

The background of the entire slide is a photograph of the United States Capitol building in Washington, D.C., taken at sunset. The sky is a mix of purple, pink, and blue. The building's dome is the central focus, with its iconic statue on top. The building's facade is lit up from within, and the American flag is visible on a pole in front of the entrance.

## *Bipartisan Congressional Briefing*

**The Latest Insights and Opportunities for Improving  
Family Planning Options for Maternal Wellbeing**

Wednesday, July 12, 2023



**5:00**

*Bipartisan Congressional Briefing:*

# The Latest Insights and Opportunities for Improving Family Planning Options for Maternal Wellbeing

Sponsored by:



July 12th, 2023



**POLICY CENTER**  
FOR Maternal Mental Health™

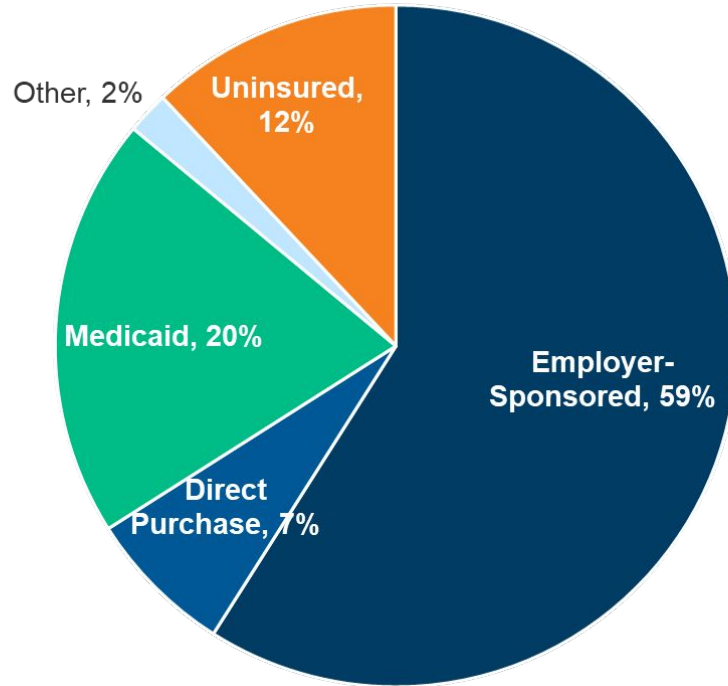
*Formerly 2020 Mom*



# **Brittni Frederiksen, PhD, MPH**

Associate Director for Women's Health  
Policy

# Health Insurance Coverage of Women 18-49, 2021









Among 66.9 million women ages 18-49

NOTES: "Other" includes those covered under the military or Veteran's Administration, as well as nonelderly Medicare enrollees.  
SOURCE: KFF estimates based on 2021 American Community Survey, 1-Year Estimates

# Contraceptive Coverage Requirement under the ACA






## Hormonal Methods

### Long-acting Methods



	Sterilization Surgery for Women
	Sterilization Implant for Women
	<del>Sterilization Surgery for Men</del>
	IUD Copper
	IUD with Progestin
	Implantable Rod

	Shot/ Injection
	Oral Contraceptives "The Pill" (Combined Pill)
	Oral Contraceptives "The Pill" (Extended/Continuous Use Combined Pill)
	Oral Contraceptives "The Mini Pill" (Progestin Only)
	Patch
	Vaginal Contraceptive Ring
	Diaphragm with Spermicide

### OTC Methods

	Sponge with Spermicide
	Cervical Cap with Spermicide
	<del>Male Condom</del>
	Female Condom
	Spermicide Alone

### Emergency Contraceptives

	Levonorgestrel 1.5 mg (1 pill) Levonorgestrel .75 mg (2 pills)
	Ulipristal Acetate

