SB 156

<TARGET><BILL>SB 156</BILL><SUBJECT>SB 156</SUBJECT><COMM>SHSS29</COMM></TARGET>

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/22/16

FURTHER: Labor and Commerce

Date of 5-Day Notice: 1/28/16
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: MAR 3 1 2016

Health and Social Services Committee considered SENATE BILL NO. 156

SB 156-INSURANCE COVERAGE FOR CONTRACEPTIVES

"An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services; and providing for an effective date."

and recommends:

[ ] be **replaced** with **CS** SB 156 (HSS) [✓] *Same Title* [ ] *New Title*

[ ] adopt **previous CS** _____ (_____) [ ] *Same Title* [ ] *New Title*

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #
CED			✓	1
DHS	✓			2

PREVIOUS FISCAL NOTE(S)				
Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	ELLIS	X			
	Stolte			✓	
CHAIR:	STEDMAN	✓			

ALASKA STATE LEGISLATURE

WORLD TRADE

RULES COMMITTEE

ADMIN REG REVIEW

EDUCATION COMMITTEE

WHILE IN SESSION
STATE CAPITOL
JUNEAU, AK 99801
(907) 465-4930

•

WHILE IN ANCHORAGE
716 W. 4TH AVE
ANCHORAGE, AK 99501
(907) 269-0174

SENATOR BERTA GARDNER
SENATE MINORITY LEADER

Sponsor Statement SB 156

All across Alaska, women working in rural areas, in the tourism industry, in the military, and on the North Slope, do not always have ready access to women's health services, thereby posing limitations on their ability to control whether and when they conceive children. My bill, SB 156, mandates insurance companies to pay both private and Medicaid claims and reimburse health care providers for an initial 3 month supply (to gauge adverse reactions), which is then followed by a 12 month supply of contraceptives, including but not limited to birth control pills and hormonal contraceptive patches. Additionally, SB 156 includes an exemption for religious employers in order to ensure First Amendment protections.

Unintended pregnancy has a profound effect on the economic opportunities and overall well-being of Alaskans statewide. According the Centers for Disease Control and Prevention, an unintended pregnancy is a pregnancy that is reported to have been either unwanted (the pregnancy occurred when no children, or no more children, were desired) or mistimed (the pregnancy occurred earlier than desired). Unintended pregnancy is a core concept that is used to better understand the fertility of populations and the unmet need for contraception and family planning. Unintended pregnancy mainly results from not using contraception, or inconsistent or incorrect use of effective contraceptive methods. Unintended pregnancy is associated with an increased risk of problems for both the mother and baby: if a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing, and might make poor prenatal choices due to a lack of resources or a family support system, unaddressed issues with drug and alcohol dependence, and an absence of nutritional knowledge that might otherwise keep both mother and child healthy through the prenatal experience.

Along with these health concerns, unintended pregnancy is an economic issue for Alaskan families, as well as the state Department of Health and Social Services. Nationally, 51% of all US births in 2010 were paid for by public insurance through Medicaid, the Children's Health Insurance Program (CHIP), and the Indian Health Service. Public insurance programs paid for 68% of the 1.5 million unplanned births that year, compared with 38% of planned births. Two million births were publicly funded in 2010; of those, about half were unplanned. Alaska data is consistent with national trends.

Nationally, a publicly funded birth in 2010 cost an average of $12,770 in prenatal care, labor and delivery, postpartum care and 12 months of infant care; when 60 months of care are included, the cost per birth increases to $20,716. Government expenditures on the births,

abortions, and miscarriages resulting from unintended pregnancies nationwide totaled $21.0 billion in 2010; that amounts to 51% of the $40.8 billion spent for all publicly funded pregnancies that year. To put these figures into perspective, in 2010, the federal and state governments together spent an average of $336 on unintended pregnancies for every women aged 15 – 44 in the country.

In Alaska, where health care sometimes costs more than 30% higher than national averages and Medicaid spending is one of the primary cost drivers of the state budget, these costs become even more problematic. Amid an unprecedented state budget deficit, and the fact that most Alaskan women cherish economic and professional freedoms, now is the time to allow greater access to family planning options. SB 156 will help us reach that goal.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 28, 2016

SUBJECT: Sectional summary (SB 156; Work Order No. 29-LS1144\W)

TO: Senator Berta Gardner
Attn: Katie Bruggeman

FROM: Megan A. Wallace
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1 Amends AS 21.42 by adding AS 21.42.427, which (1) requires insurance coverage for prescription contraceptives, over-the-counter contraceptives, voluntary sterilization procedures, and consultations, examinations, procedures, and medical services necessary for these products or services; (2) requires reimbursement for dispensing a prescription contraceptive; (3) precludes denial of coverage because an insured changes contraceptive methods within a 12-month period; (4) prevents an insurer from offsetting the costs of compliance; (5) prevents an insurer from restricting or delaying coverage for contraceptives; and (6) exempts religious employers if certain criteria are met.

Section 2 Amends AS 47.07.065 by expanding Medicaid coverage for prescription contraceptives, over-the-counter contraceptives, voluntary sterilization procedures, and consultations, examinations, procedures, and medical services necessary for these products or services.

Section 3 Requires the Department of Health and Social Services to immediately amend and submit for federal approval a state plan for medical assistance coverage consistent with this Act. Requires the department to notify the revisor of statutes when approval is obtained.

Section 4 Makes sec. 2 of the Act conditional on the approval required under sec. 3 of the Act.

Section 5 Provides that if sec. 2 of the Act takes effect, it takes effect the day after the commissioner of health and social services makes certification of federal approval under secs. 3 and 4 of the Act.

Section 6 Except as provided in sec. 5 of the Act, provides for a January 1, 2017, effective date.

MAW:dla
16-067.dla

Fiscal Note

State of Alaska
2016 Legislative Session

Bill Version: SB 156
Fiscal Note Number:
() Publish Date:

Identifier: SB156-DHSS-HCMS-2-23-16
Title: INSURANCE COVERAGE FOR CONTRACEPTIVES
Sponsor: GARDNER
Requester: Senate HSS

Department: Department of Health and Social Services
Appropriation: Medicaid Services
Allocation: Health Care Medicaid Services
OMB Component Number: 2077

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2017 Appropriation Requested	Included in Governor's FY2017 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2017**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Personal Services							
Travel							
Services	18.3						
Commodities							
Capital Outlay							
Grants & Benefits	2,004.4		2,004.4	2,004.4	2,004.4	2,004.4	2,004.4
Miscellaneous							
Total Operating	**2,022.7**	**0.0**	**2,004.4**	**2,004.4**	**2,004.4**	**2,004.4**	**2,004.4**
Fund Source (Operating Only)							
1002 Fed Rcpts	2,244.1		2,212.4	2,204.9	2,189.8	2,178.6	2,178.6
1003 G/F Match	(221.4)		(208.0)	(200.5)	(185.4)	(174.2)	(174.2)
Total	**2,022.7**	**0.0**	**2,004.4**	**2,004.4**	**2,004.4**	**2,004.4**	**2,004.4**
Positions							
Full-time							
Part-time							
Temporary							
Change in Revenues							

Estimated SUPPLEMENTAL (FY2016) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2017) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? yes
If yes, by what date are the regulations to be adopted, amended or repealed? 07/01/18

Why this fiscal note differs from previous version:

Not applicable; initial version.

Prepared By: Margaret Brodie, Director Phone: (907)334-2520
Division: Health Care Services Date: 02/23/2016 04:45 PM
Approved By: Sana Efird, Asst. Commissioner, Finance and Management Services Date: 02/23/16
Agency: Health and Social Services

Analysis

Under Alaska Medicaid's current State Plan, contraceptive products are covered only with a corresponding prescriber's prescription. Not requiring a prescription for over the counter (OTC) contraceptives, such as condoms, will promote increased utilization.

System Enhancements
MMIS system enhancements required to implement this change are estimated to be $18,300 (50% FMAP/50%GF).

Benefits Costs
Assumptions: an estimated 20,000 Medicaid members (of which, 7,500 are through expansion) members will take advantage of Medicaid coverage of condoms without a prescription

1 - Condoms
At an average cost of $1 per condom, 24 condoms refilled/dispensed quarterly, plus an avg. dispensing fee of $18 per refill, the annual cost will be approximately $168 per member. An estimated 20,000 Medicaid members will take advantage of Medicaid coverage of condoms without a prescription, for a total cost of $3,360,000 (of which, $1,260,000 is attributable to expansion).

2 - Oral Contraceptives: Duplication of Services
It is anticipated that approximately 10%, or 794 members who are oral contraceptive users may require duplication of services (e.g., therapy changes, replacement of lost or stolen contraceptives, and diverted contraceptives). It is anticipated that there will be approximately 7,940 female Medicaid recipient contraceptive users annually (of which, 2,940 are through expansion) contraceptive users annually. Based on an average 4-month duplication of services, and based on a $45 per month National Average Drug Acquisition Cost average for oral contraceptives, the total duplication of services cost is estimated to be (794 members * 4 months * $45) = $142,920 (of which, $52,920 is attributable to expansion)

Benefits Savings
Of the approx. 8,000 female Medicaid members who are contraceptive users, we estimate that 75% or 6,000 will use oral contraceptives. With a standard oral contraceptive failure rate of 9% as cited by the Centers for Disease Control, 540 unintended pregnancies would result. A report by Foster et. al. (2011) projects a decrease in failure rate of approximately 30% when oral contraceptives are dispensed in 12-month quantities, which would result in an oral contraceptive failure rate of 6%. However, based on variable factors in Alaska, we have estimated a failure rate of 7%. This 7% failure rate would approximate 420 unintended pregnancies. Therefore, it is approximated that the difference between a 9% failure rate and a 7% failure rate, or 120 unintended pregnancies, may potentially be avoided through dispensing 12-month quantities.

Based on Medicaid claims data, the rate of complicated births is approximately 4.4%. Applying this differential, we estimate that approximately 5.28 of the unintended pregnancies would have been complicated births, and 114.72 would have been non-complicated. The cost factor used for a complicated birth was $110,000; the cost factor used for a non-complicated birth was $8,000. Therefore, benefits savings is estimated at 5.28 * $110,000 + 114.72 * $8,000 = $1,498,560 (of which, $561,960 is attributable to expansion)

$18,300 + $3,360,000 + $142,290 - $1,498,560 = $2,022,660, or **$2,022.7 net total SFY2017 cost**

Analysis Continued

FUND SOURCE:
The Medicaid FMAP / GF rates for 2017 - 2022 for contraceptives is 90% / 10%
The Medicaid FMAP / GF rates for 2017 - 2022 for pregnancy-related services are 50% / 50%

The Medicaid Expansion FMAP / GF rate for SFY2017 is 97.5% / 2.5%
The Medicaid Expansion FMAP / GF rate for SFY2018 is 94.5% / 5.5%
The Medicaid Expansion FMAP / GF rate for SFY2019 is 93.5% / 6.5%
The Medicaid Expansion FMAP / GF rate for SFY2020 is 91.5% / 8.5%
The Medicaid Expansion FMAP / GF rate for SFY2021 - 2022 is 90% / 10%

In SFY2017, the total operating expenditures = $2,022.7.
We anticipate collecting $2,244.1 in federal receipts, and we anticipate a GF savings of ($221.4), based on the rates indicated above.

The $2,217.0 SFY2017 FEDERAL receipts amount is derived as follows:

System Enhancement
$18,300 * 0.5 FMAP = $9,150

Condoms
$2,100,000 * 0.9 FMAP = $1,890,000
$1,260,000 * 0.975 FMAP = $1,228,500

Oral Contraceptives
$89,325 * 0.9 FMAP = $80,392
$53,595 * 0.975 FMAP = $52,255

Benefit Savings, Unintended Pregnancies Avoided
($936,600) * 0.5 FMAP = ($468,300)
($561,960) * 0.975 FMAP = ($547,911)

$9,150 + $1,890,000 + $1,228,500 + $80,392 + $52,255 + ($468,300) + ($574,911) = $2,244,086 or $2,244.1

The logic of the calculations derived for 2017 through 2022 is the same except that the FMAP rates are adjusted to reflect the listed annual rates above, and the system enhancement cost is SFY2017 only.

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Analysis Continued

The ($221.4) SFY2017 GF Match is derived as follows:

System Enhancement
+ $18,300 * 0.5 FMAP = $9,150

Condoms
+ $2,100,000 * 0.1 FMAP = $210,000
+ $1,260,000 * 0.025 FMAP = $31,500

Oral Contraceptives
+ $89,3250 * 0.1 FMAP = $8,932
+ $53,595 * 0.025 FMAP = $1,340

Benefit Savings Unintended Pregnancies Avoided
($936,600) * 0.5 FMAP = ($468,300)
($561,960) * 0.025 FMAP = ($14,049)

$9,150 + $210,000 + $31,500 + $8,932 + $1,340 + ($468,300) + ($14,049) = ($221,427) or ($221.4)

The logic of the calculations derived for 2017 through 2022 is the same except that the FMAP rates are adjusted to reflect the listed annual rates above, and the system enhancement cost is SFY2017 only.

ALASKA STATE LEGISLATURE

WORLD TRADE

RULES COMMITTEE

ADMIN REG REVIEW

EDUCATION COMMITTEE

WHILE IN SESSION
STATE CAPITOL
JUNEAU, AK 99801
(907) 465-4930

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WHILE IN ANCHORAGE
716 W. 4TH AVE
ANCHORAGE, AK 99501
(907) 269-0174

SENATOR BERTA GARDNER
SENATE MINORITY LEADER

Explanation of Changes, CS SB 156 Version N

Version N includes one major change: the removal of the provision that mandates coverage of over the counter contraceptives.

