



**Testimony of
Guttmacher Institute**

**Submitted to the
Committee on Preventive Services for Women
Institute of Medicine
January 12, 2011**

The Guttmacher Institute is a private, nonprofit organization dedicated to advancing sexual and reproductive health in the United States and worldwide through research, policy analysis and public education. We are pleased to have the opportunity to submit this testimony on women's preventive health services and the provision of the Patient Protection and Affordable Care Act known commonly as the Women's Health Amendment.

The Women's Health Amendment will allow the Department of Health and Human Services, with this panel's assistance, to address critical gaps in the package of preventive services currently required to be covered without cost-sharing by all new private health plans. We will focus on one such gap that falls within the Guttmacher Institute's primary areas of expertise: family planning. Specifically, we urge this panel to recommend that the Department comprehensively incorporate under the rubric of women's preventive care and screenings the full range of reversible and permanent contraceptive drugs, devices and procedures; related clinical services necessary to appropriately supply those methods, including injections, insertion and removal of an IUD or implant, and fitting for a diaphragm or cervical cap; and the contraceptive counseling needed to promote optimal method choice and effective use.

Contraceptive services and supplies fit any reasonable definition of preventive care, and their effectiveness is supported by a strong body of evidence. Contraception helps women avoid unintended pregnancy and improve birthspacing, with substantial, positive consequences for infants, women, families and society. Although cost can be a daunting barrier to effective contraceptive use for an individual woman, 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. For all these reasons, contraceptive services have long been recognized by government bodies and a wide range of other experts, including leading health care professional organizations, as a vital and effective component of preventive and public health care.

The Preventive Benefits of Contraceptive Services and Supplies

This is not the first time that the Institute of Medicine has considered contraception and unintended pregnancy in the United States. In a 1995 report, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, the Institute's Committee on Unintended Pregnancy described in detail the potential consequences of unintended pregnancy and the importance of contraceptive use for preventing them.¹ That report linked unintended pregnancy to a wide array of health, social and economic consequences, from delayed prenatal care and poor birth outcomes to maternal depression and family violence to a failure to achieve educational and career goals. And, indeed, one of its key recommendations for addressing unintended pregnancy was the same as our recommendation today: to reduce "financial barriers" to contraceptive use by "increasing the proportion of all health insurance policies that cover contraceptive services and supplies, including both male and female sterilization, with no copayments or other cost-sharing requirements, as for other selected preventive health services."

A 2009 report from another Institute of Medicine panel, this one assigned to review the Title X national family planning program, echoed the 1995 report's findings about the risks of unintended pregnancy and also emphasized the importance of birthspacing in preventing such complications as low birth weight and premature birth.² A considerable amount of new research on these subjects has been published since the 1995 report, and the overall conclusions are well established: Contraceptive services and supplies are effective in helping women and couples time and space their pregnancies, and that in turn has important health, social and economic benefits.

Preventing Unintended Pregnancy and Helping Women Plan and Space Pregnancies

- *Contraceptive methods are highly effective for the prevention of pregnancy.*

The Food and Drug Administration has approved a wide range of contraceptive methods for preventing unintended pregnancy. All of these methods, if used perfectly, would have negligible failure rates. In practice, methods vary in how effective they are, with methods that require more user involvement having higher "typical use" failure rates than those that require less. Still the use of any method is still far more effective than using no method at all, since couples using no method of contraception have approximately an 85% chance of an unintended pregnancy within 12 months.^{3,4}

Female and male sterilization, the IUD and the implant all have typical use failure rates of 1% or less, meaning that couples have a 1% or less chance of an unintended pregnancy within the first 12 months of using them.^{3,5} The typical use failure rates for injectable and oral contraceptives are 7% and 9%, respectively, due to some women missing or delaying an injection or pill.⁶ The probability of failure for couples using condoms (17%) is somewhat higher, again primarily due to imperfect use of the method. And, the failure rate for couples using fertility-awareness-based methods results is even higher (25%), although use of such methods is still far more effective than using no method at all.

- *Contraceptive use reduces the occurrence of unintended pregnancy and abortion.*

The effectiveness of contraceptive use for individual women and couples translates into lower rates of unintended pregnancy and subsequent abortion among the broader population. Cross-country comparisons provide some evidence for this relationship: Unintended pregnancy in the United States is higher than in other developed countries, and contraceptive use is lower. Whereas 49% of pregnancies in the United States are unintended, the corresponding percentage in France is only 33%, and in Edinburgh, Scotland, it is only 28%.⁷ Compared with the United States, these countries have much lower proportions of women at risk for unintended pregnancy who use no contraception at all; while this figure is 11% in the United States, it is only 3% in France and 3% in the United Kingdom.