### Natural Cycles Mobile App

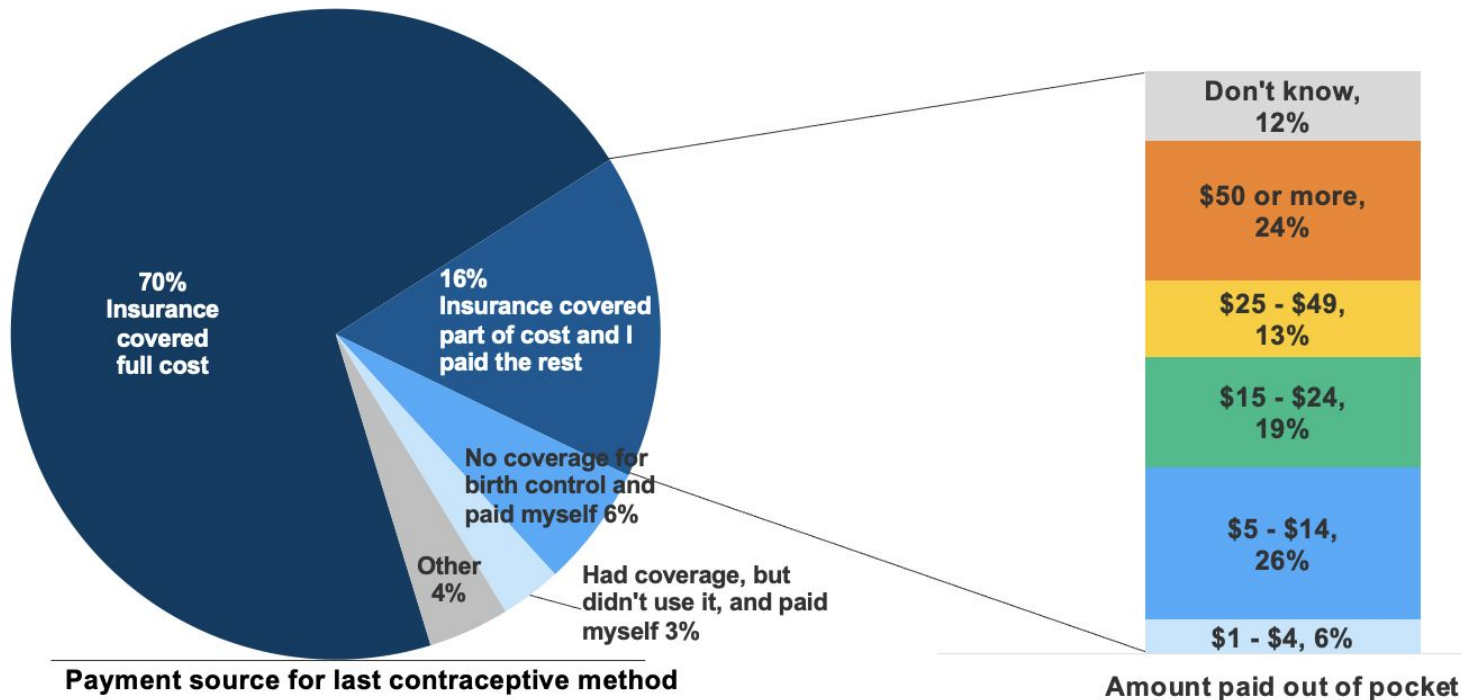


Phexxi?, Anovera?, Twirla?

**KFF**

# Out-of-Pocket Spending on Contraception Can be Substantial Even When Covered by Private Insurance

Insurance coverage and out of pocket spending for most recent contraceptive method among females ages 18-49 with private insurance who have used contraception in past 12 months:



NOTE: Among women ages 18-49 with private insurance who have used contraception in the past 12 months. Excludes those who only used condoms as a contraceptive method in prior 12 months. See questionnaire for full question wording.

SOURCE: KFF Women's Health Survey 2022





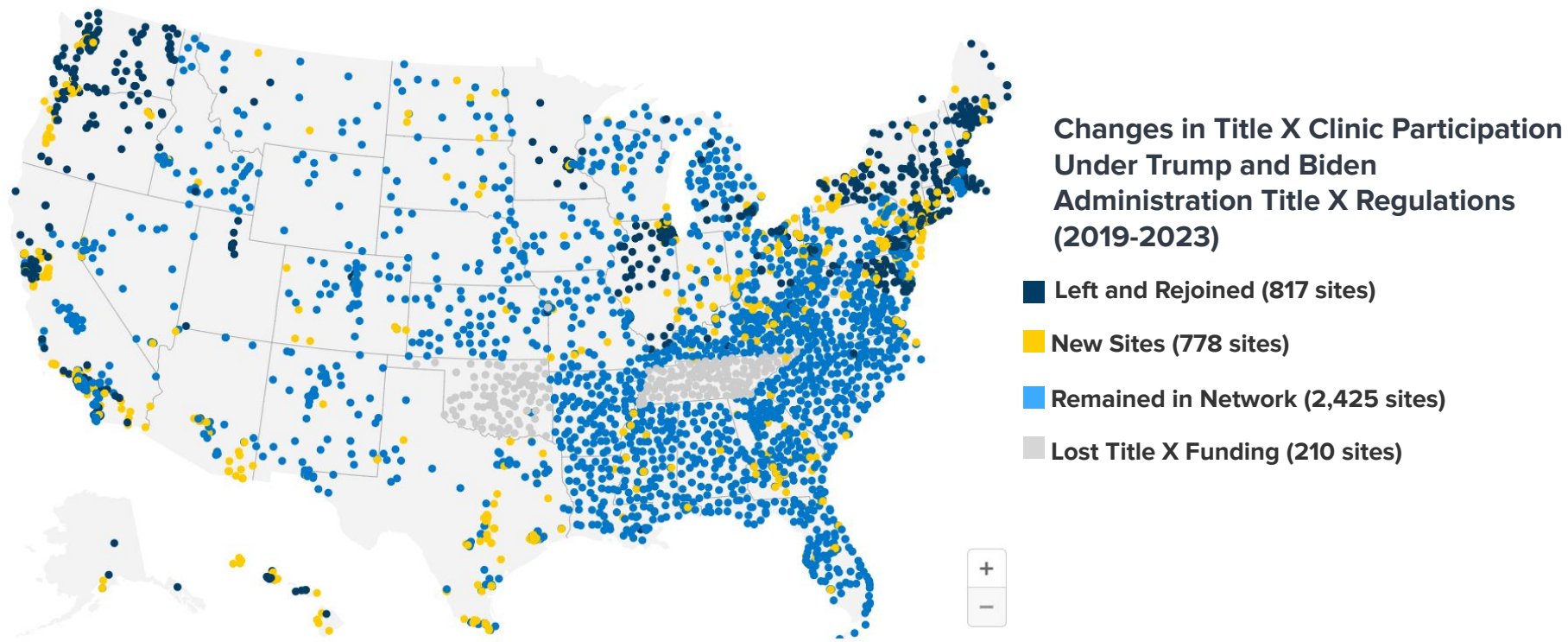
# Medicaid is the Largest Public Payer for Family Planning

