Texas Women's Healthcare Coalition
PROMOTING ACCESS TO PREVENTIVE HEALTHCARE FOR ALL TEXAS WOMEN

Comments in Response to the Request for Information on Coverage of Over-the-Counter Preventive Services for the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services
December 3, 2023

The **Texas Women's Healthcare Coalition (TWHC)** is a partnership of 88 healthcare, faith, and community-based member organizations - dedicated to improving the health and well-being of Texas women, babies, and families by ensuring access to preventive healthcare for all Texas women. Access to preventive and preconception care – including health screenings and contraception – means healthy, planned pregnancies and the early detection of cancers and other treatable conditions.

We thank the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (the Departments) for this opportunity to provide information on the potential benefits and costs surrounding insurance coverage for over-the-counter (OTC) birth control.

TWHC supports the Departments' efforts to require health plans and health insurance issuers to cover OTC preventive items and services without cost-sharing and without a prescription by a healthcare provider, as this requirement would increase contraceptive use consistency, resulting in lower unplanned pregnancy rates and improved health outcomes for women, babies, and families across the country. It would lessen or eliminate many of the major obstacles women face when searching for birth control – specifically, the logistical issues that come with trying to obtain a prescription, the high costs of copays that many women cannot afford, and the confusion that comes with trying to determine which health plans cover OTC contraception and what requirements they have for coverage.

However, we also acknowledge that pharmacists, providers, health plans, health insurance issuers, and even consumers may face many issues with implementation if this requirement were to be enforced, including confusion surrounding the proper billing protocols and claims processing, market segmentation and a lack of uniform guidance, and a lack of public awareness on this new coverage opportunity. **TWHC believes that the Departments could offset these challenges in several ways:**

- By adopting strategies used by states with required OTC preventive item coverage laws;
- By issuing clear federal recommendations for billing protocols and claims processing;
- By implementing a thorough communications strategy to inform consumers and providers of the new coverage requirements; and
- By involving stakeholders, especially pharmacists and healthcare providers, in all facets of implementation planning.

Additionally, we strongly urge the departments to utilize these strategies with relevant stakeholders to make this transition as seamless as possible:

- Require health plans to implement point-of-sale coverage in pharmacy and retail settings, and encourage health plans to modify their claims processing systems to accommodate the expected influx of OTC claims from retail and pharmacy settings;
- Require health plans to prove that any medical management requirements they impose for OTC birth control are medically necessary as supported by scientific evidence and do not impose undue burdens on access for enrollees;
- Create clear, written guidance for pharmacies and other retail settings to place OTC birth control on the shelves, not behind the counter, to reduce the stigma of purchasing this medication that many women face; and
- Require that OTC birth control claims on health plan documentation be coded to a generic pharmacy charge in order to protect patient privacy and access for women who may not be safe in their homes.

Current Barriers with Access to and Utilization of OTC Preventive Products

As the Request for Information notes, the FDA's recent approval of Opill as the first OTC birth control pill creates a new and exciting opportunity to increase access to contraception.

Oral contraceptives are the most commonly used method of reversible contraception in the United States. According to the 2022 Kaiser Family Foundation (KFF) Women's Health Survey (a nationally representative survey of 6,442 people ages 18 to 64, including 5,201 females and 1,241 males), 90% of women aged 18 to 64 have used contraception at some point in their reproductive years, and one-third of reproductive age females report using oral contraceptives (33%) in the 12 months prior to taking the survey (1). Yet many women struggle to consistently obtain and use their preferred form of birth control. Running out of birth control pills is among the primary reasons women discontinue oral contraceptive use. Studies have found that discontinuation rates range from 25% to 85% during the first 6 to 12 months of use due to barriers in access and supply. In one study, nearly 30% of women taking oral contraceptives reported that they missed a pill because they could not get the next pack on time (2).

