

Family Planning and Health Care Reform: The Benefits and Challenges of Prioritizing Prevention

By Rachel Benson Gold

If the Obama administration and key members of Congress are consistent about one thing, it is that the health care reform they seek for the nation must place a high priority on prevention. The importance of preventive health care has been a long-standing refrain among policy-makers, providers, advocates, payers and even individuals seeking to obtain needed services for themselves and their families. But one reason moving the country from an “illness” to a “wellness” paradigm still remains largely rhetorical is the immensity of the challenge involved in fundamentally reorienting a health insurance system that heavily incentivizes treating people’s diseases once they have them, rather than helping people attain and maintain good health.

In many respects, family planning exemplifies both the benefits of prevention and the issues inherent in trying to remake the current health financing system to work for prevention. There should be no doubt that family planning is critical preventive health care. It enables women to avoid pregnancy when they do not want to be pregnant, plan for pregnancy when they do and foster their own health in the process—all of which yields significant health, economic and social benefits for women, their families, their communities and society overall. But like other preventive health care, family planning presents challenges for health financing mechanisms as well. At a minimum, it requires attention to nuances, such as the need for insurance to cover both a wide range of contraceptive methods and the specific medical services that individual methods require (for example, the insertion and eventual removal of an IUD). Beyond the methods, moreover, effective family planning service provision requires time-

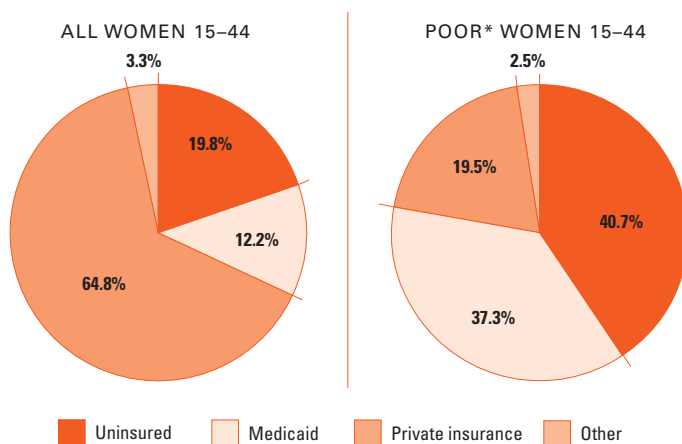
and labor-intensive activities that are at the heart of all good preventive care—including outreach, education, varying levels of counseling appropriate to a wide-ranging clientele and client follow-up. These activities are inadequately covered, if covered at all, by most health insurance today, which is still largely based on a curative model that emphasizes “doing” rather than “talking.”

Ensuring Coverage

One major challenge of health care reform, of course, is at long last to ensure that all individuals have some form of insurance coverage. This is especially important for reproductive-age women, one in five of whom currently lack coverage, and especially critical for poor reproductive-age women, four in 10 of whom are uninsured (see chart). Equally important may be achieving

GAPS IN COVERAGE

Poor women are especially likely to rely on Medicaid or to have no insurance coverage at all.



*Individuals in families with incomes below the federal poverty level. Note: Data are for 2007. Source: Guttmacher Institute tabulations from the Current Population Survey, 2008.

consensus that family planning is an indispensable component of the continuum of care that must be included in all health coverage.

As recently as the early 1990s, private-sector health insurance plans typically either did not cover contraception at all or had only very limited coverage; however, a high level of attention to that fact during the Clinton administration's attempt at health care reform dramatically changed the landscape. Since that time, half the states have adopted policies mandating that private, employer-purchased plans include contraceptive coverage if they cover other prescription drugs. The impact of these laws quickly spilled over into states without mandates, because many larger insurers standardize their plans across the country; these laws have also impacted the coverage offered by large employers who self-insure, rather than purchase coverage from an insurer, even though these plans are beyond the legal reach of the state mandates. As a result, at least some level of contraceptive coverage is now the norm, rather than the exception.

Nonetheless, the situation is far from perfect, and there is real reason to be concerned about the coverage offered through small employers and in the individual market. Little specific to contraceptive coverage is known about these markets, but in general, employees of small businesses are less likely to be offered insurance at all, or to be able to afford it when they are. And small-employer plans are often both more expensive and less comprehensive than large-group plans, as are plans available to individuals who purchase on their own, rather than as part of a group.

At the other end of the spectrum is Medicaid, which insures 12% of all women of reproductive age, and 37% of poor women. As required by federal law, all state programs cover family planning. Medicaid is now the largest source of public support for family planning, contributing more than seven of every 10 public dollars.

