Lizzie Kubitz

From: Dr Tomsen [redacted]
Sent: Monday, February 27, 2017 3:48 PM
To: Lizzie Kubitz
Subject: RE: Potential letter of support for House Bill 25

Lizzie,

Absolutely I remain in support, and would be glad to help, as I did last year via Katie Bruggeman for Sen. Berta Gardner in her effort to get women access to a years' worth of contraceptives at a time.

You may be familiar already with the CHOICE study, but if you are not I highly recommend you read up on it at http://www.nejm.org/doi/full/10.1056/NEJMoa1400506#t=article or in other locations (just google "CHOICE study St. Louis") – it was a brilliant study and should be mandatory reading for all those involved in making decisions about health care financing. It certainly has rocked our gynecologic world!

In addition to supporting this bill, I have often pondered a similar issue, the cost of which is borne by women disproportionately, though it is clearly a shared problem. Namely, shouldn't HPV screening, the investigation of abnormal paps and treatment of cervical dysplasia/ HPV disease, and the cost of HPV-related cancers be expenses that are paid for more equally between men and women, despite women having what amounts to "HPV's favorite organ," the cervix. Just an idea for you and Rep. Claman to ponder.

Tina Tomsen

I would like to express my support for Rep. Claman's efforts to improve women's access to contraception.

HB 25 seeks to maintain women's access and use of contraception that has proven so successful in many locations, as well as making it possible to obtain a years' worth of contraceptive pills without obstacles.

I absolutely support this bill for many reasons. Even when one excludes women for whom a pregnancy is a significant health risk, excellent reasons include:

1) Optimum child spacing (of 2-3 years between children) has been demonstrated to improve the health of women and their children.

2) Every child raised to the age of 18 costs about the same as a mortgage; in 8/2014 the average figure for a middle-income family in the U.S. was estimated by the USDA at $245,340.

3) Teenage childbearing is a significant cost to the state and to the nation, not just financially but because of the increased risk of poor quality or frankly or damaging parenting by young and overwhelmed parents.

4) While both a man and a woman are necessary for conception, the woman disproportionately bears the responsibility for contraception and the risk of its failure.

5) The state stands to gain financially by supporting healthier childbearing and and improving the financial security of families through decreasing obstacles to contraception.

6) A woman who needs to see her practitioner only once a year to safely obtain a prescription for contraceptive pills should be able to fill that prescription when and in the amount she desires. This has long been necessary for women who will be away from their home or pharmacy (school, deployment, travel, mission trips, living remote or at remote research locations), but should not be limited to them.

7) If one can buy a years' worth of food, toilet paper, heating oil, or other necessities, buying a years' worth of contraceptives that are so essential to securing financial and personal health should also be possible.

8) The CHOICE study (http://www.nejm.org/doi/full/10.1056/NEJMoa1400506#t=article), states that have covered the expense of contraception, and finally the Affordable Care Act have all demonstrated that women who use LARCS (long acting reversible contraception, such as IUD's and implants) have had fewer unwanted pregnancies and abortions. Removing barriers to women obtaining oral contraceptives should similarly improve statistics for women using them, rather than risking lapses in their use of contraceptives, as is currently the case.

9) While the ACA made it possible for women to obtain access to LARCs they might previously not have been able to afford, it left the "loophole" open that did not require payment for removal of those devices, which in some cases was a financial obstacle when a woman needed her IUD removed and replaced, for example. This bill closes that loophole.

My only objection to this bill is that it might not go far enough – after all, expanding coverage for patients of both sexes to obtain stable long-term prescriptions that are not of an addictive or unsafe nature should be sought.

Tina Tomsen, MD

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