

## Contraception: An Integral Component of Preventive Care for Women

By Adam Sonfield

Under the health care reform law enacted in March, all new private insurance plans written after mid-September will be required to cover various, specified categories of preventive services, free of any cost-sharing. One such category is “preventive care and screenings” for women.

With a deadline looming, the U.S. Department of Health and Human Services (DHHS) will need to move quickly to develop an official interpretation of this requirement and of the specific preventive services it requires. Reproductive health providers and advocates hope and expect that it will be appropriately delineated to fully cover contraceptive services and supplies.

### The Letter of the Law

The Patient Protection and Affordable Care Act, as the health care reform law is officially titled, holds off on its most sweeping changes for several years. By 2014, two major pieces of the law will go into effect: a massive expansion to Medicaid eligibility for the lowest income Americans, and a new marketplace and subsidies to help somewhat higher income Americans purchase private insurance (related article, page 25). To help bridge that four-year gap, both substantively and politically, the law includes a series of smaller changes to public and private insurance that are designed to provide meaningful, immediate benefits to millions of people.

One of these early changes, scheduled to go into effect six months after the March 23 signing of the bill, requires all new private health plans—whether for groups or individuals—to provide coverage of a slate of preventive health services

without any cost-sharing. (The term “cost-sharing” includes a variety of ways that insurance plans require patients to share in the cost of a visit, service or supply, including flat copayments, percentage-based coinsurance and deductibles for all expenses that must be met before coverage kicks in at all.) The provision requires this coverage for four groups of services:

- items or services currently recommended by the U.S. Preventive Services Task Force (USPSTF);
- immunizations currently recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children and adolescents, as recommended by guidelines supported by the Health Resources and Services Administration (HRSA); and
- preventive care and screenings for women, also as recommended by HRSA-supported guidelines.

The first two of these groups are very specific—and extremely narrow. The USPSTF currently recommends only about three dozen services. Several of these are related to reproductive health: screening for breast and cervical cancer, and screening and counseling for HIV and several other specific sexually transmitted infections (STIs). The ACIP recommendations, meanwhile, include vaccination for human papillomavirus (HPV) and hepatitis B; both infections can be transmitted sexually, and both vaccines may be provided as part of a family planning visit for adolescents or young adults. The HPV vaccine, especially, is expensive, and may currently require substantial cost-sharing, when it is covered at all.

In writing this provision of health care reform, however, Congress recognized that the USPSTF and ACIP recommendations are too limited to serve as the sole guideline for insurance coverage of preventive services. The USPSTF has the capacity to look at only about 15 services each year, and focuses its efforts on crafting recommendations that may improve current clinical practices and on keeping its highest priority recommendations up to date. At the same time, it often varies its recommendations for different demographic groups, so that it recommends a service for some groups and reserves judgment for others; in the latter case, it is expected that patients and their health care providers would discuss the pros and cons of the service and come to their own conclusion. Moreover, the task force focuses on specific screenings and counseling, rather than the broader, overall preventive-care visit. Under many insurance plans today, patients are expected to make a single copayment for a wellness visit, rather than pay for specific pieces of that visit—so, eliminating cost-sharing for specific pieces would in many cases be meaningless.

Because of concerns over the limitations of these recommendations, the authors of the preventive health amendment originally included a third category for required, cost-sharing-free coverage: preventive care and screenings for infants, children and adolescents, as delineated in guidelines written by the American Academy of Pediatrics and supported by HRSA. Those guidelines include a wide array of preventive services for minors that go well beyond the small list of screenings, vaccines and counseling recommended by the USPSTF and ACIP. Included in its 2010 list of insurance billing codes for pediatric preventive care are those for contraceptive management, routine gynecologic examination and pelvic exams. Indeed, the guidelines 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.”

