, please.

Shorter supplies can result in women missing their
pills due to delays in receiving their supply.

And we found that a third of hormonal
contraceptives users report that they've missed

taking their birth control because they couldn't
get their next supply in time.

This was higher among women with low incomes
and a problem for nearly half of uninsured females.

Ensuring
people have access to continuous contraceptive

supply becomes even more important
without access to abortion.

Next slide, please.

The contraceptive coverage requirement through

the Affordable Care Act has made contraception
more affordable for many, with 70% of females

with private insurance
saying that their insurance covered the full cost.

However, 16% of privately insured
females are still reporting

having to pay for part of their
cost of their contraceptive method.

This is consistent with other research
that we've published,

and there could be a number of reasons for this.

So they could be using a brand name contraceptive
that has a generic alternative

covered by their plan.

They could still be enrolled in a grandfathered
health plan, which isn't that common any longer.

Or they could be covered through a plan

by an employer
that has a religious objection to contraception.

A quarter of females say they paid
$15 to $14 out of pocket for their last method.

But another quarter say
they paid $50 or more, with affordability

being one of the main reasons
people are not using their preferred method.

There is more work to do to ensure
people can get their preferred

method covered without cost sharing.

Next slide, please.

And surprisingly, although the ACA is requirement

for most insurance plans
that cover the cost of contraceptives for women

took effect over ten years ago,
many people are still unaware of this requirement.

Four in ten reproductive age
females do not know that

plans are required
to cover contraceptives for women.

And conversely, while there's no
federal requirement for coverage of vasectomies,

one in three males and females
incorrectly believe there is.

So awareness
could still be raised about this requirement.

Next slide, please.

But for those who are uninsured, cost
can pose an even greater barrier.

And one in five uninsured females
of reproductive age say they had to discontinue

using a contraceptive method
because they couldn't afford it.

This is also the case for nearly one in ten females
who are Hispanic

or those who make less than

This is even

the case when there are clinics like Title X clinics
that provide care on a sliding scale

or at no charge without coverage
or access to free or low cost services.

Uninsured females are faced with having

to pay for out of pocket for contraceptive use,
a method they don't prefer.

Or go without contraception altogether.

And among females

who say that they had to stop using a method due
to affordability problems.

Many let their health care provider
know that they couldn't afford their method,

but nearly four in ten
didn't make their provider aware.

Next slide, please.

For those who have a lapse

in their contraceptive supply or need a backup
method, emergency contraception

can be used within 3 to 5 days of unprotected sex
or contraceptive failure to prevent pregnancy.

Emergency contraception has been available
over the counter for the past ten years,

and about a third of reproductive age
females have ever used it. In the last 12 months.

However, nearly one third of reproductive age
females say that they would not know

where to get emergency contraceptive pills
if they wanted or needed it.

Lack of knowledge about where to get said
pills is higher among females

living in rural areas compared to those
who live in urban or suburban areas.

And while Plan B is an OTC drug.

Studies have found that access
in pharmacies can be limited,

particularly in rural communities.

Next slide, please.

While emergency contraception
has been available over the counter for many years,

an application for the first over-the-counter daily
oral contraceptive pill was submitted to the FDA

this July and, if approved, will provide
another opportunity to expand contraceptive access.

birth control pills in the last 12 months

see that they would be likely
or very likely to use OTC birth control.

This is compared to 40% of other
contraceptive users

and 20% of people that don't use contraception,
which isn't shown on the slide.

Among those oral contraceptive users
who would be very likely or somewhat likely

to use OTC birth control
pills, the main reason they cited were convenience

and will eliminate the need to make an appointment
to receive contraception.

and 5% think it would save them

money, while 4%
don't want to have to use their health insurance.

The majority of those likely
to use over-the-counter

oral contraception
would be willing to pay up to $20 a month,

while one in ten say that they would be unwilling
or unable to pay anything,

especially when they can get it
without cost with a prescription.

Next slide, please.

And among the four in ten oral

contraceptive users who say that they'd be unlikely
to use an OTC oral contraceptive

or they're not sure, the main reason cited
where they prefer to talk to a provider before

starting or refilling birth control pills,
which again speaks to the value people place

on contraceptive counseling

and the opportunity to speak to a provider
about their contraceptive care.