Section 1. Amends AS 21.47 by adding a new section, AS 21.47.427. AS 21.47.427(a) requires a health care insurer, in the group or individual market, to provide coverage for prescription contraceptives, voluntary sterilization procedures, and specified related services, and to provide reimbursement for dispensing prescription contraceptives for a three-month period for the first dispensing and a 12-month period for subsequent dispensing. AS 21.47.427(b) – (g) contain other related compliance and coverage provisions.

Section 2. Amends AS 47.07.065 by adding new subsections (b) – (d), which require the Department of Health and Social Services to pay for prescription contraceptives intended to last for a three-month period for the first dispensing and a 12-month period for subsequent dispensing for eligible recipients of medical assistance, if prescribed to and requested by the recipient, as well as pay for specified services.

Section 3. Requires the Department of Health and Social Services to amend and submit for federal approval a state plan for medical assistance coverage consistent with sec. 2 of this Act.

Section 4. Provides that sec. 2 of this Act takes effect only if the provisions of sec. 2 of this Act receive federal approval.

Section 5. Provides for an effective date for sec. 2 of this Act.

Section 6. Except for sec. 5 of this Act, provides for a January 1, 2017 effective date.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 21, 2016

SUBJECT: Sectional summary
(CSSB 156( ); Work Order No. 29-LS1144\N)

TO: Senator Berta Gardner
Attn: Katie Bruggeman

FROM: Megan A. Wallace
Legislative Counsel MAW

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. Amends AS 21.47 by adding a new section, AS 21.47.427. AS 21.47.427(a) requires a health care insurer, in the group or individual market, to provide coverage for prescription contraceptives, voluntary sterilization procedures, and specified related services, and to provide reimbursement for dispensing prescription contraceptives for a three-month period for the first dispensing and a 12-month period for subsequent dispensing. AS 21.47.427(b) - (g) contain other related compliance and coverage provisions.

Section 2. Amends AS 47.07.065 by adding new subsections (b) - (d), which require the Department of Health and Social Services to pay for prescription contraceptives intended to last for a three-month period for the first dispensing and a 12-month period for subsequent dispensing for eligible recipients of medical assistance, if prescribed to and requested by the recipient, as well as pay for specified related services.

Section 3. Requires the Department of Health and Social Services to amend and submit for federal approval a state plan for medical assistance coverage consistent with sec. 2 of this Act.

Section 4. Provides that sec. 2 of this Act takes effect only if the provisions of sec. 2 of this Act receive federal approval.

Section 5. Provides for an effective date for sec. 2 of this Act.

Section. 6. Except for sec. 5 of this Act, provides for a January 1, 2017 effective date.

MAW:lem:dla
16-320.dla

29-LS1144\N
Wallace
3/16/16

CS FOR SENATE BILL NO. 156( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR GARDNER

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.427. Coverage for contraceptives. (a) A health care insurer that offers, issues for delivery, delivers, or renews in the state a health care insurance plan in the group or individual market shall

(1) provide coverage for

(A) prescription contraceptives;

(B) voluntary sterilization procedures; and

(C) consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices, and other products or services

provided under this paragraph;

(2) reimburse a health care provider or dispensing entity for dispensing prescription contraceptives intended to last for a

(A) three-month period for the first dispensing of the prescription contraceptive to an insured; and

(B) 12-month period for subsequent dispensings of the same prescription contraceptive to the insured regardless of whether the insured was enrolled in the health care insurance plan at the time of the first dispensing.

(b) A health care insurer may not deny coverage or reimbursement under (a) of this section because an insured changed contraceptive methods within a 12-month period.

(c) A health care insurer may not offset the costs of compliance with (a) of this section and may not require copayments, deductibles, or other forms of cost sharing for contraceptives or services covered under (a) of this section.

(d) A health care insurer may not restrict or delay the coverage or reimbursement required under (a) of this section, including use of medical management techniques that limit an insured's choice in accessing a full range of prescription contraceptives.

(e) A health care insurer shall provide coverage and reimbursement under (a) of this section to all insureds enrolled in a health insurance plan, including enrolled spouses and dependents.

(f) A health care insurer that offers, issues for delivery, delivers, or renews in the state a health care insurance plan in the group market to a religious employer is exempt from the requirements of this section with respect to the health care insurance plan of the religious employer if the religious employer opposes the coverage required under this section and is an

(1) organization that meets the criteria set out in 26 U.S.C. 6033(a)(3)(A)(i) or (iii) (Internal Revenue Code of 1986), as amended; or

(2) eligible organization that has self-certified in the form and manner specified by the United States Secretary of Labor or has provided notice to the United States Secretary of Health and Human Services, under the requirements set out in 45

C.F.R. 147.131(b)(1) - (3).

(g) In this section, "prescription contraceptive" means a drug or device that requires a prescription and is approved by the United States Food and Drug Administration to prevent pregnancy.

*** Sec. 2.** AS 47.07.065 is amended by adding new subsections to read:

(b) The department shall pay for

(1) prescription contraceptives intended to last for a

(A) three-month period for the first dispensing of the prescription contraceptive to a recipient; and

(B) 12-month period for subsequent dispensings of the same prescription contraceptive if prescribed to and requested by the recipient, regardless of whether the recipient was receiving medical assistance at the time of the first dispensing; and

(2) consultations, examinations, procedures, and medical services that are necessary to

(A) prescribe, dispense, insert, distribute, or administer prescription contraceptives; or

(B) remove prescription contraceptives.

(c) Nothing in this section requires itemized reimbursement when a service is reimbursable as part of a bundled or composite rate.

(d) In this section, "prescription contraceptive" means a drug or device that requires a prescription and is approved by the United States Food and Drug Administration to prevent pregnancy.

*** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

MEDICAID STATE PLAN INSTRUCTIONS; NOTICE TO REVISOR OF STATUTES. The Department of Health and Social Services shall immediately amend and submit for federal approval a state plan for medical assistance coverage consistent with AS 47.07.065(b) - (d), added by sec. 2 of this Act. The Department of Health and Social Services shall apply to the United States Department of Health and Human Services for any waivers necessary to implement AS 47.07.065(b) - (d), added by sec. 2 of this Act. The

commissioner of health and social services shall notify the revisor of statutes in writing if the United States Department of Health and Human Services approves the provisions of AS 47.07.065(b) - (d), added by sec. 2 of this Act.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. AS 47.07.065(b) - (d), added by sec. 2 of this Act, take effect only if the commissioner of health and social services notifies the revisor of statutes in writing under sec. 3 of this Act, on or before January 1, 2017, that the provisions of AS 47.07.065(b) - (d), added by sec. 2 of this Act, have been approved by the United States Department of Health and Human Services.

*** Sec. 5.** If AS 47.07.065(b) - (d), added by sec. 2 of this Act, take effect, they take effect on the day after the date the commissioner of health and social services makes a certification to the revisor of statutes under secs. 3 and 4 of this Act.

*** Sec. 6.** Except as provided in sec. 5 of this Act, this Act takes effect January 1, 2017.

David Scott

From: Katie Bruggeman
Sent: Tuesday, March 22, 2016 10:26 AM
To: David Scott
Subject: FW: DRAFT - for your review - SB156 points

Sorry to bombard you this morning, but Tony asked whether you'd like them to follow up with you about this estimate?

From: Newman, Anthony (HSS) [mailto:anthony.newman@alaska.gov]
Sent: Tuesday, March 22, 2016 10:06 AM
To: Katie Bruggeman <Katie.Bruggeman@akleg.gov>
Subject: RE: DRAFT - for your review - SB156 points

Katie, I have to compliment you for your perseverance and the methodical way you worked through the issues here.

Do you need us to follow up with David Scott in any way?

Tony

From: Katie Bruggeman [mailto:Katie.Bruggeman@akleg.gov]
Sent: Tuesday, March 22, 2016 10:04 AM
To: Woods, Sarah B (HSS); Newman, Anthony (HSS)
Cc: Dunkin, Susan M (HSS); Narus, Erin Y (HSS)
Subject: RE: DRAFT - for your review - SB156 points

Thanks so much! This is great news.
I know that you all are quite overburdened this session, and my boss and I both appreciate your work on this.
-Katie

From: Woods, Sarah B (HSS) [mailto:sarah.woods2@alaska.gov]
Sent: Tuesday, March 22, 2016 10:01 AM
To: Katie Bruggeman <Katie.Bruggeman@akleg.gov>; Newman, Anthony (HSS) <anthony.newman@alaska.gov>
Cc: Dunkin, Susan M (HSS) <susan.dunkin@alaska.gov>; Narus, Erin Y (HSS) <erin.narus@alaska.gov>
Subject: RE: DRAFT - for your review - SB156 points

Katie, the draft FN is in the works and moving through review. Meanwhile, version "N" of SB156 is estimated to result in $1.2 million FY2017 savings ($1,001.9 fed, $234.4 GF match). Removal of the non-prescription contraceptives from bill language is responsible for most of the cost change.

From: Katie Bruggeman [mailto:Katie.Bruggeman@akleg.gov]
Sent: Sunday, March 20, 2016 1:11 PM
To: Newman, Anthony (HSS)
Cc: Woods, Sarah B (HSS); Dunkin, Susan M (HSS); Narus, Erin Y (HSS)
Subject: Re: DRAFT - for your review - SB156 points

An estimate would be fine.
Thanks,

Katie

Sent from my iPad

On Mar 18, 2016, at 7:37 PM, Newman, Anthony (HSS) <anthony.newman@alaska.gov> wrote:

> Katie, as you undoubtedly know, we can't share or submit a formal fiscal note until a CS is adopted and moved out of committee. However, we have been getting permission from the Governor's Legislative Office to share "draft" notes after the GLO has cleared them. We can try and get one of those done for you in advance of a Wednesday hearing, but no promises. Our folks are overwhelmed.
>
> Or, are you looking for something even more informal—just a rough estimate of costs in an email?
>
> Tony

From: Katie Bruggeman [mailto:Katie.Bruggeman@akleg.gov]
Sent: Friday, March 18, 2016 10:38 AM
To: Woods, Sarah B (HSS)
Cc: Newman, Anthony (HSS); Dunkin, Susan M (HSS); Narus, Erin Y (HSS)
Subject: RE: DRAFT - for your review - SB156 points

Hi all,
I wanted to send the new version again, with incorporated changes from Legislative Legal based on some of the suggestions made by Erin.
Do you know when you will have a fiscal note ready for us to view? It's my understanding that we might have a hearing as early as Wednesday.
Thanks,
Katie

Katie Bruggeman
Aide to Senator Berta Gardner
Anchorage District I
Spenard Midtown UMed

Session Contact:
(907) 465-3881
Alaska State Capitol, Room 9
Juneau, AK 99801
www.AlaskaSenateDems.com/Gardner
www.Facebook.com/BertaGardner

From: Woods, Sarah B (HSS) [mailto:sarah.woods2@alaska.gov]
Sent: Tuesday, March 15, 2016 1:59 PM
To: Katie Bruggeman <Katie.Bruggeman@akleg.gov>
Cc: Newman, Anthony (HSS) <anthony.newman@alaska.gov>; Dunkin, Susan M (HSS) <susan.dunkin@alaska.gov>; Narus, Erin Y (HSS) <erin.narus@alaska.gov>
Subject: RE: DRAFT - for your review - SB156 points

Thx for the clarification.

Erin/Susan, ELMO version E bill and workflow have been deleted, pending the next release. Katie, this is in part why we prefer to respond to adopted versions – we know our efforts are not for naught!

From: Katie Bruggeman [mailto:Katie.Bruggeman@akleg.gov]
Sent: Tuesday, March 15, 2016 1:55 PM
To: Woods, Sarah B (HSS)
Cc: Newman, Anthony (HSS); Dunkin, Susan M (HSS); Narus, Erin Y (HSS)
Subject: RE: DRAFT - for your review - SB156 points

Sarah, good question. Based on the email that I just received from Erin Narus (copied and pasted below), there will be a few slight tweaks to Version E. I hope to have a quick turnaround with Legal after we send them suggestions for edits.

1. We do plan on adding language to resolve this comment: **"Version E of the bill does not explicitly indicate that receiving a 12-month supply of oral contraceptives is up to the discretion/choice of the patient."** We can defer to Legal as to how to phrase this correctly.

2. One follow up for you regarding this note that I received from an email from you all on 2/22: **'Sec 2, page 3, ln 22 – costs to "deliver" and "distribute" are separate'** Could you please clarify how we might address this issue? Do you recommend deleting one of those terms, or modifying the language some other way?

Thanks,
Katie

Katie Bruggeman
Aide to Senator Berta Gardner
Anchorage District I
Spenard Midtown UMed
Session Contact:
(907) 465-3881
Alaska State Capitol, Room 9
Juneau, AK 99801
www.AlaskaSenateDems.com/Gardner
www.Facebook.com/BertaGardner

From: Newman, Anthony (HSS) [mailto:anthony.newman@alaska.gov]
Sent: Tuesday, March 15, 2016 1:30 PM
To: Katie Bruggeman <Katie.Bruggeman@akleg.gov>
Cc: Davidson, Valerie J (HSS) <val.davidson@alaska.gov>; Sherwood, Jon (HSS) <jon.sherwood@alaska.gov>; Brodie, Margaret C (HSS) <margaret.brodie@alaska.gov>; Narus, Erin Y (HSS) <erin.narus@alaska.gov>; Woods, Sarah B (HSS) <sarah.woods2@alaska.gov>; Peterson, Darwin R (GOV) <darwin.peterson@alaska.gov>; Wilcox, Lacy J (GOV) <lacy.wilcox@alaska.gov>; McClanahan, Natasha S (GOV) <natasha.mcclanahan@alaska.gov>
Subject: FW: DRAFT - for your review - SB156 points

Katie, I am forwarding the below message from Erin Narus summarizing your conversation yesterday. Let me know if you would like to follow up with a conversation with the Department. Tony

****

Katie
Thank you very much for your time yesterday. Below is a summary of the points we discussed.