International comparisons also provide evidence that contraceptive use reduces women's recourse to abortion. A 2005 analysis of trends in central Asia and eastern Europe, for example, found that 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.⁸ A 2010 study focusing on the nation of Georgia found that the increased use of modern contraception was a significant contributor to that country's drop in abortion rates between 1999 and 2005, explaining 54% of the decline.⁹

Trends in unintended pregnancy rates in the United States provide further evidence of the effectiveness of contraceptive use. The proportion using contraceptives among unmarried women at risk of unintended pregnancy increased from 80% in 1982 to 86% in 2002; this increase was accompanied by a decline in unmarried women's unintended pregnancy and abortion rates over the same period, with the abortion rate for unmarried women falling from 50 per 1,000 women in 1981 to 34 per 1,000 in 2000.¹⁰

Similarly, increased contraceptive use led to a decline in the risk of pregnancy among adolescents. One study found that from 1991 to 2003, contraceptive use improved among sexually active U.S. high school students, with an increase in the proportion reporting condom use at last sex (from 38% to 58%), and declines in the proportions using withdrawal (from 19% to 11%) and no method (18% to 12%); these adolescents' risk of pregnancy declined 21% over the 12 years.¹¹ Another study found that increased contraceptive use was responsible for 77% of the sharp decline in pregnancy among 15–17-year-olds between 1995 and 2002 (decreased sexual activity was responsible for the other 23%); and increased contraceptive use was responsible for all of the decline in pregnancy among 18–19-year-olds.¹²

Contraception's impact on unintended pregnancy can be seen in the accomplishments of federal and state programs providing public funding for family planning services. More than nine million clients received publicly funded contraceptive services in 2006, and that national effort helped women avoid 1.94 million unintended pregnancies, including 810,000 abortions.¹³ By facilitating access to a more effective mix of contraceptive methods, publicly funded family planning centers enable their clients to have 78% fewer unintended pregnancies than are expected among similar women who do not use or do not have access to these services. Indeed, 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. For example, California's Family PACT program, which provides expanded access to family planning services under Medicaid,

provided contraceptives to nearly one million women in 2007, and helped them avoid 287,000 unintended pregnancies, including 79,000 to teenagers, and as a result, 118,200 abortions.¹⁴

- *Contraceptive use helps women and couples time and space their births.*

Medicaid family planning eligibility expansions that have been implemented in about half the states also provide evidence of the effectiveness of contraceptive use in helping women avoid short intervals between births, thereby reducing the risk of poor birth outcomes (see **Improving Maternal and Child Health**, below). In Arkansas, repeat births within 12 months dropped 84% between 2001 and 2005 for women enrolled in the family planning expansion, and the proportion having a repeat delivery within 48 months fell by 31%.¹⁵ In New Mexico, women accessing family planning services under the expansion were less likely to have a repeat delivery within 24 months than were women who did not access expansion services, 35% compared with 50%.¹⁶ 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.¹⁷ And in Texas, 18% of expansion participants had a repeat birth within 24 months, compared with 29% of Medicaid-eligible women who did not participate in the program.¹⁸

- *Contraceptive counseling can help women and couples improve contraceptive use.*

There have been few robustly designed studies of the effectiveness of contraceptive counseling, and some had large losses to follow up and other methodological problems.^{19,20,21} Yet, there are several strong findings in this area. A recent literature review found moderately strong evidence that postpartum counseling increased contraceptive use and decreased unplanned pregnancy rates, particularly for longer-term, more intensive counseling interventions.²² There is also strong evidence of the effectiveness of one-on-one contraceptive counseling for teens at family planning clinics in increasing method use and decreasing risky behavior in the short term.²³

In addition, there is strong evidence that interventions that target contraceptive knowledge are effective, particularly among teens. Literature reviews of sex education and contraceptive education programs targeting teens have found very strong, positive effects on contraceptive use and unintended pregnancy risk.^{23,24}

Improving Maternal and Child Health

- *Helping women and couples time and space their pregnancies improves birth outcomes.*

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 birth outcomes. Short birth intervals have been linked with numerous negative perinatal outcomes. U.S. and international studies have found a causal link between the interpregnancy interval (the time between a birth and a subsequent pregnancy) and three major measures of birth outcomes: low birth weight, preterm birth and small size for gestational age.^{25,26} For this reason, contraceptive use to help women achieve optimal spacing is important to help them improve their infants' health.

- *Planned and wanted pregnancies improve pregnancy-related behavior and outcomes.*

Unintended pregnancy has also been linked with a range of negative outcomes, particularly in regard to maternal behavior. A comprehensive review of the literature from 2008 reports that numerous U.S. and European studies have found a significant association between pregnancy intention and delayed initiation of prenatal care.²⁷ This stems in part from the fact that women are less likely to recognize a pregnancy early (within the first six weeks) if it is unplanned. Early recognition of pregnancy also affects the frequency of prenatal care visits, although after controlling for early recognition, pregnancy intention itself does not.