Please see our findings below on the **barriers to contraceptive use (including birth control pills and OTC emergency contraception) for women** in the United States:

1. **Prescription requirements create barriers to access for birth control pills, as they require women to spend valuable time, money, and resources in order to obtain and fill those prescriptions. These include resources needed to take off from work, travel, visit a doctor's office, visit a pharmacy, and more.**

One 2016 national survey of 1,385 women found that one-third (29%) of adult U.S. women who have ever tried to obtain prescription contraception report having problems obtaining a prescription or refills. Additionally, uninsured and Spanish-speaking women are more likely to report having these issues. The majority of women surveyed cited five major reasons for their difficulties with getting prescription contraception, including cost barriers or lack of insurance (14%), challenges obtaining an appointment or getting to a clinic (13%), the clinician requiring a clinic visit, exam, or Pap smear (13%), not having a regular doctor/clinic (10%), and difficulty accessing a pharmacy (4%) (21). While there are some benefits to requiring a prescription for birth control pills, such as the increased ability to counsel patients on possible side effects, this research suggests that the effects that prescription requirements have on a woman's ability to consistently obtain birth control refills may outweigh them.

As a first step in this direction, the Departments should also consider encouraging states (who have not done so already) to expand the authority of local pharmacists to directly prescribe and dispense some hormonal birth control methods. Currently, 27 states have implemented policies allowing pharmacists to prescribe and dispense self-administered hormonal methods (including the pill, patch, ring, and shot). States have been able to grant this authority through standing orders, collaborative practice agreements (CPAs), and/or issuing statewide protocols. This method of prescribing contraception has proven to be successful in the majority of these states. In Oregon, for instance, 46% of all pharmacies prescribe contraception. Additionally, among Medicaid enrollees in that state, 10% of new prescriptions for pills or patches are written by a pharmacist. However, if more states were to implement these policies, they should consider issuing written guidance to pharmacists on how they should bill for patient counseling services when prescribing (22).

2. **High costs can prevent women from being able to afford oral contraceptives, regardless of their insurance status.**

The 2022 KFF Women’s Health Survey found that for women who receive partial insurance coverage for contraception and pay the rest out-of-pocket, almost one-third (32%) pay less than $15, almost one in five (19%) pay between $15 and $24, and one-third (37%) pay $25 or more per pack (1). Additionally, according to the 2022 Emergency Contraception Access Report conducted by the American Society for Emergency Contraception (ASEC), the average selling price of individual Plan B One-Step is $49 per dose, and generics cost about $35 per dose (ranging from $5.18-$54.00) (6).

These prices are considered unaffordable for many women and the cost discourages many from consistently using their preferred method of contraception, especially those with low income or no insurance. 17% of low-income women say cost is the leading reason they aren’t using their preferred method. Additionally, one in five uninsured females of reproductive age say they had to stop using a contraceptive method because they couldn’t afford it. 6% of women on Medicaid and 3% of women on private insurance plans also cited cost as a barrier to continued use (1).

When it comes to the willingness to pay for an OTC oral contraceptive, these cost-related barriers for traditional prescribed contraception also apply. 11% of women report they would not be

willing or able to pay anything for an OTC oral contraceptive, and 39% would be able to pay $1-$10 per month. Only 16% report they would be able to pay more than $20 a month. For young people ages 15-17 specifically, they would only be willing or able to pay $10 a month for a progestin-only pill (1).

3. **The increasing prevalence of contraceptive deserts leaves many women with no place to go when they do seek out contraceptive care.**

Across the United States, studies show that over 19 million women of reproductive age are in need of publicly funded contraception, yet currently live in contraceptive deserts. Experts define contraceptive deserts as counties where the number of healthcare centers offering the full range of methods is not enough to meet the needs of the county's number of women eligible for contraception (9).

In Texas specifically, 5.8 million of our citizens live in some type of contraceptive desert (11). Our state has 254 counties, 10% of which do not have a pharmacy. Additionally, in 25 Texas counties there were no health care providers in any specialty or provider type who prescribed contraception in 2021 (27). The majority of our counties do not have access to a family planning provider, and the number of women's healthcare deserts is growing every year in our state as more hospitals close their doors (8).

For women living in these deserts, getting their birth control pills entails much more than just meeting with their healthcare provider. They must use valuable time, money, and resources to accommodate the extra travel time they must take to reach their closest family planning clinic. They must find a babysitter, take time off work, or travel long distances to access their preferred birth control method (9).

The burdens placed by contraceptive deserts have also been proven to disproportionately affect women of color and low-income people, as they are more likely to live in these areas than their white and higher-income counterparts. A 2021 study published in the Journal of Health Politics, Policy and Law found that across multiple states, racial minorities are typically overrepresented in areas defined as contraception deserts. For example, while 38.8% of California's general population is Latinx, 68% of their population living in contraceptive deserts are Latinx. And in Colorado, 0.92% of their general population is indigenous, yet 11.3% of the population living in contraceptive deserts is indigenous (11).