(1) Version E of the bill does not explicitly indicate that receiving a 12-month supply of oral contraceptives is up to the discretion/choice of the patient.

(2) Dispensing a 12-month supply has the potential of unintended pregnancies if the medication is not stored appropriately (e.g. in warm or humid places). There is a risk that a woman could have an unexpected pregnancy if the woman takes the medication thinking that it is still effective, but it had lost its potency due to inadvertent improper storage. Decreasing the total dispensing to 6-months mitigates some of this risk. This timeframe is consistent with several other Medicaid programs and ACOG recommendations which support the provision of 3 – 12 month supplies. 1

a. We talked briefly about the UCSF study we both cited (Foster et al. 2011). The study looked specifically at a single month of dispensing (in January 2006) and how that single month of dispensing correlated to pregnancies conceived between January 2006 and January 2007. The reported odds ratio is calculated based on the number of cycles the individual received at first visit in January 2006. However, the study does not clearly reference if subsequent dispensings occurred in Feb 2006 – December 2006 for those individuals who received 1- or 3-month supplies as compared to 12-month supplies. Compliance with oral contraceptives is multifactorial; the study design does not take into account some of the other key variable questions. Dispensing 6-months of supplies was not addressed in this specific study.

(3) The department will have administrative costs to put in place a process that reviews patient eligibility in subsequent months if a 12-month supply is dispensed. If a patient loses Medicaid eligibility, the cost for the months of medication where the patient no longer had Medicaid eligibility will need to shift from 90% Federal funding to 100% State GF. Decreasing the total dispensing to 6-months mitigates some of this risk.

(4) In Version E, I do not see that we are being required to add coverage of any over-the-counter contraceptives, such as condoms. The department currently covers nonoxynol-9 contraceptive creams, gels, foams, and sponges. If condoms end up in a future version of the bill, the department would have additional costs from the additional coverage of over-the-counter condoms; however, it is uncertain how significant those costs will be since Medicaid will still need to require a prescription. The coverage of condoms would require a regulation change and a state plan amendment.

(5) In Version E I no longer see a reference to payment for delivery as you pointed out. The ambiguity with respect to this section has been addressed.

1ACOG recommendations; http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Access-to-Contraception

Erin Y.N. Narus, PharmD, RPh
Pharmacy & Ancillary Services Mgr, Lead Pharmacist

Division of Health Care Services
4501 Business Park Blvd, Building L
Anchorage, Alaska 99503
Ph: 907-334-2425
Fax: 907-561-1684
erin.narus@alaska.gov
Office hours: 9:00am – 5:00pm

For Secure Communication through the Alaska Health Information Exchange
please use: Erin.Narus@direct.dhss.akhie.com ⇓Note new address

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Additional Provider Information:
http://manuals.medicaidalaska.com/docs/pharmacy.htm

Magellan Clinical Call Center: (800) 331-4475

From: Woods, Sarah B (HSS) [mailto:sarah.woods2@alaska.gov]
Sent: Tuesday, March 15, 2016 1:39 PM
To: Katie Bruggeman <Katie.Bruggeman@akleg.gov>
Cc: Newman, Anthony (HSS) <anthony.newman@alaska.gov>; Dunkin, Susan M (HSS) <susan.dunkin@alaska.gov>
Subject: RE: DRAFT - for your review - SB156 points

Just to clarify – is the committee expecting to adopt and pass out version E, or some other yet-to-be-developed refinement thereof? In other words, to which bill version are we asked to respond?

Thanks.

From: Katie Bruggeman [mailto:Katie.Bruggeman@akleg.gov]
Sent: Tuesday, March 15, 2016 1:34 PM
To: Newman, Anthony (HSS)
Cc: Davidson, Valerie J (HSS); Sherwood, Jon (HSS); Brodie, Margaret C (HSS); Narus, Erin Y (HSS); Woods, Sarah B (HSS); Peterson, Darwin R (GOV); Wilcox, Lacy J (GOV); McClanahan, Natasha S (GOV)
Subject: RE: DRAFT - for your review - SB156 points

Thank you all.

Senator Gardner will consult with the Legislative Legal team to incorporate some of these changes. At this point we do know definitively that we do not want to include coverage of condoms with this legislation.
-Katie

Katie Bruggeman
Aide to Senator Berta Gardner
Anchorage District I
Spenard Midtown UMed

Session Contact:
(907) 465-3881
Alaska State Capitol, Room 9
Juneau, AK 99801
www.AlaskaSenateDems.com/Gardner
www.Facebook.com/BertaGardner

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Erin Y.N. Narus, PharmD, RPh
Pharmacy & Ancillary Services Mgr, Lead Pharmacist
Division of Health Care Services
4501 Business Park Blvd, Building L
Anchorage, Alaska 99503
Ph: 907-334-2425
Fax: 907-561-1684
erin.narus@alaska.gov
Office hours: 9:00am – 5:00pm

For Secure Communication through the Alaska Health Information Exchange please use: Erin.Narus@direct.dhss.akhie.com ←Note new address

Drug Utilization:
http://dhss.alaska.gov/dhcs/Pages/pdl/drugutilizb_pdl.aspx

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February 2015

GUTTMACHER INSTITUTE

Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care

National and State Estimates for 2010

Adam Sonfield and Kathryn Kost

HIGHLIGHTS

- Nationally, 51% of all U.S. births in 2010 were paid for by public insurance through Medicaid, the Children's Health Insurance Program and the Indian Health Service.
- Public insurance programs paid for 68% of the 1.5 million unplanned births that year, compared with 38% of planned births.
- Two million births were publicly funded in 2010; of those, about half—one million—were unplanned.
- A publicly funded birth in 2010 cost an average of $12,770 in prenatal care, labor and delivery, postpartum care and 12 months of infant care; when 60 months of care are included, the cost per birth increases to $20,716.
- Government expenditures on the births, abortions and miscarriages resulting from unintended pregnancies nationwide totaled $21.0 billion in 2010; that amounts to 51% of the $40.8 billion spent for all publicly funded pregnancies that year.
- To put these figures in perspective, in 2010, the federal and state governments together spent an average of $336 on unintended pregnancies for every woman aged 15–44 in the country.
- In the absence of the current U.S. publicly funded family planning effort, the public costs of unintended pregnancies in 2010 might have been 75% higher.
- The total gross potential savings from averting all unintended pregnancies in 2010 would have been $15.5 billion. This is less than the total public cost of all unintended pregnancies, because even if all women had been able to time their pregnancies as they wanted, some of the resulting births still would have been publicly funded. These potential savings do not account for the public investment in family planning services and other interventions that might be required to achieve them.

February 2015

Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010

Adam Sonfield and Kathryn Kost

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ACKNOWLEDGMENTS

This report was prepared by Adam Sonfield and Kathryn Kost. Lawrence Finer, Jennifer J. Frost, Rachel Benson Gold and Rebecca Wind provided comments on drafts. It was edited by Jared Rosenberg. All are employees of the Guttmacher Institute.

We rely greatly on the work of staff from the Pregnancy Risk Assessment Monitoring System (PRAMS) Working Group and the Centers for Disease Control and Prevention, who collected, compiled and published much of the surveillance data we use in this report. We also thank staff at state health departments throughout the United States, who provided tabulations of state-level data upon request. Without their cooperation, expertise and dedicated work, the estimates provided in this report would not be possible.

The Guttmacher Institute gratefully acknowledges the general support it receives from individuals and foundations, including major grants from the William and Flora Hewlett Foundation and the David and Lucile Packard Foundation, which undergirds all of the Institute's work.

Suggested citation: Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010,* New York: Guttmacher Institute, 2015, <http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf>.

www.guttmacher.org

Introduction

Unintended pregnancy has long been acknowledged as an important health, social and economic problem in the United States—one that creates hardships for women and families and threatens the health and well-being of women and their infants.[1–4] Those consequences, in turn, have broad societal implications, including for the national economy and the extent of government expenditures.

Rates of unintended pregnancy are far higher among women living at or near the poverty level than among higher-income women—a disparity that grew substantially between 1994 and 2008.[5,6] Most of these low-income women are eligible for public coverage of pregnancy-related care through Medicaid, the Children's Health Insurance Program (CHIP) or the Indian Health Service (IHS). Thus, these programs play a central role in preserving maternal and child health, and a substantial share of the cost burden of unintended pregnancy is likely to fall on the public.

This report provides national and state-level estimates for 2010 for public expenditures on unintended pregnancy, as well as for the contribution of public insurance programs in providing essential care to pregnant women and children. It closely follows the methodology used for the Guttmacher Institute's 2006 and 2008 estimates.[7,8] However, because of several key changes to the methodology, public expenditure estimates for 2010 are not comparable with those for earlier years. Rates and numbers of unintended pregnancies in each state in 2010 are presented elsewhere.[9]

WHAT IS UNINTENDED PREGNANCY?

An unintended pregnancy is one that was either mistimed or unwanted. If a woman did not want to become pregnant at the time the pregnancy occurred, but did want to become pregnant at some point in the future, the pregnancy is considered mistimed; if she did not want to become pregnant then or at anytime in the future, the pregnancy is considered unwanted.

An intended pregnancy is one that was desired at the time it occurred or sooner.

When calculating unintended pregnancy rates, women who were indifferent about becoming pregnant are counted with women who had intended pregnancies, so that the unintended pregnancy rate only includes pregnancies that are unambiguously unintended.

In this report, births resulting from unintended pregnancies are referred to as unplanned and those resulting from intended pregnancies are referred to as planned.

Methodology

The analysis in this report is based on the methodology used for the Guttmacher Institute's first state-level estimates of the publicly funded costs of births from unintended pregnancy for 2006 and its follow-up for 2008.[7,8] More details on the methodology can be found in those reports.

This report focuses on the cost of publicly funded births: those births with deliveries paid for by Medicaid, CHIP or IHS, including Medicaid and CHIP managed care plans, and Medicaid and CHIP programs operating under Section 1115 waivers (which permit states to receive federal funding for programs that do not meet federal Medicaid and CHIP requirements). For these 2010 estimates, we have included costs of prenatal care, labor and delivery, postpartum care and 60 months of care for the child. Also, we factored in the relatively small public costs of abortions and miscarriages resulting from unintended pregnancies.

To estimate the costs of publicly funded births, we obtained three underlying state-level estimates for each state: the number of unplanned births in a given year, the proportion of unplanned births with deliveries paid for by public programs and the cost to those programs for each birth. The same three underlying estimates were also obtained for planned births and births overall.

Number of Births

A related Guttmacher Institute analysis estimated 2010 unintended pregnancy rates for all 50 states and the District of Columbia.[9] That analysis utilized birth counts from the U.S. vital statistics system; data on the intendedness of births from the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance project of the Centers for Disease Control and Prevention (CDC); data from similar state-conducted surveys; and results from multivariate linear regression analyses for several states for which data were unavailable. We obtained the estimated number of unplanned births for each state from unpublished tabulations of the data used in that analysis. Descriptions of and additional notes about those data sources can be found in that report.[9]

Births Paid for by Public Programs: Survey Data

PRAMS was the primary source for the proportion of births—all births, unplanned births and planned births—with deliveries paid for by Medicaid, CHIP and IHS. The core PRAMS questionnaire for 2010 asked how the respondent's delivery was paid for. Possible responses included Medicaid, personal income, private health insurance and up to two additional categories defined by individual states; respondents could also answer "other" and write in additional information.

PRAMS or similar data were available for 42 states. For 38 states, we obtained weighted estimates of the proportion of births paid by public funds from 2010 PRAMS data: Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

For these 38 states, we identified CHIP and IHS programs, Medicaid and CHIP managed care plans, and Medicaid and CHIP waiver programs. For some states, these payment options were included on the PRAMS questionnaire as a response option for the delivery payment question and listed either within the Medicaid payment category or as a separate category.

The IHS was included as a state-specific category in nine states in the 2010 PRAMS survey (Alaska, Minnesota, Mississippi, Nebraska, New Mexico, Oklahoma, Oregon, Washington and Wisconsin). In addition, the following state-specific programs were included in this analysis: Alabama (All Kids), Alaska (Alaska Native Health Service), Arkansas (ARKids First), Colorado (Child Health Plan Plus), Connecticut (State Administered General Assistance and Charter Oak), Florida (Medipass), Illinois (All Kids, Moms and Babies), Michigan (Medical Outpatient Maternity Services), Nebraska (Medicaid managed care), New Jersey (New Jersey FamilyCare), New Mexico (Salud!), New York (Prenatal Care Assistance Program), North Carolina (Baby Love, NC Health Choice,

Health Check, Carolina Access), Pennsylvania (adultBasic), Rhode Island (RIte Care), Tennessee (CoverKids, Cover Tennessee and TennCare), Vermont (Dr. Dynasaur), Virginia (FAMIS) and Wisconsin (BadgerCare or BadgerCare Plus).

In addition, the payment-for-delivery question included an "other" response category, allowing respondents to write in other forms of payment. Relevant write-in responses were included for 26 states with data we were able to analyze. Those included variations and misspellings of Medicaid, CHIP and IHS; alternate program names, including generic ones (e.g., "medical assistance" or "Title XIX") and state-specific ones (as confirmed on state Web sites); and the names of specific managed care plan issuers that specialize in Medicaid and other public insurance programs (as confirmed on state and issuer Web sites).