According to the same literature review, nearly all the relevant U.S. and European studies have found that children who are born from unintended pregnancies are less likely to be breastfed and are more likely to be breastfed for a shorter duration, compared with children whose births were intended.²⁷ 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, although the strength of this finding is limited by poor study design.²⁷

By contrast, maternal risk behaviors, receipt of preventive and curative care during infancy and childhood, and birth outcomes (e.g., low birth weight and premature delivery) are not strongly related to pregnancy intention, as measured by the mother's preferences, once family-background variables are included.²⁷

There is some evidence, however, that the father's intention status has significant effects on prenatal behaviors and some measures of child health. Several studies have found that unintendedness of the pregnancy by the father has negative effects on the father's involvement during pregnancy and post-birth.^{28,29,30} The level of father involvement during pregnancy, in turn, is associated both with the mother's receipt of prenatal care and the likelihood of the mother reducing smoking during pregnancy. And parental discordance in pregnancy intentions can have adverse effects. In particular, 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.³¹

Securing Additional Health, Social and Economic Benefits

- *Preventing unintended pregnancy can reduce risks to relationship stability.*

There is also some evidence that unintended pregnancy has significant negative effects on relationship stability. Both marriages and cohabitations are more likely to dissolve after an unintended first birth than after an intended first birth, even after controlling for a range of socio-demographic variables.³²

Moreover, mothers and fathers who have an unplanned birth report less happiness and more conflict in their relationship and more depressive symptoms for the mother, compared with

similar women and men who have a planned birth.³³ Unintendedness of the pregnancy by the father, in particular, is associated with greater relationship conflict and has very slight (though statistically significant) negative effects on children's attachment security and mental proficiency.³⁰

- *Prevention of unintended pregnancy with increased access to effective contraception improves social and economic conditions for women and society.*

Several studies have examined the role that contraceptive use has played in improvements in social and economic conditions for women. These studies have focused on oral contraceptives, the introduction of which in the 1960s marked the beginning of the era of modern contraceptive use. The pill remains the most popular form of reversible contraception in the United States today.

The advent of the pill allowed women greater freedom in career decisions in two main ways. The first is that having a reliable form of contraception allowed women to invest in higher education and a career with far less risk of an unplanned pregnancy. Secondly, the pill led to an increase in the age at first marriage across the total population; as a result, a woman could pursue a career or education before marrying while facing less of a risk that she would be unable to find a desirable husband later.³⁴

Researchers have been able to study these phenomena by looking at data over time and across states, taking advantage of changes in state policies during the late 1960s and early 1970s that lifted restrictions on access to the pill for young, unmarried women. One study found that legal access to the pill led to increased pill use and age at first marriage in these states, and in turn, increased these women's participation in the workforce.³⁵ A second study concluded that legal access to the pill before age 21 significantly reduced the likelihood of a first birth before age 22, increased the number of women in the paid labor force and raised the number of annual hours worked.³⁶ And a third study found that early legal access to the pill led to more children born to mothers who were married, college-educated and had pursued a professional career.³⁷

- *Contraceptive methods have additional health benefits unrelated to preventing and timing pregnancy.*

A 2010 practice bulletin from the American College of Obstetricians and Gynecologists summarizes a large body of literature discussing the noncontraceptive benefits of hormonal contraceptive methods.³⁸ It finds that hormonal methods can help address several menstrual disorders, including dysmenorrhea (severe menstrual pain) and menorrhagia (excessive menstrual bleeding, which can lead to anemia if untreated). Methods that contain both estrogen and progesterone can address excess hair growth and acne. 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 clear, long-term benefits in reducing a woman's risk of developing endometrial and ovarian cancer, and to provide short-term protection 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.^{39,40} According to the most recent summary of the evidence by the Centers for Disease Control and Prevention (CDC):

Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS. In addition, consistent and correct use of latex condoms reduces the risk of other sexually transmitted diseases (STDs), including diseases transmitted by genital secretions, and to a lesser degree, genital ulcer diseases. Condom use may reduce the risk for genital human papillomavirus (HPV) infection and HPV-associated diseases, e.g., genital warts and cervical cancer.⁴¹

Financial Barriers to Contraceptive Use

Contraceptive use is an essentially universal experience in the United States; 98% of sexually experienced American women have used a contraceptive method at some point in their lives.⁴² But many women face problems in doing so. Only two-thirds of the 43 million sexually active women at risk of an unintended pregnancy in 2002 were practicing contraception consistently and correctly all year. Six percent did not use a method all year, 10% had a gap in use of at least one month and 19% reported inconsistent use, such as skipping pills. This behavior has clear consequences: The one-third of women reporting nonuse or inconsistent use account for 95% of unintended pregnancies.¹³

As the Institute of Medicine, among many others, has itself acknowledged, there are myriad reasons why women and couples do not practice contraception or make imperfect use of a method.¹ No one intervention will eliminate unintended pregnancy and ensure that all births are planned ones. Nevertheless, it is clear that the financial costs of contraceptive services and supplies are one important barrier to effective use. Requiring insurance plans to cover contraception without cost-sharing would help women overcome this barrier.