One in five cite safety concerns,
even if it was approved by the FDA.

Another 18% have health insurance or cost concerns.

And given that contraception prescribed by a health
care provider is currently covered by insurance

through the ACA, there is still a question
about whether over-the-counter

oral contraception will be covered by insurance
without a prescription.

However, in the most recent federal guidance
about ACA implementation,

plans are encouraged to cover OTC
emergency contraception without cost sharing

when it is purchased without a prescription,
but the guidance does

not currently require it.

Next slide, please

And with that, I'll sum up a few takeaways
that will lead us into our discussion.

Affordability of contraception
remains a barrier to use for some,

particularly for those who are uninsured
or have low incomes.

And even a percentage of people with health
insurance are still paying out of pocket.

Ideally, people would have access to a 12-month
supply of contraception.

And even though a number of states have laws
requiring 12-months supply,

the majority of women are only getting 3
to 5 months of contraception at a time.

Our survey found an overwhelming need

for more information
with persistent gaps in coverage requirements

and just a desire for more information
about methods and their side effects.

Overall, contraceptive care is currently falling
short and centering patient needs and preferences,

especially when people really value
the provider-patient relationship.

And finally, there are a number of new avenues
for expanding access to contraception,

like telecontraception
and over-the-counter access.

But many are still unaware
of these potential access points.

With that, I'll turn it over to Alina.

Thanks so much, Brittni, for that

extremely comprehensive overview.

To help us put the findings that Brittni just

presented in a policy context,
we have four great panelists.

I like to invite the panelists
to turn their cameras on.

These are

really national experts
who have spent the better part of their career

focusing on how to improve systems of care

that provide sexual and reproductive health
care to people across the country.

But before we get started with the discussion,
I'd like to invite each of the panelists

to take a few moments and really
I mean a few moments to share with your audience,

your impressions on a couple of the findings
that Brittni just presented that stood out to you.

I'd like to start I'll start with Dr.

Barreiro, please.

Hi, everyone.

Great to be here.

I thought that was such
a illuminating presentation.

And I think a few of the things that stuck out
for me

were first, that a quarter of people
were not using their preferred method.

And I was particularly interested

in the differences by

by income level.

And I was curious, I know you didn't show this,
but at some point maybe we can discuss it

whether the reasons for not using preferred methods

were also different by income level,
and particularly

the that the provider suggested a different method
because if there is a difference,

it could suggest diminished autonomy for people

with lower incomes and certainly

that the method was costly or not

available could suggest diminished access.

So I was curious about that.

The other thing that really was sad to see is the

the data on 12-month dispensing.

So we know that I think at this point 18

states have required that insurers cover

in a single fill,

and yet only 3% of people
nationwide are getting it.

And I know that the sampling
was across the country, but even in Oregon,

a recent paper by Maria Rodriguez is consistent,
right?

Just looking at Oregon, less than eight,

which has long had this legislative mandate,

less than

than three months of dispensing.

And I was hopeful that the pandemic
might have shifted that and increased demand

for extended supply.

But your survey was conducted
just this summer and we're still only seeing 3%.

So I think one of the things
that kind of consistently comes through

is that, you know, the policy,
I think, is the floor

and you know how important it is
to spend time on implementation.

And because that's really where, you know,
the real hard work is. We think it's sometimes

like focusing on changing policy, but changing
behaviors and information and attitudes.

Victoria, love to hear your thoughts.

Alina Hello, everyone.

It's great to be here.

The survey data super fascinating,

really appreciated the focus
on OTC access as well,

and I thought that the data around six in ten birth
control

users said that they would be likely
to use OTC birth control pills.

And that was really fascinating
and even more interesting

that two in five or 39%

of reproductive age
females said that they would be likely to use

an OTC birth control pills if they weren't required
to have a prescription and approved by the FDA.

I actually did a similar study in 2015

and found that
that same number, that same two in five or 39%

number came up as well.

For us around folks who are interested, US

women and teens interested in an potency progestin
only pill.

So it's great
to see that that those numbers are consistent.

And it really shows that the data is strong

and it's encouraging to see that
folks are really interested in this.

Now, the thing that stood out for me was the

that I recalled that

Kaiser Family Foundation did a study

or a poll in 2020 and found that overall opinions

were about 70% of women overall supported
taking birth control pills over the counter.