- Family planning is a mandatory benefit under Medicaid that all states must cover
- Cost-sharing prohibited
- Federal government pays 90%
- Managed care enrollees may go out of network to get family planning – Beneficiaries may get care from any willing participating provider
- No federal definition about what states must include as family planning; All states do cover prescription methods, but sometimes use other policies that limit utilization, such as preferred drug lists, or requiring a prescription for OTC methods
- 30 states currently extend Medicaid coverage for family planning only to individuals who do not qualify for full-scope

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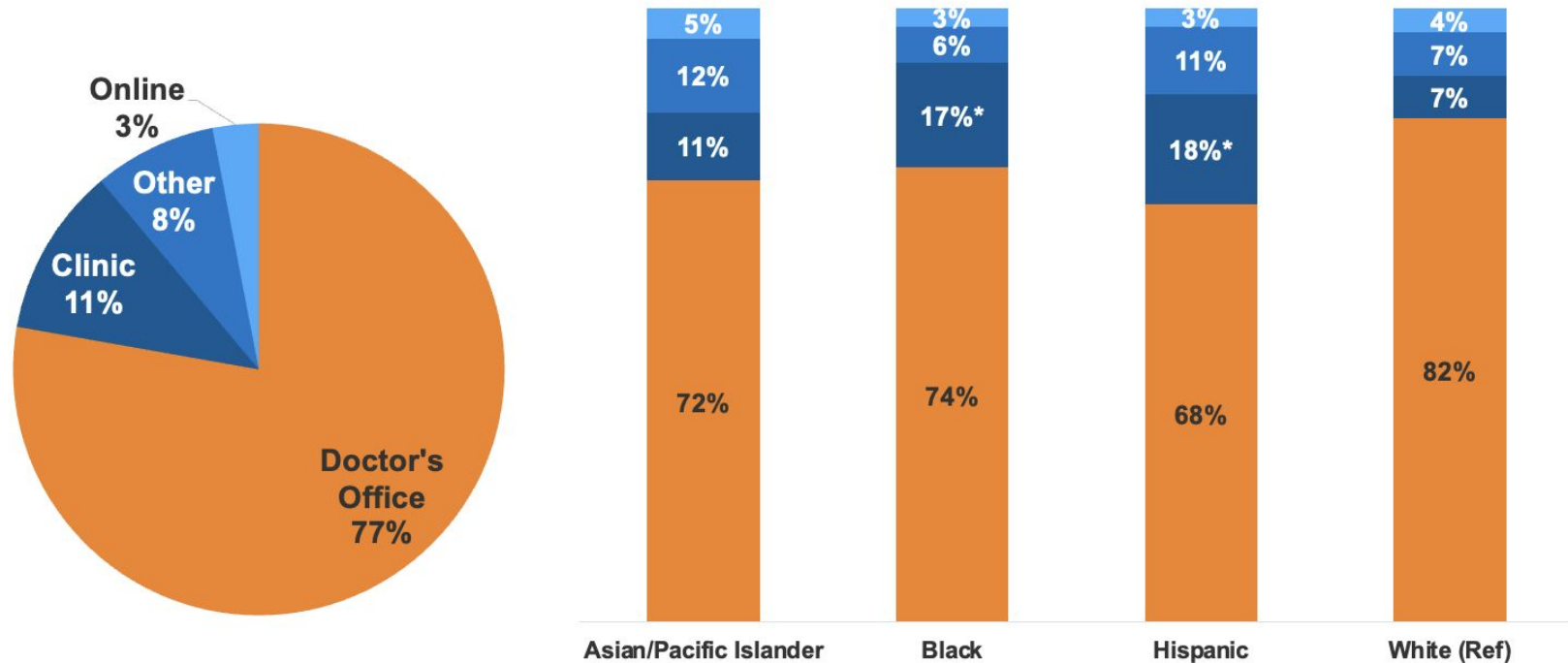
# The Title X Network Has Undergone A Number of Changes Over the Past Several Years



NOTE: Sites include sub-recipients and service sites de-duplicated by address.

SOURCE: KFF [Rebuilding the Title X Network Under the Biden Administration](#)

# Most Visit A Doctor's Office For Contraceptive Care, But Clinics Play An Important Role for Many Black and Hispanic Females



NOTE: Among females ages 18-49 who report using a method of contraception in the past 12 months. Other includes pharmacies, drug stores, or some other place.

SOURCE: KFF Women's Health Survey 2022

# Biden Administration's Executive Order on Strengthening Access to Affordable, High-Quality Contraception and Family Planning Services

New Guidance for Private Health Insurance Coverage of Contraception

Promote Increased Access to Over-the-Counter Contraception

Expand Family Planning Through Medicaid

Improve the Coverage of Contraception through the Medicare Program

Support Access to Contraception for Service Members, Veterans, and Federal Employees