- *The costs of contraceptive services and supplies can be considerable.*

Methods of contraception vary not only in their effectiveness, but also in their costs and the timing of those costs. Condoms are relatively inexpensive on an individual basis, but 50 cents or a dollar per use can add up to substantial amounts of money over a year, much less the 30 years that the typical woman spends trying to avoid pregnancy. Brand-name versions of the pill, patch or ring can cost upwards of \$60 per month if paid for entirely out-of-pocket, although generic oral contraceptives can cost considerably less; these methods also require periodic visits to a health care provider, at additional cost. Long-acting or permanent methods, such as the IUD, implant or sterilization, are most effective and cost-effective, but all can entail hundreds of dollars in up-front costs.⁴³

For many women, including the 11 million women of reproductive age (15–44) with incomes below the federal poverty level in 2009,⁴⁴ these can be daunting expenses. That can be true even for those women with insurance coverage: Average copayments in employer-sponsored insurance have increased considerably over the past decade, to \$49 in 2010 for “nonpreferred” brand-name drugs, \$28 for preferred drugs and \$11 for generics, for plans with a three-tier formulary (the industry standard).⁴⁵ With copayments so high, private insurance is in many cases

today providing only a marginal discount from what a woman would pay out-of-pocket at a drug store without insurance. In fact, a 2010 study found that privately insured women using oral contraceptives whose plan covered prescription drugs paid half (53%) of the cost of the pills, amounting to \$14 per pack, on average. The same study found that the out-of-pocket expenditures for a full year's worth of pills amounted to 29% of the women's annual out-of-pocket expenditures for all health services.⁴⁶

- *Cost concerns are an important factor in contraceptive method choice and use.*

Several studies indicate that costs play a key role in the contraceptive behavior of substantial numbers of U.S. women. A national survey from 2004 of women 18–44 who were using reversible contraception found that one-third of them would switch methods if they did not have to worry about cost; only four in 10 of those women were using a hormonal method or an IUD, and nearly half were relying on condoms. In fact, women citing cost concerns were twice as likely as other women to rely on condoms or less effective methods like withdrawal or periodic abstinence.⁴⁷

Similarly, in a nationally representative survey from 2005 of private family practice physicians and obstetrician-gynecologists, two-thirds of the providers believed that at least 10% of their clients experienced difficulty paying for visits or services, including 7% of providers who believed this was the case for at least half their clients. Six in 10 of the family practice physicians and seven in 10 of the obstetrician-gynecologists believed that reducing costs for insured patients by improving coverage of contraceptive care would be very important for improving their patients' contraceptive method use. A parallel survey of providers at publicly supported clinics found similar results, although more of them (22%) reported having at least 50% of their clients experiencing cost barriers.⁴⁸

The current recession, more severe in depth and length than any in this country in decades, has provided further evidence. A 2009 study of low- and middle-income sexually active women found that 52% of them were worse off financially than the year before. Of those who were worse off, three-quarters said that they could not afford to have a baby right then. And while nearly four in 10 of those worse off reported being more careful in their contraceptive use in the current economic climate, many of the financially challenged women reported barriers to contraceptive use: 34% said they had a harder time paying for birth control, 30% had put off a gynecology or birth control visit to save money, 25% of pill users saved money through inconsistent use and 56% of those with jobs worried about having to take time off from work to visit a doctor or clinic.⁴⁹

A recent study of 10,000 women in the St. Louis area provides clear evidence of the impact that removing financial barriers can have on contraceptive use. When study participants were offered the choice of any contraceptive method, including long-acting reversible methods of contraception such as the IUD and implant, at no cost, two-thirds chose long-acting methods, a level far higher than in the general population.⁵⁰

All of this helps explain why, according to the most recent data, rates of unintended pregnancies are far higher among poor women (112 per 1,000 women under 100% poverty in 2001) and low-income women (81 per 1,000 women at 100–199% poverty) than among higher-income women

(29 per 1,000 women at or above 200% poverty).⁵¹ Indeed, that disparity increased substantially between 1994 and 2001, as the unintended pregnancy rate declined among higher-income women but grew among poor and lower-income women.