Meanwhile, public concerns over the USPSTF recommendations crystallized late in 2009 when the task force issued revised guidance on mammograms, recommending that regular screenings for breast cancer begin at age 50, rather than age 40, and take place every two years, rather than annually. Although not intended to dissuade earlier or more frequent mammograms for specific women considered by their doctors to be at heightened risk, a wide range of critics decried the new guidelines for sending a mixed message to women about the importance of mammography and for potentially leading insurers to deny coverage for screenings outside the guidelines’ new parameters. Conservative opponents of the administration’s health care reform legislation seized on the USPSTF recommendations as evidence that reform would lead to federal “rationing” of care.

In response, the Senate approved an amendment to health care reform that effectively negated the new mammography recommendation. More importantly, Sen. Barbara Mikulski (D-MD) successfully leveraged the controversy to secure passage of an amendment adding women’s preventive care and screenings as a fourth category of mandated preventive services. The amendment was adopted by a vote of 61-39.

The Mikulski amendment is tied by law to guidelines from HRSA, but in contrast to the category for minors’ care, such guidelines do not currently exist. Accordingly, HRSA must quickly flesh them out in the coming months if they are to be up and running by the time the preventive care provision takes effect in September, or anytime soon thereafter.

### **Contraception as Preventive Care**

Although much of the floor debate over Mikulski’s amendment centered on mammography, the provision itself was clearly designed to guarantee coverage without cost-sharing of a far broader group of preventive services, notably including family planning. At least six senators joined Mikulski in praising the amendment’s inclusion of family planning. According to Sen. Al Franken (D-MN), for example, “several crucial women’s health services are omitted” from the

USPSTF 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.” Similarly, Sen. Barbara Boxer (D-CA) 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.” Her state colleague, Sen. Diane Feinstein (D-CA), 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.” Even Sen. Ben Nelson (D-NE), who voted against the amendment because of spurious claims that it could somehow 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.”

To date, HRSA has not indicated how it will go about drafting the guideline it is now directed to write. With limited staff and resources, and with a large number of concurrent deadlines in September to implement pieces of health care reform, it appears that HRSA may look to an Institute of Medicine panel or another outside body to do the heavy lifting; even so, the guidelines may not be ready this fall. As it considers the appropriate scope of recommendations for women’s preventive and screening services, such a panel will have ample precedents to point to for including contraceptive counseling, services and supplies.

### National Goals

The case for contraception as preventive care is perhaps made best by the federal *Healthy People* series, updated every decade by DHHS to set the official public health goals for the United States. As described by one of the preliminary documents for the upcoming goals for the year 2020, “Healthy People frames the Nation’s prevention agenda through a set of science-based, 10-year national objectives for promoting health and preventing disease.”

The current iteration of these goals, *Healthy People 2010*, describes the importance of family planning services in terms of preventing the social, economic and medical costs of unintended pregnancy. In this context, it is the medical costs that are most relevant: “Medically, unintended pregnancies are serious in terms of the lost opportunity to prepare for an optimal pregnancy, the increased likelihood of infant and maternal illness, and the likelihood of abortion....The mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all. She is less likely to breastfeed and more likely to expose the fetus to harmful substances, such as tobacco or alcohol. The child of such a pregnancy is at greater risk of low birth weight, dying in its first year, being abused, and not receiving sufficient resources for healthy development.”

The CDC cites similar reasons for its own work to prevent unintended pregnancy and for labeling family planning as one of the top 10 public health achievements of the 20th century. And, indeed, there is clear evidence that contraception is effective preventive care. For example, publicly funded contraceptive services and supplies alone help women in the United States avoid nearly two million unintended pregnancies each year. In the absence of such services (from family planning centers and from doctors serving Medicaid patients), estimated U.S. levels of unintended pregnancy, abortion and unintended birth would be nearly two-thirds higher among women overall and nearly twice as high among poor women. The evidence is just as clear internationally: In 2008, use of modern contraceptives helped women prevent 188 million unintended pregnancies and, by doing so, prevented some 1.2 million newborn deaths and 230,000 maternal deaths and saved tens of millions of years of productive life (related article, page 12).

