

## The Case for Insurance Coverage of Contraceptive Services And Supplies Without Cost-Sharing

By Adam Sonfield

A provision in the 2010 health reform legislation, the Affordable Care Act (ACA), requires all new private health plans to cover certain specified preventive health services without any out-of-pocket costs to consumers, such as copayments or deductibles. An initial list of such services, based on three sets of existing guidelines, began affecting insurance plans in September 2010. Reproductive health services on that list include cervical cancer screening, screening and counseling for HIV and several other sexually transmitted infections, and vaccination for human papillomavirus (HPV).

In November 2010, an advisory panel convened by the Institute of Medicine (IOM) began to develop a fourth set of guidelines—for women's preventive health care—as required under an amendment to the ACA authored by Sen. Barbara Mikulski (D-MD). Debate on the Senate floor made clear that the Mikulski amendment was intended by its supporters to include contraceptive counseling, services and supplies, as well as an annual well-woman gynecologic exam and other key services. The IOM panel is scheduled to make its recommendations in the spring to the Department of Health and Human Services (DHHS), which is

charged with adopting a final set of guidelines and has set a goal of doing so by August.

Supported by a strong, long-standing body of evidence, contraceptive services have long been recognized by both government bodies and a wide range of private-sector experts as a vital and effective component of preventive and public health care. Contraceptive use helps women avoid unintended pregnancy and improve birthspacing, which in turn have substantial positive consequences for infants, women, families and society. Moreover, although cost can be a daunting barrier to effective contraceptive use on the part of individual women, the evidence strongly suggests that insurance coverage of contraceptive services and supplies without cost-sharing is a low-cost or even cost-saving means of helping women overcome this obstacle.

### Preventive Benefits

#### Planning and Spacing Pregnancies

The range of contraceptive methods approved by the U.S. Food and Drug Administration are all highly effective for the prevention of pregnancy. Contraceptive methods such as sterilization, the IUD and the implant have failure rates of 1% or less. For injectable and oral contraceptives, typical-use failure rates, which account for the difficulties many women experience using contraception consistently and correctly over long periods, are 7% and 9%, respectively, because some women miss or delay receiving an injection or taking a pill. But use of any method is far more effective than using no method at all: Couples who do not practice contraception have approximately an 85% chance of an unintended pregnancy within a year.

*This article is adapted from testimony submitted by the Guttmacher Institute to the IOM's Committee on Preventive Services for Women in January 2011 and from a comprehensive literature review on which the testimony was based. The testimony was drafted by Adam Sonfield, Rachel Benson Gold and Cory L. Richards, and the literature review was conducted by Kathryn Kost and Isaac Maddow-Zimet. Both efforts were aided by the input and review of numerous other members of the Guttmacher Institute staff. A complete set of references for the information and research findings cited in this article may be found on the Guttmacher Institute's web site, at <http://www.guttmacher.org/pubs/CPSW-testimony.pdf>*

Cross-country comparisons provide some evidence that contraceptive use at the individual level translates into lower national rates of unintended pregnancy and subsequent abortion. For example, according to a 2005 analysis of trends in central Asia and eastern Europe, as use of modern contraceptive methods increased rapidly in those regions during the 1990s, abortion rates declined significantly, even as fertility rates and the number of children desired also declined.

In the United States, increased contraceptive use—particularly among unmarried women and among teenagers—has paralleled substantial declines in unintended pregnancy and abortion. Notably, increased contraceptive use has been found to be responsible for 77% of the sharp decline in pregnancy among 15–17-year-olds between 1995 and 2002, and for all the decline among 18–19-year-olds over that period.

Contraception's impact on unintended pregnancy may also be seen in the accomplishments of publicly funded family planning services, which in 2006 helped women avoid 1.94 million unintended pregnancies, 810,000 of which would have ended in abortion. In the absence of this public effort, levels of unintended pregnancy and abortion would be nearly two-thirds higher among U.S. women overall and close to twice as high among poor women.

Similar results have been found through evaluations of specific state programs, including those that expand eligibility for family planning services under Medicaid. California's expansion helped women avoid 287,000 unintended pregnancies and 118,000 abortions in 2007. In Arkansas, repeat births within 12 months dropped 84% between 2001 and 2005 for women enrolled in the family planning expansion. And in Rhode Island, the proportion of mothers on Medicaid with birth intervals of less than 18 months fell from 41% in 1993 to 28% in 2003, and the gap between privately insured and publicly insured women narrowed from 11 percentage points to less than one point over that time.