Bolster Contraception Access Across Federally-Supported Health Care Programs

Support Access to Affordable Contraception for Employees and College Students

Promote Research and Data Analysis on Contraception Access



Moderator:  
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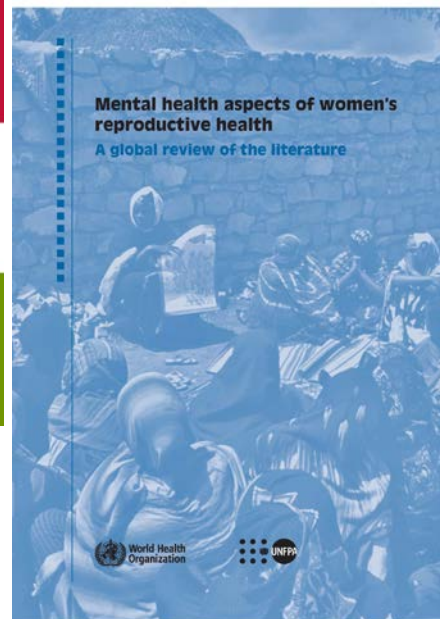
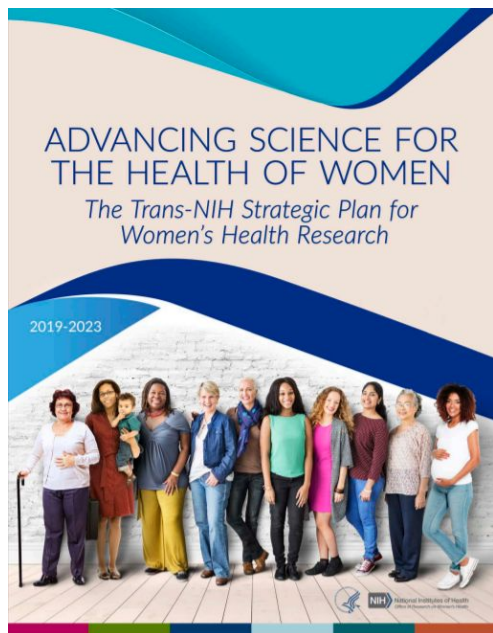
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# Priorities for Women's & Maternal Health Research in the U.S. and Worldwide





# Unmet Needs for Family Planning & Reproductive Healthcare Among Women With Mental Health Considerations

## Depression, anxiety, and related conditions are associated with:

- ↑ Risk of contraceptive nonuse, inconsistent use, use of less effective methods, discontinuation
- ↑ Risk of unplanned and mistimed pregnancies
- ↓ Rates of receipt of pregnancy-related services during prenatal/postpartum periods
- ↑ Risk of sexually transmitted infections, including HIV
- ↑ Risk of sexual and intimate partner violence, reproductive coercion
- ↓ Rates of receipt of preventive women's health services:
  - Preconception care; counseling and health promotion
  - Breast and cervical cancer screenings
  - STI screenings and treatment

# Social Adversity & Toxic Stress Shape Women's Access to Quality Care & Their Reproductive & Mental Health

- **There has been less research, programmatic, and policy attention on the role of stress**
- **Biological and psychological effects of stress negatively impact women's health outcomes and inequities, in the short and long run**
  - Prolonged exposure to adverse life events (racism, poverty, violence, social determinants) causes inflammatory, immune, and neuroendocrine dysfunction
  - Disproportionately impacts the most socially vulnerable and marginalized groups of women
  - These same groups face less access to quality health services and fewer socioenvironmental resources to ensure healthy pregnancies and babies
  - Contributes to risk of adverse reproductive and mental health outcomes during pregnancy, postpartum, and across the life course



# Findings on Social Disparities in the Relationships Between Depression, Stressful Life Events, & Unplanned Pregnancy Among a National Sample of U.S. Women

**Adjusted Hazard Regression Models Estimating Effect of Depression on Risk of Unplanned First Pregnancy, Stratified by Race/Ethnicity and Income Level (Overall effects OR 1.21, CI 1.02-1.44, p=0.03)**

RACE/ETHNICITY	Hispanic (n = 843)			Black or African-American (n = 1,148)			Asian (n = 275)			Other (n = 141)			White (n = 3,145)		
	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p
Moderate/severe depression	<b>1.44</b>	(1.01, 2.06)	0.045*	<b>1.36</b>	(1.00, 1.83)	0.048*	<b>3.25</b>	(1.62, 6.53)	<0.01**	1.16	(0.31, 4.33)	0.83	1.12	(0.89, 1.41)	0.34

PARENTAL INCOME	\$0 to \$19,999 (n = 1,170)			\$20,000 to \$49,999 (n = 2,300)			\$50,000 to \$74,999 (n = 1,271)			\$75,000 or higher (n = 811)		
	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p
Moderate/severe depression	<b>1.48</b>	(1.11, 1.98)	0.01*	<b>1.33</b>	(1.05, 1.68)	0.02*	0.79	(0.54, 1.15)	0.21	0.87	(0.47, 1.61)	0.65

AGE AT UNINTENDED FIRST PREGNANCY	<20 years (n = 5,547) <sup>a</sup>			20-24 years (n = 5,639) <sup>b</sup>			>24 years (n = 3,978) <sup>c</sup>		
	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p
Moderate/severe depression	<b>1.35</b>	(1.07, 1.71)	0.01*	1.15	(0.90, 1.46)	0.27	<b>0.47</b>	(0.25, 0.86)	0.01*

(NICHD K01HD080722-01,  
Hall et al, JAH, 2017; Hall et al, SSM-PH, 2018)

# Overall effects SLE score 1-2 above mean on risk of unplanned first pregnancy HR = 1.11, 95% CI: 1.04-1.17, p<0.01

## Adjusted Hazard Models Estimating Effect of SLEs on Risk of Unplanned First Pregnancy Stratified by Race/Ethnicity, Parental Income Level, and Age