We also obtained tabulations from PRAMS-like surveys in four states: California (2011 Maternal and Infant Health Assessment, or MIHA), Idaho (2010 Pregnancy Risk Assessment Tracking System, or PRATS), Iowa (2010 Barriers to Prenatal Care survey) and Kentucky (2008 PRAMS pilot survey).

Births Paid for by Public Programs: Multivariate Regression

For the remaining nine jurisdictions, PRAMS or similar data were unavailable: Arizona, the District of Columbia, Indiana, Kansas, Montana, Nevada, New Hampshire, North Dakota and South Dakota. For these, we report, in Table 1, estimates from a study by Markus and colleagues (2013) on the proportion of all births paid for by Medicaid in 2010.[10]

That study, however, does not include estimates for unplanned births or planned births. Instead, we used a multivariate linear regression analysis to predict estimates of the proportions of unplanned and planned births paid for by public coverage (including Medicaid, CHIP or IHS).

In the model, each of the 42 states with data represented an observation. The dependent variable was the proportion of unplanned births for which the delivery was covered by public insurance. (A separate model was estimated for planned births.) Independent variables, measured at the state level, included measures of the demographic composition of women aged 15–44, overall birthrate, unplanned birthrate, proportion of all births paid for by Medicaid and income-eligibility threshold for pregnancy-related care under Medicaid and CHIP. The model's demographic measures included the percentage of women of reproductive age in the state who were in a particular age-group (15–19, 20–24 and 25–34), race or ethnicity category (non-Hispanic white, non-Hispanic black, Hispanic, and American Indian or Alaskan Native), poverty status category (proportion below the poverty line) and insurance category (Medicaid/CHIP and uninsured); the reference categories, which were excluded to prevent overspecification of the model, were 35 or older, non-Hispanic other, proportion at or above the poverty line and proportion with private insurance, respectively. This model was identical to the model used for the 2008 study.[8]

The R^2 of the final model indicated that 89% of the variation in the proportion of unplanned births that were publicly funded and 95% of the variation in the proportion of planned births that were publicly funded could be accounted for by the independent variables.

Standard errors for the nine predicted values of the proportion of unplanned births that were publicly funded ranged from 0.01 to 0.05, except for in the District of Columbia (0.10), which is somewhat unlikely to conform to a model in which all the other observations are states, as opposed to cities. Standard errors for the nine predicted values of the proportion of planned births that were publicly funded ranged from 0.01 to 0.04 (0.06 for the District of Columbia).

Cost per Publicly Funded Birth

State-level data on the average cost of a Medicaid-funded birth and 12 months of infant care in 2010 were drawn from an earlier Guttmacher Institute report.[11] Data on the cost of a CHIP- or IHS-funded birth were not available; for the current analysis, we assumed that it was the same as for a Medicaid-funded birth. Briefly, data on these Medicaid costs are not consistently collected for all states, but were available in applications or evaluations completed by 25 states that have sought a federal waiver to expand Medicaid eligibility specifically for family planning services (adjusted for inflation when necessary), and from another 10 states and the District of Columbia in response to a Guttmacher Institute survey.[12] For the remaining 15 states, we obtained estimates by averaging the available data and adjusting for differences among states in their Medicaid payment rates for physicians.

Additional data on the average cost of Medicaid-funded care for months 13–60 were drawn from a Guttmacher Institute analysis published in 2014, which expanded and updated our methodology for assessing the public savings related to U.S. publicly funded family planning services.[13] That analysis relied upon 2010 state-level data from the Medicaid Statistical Information System.

For the current analysis, we separated the average cost of a Medicaid-funded birth for each state into state and federal costs, on the basis of the state's FY 2010 federal medical assistance percentage (i.e., the proportion of medical costs under Medicaid for which states receive

reimbursement from the federal government).[14]

We multiplied the number of unplanned births in each state by the proportion of such births paid for by public programs to arrive at each state's number of publicly funded unplanned births. That figure was then multiplied by the average cost of a Medicaid-funded birth in the state to arrive at a total cost for the state. The same process was used for the cost of all publicly funded births in each state (including planned births, which we subsequently calculated by subtraction).

Public Costs for Miscarriages and Abortions

One change from the 2006 and 2008 iterations of this analysis is that, for 2010, we included estimates of the public costs of miscarriages and abortions to arrive at a more complete estimate of the total public costs of unintended pregnancies. Neither addition had a substantial effect on the nationwide total costs, with miscarriages accounting for 1.5% of total costs and abortions accounting for 0.3%.

We obtained unpublished numbers of total miscarriages and of miscarriages from unintended and intended pregnancies from a related Guttmacher Institute analysis of 2010 unintended pregnancy rates.[9] Following the methodology of the Guttmacher Institute's expanded assessment of the benefits and savings from publicly funded family planning services,[13] we assumed that the proportion of miscarriages that were publicly funded was equal to the proportion of births that were publically funded. That same report estimated that the average cost of a publicly funded miscarriage is 9.8% of the average cost of publicly funded maternity and infant care. We applied that estimate here to arrive at state-level cost estimates per miscarriage.

Public expenditures for abortions in 2010 were published in a prior Guttmacher Institute report.[12] Almost all of those costs are for the 17 states that use their own funds to pay for abortions for publicly insured women.

Potential Savings from Preventing Unintended Pregnancies

The Guttmacher Institute's expanded assessment of the benefits and savings from publicly funded family planning services also included an adjustment to account for the likelihood that some unintended pregnancies would not actually result in public savings if prevented.[13] That is because, in some cases, a woman who is able to prevent a mistimed pregnancy, but eventually has a wanted one, may only delay rather than avoid the costs to public insurance. The expanded assessment concluded that 73.3% of unplanned publicly funded births would be cost-saving to the government if prevented. The methodology for arriving at that adjustment factor is described in detail in the original report. (The adjustment factor is based on national data; state-level adjustments were not feasible with existing data.)

For this report, we estimated the total public costs for unintended pregnancies, alongside a second set of estimates for the potential gross savings from preventing those unintended pregnancies. To arrive at the second set of estimates, we applied the 73.3% adjustment factor to the costs of unplanned births. Note that these estimates do not account for the cost of the public investment (e.g., in family planning services) that might be required to achieve these potential savings.

National Totals

According to the National Survey of Family Growth (NSFG), there were an estimated 1.67 million unplanned births in the United States in 2008;[15] by comparison, the state-specific estimates from the 2008 iteration of this study summed to 1.81 million unplanned births that year.[8] To account for that difference, in the 2008 report, we presented both unadjusted U.S. totals (summed from the state-level data) and adjusted U.S. totals (for unplanned births, that was calculated as 92.5%—1.67 million divided by 1.81 million—of the unadjusted totals). Throughout that report, we referred exclusively to adjusted totals when discussing national estimates.

For 2010, we did not have a national estimate from the NSFG of unplanned births. (The most recent national estimate is from 2008; the next national estimate, which is expected to be published later this year, will be for 2011.) Therefore, we continued to use the 92.5% adjustment factor from the 2008 iteration of this study.

Limitations

Our estimates are subject to a number of limitations, many of which are inherent to the array of sources from which data were drawn and have been discussed previously.[16,17] Several others are important to highlight here.

Our method of attributing costs to state and federal governments has shortcomings. There are two ways it could understate federal contributions: We did not account for enhanced federal reimbursement to states for pregnant women enrolled in CHIP, rather than Medicaid; nor did we assign costs paid for by the IHS entirely to federal expenditures (IHS does not have a state matching component). Our method could overstate federal contributions, as well. We did not reduce federal expenditures to account for the typically lower reimbursement rate to states for women covered by Medicaid only for labor and

delivery on an emergency basis (e.g., for undocumented immigrants). The number of births affected by all three of these limitations, however, was relatively small, compared with the group for whom states receive reimbursement at their standard federal medical assistance percentage.

The public expenditures for unintended pregnancies, intended pregnancies and all pregnancies estimated in this paper for 2010 are not comparable with the public expenditures estimated in earlier Guttmacher papers for 2006 and 2008. As noted above, we included costs of prenatal care, labor and delivery, postpartum care and 60 months of care for the child, and we also factored in the relatively small public costs of abortions and miscarriages resulting from unintended pregnancies. The 2006 and 2008 estimates included only 12 months of care for the child, and did not include the costs of abortions and miscarriages.

Findings

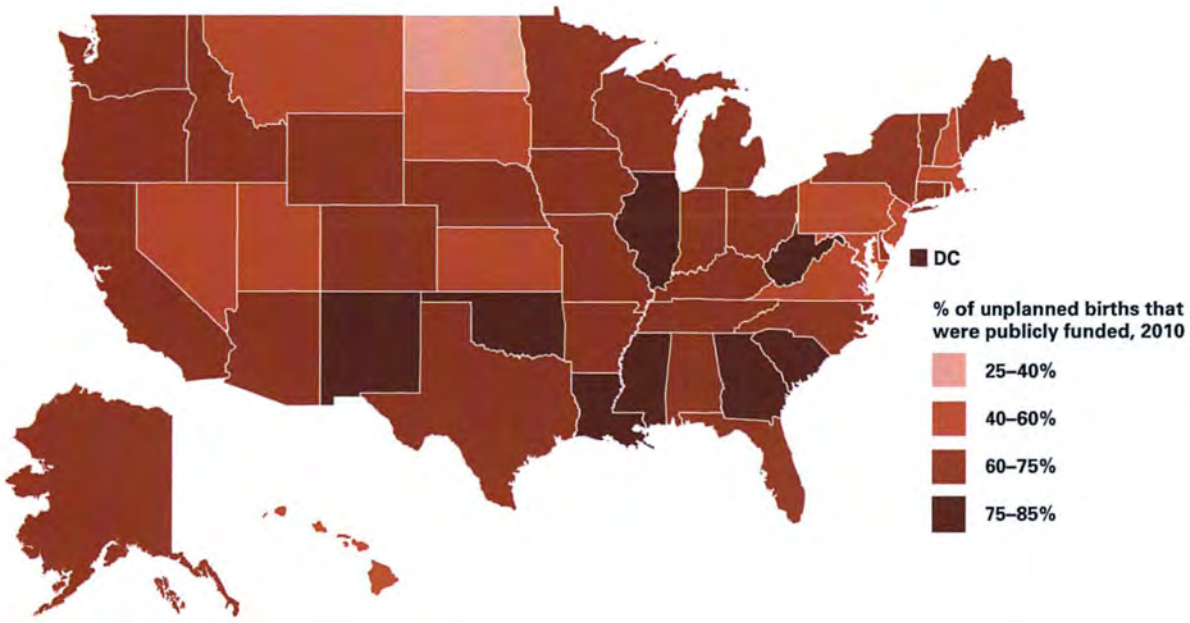
Publicly Funded Births

- Nationally, 68% of the 1.5 million unplanned births in 2010 were paid for by public insurance programs, compared with 51% of all births and 38% of planned births (Table 1).
- Two million births were publicly funded in 2010; of those, about half—1.0 million—were unplanned. (By comparison, 1.5 million out of 4.0 million total births nationwide were unplanned, 38%.)
- In eight states and the District of Columbia, at least 75% of unplanned births were paid for by public programs (Map 1). Mississippi was the state with the highest proportion (82%); the proportion in the District of Columbia was 85%. All but two of those nine jurisdictions are in the South (as categorized by the U.S. Census Bureau), a region with high levels of poverty.
- In six states, the proportion of unplanned births paid for by public programs was below 50%; North Dakota had the lowest proportion (37%). The six states with the lowest proportions follow no clear geographic pattern
- State-level patterns for public coverage of all births (Map 2) and planned births were very similar to those for unplanned births. Mississippi and the District of Columbia had the highest proportions, and other southern states followed closely. New Hampshire and North Dakota had the lowest proportions paid for by public insurance programs.