It is no surprise, therefore, that 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 focus area in every edition. In 2010, there were 13 objectives within the family planning focus area, mostly related to preventing unintended pregnancy and

improving contraceptive access and use. Notably for health care reform's preventive care provision, one of those objectives was to "increase the proportion of health insurance plans that cover contraceptive supplies and services." This is important, according to the report, "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."

### Public Health Programs

Several other key precedents come directly from federal public health programs. One important example is in the federal law authorizing funding for community health centers, Sec. 330 of the Public Health Service Act. Within the list of services that centers are required to provide 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. 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. In fact, the first federal funding for contraception came through the maternal and child health program in the early 1940s.

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 DHHS]." 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.

### Provider Guidelines

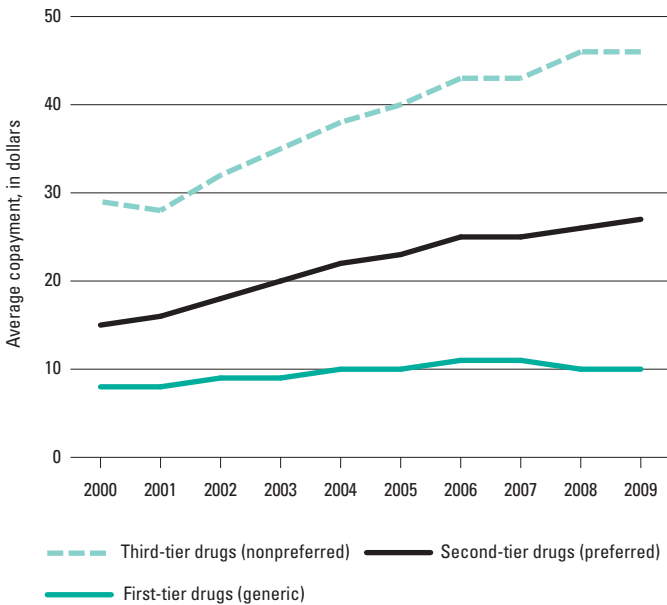
Numerous health care provider associations have also touted the importance of family planning as preventive care, including the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists (ACOG) and the Society for Adolescent Medicine.

Family planning has been a long-standing focus area for the American Public Health Association (APHA), perhaps the nation's preeminent umbrella group for public health and preventive care. Its Population, Reproductive and Sexual Health section—one of 27 sections within the association—was founded in 1975, and APHA has been an active supporter of increased access to contraception to help women and couples time, space and ultimately limit the number of their children. The March of Dimes, too, has lent its support to publicly funded family planning, noting that the "central purpose of family planning is to promote healthy births," by improving birth spacing and helping women obtain timely prenatal care.

Among the provider associations, ACOG has been particularly vocal in its support for an appropriately broad interpretation of the Mikulski language, citing the group's own, extensive guidelines for women's preventive care. In comparing its own guidelines with the current USPSTF recommendations, ACOG highlights several crucial limitations of the latter, including its lack of a current recommendation on family planning counseling and on prescription contraceptive drugs, devices and related services. The association 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."

## COVERED AT A COST

Average copayments have increased rapidly over the past decade for the brand-name drugs placed in the second and third tiers of insurers' prescription drug benefits.



Source: Kaiser Family Foundation and Health Research & Educational Trust, 2009.

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.”