And then this study said 77%.

So it's been a 7% increase over just two years.

And that's not surprising
given the context that we're in now.

But it's great to see that interest is increasing.

We're not exactly sure
if it's going to be statistically significant.

We will check that out.

But it is always reassuring when it goes the

the way that you hope it will go. Kami.

Sure.

Thanks, Alina.

Great to be here today.

I think that the things that stood out for me
similarly to Sonia were

that people are not getting the methods
that they want.

getting the methods they wanted, as well as people

not getting the education that they need
to make decisions about their contraception.

So seeing that there are only 30% of respondents
had what they needed to make those decisions.

You know, again, I know it's a national survey,
but we've done a lot of work in Texas to study

the differences in our provider settings,
especially looking

at what Title X clinics can do
for our patients here in Texas

versus what our state-only funded entities
feel like they are able to do in a state

that has restrictive policies on not only abortion
but contraception

a lot of misinformation on that
that make providers concerned

about offering the full range of methods,
including emergency contraception.

So knowing that, you know, our studies in Texas
have found that Title X clinics

are the places where people have the least barriers
to the full range of access

and the the places where providers are offering

the most evidence based care.

Just highlighting
I know this really focused on a lot of folks

going into it's a doctor's offices and not clinics,
but thinking about the types of care

that the most marginalized people,
which we did see overrepresented

in clinical care, get those,

those care in those spaces
that meet them where they are, are client-centered.

Counseling
methods are more represented in those spaces,

and the full range of methods are available.

So just thinking about that, especially as we see
increasing attacks on contraceptive methods

post Roe, the importance of supporting title
ten clinics, funding Title

X clinics and advancing evidence based care
in those spaces and across the health care system.

And Amy. Great to be here.

Thanks, Alina.

One of the things that really strike me
is looking at the study

that 50% of contraception users are white,

which leads the question of inclusivity and equity

and really how different type of contraception
platforms are designed.

The other piece that stood out to me on that slide
is that 35% of users with household

income of 200% or below the federal poverty level

were using contraception.

And I think this is also something
that's really interesting about access,

where oftentimes we see potentially removal

of needing to go to a doctor in person
or being able

to go to the pharmacy in person
to pick up, as increased access.

But there's a lot of different facets of access,
and affordability is a huge component of it.

And the far majority of contraception platforms
unfortunately do not accept Medicaid,

which makes it very limiting, particularly
for individuals from lower income settings.

The other piece that to add on Carrie's
point is importance of education.

So first, post the Dobbs decision

we saw an increased demand
in emergency contraception.

However, mixing that demand
or also people that were looking for emergency

contraception for different use cases
that weren't actually appropriate.

So, for example, many thought that emergency
contraception could be used for abortions

or they were thinking about emergency contraception
in place of other birth control methods

so that really goes to show how important it is
to help

people understand
different forms of birth control methods,

what emergency contraception is,
as well as the differences to medication abortion.

Yeah, I think

what kind of comes through is what a heavy lift
we're going to have right now

in terms of educating people about,
you know, what the options are out there

and kind of the distinction
between emergency contraception and medication.

abortion is, you know,
particularly has become particularly visible.

But I think that there's a lot of other work
that needs to be done.

Well, thank you for that.

What I'd like to now do is turn to some

questions.

And I'm going to turn first to Kami,
because I really love to hear your take

on the challenges to provision of contraception
in states that ban abortion.

I know you've been you're in Texas,

you're a Louisiana native,
so you have a lot of experience in that space.

And that certainly is the big elephant in the room.
With abortion banned,

what's kind of top on your mind
about what can be done

to improve contraceptive access?

Yeah, I mean, I think one of the biggest concerns
I have after living

and working in Texas for ten years
is a lot of misinformation, right?

So we already live in a state
where our state legislature has,

you know, repeatedly attacked the family

planning safety net, exclusive of abortion
providers.

Those attacks, you know, started in 2011

and we're going into,
you know, the seventh legislative session

with with an intense focus on abortion, family
planning, care.

Our state funded programs do not cover
emergency contraception.

They treat it as an abortifacient.

now, in our Medicaid family planning waiver,

in our state funded family planning program.

So there are some serious concerns
about how far the legislature in Texas

and other states will go to redefine line

contraceptive methods as abortifacients.