Medicaid gives women a way to pay for care, but Medicaid enrollees still need a provider from whom they may obtain that care.

The regular, state-set income eligibility levels for Medicaid, however, are extremely low, averaging only two-thirds of the federal poverty level (which is \$18,310 for a family of three in 2009).

Moreover, the program is usually limited to low-income families, which means that it is of little help to women seeking to delay a first pregnancy. Because of these limitations, 21 states have obtained federal permission, known as a waiver, to expand coverage for family planning under the program to women above the regular, state-set income levels, whether or not they already have children. Nearly all of these states set the income-eligibility ceiling at the same level used in the state to determine eligibility for coverage of preg-

nancy-related care under Medicaid, generally at or near 200% of poverty. [A pro-

vision that would have greatly eased the process for states seeking to expand Medicaid eligibility for family planning was approved by the House Energy and Commerce Committee as part of the economic stimulus package in late January. It was removed from the bill, however, as a result of pressure brought by Republican members seeking to scuttle the legislation (related article, page 2).]

As an insurance mechanism, Medicaid gives women a way to pay for care, but Medicaid enrollees—like all women—still need a provider from whom they may obtain that care. Currently, 2.2 million women with Medicaid coverage obtain family planning services from private physicians, and 2.5 million women with Medicaid coverage obtain care at one of the 8,200 publicly funded family planning centers across the nation. Funds through the Title X family planning program and other flexible sources—such as state family planning dollars and the federal maternal and child health block grant—are critical to sustaining the basic infrastructure of this provider network, paying for everything from staff salaries to medical supplies to utility bills. Title X funds also support the clinical care provided to individuals who are uninsured and cannot qualify for Medicaid.

Making Coverage Work for Prevention

As difficult as it will be, ensuring universal insurance coverage is only the first step. What is critical is that insurance systems be reoriented to value—meaning, adequately cover and reimburse—those activities critical to making a preventive service such as family planning work.

For private plans, ensuring adequate coverage means giving women the widest possible choice of contraceptive methods from which to choose the method they are most likely to be able to use consistently and correctly over time. Beyond that, plans must cover all components of providing the method, including the drug or device itself and any clinical services that are necessary, such as the insertion of an IUD or the injection of Depo-Provera. Finally, the cost-sharing required under private coverage cannot be prohibitive and must not be an impediment to a woman's choosing the method most appropriate for her.

A major issue when it comes to Medicaid is the adequacy of provider reimbursement, which according to data from family planning centers, covers only about half of the actual cost of providing care, on average. Reimbursement levels need to take into

account the administrative and staffing costs of providing care, as well as the full cost

to providers of contraceptives and other supplies. Once reasonable levels are established, they should be adjusted annually to reflect changes in the cost of providing care. Failing to do so threatens the financial viability of family planning centers and serves as a powerful disincentive to private physicians, whose participation is important in reaching all those in need. At the same time, reimbursement processes should be made as simple as possible, to reduce unnecessary red tape and to ensure timely provider payment.

But likely the hardest shift for both public and private payers will need to be the one away from valuing “doing” over “talking.” This is of the utmost importance for a service such as a family

planning visit, which—although it includes a physical examination and related medical tests and procedures—is in large part dependent on a high-quality interaction between the provider and the woman. Matching a woman with the method that is right for her involves addressing deeply personal, sometimes sensitive questions about her sexual behavior and life circumstances. Although this component of care is important for all clients, it may be especially critical for new contraceptive users or individuals dealing with complex issues such as homelessness, substance abuse, family violence or mental health concerns. And this entire discourse must take place against the backdrop of important cultural differences and sensitivities, and many clients' need for confidentiality.

It is axiomatic, then, that giving the woman the best chance to be successful in using her chosen method means that her provider has to be able to spend some real time with her. And the only way that is going to be a realistic scenario is if providers are adequately compensated for that time. But reconfiguring our health care financing system, both public and private, to do so will require a major paradigm shift.

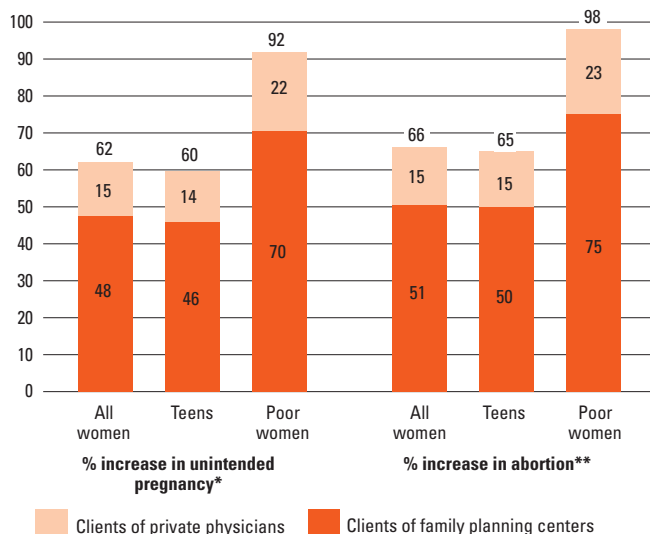
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For now, public providers rely on sources such as Title X, whose funds are already