4. **Gaps in federal and state requirements, in tandem with varied insurance practices, have led to inconsistent and incomplete coverage for birth control pills across the country. This leaves many women unsure and uninformed as to what their options are for assistance with birth control pills and OTC emergency contraception.**

The requirements women must fulfill in order to receive coverage for their birth control pills vary depending on whether they have insurance at all, and then which private insurance plan they are enrolled in, or which state Medicaid plan they are enrolled in. Additionally, the amount of coverage they

receive for their birth control pills also varies depending on which of these plans they are enrolled in. The type of contraception they can be covered for varies as well.

As noted in the Request for Information, federal law requires most private health insurance plans and Medicaid expansion programs to offer contraception coverage; however, they are not prohibited from enforcing prescription requirements. Most of these plans, therefore, do have prescription requirements in place, but not all. At the same time, many private plans are not required to cover contraception at all because they existed prior to the ACA (otherwise known as “grandfathered” in). Additionally, some Medicaid waiver and state-funded family planning programs, including those in Texas, do not offer coverage for OTC emergency contraception (2).

This lack of uniform coverage and requirements for women often results in them being uninformed about their options, as the 2022 KFF Women’s Health Survey indicates. Four in ten reproductive age females (41%) do not know that private health insurance plans are required to offer contraceptive coverage for women (1). Additionally, out of the women interviewed who reported having to pay at least partially out-of-pocket for their birth control pills, half (50%) of this group do not know *why* they had to pay part of the cost out-of-pocket. 16% report they had to pay part of the cost themselves because they wanted a certain brand of contraception that was not covered by their plan, and 5% to 10% report that it was because their prescribing provider or pharmacy was out of network (1).

5. **Many women experience stigma, bias, or other discrimination from their healthcare providers when trying to obtain or fill a birth control prescription; this discourages many from seeking out contraceptive care, or leaves many dissatisfied with their level of contraceptive care.**

According to the 2022 KFF Women’s Health Survey, one in ten (9%) women aged 18-64 report having experienced discrimination because of their age, gender, race, sexual orientation, religion, or some other personal characteristic during a healthcare visit in the past two years. For most of these women, these opinions come from how they were treated by their healthcare providers at their appointments. 29% of women aged 18-64 report that their doctors have dismissed some of their health concerns within the past two years. Within that same time period, 15% report that a healthcare provider did not believe they were telling the truth during an appointment, 19% report their doctor assumed something about them without asking, and 13% say that a provider suggested they were personally to blame for a health problem they were facing (17).

These reports of healthcare provider bias also vary depending on differences in race, income, insurance coverage, and pre-existing health conditions. 36% of women with a disability or ongoing health condition report that a healthcare provider had dismissed their concerns in the past two years, compared to 22% of women who do not. Additionally, 18% of Black women who have seen a provider in the past two years say that their provider did not believe they were telling the truth, compared to only 15% of White women and 7% of Asian and Pacific Islander women (17).

While the majority of healthcare providers are likely to not explicitly endorse discrimination across age, gender, race, or other characteristics - stereotypes surrounding various patient demographics can implicitly influence which medical treatments providers choose to offer or deny for their patients (18).

With contraceptive care specifically, providers may incorporate their personal views on whether and when an individual should or should not have children when administering prescriptions. Or they may prioritize their beliefs about how to best optimize patient health and pregnancy outcomes over their patients' reproductive health goals (18). According to the National Women's Law Center, there have been numerous reports of these exact situations occurring when people attempt to fill their prescriptions for contraceptives at pharmacies in at least 26 states (20). Nationwide drugstore chains, including CVS and Walgreens, have explicit company policies that allow employees to deny prescriptions for birth control or purchases of condoms based on their religious or moral beliefs (19). Yet only 8 states have passed legislation explicitly requiring pharmacists or pharmacies to provide medication to patients, and only 7 state pharmacy boards have issued policy statements that allow refusals but prohibit pharmacists from obstructing patient access to medication (20).

6. **Underserved populations, rural areas, and communities of color are disproportionately impacted by these barriers to contraceptive use due to systemic inequities in our healthcare system.**

This can be seen when looking at the access and utilization rates of contraception across different demographics.

