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

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 teleconceptive 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 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 18-54.

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.

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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.

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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.

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

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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.

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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 say that 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.

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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.

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Only 30% of contraceptive users
say that they had all the information they needed before choosing their birth control method.

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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.

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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.

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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.

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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.

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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.

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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

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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.

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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 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 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

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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.

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 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 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 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,
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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 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 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 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 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 maybe maybe the typical timeline is around ten months, but that's not guaranteed.

So 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

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

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 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

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

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