- *Insurance coverage improves use of needed care, including contraceptive care.*

Insurance coverage is designed to help people afford the care they need, and there is ample evidence that it does so. One-quarter of uninsured adults say they went without needed care in 2009 because of its cost, compared to 4% of adults with private coverage. Similar numbers said they could not afford to fill a prescription. More than half reported having no usual source of health care, versus only 10% among the privately insured. The uninsured have also been shown to be less likely to receive timely preventive care and screenings.⁵²

Researchers have found similar results specifically related to insurance coverage and contraceptive use. Comparing publicly or privately insured women with uninsured women, three recent studies have found that lack of insurance is significantly associated with reduced use of prescription contraceptives, even when controlling for a range of sociodemographic factors.^{53,54,55} One of these studies also indicated that prescription contraceptive use increased between 1995 and 2002 among privately insured women because of state contraceptive coverage mandates enacted during that period, although the evidence on this point is less strong.⁵³

In addition, there is some evidence from states' Medicaid family planning eligibility expansions that coverage of contraceptive services and supplies has helped women improve their use of contraceptives. In Washington state, for example, the proportion of clients using a more effective method (defined as hormonal methods, IUDs and sterilization) increased from 53% at enrollment to 71% one year later, according to the state's program evaluation.⁵⁶ Similarly, program clients in California were both more likely to use any method and to use a more effective method than they were before enrolling in the program.¹⁴

- *Removing cost-sharing barriers can further improve use of needed care.*

Numerous studies have demonstrated that even seemingly small cost-sharing requirements can dramatically reduce use of health care, particularly among lower-income Americans. According to the most recent synthesis of this research, from December 2010, this is true for preventive care and prescription drugs, and most people do not distinguish between essential and nonessential care.⁵⁷ It is largely because of such findings that Congress has acted to eliminate cost-sharing for preventive services.

There is evidence that the impact of cost-sharing would specifically apply to contraceptive services and supplies. A recent study looked at the impact of a 2002 change in benefits at Kaiser Permanente Northern California to eliminate cost-sharing for the most effective forms of contraception (IUDs, implants and injectables). It found sizable increases in use of these methods—by 137% for IUDs and 32% for injectables—and a resulting reduction in women's likelihood of contraceptive failure.⁵⁸

A study from the early 1980s looked at a policy change in California under which the state began charging copayments for state-funded family planning services. The study, commissioned by the state department of health, found that nearly one in four clinics that charged copayments saw a decrease in their client population, and a similar proportion reported a decrease in necessary follow-up visits.⁵⁹

Costs and Cost-Savings of Contraceptive Coverage

As with almost any attempt to mandate coverage of specific services in private insurance, a primary objection to designating contraception as preventive care under the Women's Health Amendment may be concerns that doing so would lead to increased premiums and more costs for the entire health care system. The evidence on that front may be mixed for preventive care in general, but that is not the case for contraception.

- *Public-sector services are highly cost-effective.*

Publicly funded contraceptive services and supplies have been demonstrated repeatedly to be highly cost-effective. For example, every dollar invested by the government for contraception saves \$3.74 in Medicaid expenditures for pregnancy-related care related to births from unintended pregnancies. In total, the services provided at publicly funded family planning clinics resulted in a net savings of \$5.1 billion in 2008.⁶⁰ 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.

Similar results have been found in program evaluations for states' Medicaid family planning expansions, and the Centers for Medicare and Medicaid Services recently noted that states have been allowed to initiate these expansions precisely because of their cost-effectiveness.⁶¹ For example, according to a federally funded evaluation of states' expansions completed in 2003, all of the programs studied yielded significant savings to the federal and state governments, with states as diverse as Alabama, Arkansas, California, Oregon and South Carolina each saving more than \$15 million in a single year.⁶² More recently, Wisconsin estimated that its program generated net savings of \$159 million in 2006,⁶³ and Texas estimated that its program yielded net savings of \$42 million in 2008.⁶⁴

A 2010 review of policy interventions designed to address unintended pregnancy found that publicly funded family planning efforts have been effective and "would be even more so if they could increase the use not just of contraceptives, but of long-acting, reversible contraceptive methods."⁶⁵ That same review presents simulations of the costs and benefits of three policy initiatives: a condom-promotion mass media campaign, a teen pregnancy prevention program addressing both abstinence and contraceptive use and a Medicaid family planning expansion. It found that all three would save substantial amounts of public dollars, with the Medicaid expansion saving \$4.26 for every \$1 spent.