And as you talked about at the top, Alina,
the Dobbs

decision makes it very disconcerting

that a state legislature can define something

as abortion or define life as they see fit

and regulate it.

And so we're really concerned
about increased attacks on emergency contraception,

LARC methods, especially IUDs
that can be used for emergency contraception.

You know, I think that the thing
that we have always tried to do

is to overcommunicate
and to educate, especially with our providers,

to make sure that they feel confident
in their provision of care.

You know, we're hopeful that our federal partners

will continue to clarify

what contraceptive care is and isn't

what abortion care is and isn't,
and will help enforce

the requirements of federal funding
be that Medicaid or Title X.

But we you know, we as you mentioned at the top,

we had a pretty adverse decision in Texas on Friday
that is is,

you know, has the potential to threaten
confidential care for minors.

So I think the thing that we can do most is

create some

education and some advocacy opportunities around

what contraceptive care is,

how it benefits the public safety,

you know, the public

and, you know, continue to

continue to define contraception

as not abortion, but also work in concert with our
our folks

on the abortion side, because the same folks
who need contraceptive care need abortion care.

So, that's going to be a challenge moving forward

with folks who need abortion care,

then need contraception care
or contraceptive care afterwards.

Sonia, I wondered if you had some thoughts to add
to this as you're sitting in a federal agency

that's, you know, charged with providing
contraceptive care across the country.

Yeah, I mean, I think, you know, right now
what's top of mind is ensuring

equitable,
patient centered contraceptive care at OPA.

And I think there's a number of of things
that our office is starting to do.

But even part of the broader
vision of sort of moving towards

that Northstar where everyone can get
the method of their choice in whatever

setting is, you know,
is something that we have been thinking about.

And I think, you know,

Amy and Victoria will talk about it more, but

certainly expanding access both within

and outside of the health care system,

we recognize that the health care system
is another institution,

unfortunately, that's imbued with,
you know, a class and race hierarchy.

And therefore it is an oppressive
and even traumatic system for many people.

So we just need to be more deliberate
in ensuring that people are able to access

contraception in the ways
they want to, in a way that's safe and timely.

And, you know, to all of your points,
if we are going to use some of these innovative

service delivery options

outside of the formal health care system, things
like over-the-counter,

pharmacist provision, online platforms,
we have to couple it

with dissemination of high

quality online, you know, either
decision support tools or educational resources

to really support
people's informed decision making.

And clearly, we have to think about cost, right,
to make these delivery systems feasible.

So really thinking about, again,
innovative payment and reimbursement systems

to ensure that people can get these methods
outside of the care system

in terms of also, you know,

payment reform
and I know some of your data speaking to this,

we have an incredibly fragmented system
which allows for wide variation and coverage.

I mean, this can often result
in a two tiered system in which there are

practices and policies

that can systematically constrain

socially disadvantaged people's
reproductive autonomy.

Or conversely, they could give preferential access

to certain methods such as LARC,

feeding the reality at worst,
and the impression at best that we're targeting

certain populations to use provider
controlled methods, such as sort of disparate

immediate postpartum coverage

of LARC and Medicaid populations
compared to private insurance.

And for those who may not be as immersed
in the world of contraception

LARC, are there IUDs and implants?

It stands for Long
Acting Reversible Contraceptive Methods,

which tend to be more expensive

but and more effective. But

so sometimes they have been more difficult
to access for individuals

without insurance or with private coverage
as compared to some of the public programs

which have embraced LARC access.

And then, you know, the other thing

that I think was thinking a lot about is patient-
centric counseling.

And again, your data speak spoke to this, right?

But I think it was 40% of

people rated across all of the

the four domains as being excellent care.

And there's been recent data again
published in contraception that

that the even the sort

of the ratings of excellent

was was quite different

across demographic characteristics
the ones you might expect right. Specifically

having lower income, being black,

having not heterosexual identity,

and non-English speaking were associated

with lower patient-centered counseling and ratings.

And so we will be publishing

and we're working right now
on updating our evidence

based guidelines for equitable,
patient-centered family planning care that,

you know, we hope will be a model
not just for Title X clinics,

but all care settings in which people are receiving
sexual and reproductive health care.

And then I'd say, finally,
another thing that OPA is thinking a lot

about is making sure
that we're incorporating metrics, including

performance metrics,

to ensure progress
towards equitable, patient-centered care.