According to a 2023 survey of people who identify as Asian American, Native Hawaiian or Pacific Islander, Black or African American, Indigenous, or Latina/Latinx and have used or wanted to use a contraceptive method in the past year, 45% percent of respondents reported they had experienced at least one challenge accessing contraception in the past year (4). Compared to White women, Black women are less likely to use any contraceptive method. Specifically, more than a quarter (27%) of Black women report that they are not using contraception - compared to one in five (21%) Hispanic women, 17% of Asian and Pacific Islander women, and 13% of White women (1). Additionally, Black and Hispanic women are less likely to use a highly or moderately effective method of contraception (versus a more ineffective method) (3).

For women with varying incomes and health insurance coverage, these disparities persist as well. The 2022 KFF Women's Health Survey found that 23% of females with low incomes report not using contraception compared to 14% of individuals with higher incomes. Nearly half (46%) of uninsured females and four in ten (41%) females with Medicaid also report having to miss their birth control because they were not able to get their next supply on time (1).

Finally, numerous studies have shown that women living in rural communities experience poorer health outcomes and have less access to healthcare, compared to women living in metropolitan areas. This remains true for their reproductive healthcare and access to contraception. Many rural areas have limited numbers of healthcare providers, especially women's health providers. Less than one-half of rural women live within a 30-minute drive to the nearest hospital offering perinatal services (5). As a result, over 1.6 million American women aged 13 to 44 are in need of publicly funded contraception, yet live in counties without access to a single health center that provides the full range of contraceptive methods (9).

Barriers to contraceptive use for women also include a lack of reliable transportation, and not having sufficient information about contraceptive options and how to use them effectively. These factors contribute to health disparities among underserved populations.

Transportation barriers impact access to reproductive care for underserved populations. For women living in rural or economically disadvantaged areas, the lack of reliable transportation can be a major hindrance to accessing necessary reproductive health services. Public transportation options in these areas are often limited or non-existent. And private transportation can be unaffordable. The time and cost associated with travel can discourage or prevent women from seeking care, including routine follow-ups and contraceptive access. Data from the National Health Interview Survey (1997-2017) examined transportation barriers across racial/ethnic groups and found that Hispanic populations had greater odds of reporting a transportation barrier when seeking care (25). Lack of reliable transportation exacerbates health disparities and can have long-term impacts on the well-being of these underserved populations.

Further, women experiencing homelessness tend to use the least effective contraceptive measures due to financial burdens. In a cross-sectional study of 54 childbearing women experiencing homelessness in Chicago, 80% had health insurance and 90% knew where to obtain birth control. However, a significant barrier to avoiding pregnancy was a lack of comprehensive contraceptive counseling from their healthcare provider (26). Many homeless women experience a range of feelings and challenges when talking to their healthcare provider, which may include mistrust and fear due to past negative experiences with the healthcare system. This can lead to reluctance in sharing personal information when accessing reproductive care. Thus, it is imperative that effective contraception be accessible to this underserved population who wish not to have an unintended pregnancy.

Potential Implementation Issues with OTC Contraception Coverage Requirements

When considering how the United States healthcare system will implement the proposed OTC preventive items and services coverage requirement, the Departments should explore and adopt the lessons learned by states that have already passed identical laws or regulations.

Currently, 6 states (California effective in 2024, Maryland, New Jersey, New Mexico, New York, and Washington) have laws or regulations requiring state-regulated private health insurance plans (both individual and fully-insured employer-sponsored plans) to cover, without cost-sharing, OTC contraception without a prescription. For most of these states, this coverage is specific to emergency contraception (like Plan B One-Step) or condoms. Additionally, 7 states (California effective in 2024, Illinois, Maryland, Michigan, New Jersey, New York, and Washington) cover at least some OTC contraceptive methods without a prescription for Medicaid enrollees. These states are only able to do so using state funds rather than federal (2).

Please find our **recommendations below for implementing** the OTC preventive items and services coverage requirement:

1. **The Departments must ensure that pharmacists, providers, health plans, and health insurance issuers have clear and uniform guidance on billing protocols and claims processing for OTC birth control.**

According to a 2023 KFF report that surveyed nearly 80 stakeholders (including pharmacists, health plans, and state Medicaid officials) involved in the coverage and provision of OTC contraception in seven of the states described above, pharmacists in these states are confused as to how they should process claims for OTC contraception. Within the majority of electronic claims systems they use, there is a required field in which the pharmacist must insert the prescriber's National Provider Identification (NPI) number. However, because a prescriber is not required for an OTC product in these states, pharmacies need clear direction from insurers or pharmacy benefit managers (PBMs) on how to fill out the claims form. Yet, the communication between these stakeholders is lacking (2).