### Maternal and Child Health

The most direct, positive effects of helping women and couples plan the number and timing of their pregnancies and births are those related to improving maternal and child health outcomes. According to U.S. and international studies, a causal link exists between the interpregnancy interval (the time between a birth and a subsequent pregnancy) and three major birth outcomes measures: low birth weight, preterm birth and small size for gestational age.

In addition, according to a 2008 literature review, numerous U.S. and European studies have found an association between pregnancy intention and delayed initiation of prenatal care. This stems in part from the fact that women are less likely to recognize a pregnancy early if it is unplanned; early recognition of pregnancy also affects the frequency of prenatal care visits. Furthermore, compared with children born from intended pregnancies, those born from unintended pregnancies are less likely to be breastfed at all or for a long duration. Breastfeeding, in turn, has been linked with numerous positive outcomes throughout a child's life.

Moreover, although evidence is limited, several studies from the United States, Europe and Japan suggest an association between unintended pregnancy and subsequent child abuse. There is also some evidence of an association between unintended pregnancy and maternal depression and anxiety.

The father's intention status appears to have significant effects on his involvement during pregnancy and following the birth. This, in turn, is associated both with the mother's receipt of prenatal care and her likelihood of reducing smoking during pregnancy. In addition, infants born to mothers and fathers who differed in their pregnancy intention face significantly higher risks of several adverse maternal behaviors and birth outcomes than those born to parents both intending the birth.

### Social and Economic Benefits

Both married and cohabiting couples are more likely to separate after an unintended first birth than after an intended first birth. Moreover, compared with those who have had a planned birth, women and men who have had an unplanned birth report less happiness and more conflict in their relationship, and women report having more symptoms of depression.

Several studies have examined the role that contraceptive use—particularly the use of oral contraceptives—has played in improvements in social and economic conditions for women. The advent of the pill allowed women greater freedom in career decisions, by allowing them to invest in higher education and a career with far less risk of an unplanned pregnancy. Several studies have found that legal access to the pill led to increased pill use, fewer first births to high school- and college-aged women, increased age at first marriage, increased participation by women in the workforce and more children born to mothers who were married, college-educated and had pursued a professional career.

### Additional Health Benefits

Contraceptive methods have additional health benefits beyond those related to preventing and timing pregnancy. A 2010 analysis of the literature found that hormonal contraceptives can help address several menstrual disorders, including dysmenorrhea (severe menstrual pain) and menorrhagia (excessive menstrual bleeding). Hormonal contraceptives can also prevent menstrual migraines, treat pelvic pain due to endometriosis and treat bleeding due to uterine fibroids. Perhaps most notably, oral contraceptives have been shown to have long-term benefits in reducing a woman's risk of developing endometrial and ovarian cancer, and short-term benefits in protecting against colorectal cancer.

And, of course, the male and female condom can help prevent sexually transmitted infections, including HIV, among sexually active women and men. According to the most recent summary of the evidence by the Centers for Disease Control and Prevention (CDC), consistent and correct use

of latex condoms is highly effective in preventing the sexual transmission of HIV. It also reduces the risk of other sexually transmitted infections, particularly those transmitted by genital secretions, and may reduce the risk for HPV infection.

### Financial Barriers

Contraceptive use is essentially universal in the United States: Ninety-eight percent of sexually experienced American women have used a method at some point in their lives. However, many women face problems in using contraceptives or using them consistently. Among the 43 million women at risk of an unintended pregnancy in 2002, 6% did not use a method all year, 10% had a gap in use of at least one month and 19% reported inconsistent use (e.g., skipped pills). This behavior has clear consequences: The one-third of women who do not use a method or who use one inconsistently account for 95% of unintended pregnancies.

Although there are myriad reasons behind these distressing statistics, cost is one important barrier. Brand-name versions of the pill, patch or ring can cost a woman upwards of \$60 per month if paid entirely out-of-pocket, not including the cost of a visit to a health care provider. Long-acting or permanent methods, such as the IUD, implant or sterilization, are most effective and cost-effective, but can entail hundreds of dollars in up-front costs.