And in that, we have to we have to really
think about what are we trying to accomplish?

Is it really reduction of unintended pregnancy,

which we know is not a universally negative
outcome for everyone.

So instead we're thinking about ways to measure

ensuring that people's reproductive
needs were assessed and addressed, ensuring

respectful and informative counseling,
improving timeliness and efficiency of care.

And so those kinds of those kinds of measures
that I think will really help move us again

towards more equitable,
patient-centered contraceptive care.

Thank you.

I'm going to shift the conversation
a little bit because, you know, Victoria

and Amy have actually been working on

shifting this into control
outside of clinical settings,

really helping people get access to,

you know, oral contraceptives over the counter
or just using,

you know, their phones
with a telecontraception app.

So, Amy, can you tell us a little bit about how
how does telecontraception work?

Sure.

So the idea of telecontraception is actually
to make it really accessible for individuals

to be able to get a contraceptive prescription
as most delivery. For the most part.

the model is where an individual log on
to the company's website

or download
their app, fill a medical questionnaire.

For some of the platforms.

There's an option to do a consultation, whether
it's audio consultation or video consultation.

I would say for the majority of popcorns, it is not
an option unless it's required in the States.

And then after that
they'll be connected to a clinician,

where the clinician
will review their information, buy a prescription,

and that individual received deliveries
from a mail order pharmacy.

Some of the benefits of telecontraception
is that it does make it really accessible,

making it really private,
as well as discreet for people to be able to

connect with the physician.

Of course,
I think the there's also challenges to it as well.

For example, what we saw in the data earlier of
how do you create

an inclusive,
welcoming experience and try and minimize

bias in the experience via contraception,

which has not largely been studied.

And I know that you've been trying to work
with payers.

I mean, one of the things that, you know, has come up
is the fact that, you know,

even though we have these laws
and policies that require plans to cover

contraception without cost sharing,
Medicaid has long

been required to cover contraception
without cost sharing.

It's been from,
you know, conversations that we've heard about,

it's been pretty challenging
for kind of these newer developments

to actually partner with state programs
and through payers as well.

Tell us a little bit about 28 Health's experience.

Yeah.

So there's several different components
that as a contraception company

we have to think about in order
to be to accept Medicaid.

So one piece is the type of clinicians
we work with.

So for example, we work with physicians
that are Medicaid-registered,

so that the scripts they write
can be reimbursed by Medicaid.

And then the other piece,
as well as the pharmacy partners that we work with.

So we work with a variety of regional and local
pharmacies that are able to contract with Medicaid.

So there's many states
where one of the requirements is for a pharmacy

to have a physical presence in that state
or a neighboring state in order

be contracted with Medicaid.

There are definitely limits in terms of thinking
about how the contraception companies

and their ability
to widely serve across the nation,

just because it's not really one market
that we're in, it's really state by state.

And you have to be able to piece
all these components together in order to support

Medicaid recipients.

Great.

Thank you.

And I want to turn to Victoria, because I know

this is an area that you have put

a tremendous amount of work in, in terms of,
you know, educating

and kind of laying the groundwork
for an over-the-counter

oral contraceptive pill.

Tell us, where are
where are we with the FDA in terms of this process?

Sure. Thanks, Alina.

Love all the comments.

The other panelists
weren't really talking about all options here.

Yeah.

So in terms of the FDA process,

in order to switch a birth control pill
or any prescription-

only product over the counter,
you have to have a pharmaceutical company

that is willing to submit an application to the FDA
for what we call an act to open some switch.

And there are many different
formulations of birth control pills,

and through the FDA process,
you have to go one formulation at a time

to get each formulation approved.

So right now, we know of two companies

that are pursuing an RX to OTC switch.

One is focused on a progestin-only pill

and the other is focused

on a combined oral contraceptive.

The progestin-only pill has an application
that has been

submitted to the FDA by HRA Pharma
and that was announced in July.

The COC or combined oral contraceptive is

a little bit more

behind in the process and hasn't submitted an
application yet,

but the FDA process is a very rigorous one.

You have to really go through several studies
and phases

to really show
that it's appropriate for over-the-counter use.