stretched thin, to cover the “talking” that insurance mechanisms may not. Although that situation theoretically could change, the other roles that Title X plays are unlikely to diminish. No insurance program will provide the support to the underlying provider infrastructure that Title X can and does. Moreover, it can fund the time-intensive efforts necessary to reach out into the community and enable clients to feel comfortable coming in for care. It can also provide language assistance and culturally sensitive care that is essential for many clients. And finally, flexible funding sources such as Title X enable providers to selectively deploy resources in a way that best meets their communities' needs.

DEMONSTRATED IMPACT

In the absence of publicly funded family planning, levels of unintended pregnancy and abortion would be dramatically higher.



*Compared with national unintended pregnancy levels in 2001. **Compared with national abortion levels for 2004. Most recent data available for each type of event. Source: Guttmacher Institute, 2009.

Worth the Effort

The highly beneficial impact of family planning on the health and well-being of women and their families has been extensively documented. Much of the documentation comes from the public sector, but the data are illustrative. They amply demonstrate that as hard as it will be to reconfigure financing systems to work for family planning, doing so clearly will be worth the effort.

Preventing Unintended Pregnancies and Delaying First Births

Each year, publicly funded family planning in the United States allows women to avoid 1.94 million unintended pregnancies. Without these services, levels of unintended pregnancy and abortion in the United States each year would be about two-thirds higher among women overall and among teens, and almost twice as high among poor women (see chart). Absent publicly supported services, the U.S. abortion rate—currently one-third below its peak in 1980—would be higher than it has ever been.

More than nine in 10 women receiving publicly funded family planning services would be eligible for Medicaid-funded prenatal, delivery and

postpartum care services if they became pregnant. As a result, every dollar invested in helping women avoid pregnancies they do not want to have saves \$4.02 in federal and state Medicaid expenditures.

Data from state Medicaid expansion efforts emphasize the critical importance of family planning in helping young women to delay a first birth. In Arkansas, for example, the average age at first birth for women enrolled in the Medicaid family planning expansion rose nearly three and a half years between 1998 and 2005, while it went up just over two years for all Medicaid enrollees in the state. In 2002 alone, California's program enabled 44,000 teens to avoid pregnancy, thereby preventing 21,000 teen births.

Enabling young women to delay childbearing until after their teen years improves the health and well-being of both the young women and their children, but also has a less-discussed—but no less critical—impact on women's personal autonomy and their educational, social and economic opportunities. Economists assessing the impact of the availability and use of oral contraceptives in late 20th century America concluded that they substantially increased women's age at marriage. This in turn led to a significant increase in women's participation in the labor force, resulting in their greater financial independence. Moreover, the increase in the age of marriage essentially made the investment in higher education worthwhile for women who otherwise would have left the workforce in their early 20s, or perhaps never have entered it at all. This investment opened a host of new doors for women and brought a marked increase in women's entrance into professions that historically had been dominated by men, such as law and medicine.

Accessing Basic Care and Fostering Personal Health

Although contraception is at its core, the package of services provided at publicly funded family planning centers is much broader. Women obtaining care at a family planning center typically receive a breast exam and screening for hypertension, diabetes and other chronic conditions, and are evaluated to identify the need for

counseling related to substance abuse, nutrition or mental health. One in six women who obtain a Pap test or a pelvic exam nationwide do so at a publicly supported family planning center, as do one in three women who are tested for HIV or who receive counseling, testing or treatment for an STI other than HIV.

In short, the package of basic preventive sexual and reproductive health services routinely provided in family planning centers—including contraceptive services and supplies—is essentially the same package of care a private physician offers a woman during her annual gynecologic exam. In many cases, family planning centers are able to treat conditions that are diagnosed in the course of a routine visit, such as STIs or urinary tract infections. In other cases, such as when a breast exam reveals something troubling or an HIV test yields a positive result, family planning centers will refer the client to another provider for follow-up care.

It is therefore not at all surprising that more than six in 10 women who obtain their contraceptives at a family planning center report that the center is their usual source of health care (see chart). For some women, the numbers are much higher: About three-quarters of poor women who obtain care at a family planning center consider the center to be their usual source of care. These numbers are similar for women who are uninsured, who are black or Latina, or who were born outside the United States.