To address this issue, pharmacists and private insurance plans in these states have utilized two main strategies to process claims and reimburse their consumers. Many of the stakeholders interviewed in the 2023 KFF report expressed that they currently use these strategies to bill for emergency contraception (like Plan B One-Step) without a prescription, and they believe that identical methods could be used to bill for an OTC daily oral contraceptive (2). **These strategies should be explicitly outlined and required by the Departments if they pursue implementing the OTC preventive items and services coverage requirement.**

If private plan enrollees obtain the OTC preventive product at the pharmacy counter, pharmacists will submit a claim to the plan using their own NPI number, pharmacy NPI number, or dummy NPI, depending on the plan and state protocol. Enrollees usually must purchase it from an in-network pharmacy in order for it to be covered. This approach is similar to how pharmacists billed for at-home COVID-19 tests in many situations (2).

If private plan enrollees purchase the OTC preventive product outside of a pharmacy setting (at a retail store, for example), they can then submit a claim with the receipt to their insurance company for reimbursement, similar to the reimbursement mechanism that was used for some at-home COVID-19

tests (2). However, as described in our next recommendation, it must be noted that this practice creates a cost and access barrier that disproportionately impacts people working to make ends meet and low-income consumers (2).

For women enrolled in Medicaid programs that cover non-prescribed OTC contraception using state funds, pharmacists in these states reported using a Universal NPI number to submit a claim without enrollment cost-sharing. This process involves the pharmacist entering a dummy, blank, or state-specific universal NPI in the prescriber field. Three state Medicaid programs and several MCOs involved in the 2023 KFF report cited using this strategy (2).

2. **It is imperative that point-of-sale coverage in pharmacy and retail settings be implemented by health plans to ensure that patients do not have to face upfront costs and barriers to reimbursement. Health plan systems for claims should be modified to accommodate the expected influx of OTC claims from retail and pharmacy settings.**

As described in our earlier recommendation, most private health plan enrollees have coverage for OTC contraception (like Plan B One-Step) at point-of-sale coverage at in-network pharmacies. If enrollees wish to obtain the OTC preventive items at out-of-network pharmacies or retail locations are required to initially pay out-of-pocket, then submit a reimbursement claim to their plan afterwards (2).

However, this process poses numerous financial and logistical barriers for consumers. Many may not have an in-network pharmacy within miles of their residence, thus forcing them to go through this reimbursement process if they want to obtain an OTC preventive product. Many may not be able to afford paying for their OTC preventive products in full upfront, and they may not have the time necessary to navigate their plan's reimbursement process.

Additionally, if a consumer does not have a prescription number, as in the case of women who seek OTC contraception in states where prescriptions are not required for coverage, the reimbursement systems they use may not allow the claim to be submitted with a missing field. Even if the consumer manages to submit the claim electronically or by paper, it may be unlikely that the claim will be adjudicated because of the missing prescription number. A consumer's only option then may be through an appeals process with the carrier or PBM, and then to the state regulator.

3. **Health plans must be required to prove that any medical management requirements they impose for OTC birth control are medically necessary as supported by scientific evidence and do not impose undue burdens on access for enrollees.**

Some requirements to be avoided include limiting the supply of OTC birth control pills that women may receive coverage for at one time and enforcing prescription requirements (as discussed earlier).

Typically, private health plans cover 30 to 90-day supplies of prescription birth control pills at one time (13). Despite this, research has shown that women who receive a one-year supply of their birth control pills are 30% less likely to have an unintended pregnancy, compared to women who obtain 30 to 90-day supplies. Additionally, women who receive a one-year supply of birth control have been found to be 28% more likely to continue to use them 15 months later (14). This is because limiting the supply of contraceptives to short, monthly intervals can reduce timely access to contraception and create gaps in use (13). Health plans must be discouraged, or even prevented, from imposing supply limits on OTC contraception coverage, to make the most out of these benefits.