We at Free the Pill and our coalition supports
bringing birth control pills over the counter

because they're 60 plus years of data
that show that it's safe and effective

and we believe that it's truly safe
and effective for over-the-counter use.

In July, HRA announced

that it had submitted its application to the FDA.

FDA typically takes about ten months
or so to review the application.

So we're expecting a decision in 2023,

which is extremely-- May, is that may maybe maybe

the typical timeline is around

ten months, but that's not guaranteed.

So we're we're looking for the FDA
to follow the science and the data on this.

Consider the broad public health benefits
and make a decision

based off of that and really wanting
to hold them accountable to doing that.

There's. Go ahead.

Sorry.

I was just so assuming that this
this gets approved and, you know, we have I think

folks have

a lot of confidence that it could happen.

But, you know, we have an experience
with emergency contraception as well,

which was kind of a very kind of slow uptake
and a lot of controversy at the FDA.

What do you think is going to be the impact
of having

an over-the-counter
pill in terms of contraceptive use?

Sure.

So an OTC birth control pill would

significantly reduce barriers to contraception.

Over-the-counter birth control
pills would particularly expand access

for the communities that face
the most barriers due to systemic inequities.

I think other folks on the panel
mentioned black indigenous, Latin

folks,
AAPI communities, other communities of color,

young people, immigrants, LGBTQ

folks, folks in rural communities,

or a lot of the folks
who have these barriers to access

and bringing a birth control pill over
the counter would really address

some of the unnecessary hoops that folks
have to jump through to get to a clinic visit,

to get a provider to give them a prescription.

Oftentimes, folks
have to take time off of school or work.

They have to find childcare,
if they have a child, to get to that appointment,

getting transportation, etc., etc..

So it would really address
some of these barriers and expand access.

We know that some of these barriers
have also been exacerbated

given the pandemic and folks
limited access to health care.

So this is truly an issue of health

equity and people deserve

and should be able to access
health care on their own terms.

And an over-the-counter birth control
pill would really allow them to do that.

So I do want to say, like,
although our survey did find,

you know, pretty broad scale, generous support,
there was some reluctance by some.

And I think that the issue
of the role of the clinician and I want to say,

because my nurse friends
and my other advanced practice clinician friends

would kill me
if I didn't also say that it's not just physicians

who are critical in providing contraceptive care.

Advanced practice.

clinicians play a really a central role

both in and particularly in

publicly funded family planning settings,
but not exclusively.

So I had to get that in.

But I am just

wondering, you know, how does that
I mean, do you have thoughts about how to kind of

incorporate or work
with kind of clinic, clinical settings as well?

Both.

I think, you know, with Amy has it's
kind of similar issues.

You know, people feel confident
and there is mistrust and about getting,

you know, getting things,
you know, through a pharmacy

that's not through the pharmacy
with a prescription.

And I think a lot of us have been told that

there you know, there are all sorts of side effects
and dangerous things about contraception.

How do we kind of deal with the fact that
in most cases it's extremely safe and effective?

At the same time, we want to make sure
that people do have the information that they need.

Right.

And I think that some of the challenges
that have already been brought up

has been education
and get getting folks the right information

so that they can make informed decisions
about their own care.

And I think that that is really critical.

And over-the-counter

birth control pill doesn't prevent someone

from engaging with a provider
to get more information.

If it's on the shelf at a pharmacy,
you can always talk

to a pharmacist
that you want more information about that.

That's another provider that can provide education
and information on this.

So we do want to make sure that anyone who does
want to engage with the health care provider

and get more information
has access to that, in many different ways.

Great.

I'm going to I'm keeping my eye on the clock.

And I do want to leave some time for questions.

This always happens.

We think an hour is plenty of time
and in fact, it's not.

So, Brittni,
I'm going to ask you to turn your camera on

so that you can join us
because we have some questions about the

the survey and maybe we'll start with that.

The first one is: Outside

the population that reports that they aren't
using their preferred birth control method,

is there any information on insurance
not covering or not

fully covering what they need,

what they needed.

We have anything else about that?

Well, we don't ask specifically if people

getting the contraceptive that they need.

The question we ask, if you could choose
any type of birth control in the future,

regardless of costs or other possible barriers,
what method would you be most likely to use?

But I do think, as we've mentioned, I don't know
we mentioned earlier about medical necessity.

If people need a birth control method,
they can work

with their provider
to get that covered under the ACA.