Planning for and Achieving Healthy Pregnancies

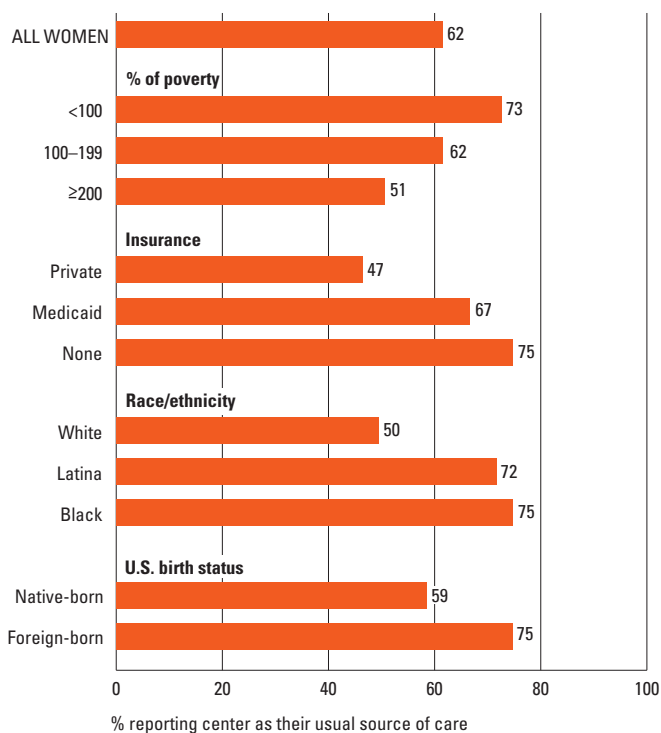
Maternal and child health advocates have long been talking about the importance of “preconception care,” but operationalizing the concept has been difficult. In practice, if it happens at all, preconception care often constitutes little more than a single prepregnancy health assessment visit. The Select Panel on Preconception Care, a group of national organizations and experts convened by the Centers for Disease Control and Prevention in 2005, argued strongly that it should be much more. According to the panel, to fulfill its promise, preconception care should comprise ongoing care before and between pregnancies that can “identify and modify biomedical, behavioral and social risks to a woman’s health or pregnancy outcome through prevention and management.”

If adequately funded and provided comprehensively within a public health model, family planning is a significant down payment on this expansive notion of preconception care. As the name implies, family planning in the broadest sense enables women to plan for their families, by timing, spacing and limiting their pregnancies.

In addition to helping women delay a first pregnancy, family planning promotes healthy spacing between pregnancies, reducing a widely acknowledged risk factor for low birth weight, premature birth and, ultimately, infant mortality. Little wonder then that both the March of Dimes and the National Governors Association consider expanding Medicaid eligibility for family planning an important step that states can take to improve birth outcomes.

GO-TO PROVIDERS

The large majority of women who obtain care at a family planning center consider it their usual source of care.



Note: Among women receiving care from a family planning center, 2002. Source: Guttmacher Institute, 2008.

Indeed, state Medicaid eligibility expansions have demonstrated family planning's critical role in helping women to lengthen the intervals between their pregnancies. In Oklahoma, the proportion of women using contraceptive services within six months of a Medicaid-funded delivery rose 20% in two years. In Arkansas, repeat births within 12 months dropped 85% for women enrolled in the family planning expansion between 2001 and 2005. And in Rhode Island, the proportion of women having a Medicaid-funded birth becoming pregnant again within 18 months plummeted following initiation of the state's family planning expansion in 1993; in 2000, for the first time, Medicaid enrollees in the state were less likely to have a short inter-pregnancy interval than were privately insured women.

Moreover, family planning gives women a critical connection to the health care system before pregnancy. By providing access to basic preventive health care, family planning fosters a

woman's ability to eventually enter into pregnancy having already identified and addressed any preexisting health concerns and issues. It gives providers the opportunity to discuss simple steps a woman can take, such as folic acid supplementation or rubella vaccination, to prepare for pregnancy at some point in her future, as well as more difficult steps, such as stopping smoking or losing weight to reduce her blood pressure and the risk of diabetes. Finally, as the March of Dimes emphasizes, connecting a woman to the health care system prior to pregnancy increases the likelihood that she will obtain the timely prenatal care she needs once she becomes pregnant.

In short, family planning exemplifies the potential benefits of a national health care system that truly prioritizes prevention. As a cornerstone of basic health care for women, it should be looked at—and valued as such—by policymakers and payers alike. www.guttmacher.org