- *Private insurance coverage of contraception is also cost-effective.*

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 for private or public payers when taking into account the costs of unintended pregnancies averted.^{43,66,67} Long-acting methods in particular are extremely cost effective when looking at a longer-term perspective (at least five years). According to the most recent analysis, from 2009, the copper IUD and vasectomy are most cost-effective.⁴³

Some studies have looked at cost-savings for private insurers specifically. Notably, the federal government, the nation's largest employer, reported that it experienced no increase in costs at all after Congress required coverage of contraceptives for federal employees in 1998.⁶⁸ A 2000 study by the National Business Group on Health, a membership group for large private- and public-sector employers to address their health policy concerns, estimated that it costs employers 15–17% more to *not* provide contraceptive coverage in employee 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.⁶⁹ Mercer, the employee benefits consulting firm, conducted a similar analysis that year and also concluded that contraceptive coverage should be cost-saving for employers.⁷⁰

These savings in private health insurance from covering contraception should only increase as a result of the Affordable Care Act, with its new requirements that will close gaps in the coverage of maternity care, prevent insurers from excluding coverage for preexisting conditions and encourage greater and more stable levels of insurance coverage overall.

- *Savings from covering contraceptive services and supplies—even without cost-sharing—can be expected to exceed the costs.*

A more recent National Business Group on Health report—a 2007 guide for employers providing a recommended minimum set of benefits for maternal and child health—calls for coverage of the full range of prescription contraceptive methods, sterilization services, lab tests, counseling services and patient education. For all of the included preventive services, including those to prevent unintended pregnancy, the guide “recommends zero cost-sharing...to avoid real or perceived financial barriers, and to increase utilization.”⁷¹ The report includes actuarial estimates by PricewaterhouseCoopers for its recommendations. It found that the addition of the full range of contraceptive services and supplies without cost-sharing to a plan that currently includes no coverage at all would cost about \$37 per member per year for an HMO and \$41 for a PPO. Notably, the study estimates that PPO enrollees today pay about one-third of this amount in cost-sharing.

Roughly \$40 per member per year is miniscule when compared with overall insurance premiums: In 2010, average annual premiums in employer-sponsored coverage were \$5,049 for an individual employee and \$13,770 for family coverage.⁴⁵ Moreover, because most plans already include at least some of those benefits, the actual cost of meeting these recommendations would be considerably lower.

These actuarial estimates do not take into account the potential cost-savings from contraceptive care. Yet, based on prior research on the cost-effectiveness of covering contraception, the guide predicts that the savings from cost sharing—free coverage of contraceptive services and supplies will exceed the costs.⁷¹

Precedents for Recommending Contraception as Preventive Care

Given the wealth of evidence supporting the effectiveness of contraception as preventive care, it may be surprising to some that this panel must consider the topic at all. It is doing so, however, because of limitations in the three other, existing sets of government-supported guidelines that Congress used as the basis for the preventive health coverage requirement it established as part of the Affordable Care Act. Two of those guidelines are limited in scope to immunizations and to pediatric care. The third—items or services currently recommended by the U.S. Preventive Services Task Force—has the potential to include contraceptive services and supplies, but does not do so currently. In fact, however, among the task force’s roughly three dozen current A or B recommendations, only two recommend a specific type of preventive medication for some adult populations: aspirin to prevent cardiovascular disease and folic acid supplementation.⁷²

The Women’s Health Amendment, authored by Sen. Barbara Mikulski of Maryland, was designed to address these limitations by adding women’s preventive care and screenings as a fourth category of mandated preventive services. Although much of the floor debate over the amendment centered on mammography, the provision itself was intended to guarantee coverage without cost-sharing of a far broader group of preventive services, notably including family planning.

Based on an analysis of the *Congressional Record*, at least six senators joined Mikulski in praising the amendment’s inclusion of family planning. According to Sen. Al Franken of Minnesota, for example, “several crucial women’s health services are omitted” from the U.S. Preventive Services Task Force’s recommendations and “Senator Mikulski’s amendment closes this gap” by including other key services, “such as the well woman visit, prenatal care, and family planning.”⁷³ Similarly, Sen. Barbara Boxer of California asserted that “these health care services include annual mammograms for women at age 40, pregnancy and postpartum depression screenings, screenings for domestic violence, annual women’s health screenings, and family planning services.”⁷⁴ Her state colleague, Sen. Dianne Feinstein, also included family planning in describing the scope of the amendment, and then summed it up succinctly: “In other words, the amendment increases access to the basic services that are a part of every woman’s health care needs at some point in her life.”⁷⁵ Even Sen. Ben Nelson of Nebraska, who voted against the amendment because of spurious claims that it could mandate coverage of abortion, said he did so “with regret because I strongly support the underlying goal of furthering preventive care for women, including mammograms, screenings, and family planning.”⁷⁶

This recognition in the amendment’s legislative history of family planning as preventive care was not revolutionary. Rather, these services have long been recognized by government bodies and other expert organizations as a vital, effective component of preventive and public health care. In including contraceptive services and supplies in its recommendations for women’s preventive services, this panel would be following a wide array of precedents.