I don't know if a lot of people are aware of that,

and I also trust that the method

that people prefer to use
is probably the method that they also need.

So I'm trusting people's preferences there. Right.

I don't know.

Sonia, you have any thoughts to add on that?

Probably.

No. I mean, I agree with

the one that they they want is what they mean.

So I was particularly interested in that, you know,
and then sort of the survey doesn't do it.

But I think when there is a discrepancy
and it sounds like that was the methodology, right?

You asked them what they would use
and and what they're using now.

I was particularly interested in the

the the response that the the provider

recommended something else and how that sort of

how that response is stratified across

different participant demographics.

This is

a question actually that I think
is a really important one, which is:

I would love to hear your thoughts
on post-abortion contraceptive care

for people who travel from band states
to abortion access states.

Should this be a policy
and a clinical practice priority?

I don't know, Kami.

I see you nodding a lot. Absolutely.

You know, and we are hopeful

a lot of family
planning clinics have the capacity to do this.

And we are hopeful that we can work

with our federal partners, especially those
who are getting federal dollars to do this.

There's, as I said, there's a lot of misinformation.

There's a lot of concern

around abortion

and federal dollars
and the Hyde Amendment and Title X restrictions.

And after FQHC funding.

And we really need to do a better job of sharing
when abortion care can happen

in those settings, when contraceptive care
can happen in those abortion settings.

We've seen states that are,

you know,

safe haven states for folks
start to invest in this.

So in California,

we saw not only funding for abortion care for folks

coming out of state, but also contraceptive care.

And that is in development.

You know, in New Jersey,
we've seen some increased funding

for abortion care and trying to figure out
how to make sure this is seamless.

Again, reproductive health care is a continuum,

and abortion care
and contraceptive care are often care

that people need at different points in their lives
and sometimes at the same time.

And it's reducing a barrier.

You know, those folks that are traveling
to other states to get abortion care,

they're probably facing restrictions and barriers
to contraceptive care in their home states.

Now, we know that folks in Texas

cannot always get the long acting methods
they want and need

because providers don't offer them
because they have objections to offering that care.

They're not properly trained on that care

or they don't have the funding
they need to offer that care.

So those are things we really need to figure out
how we can meet people where they are.

And in states are investing
additional resources in abortion care.

We need to be thinking about holistic care.

Sonia, I see you have. You know this,

I think this is such an important area

and I just wanted to highlight

I think it's particularly problematic for states

that don't have Medicaid coverage for abortion
because that's where the real

fragmentation occurs, right?

People are going to clinics
to get their abortion care.

And then on

the clinics are not able to get reimbursed
for contraceptive care at an abortion site,

or at least and I don't know how true that is,

but that is certainly reported in Pennsylvania
where that is.

So just just to clarify for the audience,
a medicaid federal dollars

cannot be used to pay for abortion

unless the pregnancies, a result of rape or incest
are a threat to the pregnant person's life.

But in cases, you know, in some cases, states

set aside their own funds to pay for abortion.

California, New York, there are about, I think, 16

states last I checked that that do that.

So these are state.

But then there are other states
where abortion could still be available.

It hasn't been banned
like in Pennsylvania, for example.

But the Medicaid program
does not pay for abortions,

but they do pay for family planning services.

Right.

I think that that's kind of one of the areas
where I think, you know, people are thinking

right now, how can we you know, if there are cases
where, you know, how can we improve?

Also, abortion access and coverage in states
where it's still permitted

is is an area that I know
many folks are thinking about right now.

The next question I have is for Amy,

which I just had it here.

Yeah.

One of the
what are the best practices for considering equity

and inclusivity in design
for tele contraception offerings?

And another question that has come up

is also about privacy
and how do you ensure privacy of your clients.

I think stat had a piece today on some of these

telehealth apps and their relationships
with some of the other larger

social media platforms and information platforms.

Yeah.

Both really great questions. From the design side.

One of the things that we do
is making sure that we involve

our users in the community,
that we serve through that process.

So our focus is specifically serving
low income women as well as women of color.

So whether it is through phone calls and surveys,

we try and every time we're launching something
new, every client that we create, we do

try and get user feedback to better understand,
Is this something that feels like

it resonates to you?

There's also other considerations as well.