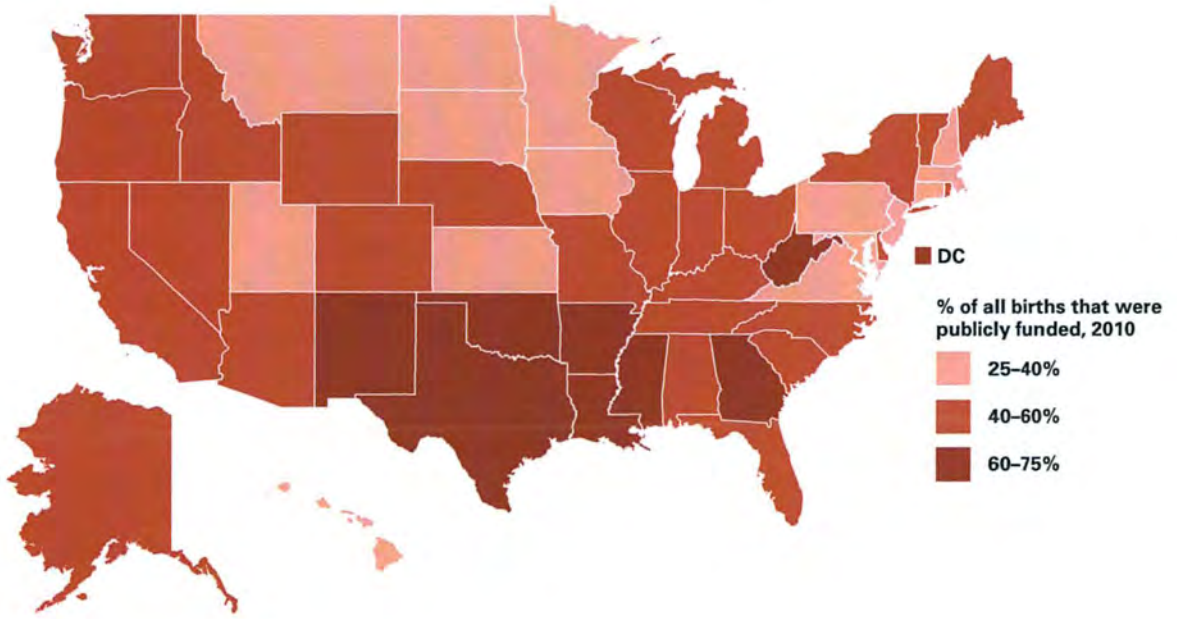
Public-Sector Costs

- On average, a publicly funded birth cost $12,770 in prenatal care, labor and delivery, postpartum care and the first 12 months of infant care; care for months 13–60 cost, on average, another $7,947, for a total cost per birth of $20,716 (Table 2).
- Government expenditures on unintended pregnancies nationwide totaled $21.0 billion in 2010; of that, $14.6 billion were federal expenditures and $6.4 billion were state expenditures (Table 3).
- In 19 states, public costs related to unintended pregnancies exceeded $400 million (Map 3). Texas spent the most ($2.9 billion), followed by California ($1.8 billion), New York ($1.5 billion) and Florida ($1.3 billion). (Those four states are the nation's most populous.)
- To put these figures in perspective, the federal and state governments together spent an average of $336 on unintended pregnancies for every woman aged 15–44 in the country.
- The average per woman aged 15–44 public expenditures on unintended pregnancies ranged from $107 in New Hampshire to $790 in Alaska; expenditures varied by state for a number of reasons, including variations in medical costs, the proportions of women who are poor and on Medicaid, the proportions of all births that are unplanned and the overall fertility rate of women in the state.
- The total potential gross savings from enabling women to avert all unintended pregnancies in 2010 would have been $15.5 billion. This is less than the total public cost of all unintended pregnancies (74% of that total), because even if all women had been able to time their pregnancies as they wanted, some births still would have been publicly funded when they eventually occurred. In other words, improved access to and use of contraceptives would have, in some cases, only delayed the public costs, rather than avoided them entirely. (These potential savings do not account for the public investment in family planning services and other interventions that might be required to achieve them.)
- The federal and state governments spent $19.8 billion for planned pregnancies in 2010; when added to the $21.0 billion for unplanned pregnancies, the total for all publicly funded pregnancies was $40.8 billion (Table 4). Thus, 51% of government expenditures on pregnancies in 2010 were spent on unplanned pregnancies.
- According to prior Guttmacher Institute research, the public investment in family planning services resulted in $15.8 billion in gross savings in 2010 from helping women avoid unintended pregnancies and the resulting births, abortions and miscarriages.[13] Putting that in the context of this study's findings, in the absence of the publicly funded family planning effort, the annual public costs of unintended pregnancy might be 75% higher—$36.8 billion, instead of $21.0 billion.

MAP 1. Medicaid and other public insurance programs paid for 68% of U.S. births resulting from unintended pregnancies in 2010, including at least 60% of births in 37 states and the District of Columbia



MAP 2. Medicaid and other public insurance programs paid for 51% of all U.S. births in 2010, including at least 40% of births in 35 states and the District of Columbia



MAP 3. Government expenditures on unintended pregnancies totaled $21 billion in 2010, and surpassed $400 million in 19 states

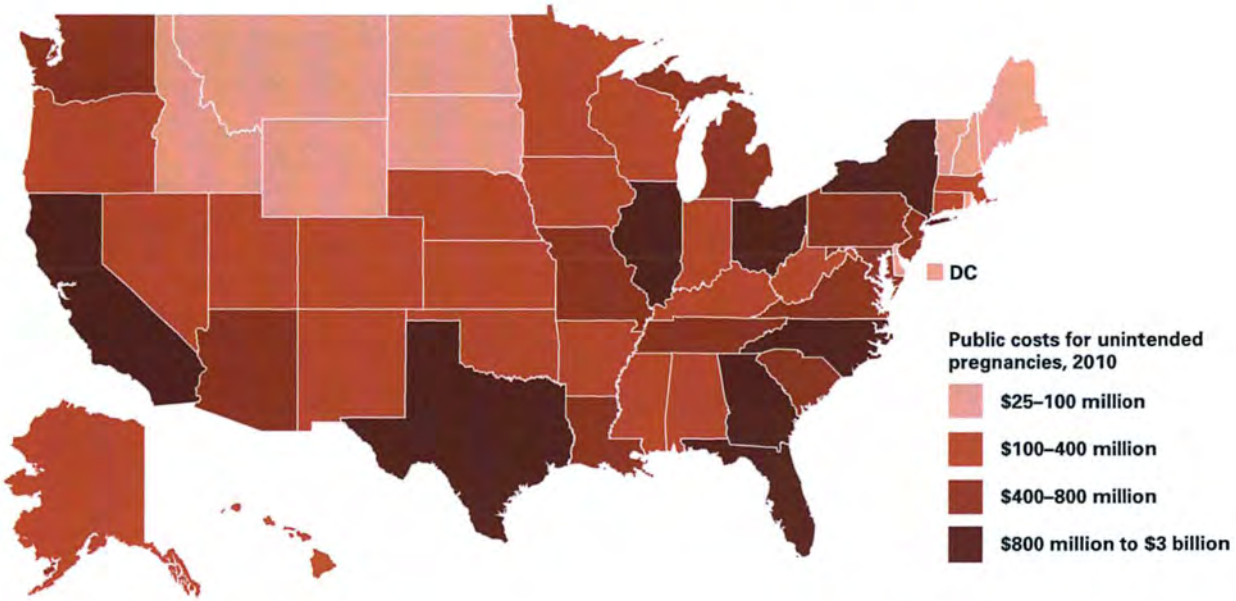


TABLE 1. Number of births, and percentage and number that were publicly funded, by pregnancy intention status, 2010

	No. of births			% that were publicly funded			No. that were publicly funded		
	All	Unplanned	Planned	All	Unplanned	Planned	All	Unplanned	Planned
U.S. total									
Adjusted	3,999,400	1,524,700	2,474,600	50.5	67.8	38.3	2,018,000	1,033,600	984,400
Unadjusted	3,999,400	1,648,800	2,350,500	50.5	67.8	38.3	2,018,000	1,117,700	900,300
State									
Alabama	60,100	29,500	30,500	58.2	61.6	38.4	34,900	18,200	16,800
Alaska	11,500	4,600	6,800	55.1	64.3	48.8	6,300	3,000	3,300
Arizona*	87,500	37,500	49,900	53.3	64.6	43.9	46,600	24,200	22,400
Arkansas	38,500	19,000	19,500	60.4	72.3	48.7	23,300	13,800	9,500
California	510,200	163,800	346,400	49.7	64.3	42.7	253,600	105,300	148,300
Colorado	66,400	23,800	42,600	44.2	63.8	33.3	29,300	15,100	14,200
Connecticut	37,700	13,000	24,700	35.5	60.8	22.2	13,400	7,900	5,500
Delaware	11,400	4,600	6,700	51.7	71.3	38.3	5,900	3,300	2,600
District of Columbia*	9,200	4,300	4,800	67.9	84.6	55.9	6,200	3,700	2,600
Florida	214,600	101,100	113,500	55.2	70.6	41.5	118,500	71,400	47,100
Georgia	133,900	68,800	65,100	61.6	80.5	41.5	82,500	55,500	27,000
Hawaii	19,000	8,700	10,300	37.0	49.9	26.2	7,000	4,300	2,700
Idaho	23,200	7,700	15,500	43.0	60.4	34.2	10,000	4,700	5,300
Illinois	165,200	70,200	95,000	55.5	78.3	38.7	91,700	55,000	36,700
Indiana*	83,900	35,500	48,400	46.6	64.6	33.6	39,100	22,900	16,200
Iowa	38,700	13,800	24,900	37.9	61.5	24.8	14,700	8,500	6,200
Kansas*	40,600	16,300	24,300	32.5	47.2	22.1	13,200	7,700	5,500
Kentucky	55,800	22,700	33,100	47.4	66.8	32.0	26,400	15,200	11,300
Louisiana	62,400	33,700	28,700	67.1	78.7	53.4	41,800	26,500	15,300
Maine	13,000	5,100	7,900	53.3	74.7	39.5	6,900	3,800	3,100
Maryland	73,800	32,600	41,200	39.2	58.2	24.0	28,900	19,000	9,900
Massachusetts	72,900	23,200	49,600	35.3	56.4	25.5	25,700	13,100	12,600
Michigan	114,500	51,000	63,600	52.9	71.9	37.8	60,600	36,600	24,000
Minnesota	68,600	22,000	46,600	39.2	66.7	26.2	26,900	14,700	12,200
Mississippi	40,000	22,700	17,300	70.5	81.9	55.6	28,200	18,600	9,600
Missouri	76,800	34,600	42,100	50.2	72.2	33.9	38,500	25,000	13,500
Montana*	12,100	4,400	7,600	35.0	47.8	28.8	4,200	2,100	2,100
Nebraska	25,900	10,000	16,000	43.1	63.1	30.7	11,200	6,300	4,900
Nevada*	35,900	13,200	22,700	44.1	60.0	35.2	15,800	7,900	7,900
New Hampshire*	12,900	4,100	8,700	29.9	52.7	18.7	3,800	2,200	1,700
New Jersey	106,900	38,600	68,300	36.2	52.4	27.0	38,700	20,200	18,400
New Mexico	27,900	13,200	14,600	64.4	77.1	52.9	17,900	10,200	7,700
New York	244,400	84,000	160,400	52.2	70.2	42.7	127,500	59,000	68,500
North Carolina	122,400	55,300	67,000	55.2	74.8	38.9	67,500	41,400	26,200
North Dakota*	9,100	3,500	5,600	28.5	36.8	21.2	2,600	1,300	1,300
Ohio	139,100	65,300	73,900	49.3	68.7	32.2	68,600	44,800	23,800
Oklahoma	53,200	24,300	29,000	65.2	80.7	52.2	34,700	19,600	15,100
Oregon	45,500	16,700	28,900	52.6	69.9	42.7	24,000	11,700	12,300
Pennsylvania	143,300	59,300	84,000	38.5	53.5	28.0	55,200	31,800	23,400
Rhode Island	11,200	4,300	6,900	51.5	70.1	39.8	5,800	3,000	2,700
South Carolina	58,300	24,000	34,300	56.5	78.6	41.1	33,000	18,900	14,100
South Dakota*	11,800	5,100	6,700	36.0	46.2	25.3	4,200	2,400	1,900
Tennessee	79,500	39,200	40,300	59.4	73.7	45.5	47,200	28,900	18,300
Texas	386,100	180,700	205,400	60.9	73.7	49.6	235,100	133,200	101,900
Utah	52,300	16,900	35,300	35.6	53.3	27.3	18,600	9,000	9,600
Vermont	6,200	2,200	4,000	50.2	73.5	37.7	3,100	1,600	1,500
Virginia	103,000	43,700	59,300	33.1	45.4	25.7	34,100	19,800	14,300
Washington	86,500	31,500	55,000	45.2	63.1	34.9	39,100	19,900	19,200
West Virginia	20,500	9,300	11,200	63.6	76.0	53.2	13,000	7,100	5,900
Wisconsin	68,500	27,200	41,300	42.6	62.0	27.0	29,200	16,900	12,300
Wyoming	7,600	2,800	4,700	46.4	67.4	33.7	3,500	1,900	1,600

*For these states, the number of unplanned births and the proportion of planned and unplanned births that were publicly funded were estimated by regression analyses. *Note:* Unadjusted U.S. total is the sum of individual state-level data. Adjusted U.S. total has been adjusted to match the number of unplanned births estimated in the National Survey of Family Growth (calculated as 92.5% of the unadjusted total for unplanned births).

TABLE 2. Cost per publicly funded birth and miscarriage, 2010

	Cost per publicly funded birth			Cost per publicly funded miscarriage
	Maternity care and months 1–12	Months 13–60	Total	
U.S total	$12,770	$7,947	$20,716	$1,252
Alabama	10,006	7,536	17,541	981
Alaska	23,825	13,583	37,408	2,335
Arizona	15,863	11,405	27,268	1,555
Arkansas	12,755	10,824	23,579	1,250
California	10,286	5,778	16,064	1,008
Colorado	9,406	6,027	15,433	922
Connecticut	16,736	9,090	25,826	1,640
Delaware	16,736	11,309	28,045	1,640
District of Columbia	7,169	10,157	17,326	703
Florida	10,748	7,458	18,206	1,053
Georgia	10,837	5,445	16,282	1,062
Hawaii	18,080	7,754	25,835	1,772
Idaho	15,457	3,260	18,717	1,515
Illinois	11,152	5,366	16,518	1,093
Indiana	10,460	5,690	16,150	1,025
Iowa	13,894	6,475	20,368	1,362
Kansas	13,947	7,283	21,230	1,367
Kentucky	14,887	9,701	24,588	1,459
Louisiana	16,779	7,401	24,180	1,644
Maine	9,414	5,745	15,159	923
Maryland	14,760	9,246	24,006	1,447
Massachusetts	15,109	11,670	26,779	1,481
Michigan	9,853	7,975	17,828	966
Minnesota	10,594	11,690	22,284	1,038
Mississippi	7,090	7,112	14,201	695
Missouri	11,572	8,897	20,468	1,134
Montana	13,079	5,833	18,912	1,282
Nebraska	14,411	6,541	20,953	1,412
Nevada	6,759	6,042	12,801	662
New Hampshire	5,848	6,267	12,115	573
New Jersey	15,233	7,649	22,882	1,493
New Mexico	13,102	9,908	23,010	1,284
New York	15,442	9,839	25,281	1,513
North Carolina	13,299	7,126	20,425	1,303
North Dakota	12,338	6,980	19,318	1,209
Ohio	10,925	7,220	18,144	1,071
Oklahoma	10,176	6,505	16,681	997
Oregon	7,314	6,956	14,270	717
Pennsylvania	11,015	11,580	22,596	1,080
Rhode Island	14,955	9,841	24,797	1,466
South Carolina	13,930	7,492	21,422	1,365
South Dakota	13,830	6,898	20,728	1,355
Tennessee	7,657	10,539	18,197	750
Texas	11,574	9,924	21,498	1,134
Utah	12,552	4,673	17,225	1,230
Vermont	10,857	8,225	19,082	1,064
Virginia	16,946	8,163	25,109	1,661
Washington	15,886	6,929	22,815	1,557
West Virginia	13,017	7,169	20,186	1,276
Wisconsin	12,667	5,643	18,310	1,241
Wyoming	21,036	7,460	28,496	2,062