Precedents from the Federal and State Governments

- *Family planning was designated one of the top 10 public health achievements of the 20th century by the Centers for Disease Control and Prevention.*

Along with such other preventive care breakthroughs as the smallpox and polio vaccines, and the public health campaigns that have greatly reduced tobacco use, the CDC included the development of and improved access to effective contraception among the 10 great public health achievements of the 20th century. CDC described its decision-making process for including topics on this list as “based on the opportunity for prevention and the impact on death, illness, and disability in the United States.”⁷⁷

According to the CDC report, access to family planning services has led to smaller families and improved birthspacing, which in turn have “contributed to the better health of infants, children, and women, and have improved the social and economic role of women.”⁷⁸ The report also highlights the role of condoms in preventing STIs, and notes that the “noncontraceptive health benefits of oral contraceptives include lower rates of pelvic inflammatory disease, cancers of the ovary and endometrium, recurrent ovarian cysts, benign breast cysts and fibroadenomas, and discomfort from menstrual cramps.”

- *Expanding access to family planning services to improve pregnancy planning and spacing and to prevent unintended pregnancy is a national goal under Healthy People 2020.*

The federal *Healthy People* series is updated every decade by the Department of Health and Human Services to set the nation’s prevention agenda through a set of science-based objectives for health promotion and disease prevention. Family planning was one of the five priority areas listed under “preventive health services” in the first *Healthy People* in 1979 and has been a major focus area in every edition.⁷⁹

In the current iteration of these goals, *Healthy People 2020*, there are 15 objectives within the family planning focus area, mostly related to preventing unintended pregnancy, improving birthspacing and improving contraceptive access and use. Notably for this panel, one of those objectives is to “increase the proportion of health insurance plans that cover contraceptive supplies and services.”⁸⁰ That objective was first introduced in the 2010 iteration, which described it as important “because in the absence of comprehensive coverage, many women may opt for whatever method may be covered by their health plan rather than the method most appropriate for their individual needs and circumstances. Other women may opt not to use contraception if it is not covered under their insurance plan.”⁸¹

In describing why its family planning objectives are important, *Healthy People 2020* echoes the research findings laid out earlier in this testimony. Specifically, it highlights “negative outcomes associated with unintended pregnancy,” including “delays in initiating prenatal care; reduced likelihood of breastfeeding; poor maternal mental health; lower mother-child relationship quality; [and] increased risk of physical violence during pregnancy.” It also notes that “the negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers...are less likely to graduate from high school or attain a GED by the time they reach age

30; earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing; [and] receive nearly twice as much Federal aid for nearly twice as long.”⁸²

- *Contraceptive services and supplies are provided as preventive care under federal public health and insurance programs.*

Federal health programs provide additional precedents for recognizing contraception as preventive care. A key example is in the federal law authorizing funding for federally qualified health centers, Sec. 330 of the Public Health Service Act. Within the list of services that centers are required to make available is a collection of “preventive health services” that specifically includes family planning, alongside such others as prenatal and perinatal care, cancer screening, immunizations and well-child care.⁸³

Similarly, states have for many years provided funding for family planning services under a variety of federal block grants with a preventive care focus, including the Maternal and Child Health Block Grant and the Preventive Health and Health Services Block Grant.⁸⁴ In fact, the maternal and child health program, which dates to the 1930s, was one of the first federal funding sources for contraception.

The most recent federal precedent for including contraception as preventive care is from the Medicaid program. A regulation issued in April 2010, in describing options for states in designing alternative Medicaid benefit packages under a 2006 law, includes a requirement for “family planning services and supplies and other appropriate preventive services, as designated by the Secretary [of Health and Human Services].”⁸⁵

Medicaid also provides a different type of precedent: The program has for decades not only required family planning in all state programs, but also has exempted family planning services and supplies from all cost-sharing requirements. Those Medicaid requirements—along with the establishment of the Title X national family planning program around the same time in the early 1970s—were designed in large part to address the then-new research findings that closely spaced births and childbearing very early or late in a woman’s reproductive years could lead to adverse health outcomes for both mothers and their children.

Precedents from Nongovernmental Organizations

- *Contraceptive services and supplies are recommended as preventive care by numerous respected health care provider associations.*

A wide range of health care provider associations, including the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Adolescent Health and Medicine, have recommended the use and coverage of contraceptive services and supplies, including clinical contraceptive counseling.^{86,87,88,89,90,91}

For example, ACOG has long argued that “contraception is basic, preventive health care and should be readily available and treated the same as prophylactic therapies for other medical

conditions.” Beyond their primary purpose of preventing unplanned pregnancies and promoting planned, healthy ones, hormonal contraceptives have for years been prescribed “to alleviate heavy bleeding, irregular periods, and acne and to protect against a number of other health problems that affect women, such as ovarian cysts, bone loss, benign breast disease, the symptoms of polycystic ovary syndrome, and anemia.”⁹²