RACE/ ETHNICITY	Hispanic (n = 843)		Black or African-American (n = 1,148)		Asian (n = 275)		Other (n = 141)		White (n = 3,144)						
	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p			
SLE score 1-2 SD above mean	1.47	(0.85, 2.56)	0.17	<b>1.46</b>	(1.03, 2.07)	0.03*	1.99	(0.56, 7.05)	0.28	<b>4.67</b>	(1.41, 15.46)	0.01*	<b>1.36</b>	(1.01, 1.84)	0.05*
PARENTAL INCOME	\$0 to \$19,999 (n = 1,170)		\$20,000 to \$49,999 (n = 2,299)		\$50,000 to \$74,999 (n = 1,270)		\$75,000 or higher (n = 812)								
	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p			
SLE score 1-2 SD above mean	<b>1.44</b>	(1.04, 2.00)	0.03*	1.25	(0.93, 1.67)	0.13	1.29	(0.81, 2.06)	0.27	1.93	(0.97, 3.80)	0.06			
AGE	<20 years (N=5,546)			20-24 years (N=4,288)			>24 years (N=2,600)								
	HR	(95% CI)	p	HR	(95% CI)	p	HR	(95% CI)	p						
SLE score 1-2 SD above mean	1.19	(0.85, 1.66)	0.31	<b>1.43</b>	(1.04, 1.96)	0.03*	<b>2.22</b>	(1.19, 4.12)	0.01*						

# Implications of Lack of Access to Family Planning, Unplanned Pregnancy & Mental Health for Maternal Health & Wellbeing

## Women's subsequent mental health

- Perinatal/postpartum depression and anxiety; chronic mental health disorders

## Severe maternal morbidity and mortality

- Comorbidities contributing to risk of death and disability (e.g., suicide, overdose, eclampsia, hemorrhage, sepsis)

## Adverse birth outcomes

- Preterm birth, still birth, low birthweight

## Socioeconomic outcomes

- Reduced education, employment, earnings, and social mobility opportunities

## Long-term and intergenerational health and social impacts

- For women, their offspring, families, and communities
- Significant healthcare costs for society

# Family Planning Serves a Fundamental Role in Protecting Women's Mental Health & Pregnancy-related Outcomes

**Supporting the reproductive agency, choice, and decision-making of women and couples regarding whether/when/how to become pregnant and be parent(s) can result in:**

- Planned and wanted pregnancies; healthier pregnancies
- Increased use of pregnancy/postpartum/preventive healthcare services
- Reduced stress and improved mental health
- Improved self efficacy, self confidence, life satisfaction
- Improved women's/family socioeconomic outcomes
- Improved early child development outcomes
- Improved equity in priority public health indicators across groups of women



# Reproductive Healthcare Settings Offer an Optimal Opportunity to Promote Women's Mental Health during the Childbearing Years

**Family planning and obstetric/gynecological settings are critical points (and often sole sources) of health care access during:**

- Preconception years
- Prenatal and postpartum periods
- Parenting years and through perimenopause

**U.S. women express some preferences for integrated care models**

- Family planning and reproductive + mental/behavioral/primary health care
- Stress and social services (e.g., intimate partner violence/trauma, linkage to social/economic resources and supports)
- Culturally congruent, patient-centered, unbiased care
- Community-engaged care

***Evidence-based policies can assure women's access to quality, comprehensive care***

**Jason Lindo, PhD**  
Texas A&M University  
National Bureau of Economic Research

# Economic Approaches

**Theory:** Consider how incentives, costs and constraints affect outcomes

**Empirical Research:** Obsession with estimating *causal* effect

# Empirical Analysis of Causal Effects

Typically using methods associated with the 2021 Nobel Prize in economics and cutting-edge refinements in those methods

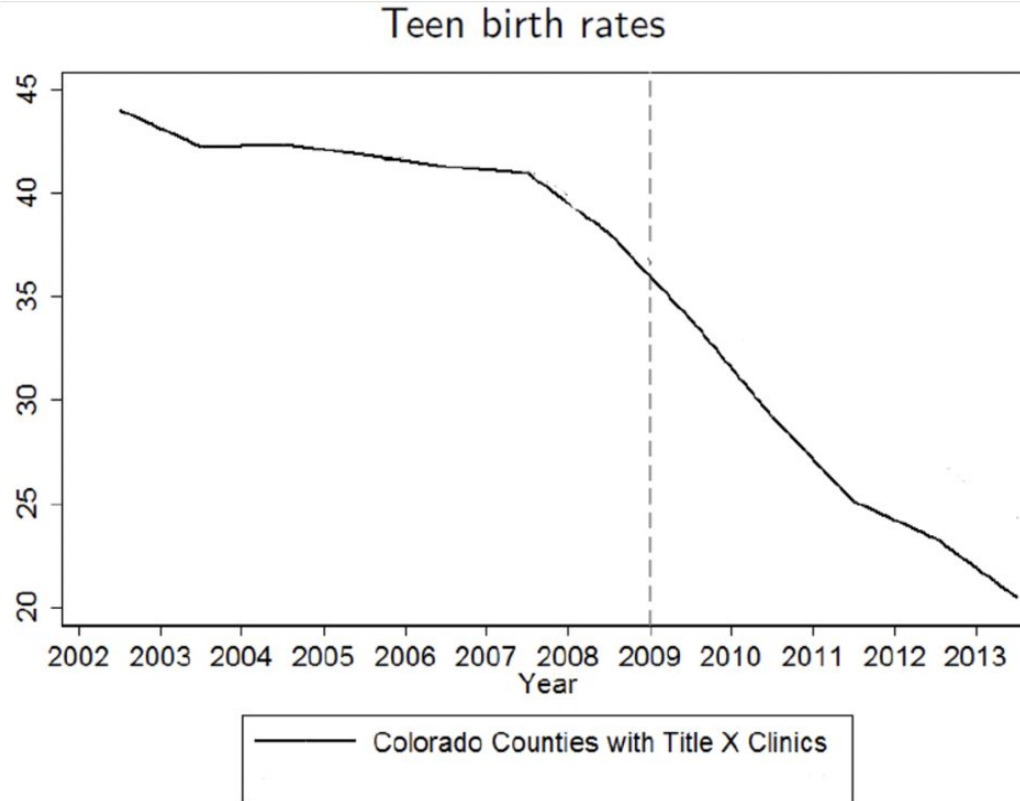
Evaluate “natural experiments” in which institutions, policy makers or other forces have generated an “experiment” we can learn from

Methods focus on trying to identify a counterfactual. What would have happened if circumstances had been different?