TABLE 3. Total public costs for and potential savings from preventing unintended pregnancies, 2010

	Public costs for unintended pregnancies				Potential gross public savings from preventing unintended pregnancies†		
	All (in millions)	Federal (in millions)	State (in millions)	Per woman 15–44	All (in millions)	Federal (in millions)	State (in millions)
U.S total							
Adjusted	$21,001.7	$14,608.8	$6,392.9	$336	$15,494.7	$10,769.1	$4,725.6
Unadjusted	22,705.9	15,797.8	6,908.0	364	16,755.9	11,645.6	5,110.3
State							
Alabama	323.2	250.5	72.6	336	238.0	184.5	53.5
Alaska	113.7	70.8	42.9	790	83.9	52.2	31.7
Arizona*	670.9	509.4	161.5	531	494.4	375.4	119.0
Arkansas	328.7	266.8	61.9	576	242.0	196.5	45.5
California	1,751.4	1,062.1	689.3	222	1,299.9	784.0	515.9
Colorado	237.3	146.1	91.1	231	174.9	107.7	67.2
Connecticut	208.5	128.4	80.1	301	153.9	94.8	59.1
Delaware	94.2	58.2	36.0	526	69.5	43.0	26.6
District of Columbia*	64.1	50.9	13.3	393	47.2	37.5	9.8
Florida	1,320.0	892.8	427.1	371	973.2	658.3	314.9
Georgia	917.5	687.7	229.7	442	676.5	507.1	169.4
Hawaii	114.5	76.7	37.8	436	84.6	56.6	28.0
Idaho	88.7	70.2	18.5	289	65.4	51.8	13.6
Illinois	923.7	571.5	352.2	351	681.4	421.5	259.8
Indiana*	375.9	284.6	91.4	292	277.1	209.8	67.4
Iowa	175.8	127.6	48.3	305	129.7	94.1	35.6
Kansas*	166.1	115.7	50.4	299	122.4	85.3	37.1
Kentucky	377.9	302.8	75.0	442	278.4	223.1	55.3
Louisiana	651.0	530.4	120.6	700	480.0	391.1	88.9
Maine	58.2	43.6	14.6	241	42.9	32.1	10.8
Maryland	466.2	285.4	180.9	391	344.7	210.5	134.2
Massachusetts	357.9	219.6	138.3	264	264.3	162.0	102.3
Michigan	662.0	485.1	177.0	346	487.8	357.4	130.4
Minnesota	332.6	203.9	128.7	318	245.2	150.1	95.1
Mississippi	267.1	226.7	40.4	442	196.6	166.9	29.8
Missouri	518.4	385.9	132.6	440	381.8	284.2	97.6
Montana*	40.8	31.7	9.1	227	30.2	23.4	6.8
Nebraska	133.6	91.9	41.7	376	98.5	67.7	30.8
Nevada*	102.9	65.8	37.1	187	75.9	48.5	27.4
New Hampshire*	26.8	16.5	10.3	107	19.8	12.2	7.6
New Jersey	477.1	291.0	186.1	275	353.6	214.9	138.7
New Mexico	239.1	191.2	47.9	599	176.5	140.9	35.7
New York	1,538.7	937.7	601.1	380	1,140.9	692.7	448.3
North Carolina	858.3	643.5	214.7	440	632.7	474.4	158.3
North Dakota*	25.5	17.9	7.7	197	18.8	13.2	5.7
Ohio	824.6	605.8	218.8	369	607.6	446.4	161.2
Oklahoma	331.0	254.0	77.0	448	243.8	187.1	56.7
Oregon	169.9	122.7	47.2	225	125.6	90.4	35.2
Pennsylvania	726.8	478.6	248.2	298	535.3	352.5	182.8
Rhode Island	76.2	48.7	27.5	356	56.2	35.9	20.3
South Carolina	411.2	327.3	84.0	443	303.2	241.3	61.9
South Dakota*	49.4	35.0	14.4	324	36.4	25.8	10.6
Tennessee	530.7	400.0	130.7	416	390.4	294.2	96.2
Texas	2,899.4	2,056.8	842.6	543	2,135.3	1,514.8	620.5
Utah	158.0	127.6	30.4	262	116.5	94.1	22.4
Vermont	31.4	21.8	9.6	265	23.2	16.0	7.2
Virginia	506.5	312.0	194.6	306	373.7	230.1	143.5
Washington	467.8	290.7	177.1	345	346.7	214.5	132.2
West Virginia	145.4	120.5	24.9	425	107.2	88.8	18.4
Wisconsin	313.5	221.4	92.1	286	231.1	163.2	67.9
Wyoming	55.3	34.1	21.3	519	40.8	25.1	15.7

*For these states, the number of unplanned births and the proportion of planned and unplanned births that were publicly funded were estimated by regression analyses. †Does not account for the cost of the public investment (e.g., in family planning services) that might be required to achieve these potential savings.
Note: Unadjusted U.S. total is the sum of individual state-level data. Adjusted U.S. total has been adjusted to match the number of unplanned births estimated in the National Survey of Family Growth (calculated as 92.5% of the unadjusted total for unplanned births).

TABLE 4. Costs for all publicly funded pregnancies and for publicly funded intended pregnancies, 2010

	All publicly funded pregnancies (in millions)			Publicly funded intended pregnancies (in millions)		
	All	Federal	State	All	Federal	State
U.S. total						
Adjusted	$40,838.9	$28,260.1	$12,578.8	$19,837.2	$13,651.3	$6,185.8
Unadjusted	40,838.9	28,260.1	12,578.8	18,133.0	12,462.3	5,670.7
State						
Alabama	620.5	481.1	139.4	297.3	230.5	66.8
Alaska	239.9	149.6	90.2	126.2	78.8	47.4
Arizona*	1,286.9	977.1	309.8	616.0	467.7	148.3
Arkansas	554.7	450.3	104.4	226.0	183.4	42.5
California	4,162.3	2,546.1	1,616.2	2,410.9	1,484.0	926.9
Colorado	458.1	282.2	176.0	220.8	136.0	84.8
Connecticut	351.0	216.2	134.8	142.6	87.8	54.8
Delaware	167.2	103.3	63.9	73.0	45.1	27.9
District of Columbia*	108.9	86.4	22.6	44.8	35.5	9.3
Florida	2,186.4	1,478.8	707.5	866.4	586.0	280.4
Georgia	1,363.0	1,021.7	341.3	445.5	333.9	111.6
Hawaii	185.1	124.3	60.8	70.6	47.5	23.1
Idaho	189.9	150.4	39.5	101.2	80.1	21.1
Illinois	1,537.3	951.2	586.1	613.6	379.7	233.9
Indiana*	640.2	484.5	155.6	264.2	200.0	64.2
Iowa	303.3	220.0	83.3	127.5	92.5	35.0
Kansas*	284.6	198.3	86.3	118.5	82.6	35.9
Kentucky	658.4	527.6	130.8	280.5	224.8	55.7
Louisiana	1,026.8	836.7	190.2	375.8	306.2	69.6
Maine	106.1	79.5	26.7	48.0	35.9	12.1
Maryland	706.8	433.4	273.3	240.5	148.1	92.5
Massachusetts	699.2	429.8	269.4	341.2	210.1	131.1
Michigan	1,094.2	801.7	292.5	432.2	316.7	115.5
Minnesota	607.3	373.1	234.2	274.7	169.2	105.6
Mississippi	405.2	343.9	61.3	138.1	117.2	20.9
Missouri	798.1	594.0	204.1	279.7	208.2	71.5
Montana*	81.3	63.2	18.0	40.4	31.5	8.9
Nebraska	237.5	163.3	74.2	103.9	71.4	32.4
Nevada*	205.1	131.1	74.0	102.1	65.3	36.8
New Hampshire*	47.1	29.0	18.1	20.3	12.5	7.8
New Jersey	904.1	553.8	350.2	426.9	262.8	164.1
New Mexico	419.4	336.3	83.1	180.3	145.1	35.2
New York	3,290.4	2,016.0	1,274.4	1,751.6	1,078.3	673.3
North Carolina	1,399.1	1,049.0	350.0	540.8	405.5	135.3
North Dakota*	50.9	35.6	15.3	25.3	17.7	7.6
Ohio	1,260.2	925.9	334.3	435.6	320.0	115.6
Oklahoma	586.2	449.8	136.4	255.2	195.8	59.4
Oregon	347.6	252.1	95.5	177.6	129.4	48.3
Pennsylvania	1,260.8	830.2	430.6	534.0	351.6	182.3
Rhode Island	144.6	92.4	52.2	68.4	43.7	24.7
South Carolina	716.3	570.0	146.3	305.1	242.8	62.3
South Dakota*	89.3	63.2	26.1	39.8	28.2	11.6
Tennessee	867.0	653.5	213.5	336.3	253.5	82.8
Texas	5,113.2	3,627.3	1,485.9	2,213.8	1,570.4	643.3
Utah	325.5	263.0	62.6	167.5	135.3	32.2
Vermont	60.7	42.3	18.4	29.3	20.5	8.8
Virginia	869.3	535.4	333.9	362.8	223.5	139.4
Washington	912.2	570.3	342.0	444.5	279.6	164.9
West Virginia	266.7	221.2	45.5	121.3	100.7	20.6
Wisconsin	541.9	382.8	159.2	228.4	161.3	67.1
Wyoming	101.3	62.4	38.9	46.0	28.3	17.7

*For these states, the number of unplanned births and the proportion of planned and unplanned births that were publicly funded were estimated by regression analyses. *Note:* Unadjusted U.S. total is the sum of individual state-level data. Adjusted U.S. total has been adjusted to match the number of unplanned births estimated in the National Survey of Family Growth (calculated as 92.5% of the unadjusted total for unplanned births).

Conclusions

This analysis demonstrates the continuing importance of Medicaid and other public health insurance programs (CHIP and IHS) for helping American women and families afford the expense of pregnancy and childbirth: These programs paid for 51% of all U.S. births in 2010, two million of them in total, including 68% of unplanned births. The role of Medicaid in funding U.S. births increased dramatically as a result of nationwide expansions in Medicaid eligibility for pregnant women in the mid-1980s. In 1985, Medicaid paid for 15% of U.S. births; by 1991, that figure had more than doubled, to 32%.[18] The role of these programs in funding U.S. births has likely expanded further since 2010. That is because the Affordable Care Act's major expansion of Medicaid—eligibility for all U.S. citizens and long-time legal residents with incomes up to 138% of the federal poverty level—started up in about half the states in 2014.

This report also highlights the substantial costs to the federal and state governments of unintended pregnancies—costs beyond the myriad health, social and economic consequences of unintended pregnancies for women and families. These public costs are most likely understated in this report: In reality, such costs would extend beyond the 60-month horizon used here. Moreover, they would also include costs from pregnancy-related care paid for by other public health programs, including indigent care programs that subsidize hospitals' uncompensated care, as well as other government benefits, such as nutrition assistance and income subsidies.

Yet, even using this conservative approach, the public costs of unintended pregnancy amounted to $21.0 billion in a single year. An estimated three-quarters of those costs—$15.5 billion—represent potential gross government savings, if women and couples could be empowered to prevent these unintended pregnancies. These potential savings do not account for the public investment in family planning services and other interventions that might be required to achieve them.

However, we know that it is possible to enable women to time and space wanted pregnancies and to prevent pregnancies they do not, and that doing so reduces public costs. The nation's current public investment in family planning services helped avert $15.8 billion in costs related to unintended pregnancies in 2010.[13] In the absence of that investment, the public costs of unintended pregnancy could have been 75% higher that year—$36.8 billion, instead of $21.0 billion.

Expanding that investment is critical to further reducing unintended pregnancies in the United States, along with the health, social and economic consequences—including public-sector costs—that follow. That would mean strengthening safety-net programs, including the Title X national family planning program. It would also mean taking every step possible to ensure that the Affordable Care Act fully reaches its potential to bolster Medicaid and other safety-net programs.

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125 Maiden Lane
New York, NY 10038
(212) 248-1111; fax (212) 248-1951
info@guttmacher.org

1301 Connecticut Avenue NW, Suite 700
Washington, DC 20036
policyinfo@guttmacher.org

www.guttmacher.org

Shifts in Intended and Unintended Pregnancies in the United States, 2001–2008

Lawrence B. Finer, PhD, and Mia R. Zolna, MPH

Objectives. We monitored trends in pregnancy by intendedness and outcomes of unintended pregnancies nationally and for key subgroups between 2001 and 2008.

Methods. Data on pregnancy intentions from the National Survey of Family Growth (NSFG) and a nationally representative survey of abortion patients were combined with counts of births (from the National Center for Health Statistics), counts of abortions (from a census of abortion providers), estimates of miscarriages (from the NSFG), and population denominators from the US Census Bureau to obtain pregnancy rates by intendedness.