So, for example, awareness of contraception

and awareness that it''s even an option
can be a challenge.

So the way that we look at how we build
that end to end support

is actually working with local nonprofits, working
with community colleges, where we find oftentimes

the women that we're trying to serve are going
to these organizations for health care resources

so that these organizations are also providing

information about contraception, whether that's
how contraception or an in-person clinic

in King or Miami, or asking questions
about privacy.

Assuring privacy has come up, I think everywhere.

But I think around contraception in particular,
there are some concerns.

Yeah, that's a that's a great point.

I think we're really thoughtful
about the way we store data,

making sure everything is secure in a.

We've gone as deep into looking at
where the data is actually for our health,

specifically which states
they're housed in. And in full transparency,

I think that is still a learning
that we're collectively doing as a digital health

community where there's definitely precautions
that we can take.

But in terms how much protection
there is for the data, if it's subpoenaed

and based on the location of the data warehouse,

I think it's still to be seen.

So I think that's on how the store data.

The other piece around privacy and
discretion, is really thinking about

what is experience like for the end user.

So for example, the majority of our users
prefer to message our doctors directly.

They find that it's a much more discreet
and private setting where they don't actually need

to find a place to do a video consultation,
which can be a challenge

if you want to keep all of your information
private from

maybe other roommates you have, or if you're living
in a multi-generational household.

Yeah.

I think that that's--

And are these telecontraception companies,

are you all like HIPA compliant?

Are you required to be HIPAa compliant
or is that a different--?

Specifically, the companies themselves
are not required to be HIPAA compliant

because the way it's typically set up
is that they have medical PCs

and they contract with the commission, so they act as a
VAA similar to other pharmacies as well.

However,

my understanding from peers I've spoken with

is that the majority do want to still be HIPAA compliant
because it is still best practice

in terms of making sure that we're storing
patient data safely.

Great.

And then one kind of last question.

Thinking about what would you--Oh, no

this this is the question that I really want to ask
is about

emergency contraception.

You know, one of the things
that I was really struck with when I saw

this is how many people don't know
how to get emergency contraception.

You know, the issue of emergency contraception,

I think, has really emerged as a hugely important

and, you know, we know that in Texas, it's excluded
from their their family planning program.

There have been there's been a lot of confusion,
I think even pretty informed

people that I've spoken to confuse medication
abortion with emergency contraception.

I'm just wondering, you know, what what we can do.

I know Victoria,

you're modeling a lot of your work

or kind of the lessons
learned from emergency contraception to OTC.

Do you have any thoughts about what

we kind of what
has to be around emergency contraception?

Sure.

So I think two two things that have also come up

earlier is implementation and operationalization.

So over-the-counter birth control pills,

over-the-counter emergency contraception,
a lot of it depends on

how you how it's going to get on the shelf
and whether it's going to be accessible.

You have to think about things like restocking
I know when Roe was overturned,

there was a shortage in emergency contraception.

So that's something also to consider.

And really trying to think about different ways to

to advertise and market and educate folks

about where things are and how to access them.

Another thing that we think a lot about is OTC

COVID tests and how the rollout of that

was and the challenges with that
and educating people about how to access that

and how to get it at an affordable price
that they could afford or covered by insurance.

So there are a lot of kind of challenges
in terms of implementation and operationalization.

So we have to think about and prepare
form taking lessons learned from

OC and also applying them for OTC pieces.

Well Unfortunately, we're out of time.

I would like to thank Brittni and each of the
panelists for really a very rich discussion.

Before I close,
I do want to remind the audience that the recording

of the web briefing
and the slide deck and the briefs that actually

from which this information is drawn
are all available on KFF.org

and registrants are going to receive an email
with a link to the recording when it's posted.

And next week, just a little plug,

be on the lookout for two more reports
from the survey. One on affordability and access

to care for women, and another on experiences
and mental health care coverage and access.

And really, I'd like to thank Brittni

for presenting the data today
and to other KFF colleagues: Usha Ranji,

Michelle Long, and Karen Diep
for all their work on this survey.

And really a heartfelt thank you to the panelists
Sonya Borrero, Amy Fan, Kami Geoffray,

and Victoria Nichols for really being so generous
with their time and wisdom today.

And most of all, for all you do to improve sexual
and reproductive health care for all.

Thank you for joining us today.