# Example: Colorado Family Planning Initiative

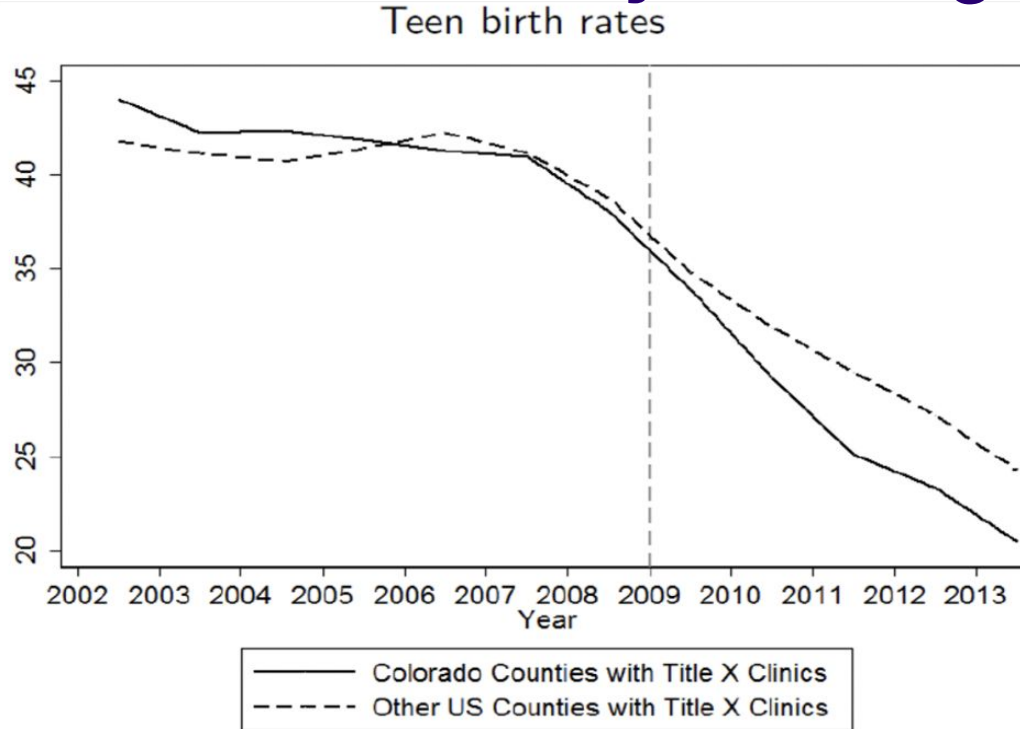
\$23 Million program aimed at expanding access to LARCs through Title X clinics beginning in 2009-2015

# Example: Colorado Family Planning Initiative





# Example: Colorado Family Planning Initiative



*This comparison indicates the CFPI reduced teen birth rates 6.4%*

Source: Lindo and Packham (2017)

# Other Studies of Impacts on Childbearing

A huge body of evidence demonstrates that policies altering access to family planning affect the timing of childbearing and completed fertility

In the interest of time, I'm going to focus on estimates of causal effects of family planning, fertility timing, and family size on other outcomes

# Effects on Education

Early legal access to contraception is associated with increases in education, especially for women from disadvantaged backgrounds

- An additional 1/2 year on average for women from the bottom third of a socioeconomic status index (Bailey et al 2012)
- Also credited with increasing the enrollment of women in professional schools (Goldin and Katz 2002)

## Effects on Education, Cont.

Avoiding childbearing before 18: (Ashcraft et al 2013)

- increases the GED completion by 5 percentage points
- increases education levels by 0.15 years on average

Women giving birth shortly before expected high school graduation vs. a few months later: (Sandler and Schulkind 2017)

- 7% less likely to graduate high school
- 5% less likely to have attended college

# Effects on Labor Force Participation (LFP)

Early legal access to contraception is associated with an 8% increase in women's LFP between ages 26 to 30 (Bailey 2006)

Avoiding childbearing before age 18 increases subsequent LFP by 5 percentage points (Ashcraft et al 2013)

Unplanned births reduce LFP by 4 percentage points (Caceres-Delpiano 2006)

# Effects on Income/Wages

Early legal access to contraception is associated with an 8% higher hourly wages during women's late forties (Bailey et al 2012)

- 2/3 explained by labor force experience
- 1/3 explained by education and occupational choice

Avoiding childbearing before 18 reduces the likelihood that women are near/below the poverty line (Ashcraft et al 2013)

Unplanned births reduce income, increase poverty, and increase welfare dependency (Caceres-Delpiano and Simonsen 2012)



# Effects on Children and Families

The impacts on women's economic outcomes have obvious implications for the resources available to their children

The initial rollout of federally funded family planning programs during the 1960s and 1970s reduced the share of children living in poverty by 7% (Bailey et al 2017)

Unplanned births increase the likelihood of divorce and have negative impacts on the IQ of previously born children (Caceres-Delpiano and Simonsen 2012, Black et al 2010)