Results. In 2008, 51% of pregnancies in the United States were unintended, and the unintended pregnancy rate was 54 per 1000 women ages 15 to 44 years. Between 2001 and 2008, intended pregnancies decreased and unintended pregnancies increased, a shift previously unobserved. Large disparities in unintended pregnancy by relationship status, income, and education increased; the percentage of unintended pregnancies ending in abortion decreased; and the rate of unintended pregnancies ending in birth increased, reaching 27 per 1000 women.

Conclusions. Reducing unintended pregnancy likely requires addressing fundamental socioeconomic inequities, as well as increasing contraceptive use and the uptake of highly effective methods. (*Am J Public Health.* 2014;104: S43–S48. doi:10.2105/AJPH.2013.301416)

The incidence of unintended pregnancy is a key indicator of a population's reproductive health, and preventing unplanned pregnancies is a priority for most sexually active men and women. In an effort to improve the nation's health, the US Department of Health and Human Services includes the goal of reducing the incidence of unintended pregnancy in its Healthy People 2020 initiative,[1] toward which it is important to monitor progress. The most recent estimates of the unintended pregnancy rate for the US population as a whole and for many population subgroups were published for 2006.[2] Since then, new data have been released that allowed the calculation of rates for 2008.

There are several reasons why newer estimates are valuable. Since the last analysis, more precise population estimates have become available, and the United States experienced an economic recession beginning in 2007 that has affected women's reported pregnancy intentions, with many women indicating that because of the economy, they would like to delay pregnancy.[3] Moreover, the recession has affected many providers' ability to offer family planning services and women's ability to access basic health care.[4]

Some changes in behaviors that affect unintended pregnancy have been noted in recent years. For example, use of highly effective long-acting contraceptive methods increased from 2002 to 2009.[5] By contrast, population shifts, that is, changes in the relative sizes of demographic subgroups, can have an impact on the unintended pregnancy rate even if rates or behaviors within subgroups are unchanged. For example, because rates are high among cohabiting women, the growing number and proportion of cohabiting couples[6] could have led to an increase in the national unintended pregnancy rate since it was last estimated.

In this article, we focus on the overall rate and disparities among several key subgroups for 2008 and shifts in intended and unintended pregnancy between 2001 and 2008. We did not include 2006 rates because it was difficult to assess real changes within a short (2-year) time frame.

METHODS

Pregnancy intention is based on women's self-reported desire to become pregnant right before conception occurred. We defined an unintended pregnancy as one that was either mistimed or unwanted. If a woman did not want to become pregnant at the time the pregnancy occurred, but did want to become pregnant at some point in the future, the pregnancy was considered mistimed. If a woman did not want to become pregnant then or at any time in the future, the pregnancy was considered unwanted. An intended pregnancy was one that was desired at the time it occurred or sooner. When calculating unintended pregnancy rates, we counted pregnancies about which women felt indifferent along with intended pregnancies; therefore, the unintended pregnancy rate only included pregnancies that were unambiguously unintended.

Our methodology built on our previously published estimates of unintended pregnancy.[2] Changes to the methodology are noted at various points in the following. The proportions of births, miscarriages, and abortions that were unintended were calculated from the National Center for Health Statistics' (NCHS) 2006–2010 National Survey of Family Growth (NSFG; for births and miscarriages that occurred between 2006 and 2010, with 2008 as the central or reference year; n = 3019) and the Guttmacher Institute's 2008 Abortion Patient Survey (for abortions that occurred in 2008; n = 9493) by each sociodemographic characteristic in this analysis.[7] Data were analyzed using Stata version 12.1 (StataCorp LP, College Station, TX).

These proportions were applied to the numbers of births, miscarriages, and abortions reported or estimated for the entire population in 2008 to determine the number

of unintended pregnancies by each pregnancy outcome. The number of births in the United States in 2008 came from the NCHS,[8,9] and the number of abortions, including both surgical and medication abortions, came from a periodic census of abortion providers conducted by the Guttmacher Institute.[10] Because there is no recognized best estimate of the number of miscarriages for each year, we followed a procedure established by researchers at the NCHS[11]: we calculated the ratio of miscarriages to births reported in the NSFG and multiplied that ratio by the actual number of US births. Multiple rounds of the NSFG were used to maximize the stability of miscarriage estimates over time. Specifically, we used miscarriages that occurred in the 7 years preceding the last 3 NSFG rounds for adults and the last 4 rounds for adolescents (1988, 1995, 2002, and 2006–2010); previous analyses used data from 2 and 3 NSFG rounds, respectively, which conformed to NCHS procedures utilized at that time. To ensure sufficient sample size, we also used 4 rounds of the NSFG to calculate miscarriages for income by race/ethnicity groups.

The total number of unintended pregnancies was obtained by summing unintended pregnancies ending in birth, miscarriage, and abortion. This total was then divided by the population of women of reproductive age (15–44 years) to determine an overall unintended pregnancy rate. This process was repeated for several population subgroups, first distributing pregnancies by subgroup and then using the subgroup population denominator to calculate the rate for each group. Distributions of pregnancies by intention for each subgroup were calculated using the NSFG. Counts of births and miscarriages were distributed using data from the US Census Bureau and the NSFG. Abortions were distributed based on the Centers for Disease Control and Prevention's annual abortion surveillance report and the Guttmacher Institute's nationally representative Abortion Patient Survey conducted in 2008.[7,12]

As in previous analyses, when calculating the percentage of unintended pregnancies that ended in abortion, we excluded miscarriages from the denominator to represent pregnancies with outcomes decided by the woman. Overall adolescent pregnancy rates varied slightly from other published reports[13] because of differences in the way miscarriages were calculated. Rates by educational attainment were limited to the population of women 20 years and older, which excluded most women who had not yet completed schooling, yet still included young women who had historically high unintended pregnancy rates.

Population counts by age and race/ethnicity came from the final intercensal estimates from the 2010 US census.[14] The 2001 rates in this report were updated using the new population estimates and should therefore replace previously published figures. Most other subgroup population distributions came from the US Census Bureau and the Annual Social and Economic Supplements of the Current Population Survey (CPS). For characteristics not tracked by those sources (e.g., religious affiliation), we used NSFG distributions.

In previous reports, our estimates were based on the proportion of cohabiting women reported in the NSFG. In this report, we strengthened our methodology by incorporating the newly available (as of 2007) individual-level measure of cohabitation included in the CPS. Although both surveys were broadly nationally representative, the substantially larger sample size in the CPS should have produced a more accurate proportion of cohabitors in the US population. To produce 2001 rates, we calculated the ratio of the number of cohabitors to the number of unmarried women in the NSFG in 2008, and applied that ratio to the 2008 CPS proportion of unmarried women to obtain a comparable proportion for 2001.

For all women of reproductive age in the United States and for several demographic characteristics (age, relationship status, income as a percentage of poverty, educational attainment, race/ethnicity, and religious affiliation) by subgroup, we present information on the proportion of pregnancies that were unintended and pregnancy rates by intention status in Table 1 and outcomes of unintended pregnancy in Table 2. For each characteristic, we discuss the basic patterns of unintended pregnancy in 2008 and substantive shifts in pregnancy intention between the 2001 and 2008 (when possible). Lastly, we present unintended pregnancy rates for 2008 for women by both income and race/ethnicity in Figure 1.

This was an aggregate-level analysis, and pregnancy rates were calculated by incorporating data from multiple datasets, which limited our ability to do statistical difference testing. One test we were able to perform was a comparison of the proportion of pregnancies (births, abortions, and miscarriages) that were unintended in 2001 and 2008 using only data from the NSFG. Although abortions were underreported in the NSFG, meaning that these proportions were lower than the ones reported in Table 1, it was likely that underreporting did not change substantially over time; therefore, although the percentages in the supplemental analysis were too low, the trend analyses should be valid. The supplemental analysis found an overall percentage increase from 42% to 46%, which was marginally significant at $P = .05$. This increase corresponded to an increase in the rate in the aggregate (i.e., main) analysis from 49 per 1000 women to 54, which was a 10% change; we therefore used 10% as our standard for a (substantively) significant difference, and we limit our discussion to differences of that size or greater.

RESULTS

Of the nearly 6.6 million pregnancies that occurred in 2008, 51% were unintended (Table 1). Although the overall pregnancy rate for the United States changed little between 2001 and 2008, women's reports indicated a small shift from intended to unintended pregnancies; the intended pregnancy rate fell slightly to 51 per 1000 women ages 15 to 44 years, and the unintended rate increased (by 10%, or 5 rate points) to 54 per 1000 women. The proportion of unintended pregnancies ending in abortion declined, from 47% to 40%, and the rate of unintended pregnancies ending in birth increased to 27 per 1000 women (Table 2).

Age

In 2008, the proportion of pregnancies that were unintended generally decreased as age increased, and women 18 to 24 years old had the highest rates of unintended pregnancy and unintended pregnancy ending in birth.

TABLE 1—Number of Total and Unintended Pregnancies, Percentage of Pregnancies That Were Unintended, and Pregnancy Rate by Intention for All US Women, by Demographic Characteristics: 2001 and 2008

Characteristic	No. of Pregnancies (Thousands), 2008		% of Pregnancies Unintended		Pregnancy Rate[a]					
					Total		Intended		Unintended	
	Total	Unintended	2001	2008	2001	2008	2001	2008	2001	2008
All women	6583	3367	48	51	103	106	54	51	49	54
Age group,[b] y										
15–19	750	612	83	82	80	69	14	13	66	57
15–17	249	227	89	91	46	39	5	4	41	35
18–19	501	385	79	77	131	114	27	26	103	88
20–24	1683	1075	59	64	173	163	72	59	102	104
25–29	1748	788	40	45	170	168	101	92	68	76
30–34	1360	479	33	35	132	141	89	92	44	50
≥ 35	1025	397	33	39	42	48	28	30	14	19
Relationship status										
Currently married	3243	1002	28	31	119	119	86	83	33	36
Never-married and not cohabiting	1339	1093	79	82	63	54	14	10	49	43
Formerly married and not cohabiting	341	233	60	68	73	67	30	22	43	46
Cohabiting	1661	1040	66	63	254	320	89	122	165	198
Income as a % of federal poverty level										
< 100	2077	1347	61	65	197	209	77	72	120	137
100–199	1768	981	55	55	145	152	66	67	79	85
≥ 200	2737	1039	37	38	74	67	46	41	28	26
Educational attainment[c]										
Not a HS graduate	986	532	49	54	148	188	75	86	73	101
HS graduate or GED	1534	796	47	52	113	116	60	56	53	60
Some college or associate's degree	1780	935	52	53	90	105	43	50	47	55
College graduate	1517	476	25	31	104	94	79	64	26	29
Race/ethnicity[d]										
White, non-Hispanic	3364	1426	40	42	86	89	52	51	34	38
Black, non-Hispanic	1172	815	67	69	137	132	45	40	92	92
Hispanic	1568	882	54	56	145	140	66	61	79	79
Religious affiliation										
Protestant	3071	1545		50		103		51		52
Mainstream Protestant	1457	775		53		106		49		57
Evangelical Protestant	1614	770		48		101		52		48
Catholic	1699	830		49		109		55		54
Other	549	240		44		94		53		42
None	1264	752		59		113		45		68

Note. GED = general educational development; HS = high school. Numbers may not sum to group totals because of rounding.
[a]Rates are per 1000 women aged 15–44 years.
[b]Females aged < 15 years were excluded because of insufficient data. The population denominator for women aged ≥ 35 years is women aged 35–44 years.
[c]Among women aged ≥ 20 years.
[d]Excludes women who self-identify as other non-Hispanic racial/ethnic groups.

Pregnancy trends between 2001 and 2008 were different by age subgroups. Among adolescents, the overall pregnancy rate declined, mostly because of a reduction in unintended pregnancies among women aged 18 to 19 years. Similarly, among adolescents, the decline in the unintended birth rate was also mostly attributable to older teens.

The shift from intended to unintended pregnancy between 2001 and 2008 was most prominent for women in their twenties. Women aged 20 to 24 years experienced a decline in the intended pregnancy rate and a relatively stable unintended rate. The overall pregnancy rate for women aged 25 to 29 years remained unchanged, but because the proportion of pregnancies that were unintended increased from 40% to 45%, their unintended rate rose. The overall pregnancy rates for women aged 30 years and older increased, mostly because of an increase in unintended pregnancy rates. Among all adult women aged 20 years and older, the proportion of unintended pregnancies ending in abortion declined, and there was a concomitant rise in the rate of unintended pregnancies ending in birth.

Relationship Status

In 2008, the proportion of pregnancies among married women that were unintended was less than half that of unmarried women. Cohabiting women had the highest unintended pregnancy and unintended birth rates in this analysis (at 198 and 101 per 1000 women, respectively), both more than 4 times the rate of noncohabiting or married women.