Currently, the state of Texas requires parental consent for all prescription contraception, including birth control pills (15). Research shows that requiring teens to get parental consent before they can access contraceptive services doesn't reduce their sexual activity. Instead, it puts their health at more risk. According to the Journal of the American Medical Association, roughly 1 in 5 teenagers would resort to unsafe sex if their parents had to be notified when they got birth control at a clinic (16). Additionally, numerous studies have shown that oral contraceptive pills are safe for use by adolescents. In 2015, the Oral Contraceptives Over-the-Counter Working Group convened adolescent healthcare experts and concluded that birth control pills are safe and effective for adolescent users. They also found that there is no scientific rationale for limiting access to a future OTC birth control pill product by age (12).

Texas currently has the 8th highest teen birth rate in the nation. With 21,604 births to Texas girls aged 10-19, a baby was born to a teen mom in Texas once every 25 minutes in 2022. After 15 years of decline, the Texas teen birth rate actually increased in 2022.

The Departments must discourage health plans and states from imposing unnecessary restrictions on OTC birth control coverage.

4. **Pharmacies and other retail settings must have clear, written guidance to place OTC birth control on the shelves, not behind the counter, to reduce the stigma of purchasing this medication that many women face.**

Concerns surrounding the physical placement of OTC birth control in pharmacies and retail locations stem from issues that have arisen with consumers' access to OTC emergency contraception in these settings. According to the 2022 ASEC Emergency Contraception Access Report, only about half (54%) of stores surveyed have emergency contraception available on the shelf. Of these, about half (48%) keep emergency contraception in a portable plastic box that customers have to bring to a register to have unlocked, and 14% of stores lock the product in a fixed display case in a store aisle. Less than one-third (28%) of these stores had EC directly on the shelf without any security enclosure (6).

While keeping emergency contraception behind physical barriers is a common practice, there is no federal or state law requiring pharmacies or retail locations to do this. The majority of these stores

claim to keep emergency contraception stored this way to prevent theft (10), even though the majority of medications can be obtained for under $50

These issues with physically accessing OTC emergency contraception in pharmacies and retail stores place an additional barrier to contraceptive care for women. Women report feeling embarrassed or intimidated when having to ask an employee to unlock or locate emergency contraception pills. Additionally, many report having concerns about buying these products with confidentiality when they are stored this way. This will discourage women from seeking out emergency contraception. The Departments must ensure that these same barriers do not translate over to OTC birth control pills.

5. **A thorough communications strategy will be needed to raise awareness of the new OTC coverage requirement for consumers, pharmacists, providers, health plans, and health insurance issuers.**

This is clear when looking at states that already require health plans to cover OTC contraception without a prescription or cost-sharing. According to the 2023 KFF report, few pharmacists and consumers in these states are aware of this coverage benefit or how to implement it. As a result, many pharmacists within these states agree that consumer claims for non-prescribed OTC contraception are rare (2).

Stakeholders within these states have made multiple suggestions on how to best communicate coverage benefits of OTC contraception to various groups. These include encouraging health plans to notify their enrollees of this coverage through their membership materials (like a member handbook, for example) and encouraging independent and chain pharmacies to post signage about the availability of OTC contraception and how to check if it's covered by insurance. They also emphasize the need for creating a single, standardized source for pharmacists to find information on billing for OTC preventive items and services (4) - these could include having health plans bulletins to pharmacies regarding protocols in filing OTC claims, or collaborating with chain pharmacies and their corporate governance to create OTC contraception billing protocol materials. Additionally, stakeholders suggest having all communications specify that OTC contraception coverage requirements do not apply to self-funded insurance plans, to avoid confusing consumers (2). The Departments should consider adopting these communications strategies, and they should use multiple languages to accommodate all pharmacists, health plans, and consumers.

6. **We strongly recommend that OTC birth control claims on health plan documentation be coded to a generic pharmacy charge in order to protect patient privacy and access for women who may not be safe in their homes.**

Nationally, over 1 in 4 women experience domestic or dating violence at some point in their lives (23). For a woman who is unsafe in her home, family, or relationship, having additional measures of privacy in place for birth control purchases will protect them. Abusive partners are known to use

methods of reproductive coercion (such as destroying pills) as a means of controlling women, and TWHC strongly supports safety and privacy measures in place to prevent this from happening (24).

The Department must ensure that insurance plans cover OTC birth control without a prescription, prior authorization, or upfront costs or cost-sharing - as this will increase contraceptive use consistency, resulting in lower unplanned pregnancy rates and improved health outcomes for women, babies, and families across the country. TWHC is eager to help with these issues, and we are happy to provide any additional information on this or other topics relating to women's health.

Respectfully,

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