# Research on Abortion Access - Same General Conclusions

Bans on abortion from 1960s reduced educational attainment, particularly for Black women (Angrist and Evans 2000, Lindo et al. 2020, and Jones 2021)

TRAP laws impairing access in more recent years reduced educational attainment, particularly for Black women (Jones and Pineda-Torres 2021)

Being denied an abortion due to a providers gestational age cutoff increases financial distress for at least five years (Miller et al. 2021)

# The Bottom Line

Pregnancy and childbearing have significant effects on educational and economic outcomes for women and their families, including their children

There is strong evidence that these outcomes are affected by policies altering women's ability to control childbearing

**L.R. Fox**  
Founder & CEO  
NEXT Life Sciences

**currently:**

**50% of  
Pregnancies  
are Unplanned**



[www.planaformen.com](http://www.planaformen.com)

**The Holy Grail:**

**Long-Acting  
Reversible  
Contraceptives**



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# **The Big Idea:**

**Include male contraceptive options in our conversations around family planning.**



[www.planaformen.com](http://www.planaformen.com)



# **Change One:**

**Male contraception is seeing rapid innovation and growth.**



[www.planaformen.com](http://www.planaformen.com)



## **Change Two:**

**Men are showing an increased interest in engaging more with their reproductive health.**

# **The Opportunity:**

**Male behavior, awareness, and interest in contraception is evolving as an organic reaction to the changing landscape of access to reproductive health care.**



[www.planaformen.com](http://www.planaformen.com)

# Step One:

**Normalize the conversation  
around family planning  
methods.**

## **Step Two:**

**Discuss the entire breadth of options available for family planning – including male forms of contraception.**



## **Step Three:**

**Understand men are willing to participate more directly in family planning.**

## **Step Four:**

**Ensure affordability, including insurance coverage, for male contraceptive options.**

## **Step Five:**

**Invest in new and novel forms  
of male contraception.**

# Looking Forward:

**LARC options offer an opportunity to relieve the burden of planning on women and to contribute to maternal mental, physical, and economic health.**




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# Thank You!

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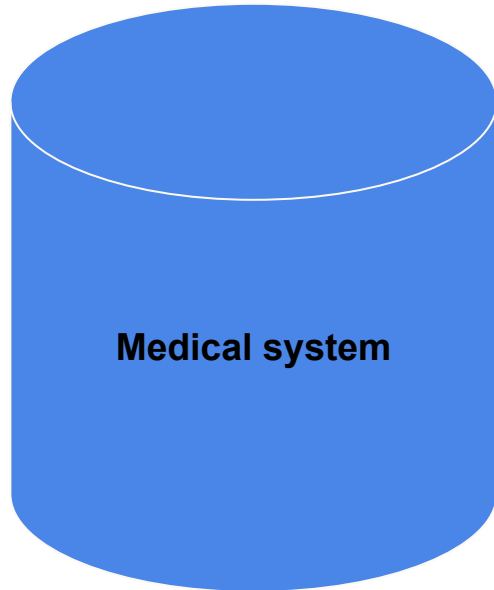
plan 

**L.R. FOX**  
FOUNDER & CEO



**Lisa Peterson**  
LMHC/LCDP/LCDS/MAC  
Chief Operating Officer  
Victa

# Silos in Healthcare



# A New Model



# Upstream Training and Technical Assistance

**Upstream's services help health centers adopt best practices that expand access to contraception. They are designed to help health centers...**



have **trained providers** on-site ready to counsel, prescribe, and place and remove the full range of methods



utilize **licensed and non-licensed staff** in key contraceptive care tasks



**source, store, and replenish** onsite provider-administered methods



source **medically-accurate educational materials** and job aids



effectively **code, bill, and submit** contraceptive services and methods for reimbursement



**adapt their EHR** to improve screening for pregnancy intention and account for contraceptive care workflows



develop **referral protocols** for when a provider-dependent method isn't available



create sustainable **policies, protocols, and processes**

# VICTA + Upstream

## Counselors -- screening at intake and annually:

Would you like to become pregnant in the next year?

YES  NO  OKAY EITHER WAY  UNSURE  N/A

Was Contraceptive education offered?

# VICTA + Upstream

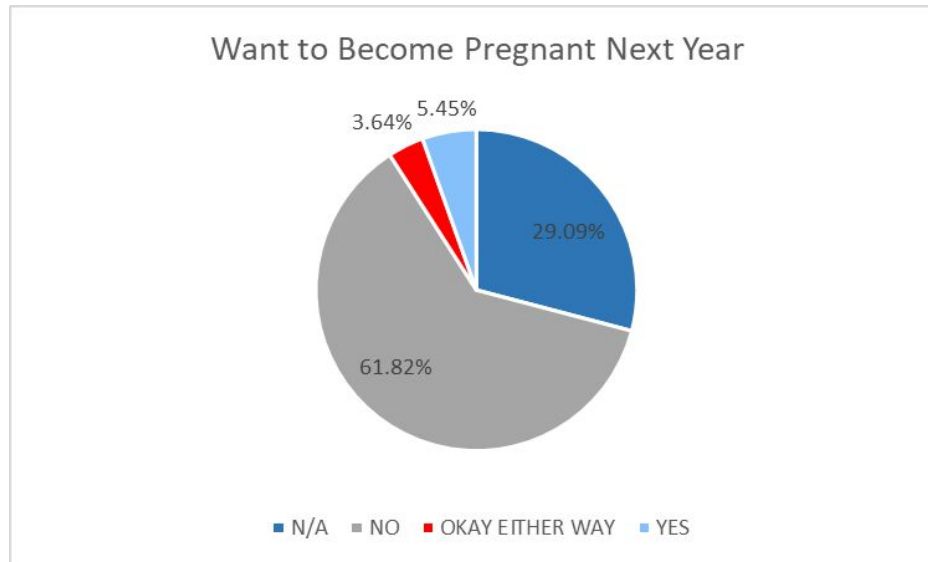
**Prescribers -- screening at intake and as indicated:**