### Impact on Health and Costs

The benefits to women and couples of universal insurance coverage of contraceptive services and supplies could be substantial. First, a nationwide coverage mandate would close several key gaps in current insurance practices. Surveys from the past decade do indicate that in the wake of a major campaign in the 1990s to change what had been inadequate insurance coverage of contraception, coverage is now strong. Nearly nine in 10 typical employer-purchased insurance plans covered the five most common methods in 2002, with similarly strong coverage of both the methods themselves and related services (such as the insertion and removal of a long-acting method,

or the act of injecting an injectable contraceptive). 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, if the new preventive care provision in health care reform were interpreted to require coverage of contraceptive counseling, that would be a meaningful breakthrough: 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 other major benefit from including contraception under the new preventive care provision would come from the elimination of cost-sharing. Average copayments in employer-sponsored insurance have increased considerably over the past decade, to as much as \$46 in 2009 for many brand-name drugs (see chart). 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. Other plans require customers to pay a percentage of the cost of a service or supply, rather than a flat copayment. This coinsurance is a particularly high hurdle for long-acting methods like the IUD and implant, which have hundreds of dollars of up-front costs for the device and its insertion, but which provide the greatest long-term effectiveness and cost-effectiveness, because they allow for fewer opportunities for misuse. Numerous studies have demonstrated that even seemingly small cost-sharing requirements can dramatically reduce use of even needed preventive care, particularly among lower-income Americans—a fact that is at the core of why Congress has acted to eliminate cost-sharing for such services. Indeed, several of the largest insurers in the country, as well as their umbrella group, America's Health Insurance Plans, publicly called for including the broader preventive care provision in health care reform.

As with almost any attempt to mandate coverage of specific services in private insurance, the primary objection to including contraception under

this provision 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. Although there are relatively little data from the private sector, publicly funded contraceptive services and supplies have been demonstrated time and again to be highly cost-effective. For example, every \$1 invested in public dollars for contraception saves \$3.74 in Medicaid expenditures that otherwise would have been needed to provide pregnancy-related care (prenatal, labor, delivery and postpartum care) for women's unintended births, as well as one year of medical care for their infants. 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.

The data that do exist for the private sector are likewise positive. According to a 1998 analysis conducted for the Guttmacher Institute by Buck Consultants, an employee benefit and actuarial consulting firm, covering contraception is a relatively low-cost proposition. The addition of coverage for the full range of reversible prescription methods to a plan that included no contraceptive coverage at all would increase costs by about \$21 per employee per year. More recently, a 2007 guide for employers from the National Business Group on Health (a membership group for large private- and public-sector employers to address their health policy concerns) recommended that all employer-sponsored health plans include comprehensive coverage of unintended pregnancy prevention services, free of any cost-sharing, as part of a recommended minimum set of benefits for preventive care. The addition of that coverage—which includes the full range of prescription contraceptive methods, sterilization services, lab tests, counseling services and patient education—to a plan that currently includes no coverage at all was estimated by PricewaterhouseCoopers to cost about \$40 per member per year. These actuarial estimates do not include any potential cost-savings from contraceptive care, although the 2007 guidelines do predict, based on prior research, that the savings will

exceed the costs. The \$40 figure is miniscule when compared with overall insurance premiums: In 2009, average annual premiums were more than \$4,800 for an individual employee and almost \$13,400 for family coverage, according to the Kaiser Family Foundation.

Meanwhile, those estimates that do include the potential cost-savings associated with contraceptive coverage have been extremely encouraging. The federal government, the nation's largest employer, reported that it experienced no increase in costs at all after a 1998 law required coverage of contraceptives for federal employees. In fact, employers should benefit from improved coverage and use of contraception. According to the Washington Business Group on Health and William M. Mercer, an employee benefits consulting firm, 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. These savings in private health insurance from covering contraception should only increase in the wake of health care reform, 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.

All told, the federal programs, clinical guidelines, evidence of effectiveness and ongoing need point to the same conclusion. As federal officials work to implement the preventive care provision in health care reform and establish guidelines for women's preventive care and screenings, they have every reason to comprehensively incorporate family planning services. This must include coverage for the full range of prescription contraceptive drugs and devices approved by the U.S. Food and Drug Administration; related clinical services necessary to appropriately supply those drugs and devices, including 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. [www.guttmacher.org](http://www.guttmacher.org)