These costs affect individual women's behavior. A national survey from 2004 found that one-third of women using reversible contraception would switch methods if they did not have to worry about cost; these women were twice as likely as others to rely on lower-cost, less effective methods. According to another recent study of 10,000 women in the St. Louis area, when offered the choice of any contraceptive method at no cost, two-thirds chose long-acting methods—a level far higher than in the general population. Findings like this help explain why rates of unintended pregnancies are far higher among poor and low-income women than among their higher-income counterparts.

Insurance coverage is designed to help people overcome these financial barriers. One-quarter of uninsured Americans went without needed care in 2009 because of cost, versus 4% of privately insured adults. And according to three recent studies, lack of insurance is significantly associated with reduced use of prescription contraceptives.

Yet, cost-sharing poses a significant problem even for women who are insured. A 2010 study found that women with private insurance that covers prescription drugs paid 53% of the cost of their oral contraceptives, amounting to \$14 per pack on average. What they would pay for a full year's worth of pills amounts to 29% of their annual out-of-pocket expenditures for all health services.

Numerous studies have demonstrated that even seemingly small cost-sharing requirements can dramatically reduce preventive health care use, particularly among lower-income Americans. And removing these barriers can have a real impact: A recent study found that when a California health insurer eliminated cost-sharing for IUDs, implants and injectables, enrollees' use of these highly effective methods increased substantially, and their risk of contraceptive failure decreased as a result.

### **Costs and Cost-Savings**

Yet, although the costs of contraception can be daunting for individual women, insurance coverage of contraceptive services and supplies—both public and private—actually saves money. Guttmacher Institute research finds that every public dollar invested in contraception saves \$3.74 in short-term Medicaid expenditures for care related to births from unintended pregnancies. In total, services provided at publicly funded family planning centers saved \$5.1 billion in 2008. (Significantly, these savings do not account for any of the broader health, social or economic benefits to women and families from contraceptive services and supplies and the ability to time, space and prepare for pregnancies.) A 2010 Brookings Institution analysis came to the same conclusion, and projected that expanding access to family planning services under Medicaid saves \$4.26 for every \$1 spent.

In terms of costs and savings for the private sector, multiple studies over the past two decades have compared the cost-effectiveness of the various methods of contraception, finding that all of them are cost-effective when taking into account the costs of unintended pregnancies averted. The federal government, the nation's largest employer, reported that it experienced no increase in costs at all after Congress mandated coverage of contraceptives for federal employees. Moreover, a 2000 study by the National Business Group on Health, a membership group for large employers to address their health policy concerns, estimated that it costs employers 15–17% more to not provide contraceptive coverage in their health plans than to provide such coverage, after accounting for both the direct medical costs of pregnancy and indirect costs such as employee absence and reduced productivity. Mercer, the employee benefits consulting firm, reached a similar conclusion. And a more recent National Business Group on Health report, drawing on actuarial estimates by PricewaterhouseCoopers, concluded that even if contraception were exempted from cost-sharing, the savings from its coverage would exceed the costs.

### **An Obvious Conclusion**

In short, the scientific evidence and the balance of costs and benefits all point to the same conclusion: As the IOM panel and DHHS work to establish guidelines for women's preventive care and screenings, they have every reason to incorporate family planning. Such incorporation should include the full range of reversible and permanent contraceptive drugs, devices and procedures; related clinical services necessary to appropriately supply those methods, such as injections and the insertion and removal of an IUD or implant; and the counseling and patient education necessary to help women and men gauge their contraceptive needs and practice contraception most effectively.

Doing so would be consonant with a wide array of precedents for promoting contraception as preventive care (related article, Spring 2010, page 2). These include precedents from federal agencies

*Continued on page 15*

---

## Insurance Coverage of Contraceptive Services and Supplies

continued from page 10

and programs, including the CDC, the federally qualified health centers program and Medicaid. They include precedents from numerous respected health care provider associations, ranging from the American Medical Association to the American Academy of Pediatrics, as well as from prominent health promotion organizations such as the American Public Health Association, the March of Dimes and the National Governors Association.

Such a recommendation would be in line with current insurance industry standards, as the vast majority of private insurance plans today cover a comprehensive array of contraceptive services and supplies. And such a recommendation would be in line with previous recommendations of the IOM itself, including those in its 1995 report, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, which included one of the earliest calls for insurance coverage of contraceptive services and supplies without cost-sharing. [www.guttmacher.org](http://www.guttmacher.org)