## ▲ Contraceptive Care

- Contraceptive education offered and provided
- Contraceptive education offered and declined
- Contraceptive method patient selected/plans to use after this visit

# Outcomes

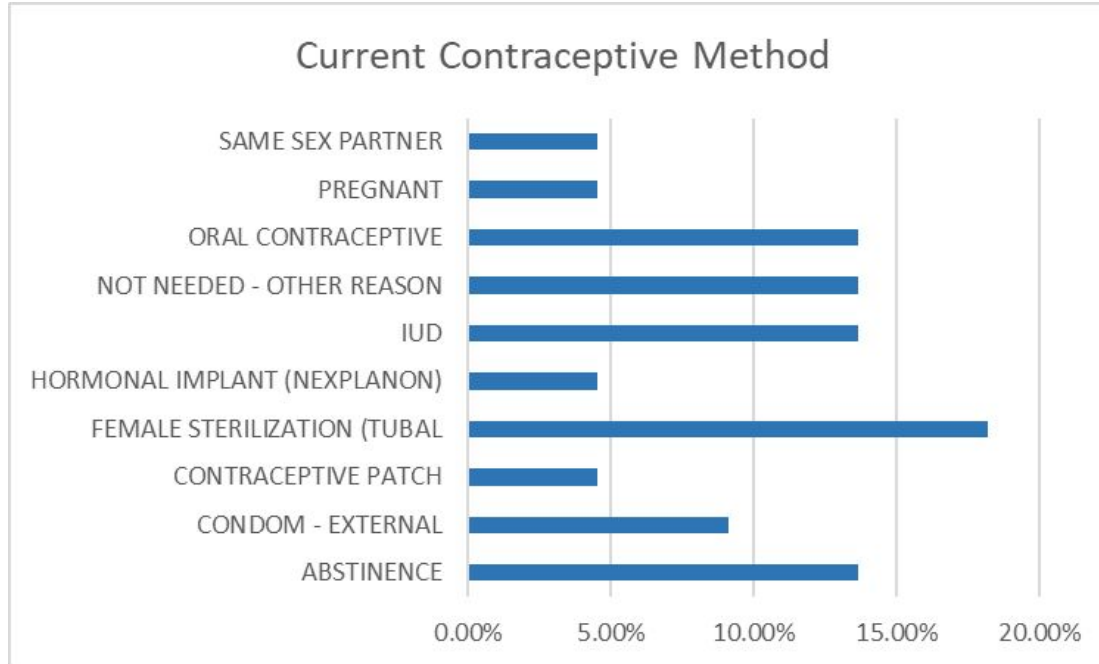
- 93% of assessments January 1 - June 30 2023 included Pregnancy Intention Screening Question for those assigned female at birth
- The majority of our clients do not want to become pregnant in the coming year





# Outcomes

End method selected during prescriber visit January 1 -June 30, 2023



# Outcomes

- NP fully trained in all Long Acting Reversible Contraceptive (LARC) methods
  - Precepting completed in partnership with another Upstream provider in the community
- Account with McKesson for necessary supplies established
- Gynecologist hired May 2023 to support expanded access to services
- CPT and ICD-10 codes loaded to EHR
- Comprehensive reproductive healthcare program launched on-site July 2023
  - Contraceptive care
  - STI testing
  - Wellness screenings

*VICTA is committed to providing a trauma-responsive environment; all services are delivered in conjunction with clinical supports and services*

# The Policy Center's Family Planning Policy Roadmap A Call to Action



## 1. Expand Free & Easy Access to Contraception Method of Choice

Through traditional and non-traditional platforms, including:

- Federally Qualified Health Care Centers (FQHCs) and Community Health Clinics (CHCs)
- Further investing in family planning providers under Title X (the Federal Family Planning Program)
- The Women Infants and Children (WIC) program
- FDA making contraception available over the counter (and at no cost through the Affordable Care Act)
- Require coverage of all FDA approved contraception, without insurer/plan limits or requirements



## **2. Invest in Ob/Gyns, Midwives and Doulas in Providing Robust Family Planning Services**

- Define roles of these providers in providing robust family planning counseling using the Person-Centered Contraception Counseling (PCCC) framework.
- Address reimbursement and billing pathways through Medicaid and Private Insurance (Commercial/ERISA) coverage.

## **3. Promote and Incentivize Forthcoming Male Contraception Options**

Support men in learning about and obtaining likely new FDA approved male contraception. Consider novel incentives for distribution, marketing and uptake.



## 4. Empower the Department of Labor to Oversee Contraception Coverage

Similar to federal mental health parity oversight, identify a Federal agency, such as the Department of Labor, to oversee insurance coverage of contraception, with enforcement capabilities.



## 5. Support Families who Have Babies

For those couples who have have babies, prioritizing low income and single parent families, provide:

- Child tax credits,
- Paid parental leave,
- Free childcare to allow and empower parents to work,
- Free diapers and formula for those unable or choose not to breastfeed,
- Coverage for postpartum in-home support so mothers can rest, heal, attend appointments, have support caring for sick infants and children, etc.

# Q & A

*Learn More*

[www.PolicyCenterMMH.org](http://www.PolicyCenterMMH.org)



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