The American Academy of Pediatrics, similarly, has promulgated preventive care standards for minors that include family planning services. Its 2010 list of insurance billing codes for pediatric preventive care, for example, include those for contraceptive management, as well as the routine gynecologic examination and pelvic exams that are often a part of a family planning visit.⁹³ Its *Bright Futures* guidelines—one of the other federally supported guidelines upon which the Affordable Care Act’s preventive coverage requirement is based—include “promoting healthy sexual development and sexuality” as one of its 10 health promotion themes, asserting that “information about contraception, including emergency contraception and STIs, should be offered to all sexually active adolescents and those who plan to become sexually active.”⁹⁴

- *Access to contraceptive services and supplies is supported by health promotion organizations.*

Family planning has also been a long-standing focus area for a number of other key health promotion organizations. That includes the American Public Health Association (APHA), perhaps the nation’s preeminent umbrella group for public health and preventive care. As early as the 1950s, APHA position statements highlighted “the healthful effects of family planning and spacing of births,”⁹⁵ and the APHA’s Population, Reproductive and Sexual Health section—one of 27 sections within the association—was founded in 1975. APHA has been an active supporter of increased access to contraception to help women and couples time, space and limit the number of their children.⁹⁶

The March of Dimes has lent its support to expanded access to contraceptive services and supplies, noting that a “central purpose of family planning is to promote healthy births,” by improving birthspacing and helping women obtain timely prenatal care.⁹⁷ The organization argues that timing a pregnancy can help a woman prevent potential pregnancy complications, such as gestational diabetes, and appropriately manage preexisting conditions that may be exacerbated by pregnancy, such as hypertension. The National Governors Association, similarly, has taken the position that expanding Medicaid eligibility for family planning is an important step states can take to improve birth outcomes because of the demonstrated ability of these programs to increase spacing between births.⁹⁸

The National Business Group on Health has published two major reports in the past several years that recommend insurance coverage of contraceptive services and supplies as effective and cost-effective preventive care. As noted above, its 2007 guide for employers on maternal and child health, created in partnership with the Health Resources and Services Administration, recommends coverage without cost-sharing of a comprehensive set of unintended pregnancy prevention services as part of a recommended minimum set of benefits for preventive care.⁷¹ And its 2006 guide for employers on clinical preventive services, created in partnership with the CDC, includes recommendations for covering counseling on contraceptive use and the full range of

reversible and permanent contraceptive methods, citing an extensive body of research evidence and provider guidelines.⁹⁹

- *Comprehensive coverage of contraceptive services and supplies is the current insurance industry standard.*

According to the last in-depth study of insurance coverage of contraception—a nationally representative survey of private U.S. health insurers in 2002—almost every reversible and permanent contraceptive method available was covered by 89% or more of typical insurance plans, with similarly strong coverage of both the methods themselves and related services (such as the insertion and removal of a long-acting method). Eighty-six percent were covering all five of the leading reversible methods at the time, and only 2% were covering none of them.¹⁰⁰ More recent surveys of employers' health plans have found similarly high levels of coverage for oral contraceptives or prescription contraceptives generally.^{45,101}

However, current coverage is likely to be less common and comprehensive than those data indicate for some types of plans, especially those offered by small employers and those sold to individuals. Moreover, studies have demonstrated little about whether plans are adequately covering the time that health care providers need for contraceptive counseling services, but anecdotal reports indicate that such reimbursement is limited at best and is a major disincentive for providers.

The high levels of current coverage are in marked contrast to coverage levels in 1993, when only 28% of typical insured plans covered the five leading reversible contraceptive methods, and the same percentage covered none at all.¹⁰⁰ The increase during the late 1990s was driven in part by the advent of state laws requiring insurance plans that cover other prescription drugs to cover the full range of prescription contraceptive drugs and devices. Today, 27 states have such a legal requirement in place for the plans they regulate.¹⁰² Congress has included a similar requirement for plans participating in the Federal Employees Health Benefits Program in every annual appropriations law since 1998. Moreover, the Equal Employment Opportunity Commission in December 2000 issued a finding that an employer's failure to cover prescription contraceptive drugs and devices in a health plan that covers other drugs, devices and preventive care is discrimination against women in violation of Title VII of the Civil Rights Act.¹⁰³

In conclusion, the scientific evidence, the public- and private-sector precedents, and the balance of costs and benefits all point to the same conclusion: As this panel establishes its recommendations for women's preventive care and screenings, it has every reason to comprehensively incorporate family planning services. This must include coverage for the full range of reversible and permanent contraceptive drugs, devices and procedures; related clinical services necessary to appropriately supply those methods, such as insertion and removal; and the counseling and patient education that health care providers should routinely provide to help women and men gauge their own contraceptive needs and practice contraception most effectively.

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