The shift from intended to unintended pregnancies was less apparent when we considered women's relationship status. Although intended and unintended pregnancy rates changed little among married women, never-married women's intended and unintended pregnancy rates both decreased, whereas formerly married women saw a decrease only in their intended pregnancy rate. Cohabiting women reported substantial increases in both intended and unintended pregnancy rates (from 89 intended pregnancies per 1000 women in 2001 to 122 in 2008, and 165 unintended pregnancies in 2001 to 198 in 2008), as well as a significant decrease in unintended pregnancies ending in abortion and an increase in the rate of

TABLE 2—Percentage of Unintended Pregnancies Ending in Abortion and Rate of Unintended Pregnancies Ending in Birth for All US Women, by Demographic Characteristics: 2001 and 2008

Characteristic	% of Unintended Pregnancies Ending in Abortion[a]		Unintended Pregnancies Ending in Birth, Rate[b]	
	2001	2008	2001	2008
All women	47	40	23	27
Age group,[c] y				
15–19	39	36	34	30
15–17	37	35	21	19
18–19	40	37	54	47
20–24	47	41	47	53
25–29	49	42	31	38
30–34	47	42	20	24
≥ 35	54	44	5	8
Relationship status				
Currently married	24	20	21	24
Never-married and not cohabiting	59	57	18	16
Formerly married and not cohabiting	66	67	12	12
Cohabiting	53	39	68	101
Income as a % of federal poverty level				
< 100	40	41	63	70
100–199	48	37	36	45
≥ 200	51	43	11	12
Educational attainment[d]				
Not a HS graduate	34	27	41	61
HS graduate or GED	43	40	26	31
Some college or associate's degree	59	48	17	24
College graduate	54	48	10	13
Race/ethnicity[e]				
White, non-Hispanic	42	36	17	20
Black, non-Hispanic	57	50	35	40
Hispanic	40	37	42	43
Religious affiliation				
Protestant		34		28
Mainstream Protestant		40		29
Evangelical Protestant		27		28
Catholic		44		26
Other		39		20
None		49		29

Note. GED = general educational development; HS = high school.
[a]Excludes pregnancies ending in miscarriage.
[b]Rates are per 1000 women aged 15–44 years.
[c]Females aged < 15 years were excluded because of insufficient data. The population denominator for women aged ≥ 35 years is women aged 35–44 years.
[d]Among women aged ≥ 20 years.
[e]Excludes women who self-identify as other non-Hispanic racial/ethnic groups.

unintended births (from 68 unintended pregnancies ending in birth per 1000 women in 2001 to 101 in 2008).

Income

As in past reports, there was a large disparity in rates by women's income level. The total pregnancy rate for poor women was more than 3 times that of women in the highest income category, and their unintended pregnancy rate was more than 5 times that of the same group. The unintended birth rate for poor women was also high.

Among poor women, the shift from intended to unintended pregnancies between 2001 and 2008 was evident. Their unintended pregnancy rate increased, and the rate of unintended births increased. Among women who were low-income but not poor, the intended pregnancy rate hardly changed, and their unintended rate increased slightly. However, because the proportion of unintended pregnancies that ended in abortion declined, their unintended birth rate rose. Wealthier women's overall pregnancy rate fell somewhat, mostly because of a decrease in the intended pregnancy rate, and although the proportion of unintended pregnancies ending in abortion declined, their rate of unintended births did not change.

Educational Attainment

The proportion of pregnancies that were unintended was lower among women with a college degree compared with women with less than a college degree (measures are for women aged 20 years and older). Women who had not completed high school had the highest rates of unintended pregnancy and unintended birth and reported a lower proportion of unintended pregnancies ending in abortion, compared with women with a high school degree or more years of schooling.

From 2001 to 2008, both intended and unintended pregnancy rates increased for women without a high school degree and for women with only some college. High school graduates (with no further education) also experienced increased unintended pregnancy rates. Among college graduates, the intended pregnancy rate decreased and the unintended rate remained relatively stable. Unintended birth rates increased for all groups.

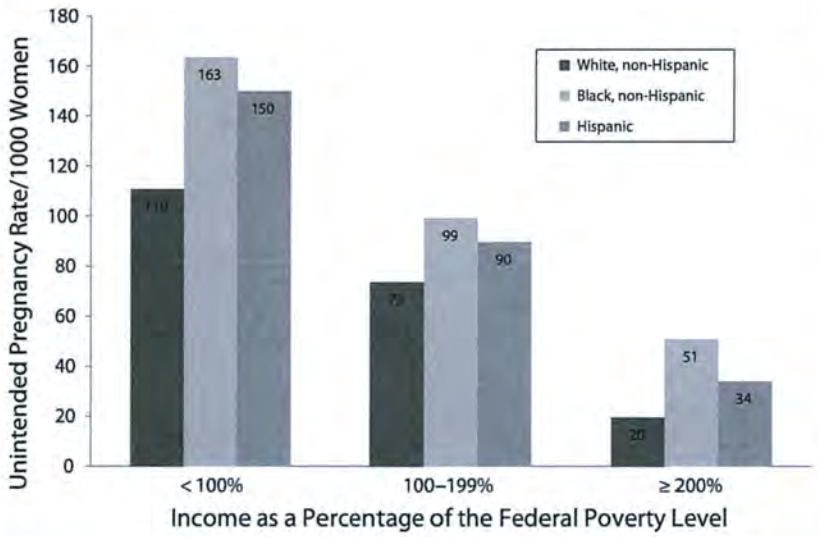

FIGURE 1—Unintended pregnancy rate by race/ethnicity and poverty status among US women: 2008.

Race/Ethnicity, Religious Affiliation, and Income

Rates of unintended pregnancy and unintended birth among minority women were more than twice the rates for White women. Black women had the highest unintended pregnancy rate, whereas Hispanic women had the highest rate of unintended births.

Overall pregnancy rates among White, Black, and Hispanic women changed little between 2001 and 2008, but unintended pregnancy rates among White women increased, and there was some evidence that the intended pregnancy rate among minority women decreased. The proportions of unintended pregnancies ending in abortion declined and unintended birth rates increased among non-Hispanic women but hardly changed among the Hispanic population.

Unintended pregnancy rates were highest among women with no religious affiliation; Catholic and Protestant women had similar rates of unintended pregnancies, but a greater proportion of unintended pregnancies ended in abortion among Catholics than among women with any other religious affiliation.

Figure 1 shows that unintended pregnancy rates varied by race/ethnicity, even when controlling for income, and that minority women had high unintended pregnancy rates across all income levels. In particular, Black women had the highest rates, with poor Black women having an unintended pregnancy rate of 163 per 1000 women.

DISCUSSION

Our results indicate that unintended pregnancy is a stubborn problem in the United States. Between 2001 and 2008, there was a slight shift from intended to unintended pregnancy. Some of this shift might be the result of the recession beginning in late 2007 and the subsequent decline in fertility desires. The shift might have offset slight increases in contraceptive use and the effectiveness of such use observed around the same time.[5]

The increase in unintended pregnancy also corresponded with an increase in unintended childbearing, which is associated with several negative maternal and child health outcomes.[15] The decline in the percentage of unintended pregnancies ending in abortion began before 2001 and might be continuing because of a number of factors, such as decreased access to abortion, including but not limited to fewer providers[10] and a growing number of state-level restrictions,[16] increased stigmatization of abortion, and increased acceptance of carrying unintended pregnancies to term.

Shifts in underlying population demographics toward groups with a high unintended pregnancy rate (such as cohabitors and Hispanic women) might have also contributed to the increase in unintended pregnancies. In addition, older women, not adolescents, appear to have been driving the trend, as did poor women and women without a college degree, including those who were likely still in school.

Although the nation as a whole and many disadvantaged population subgroups experienced higher rates of unintended pregnancy, there was a notable decline in the unintended pregnancy rate among teens, particularly among those aged 18 to 19 years. This echoed and continued a pattern of decline in teen pregnancy rates observed since the 1990s.[13] Other work has offered evidence that the declining teen pregnancy rate was primarily because of increases in contraceptive use among adolescents, particularly among those ages 18 to 19 years, as well as small decreases in sexual activity.[17]

Persistently high levels of unintended pregnancy may be caused by a complex interplay of shifts in the timing of partnering and childbearing, changes in desire for pregnancy, and changes in contraceptive use-effectiveness. We know that there has been a long-term trend toward later marriage and childbearing. As these events have shifted to later ages, the period after childbearing—during which sterilization or other highly effective long-acting methods are typically used—has become shorter. At the same time, the period between first sexual intercourse and first birth has lengthened, and sterilization is almost never used during this period, although there have been notable increases in the use of long-acting methods among younger women.[5] The methods most commonly used during this age interval remain the pill and condom, although more effective methods, such as intrauterine devices and implants, are appropriate and recommended for young women and women without children.[18]

Moreover, as indicated previously, the US economic situation likely indirectly lowered women's pregnancy intentions.[3] This would have increased the unintended pregnancy rate even if there were no changes in partnering, sexual behavior, or contraceptive use. The shift from intended to unintended pregnancy was one of the most notable findings of our analysis. The combination of later childbearing and

lower fertility preferences, therefore, might have offset the shift toward the use of long-acting methods by women who did not have any children.

Finally, we draw attention once again to the dramatic and growing differentials in unintended pregnancy rates by relationship status, income, and education. We saw large increases in intended and unintended pregnancy among the least-educated women. Relatedly, the disparity by income level continued to increase; poor women, of course, might have been hardest hit by the recession. Cohabiting women and women with few years of education also experienced the sharpest increase in the rate of unintended pregnancies ending in birth. These changes were dramatic because they far exceeded the shifts observed in most other groups. Therefore, there is a clear need to monitor changes over the next few years to see if these disparities persist or worsen.

The differentials by subgroup suggest that solving the problem of unintended pregnancy will require more than just the efforts of public health professionals; addressing fundamental social inequities in income and education are also essential. At the same time, there are plenty of questions, both quantitative and qualitative, that should be explored in this area. How do desire for pregnancy, contraceptive use patterns, and use-effectiveness differ among single, cohabiting, and married women and between women of high and low socioeconomic statuses? What are the biggest obstacles to effective contraceptive use? Structurally, are there steps that can be taken to facilitate access to contraception among disadvantaged women beyond what is already in place? Can long-acting methods serve to narrow these differences and have an impact at the population level? What impact will there be from the provision of the health care reform act designating contraception as preventive care that is covered by insurance without copays or deductibles? Answering some of these questions may bring us closer to the goal of enabling all women and couples to become pregnant when they want and avoid pregnancy when it is not desired. ■

About the Authors

Lawrence B. Finer and Mia R. Zolna are with the Guttmacher Institute, New York, NY.

Correspondence should be sent to Lawrence B. Finer, Guttmacher Institute, 125 Maiden Lane, New York, NY 10038 (e-mail: lfiner@guttmacher.org). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted April 20, 2013.

Contributors

L. B. Finer directed the study and developed the study design. M. R. Zolna conducted the analysis. Both authors conceptualized ideas, interpreted findings, and drafted the article.

Acknowledgments

This study was supported by a grant from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD; grant R01HD059896).

We would like to thank Kathryn Kost and Susheela Singh for providing guidance on study methodology, as well as Stanley Henshaw for reviewing the article. All are with the Guttmacher Institute.

Note. The authors have no conflicts of interest. The content is solely the responsibility of the authors and does not necessarily represent the official views of NICHD or the National Institutes of Health.

Human Participant Protection

This study relied on secondary data containing no personal identifiers; therefore, no institutional review board approval was necessary.

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State Facts About Unintended Pregnancy: Alaska

National Background and Context

Unintended pregnancy can have significant, negative consequences for individual women, their families and society as a whole. An extensive body of research links births resulting from unintended or closely spaced pregnancies to adverse maternal and child health outcomes and myriad social and economic challenges.(1,2) In 2008, the last year for which national-level data are available, 51% of all pregnancies in the United States were unintended including eight in 10 teen pregnancies; the U.S. unintended pregnancy rate was 54 per 1,000 women aged 15–44, a level significantly higher than that in many other developed countries.(3,4) If current trends continue, more than half of all women in the United States will experience an unintended pregnancy by the time they reach age 45.(3,5) And economically disadvantaged women are disproportionately affected by unintended pregnancy and its consequences: In 2008, the unintended pregnancy rate among women with incomes lower than the federal poverty level, at 137 per 1,000, was more than five times as high as the rate among women with incomes greater than 200% of poverty (26 per 1,000).

In any given year, the two-thirds of women in the United States at risk of unintended pregnancy who use contraceptives consistently throughout the year account for only 5% of all unintended pregnancies; fully 95% of unintended pregnancies are attributable to the one-third of women who do not use contraceptives or who use them inconsistently.(5) Public programs—notably Medicaid and the Title X national family planning program—are central to women's access to affordable contraceptive services and supplies and their ability to use contraceptives effectively. In 2013, 8.3 million women received publicly funded family planning services; these services helped women avoid 2 million unintended pregnancies, which would likely have resulted in approximately 1 million unplanned births and nearly 700,000 abortions(the remainder would have resulted in miscarriages).(6) Absent publicly funded family planning services, the numbers of unintended pregnancies and abortions in the United States would be 60% higher than they currently are.(7)

Unintended pregnancies are also costly to the federal and state governments, resulting in $21.0 billion in public expenditures in 2010.(7) Yet, these costs could have been considerably higher: By helping women avoid unintended pregnancies, publicly funded family planning services saved taxpayers $13.6 billion in 2010, or $7.09 for every $1 spent.(8)

Incidence and Outcomes of Unintended Pregnancy in Alaska

- In 2010, 48% of all pregnancies (8,000) in Alaska were unintended.(9)
- Alaska's unintended pregnancy rate in 2010 was 54 per 1,000 women aged 15–44. Nationally, rates among the states ranged from a low of 32 per 1,000 in New Hampshire to a high of 62 per 1,000 in Delaware.(9)
- The teen pregnancy rate in Alaska was 64 per 1,000 women aged 15-19 in 2010. The national teen pregnancy rate was 57 per 1,000, ranging from 28 per 1,000 in New Hampshire to 80 per 1,000 in New Mexico.(10)
- In 2010, 60% of unintended pregnancies in Alaska resulted in births and 26% in abortions; the remainder resulted in miscarriages.(9)

Public Cost of Unintended Pregnancy in Alaska

- In 2010, 3,000 or 64.3% of unplanned births in Alaska were publicly funded, compared with 68% nationally.(7)
- In Alaska in 2010, the federal and state governments spent $113.7 million on unintended pregnancies; of this, $70.8 million (52%) was paid by the federal government and $42.9 million was paid by the state.(7)
- The total public costs for unintended pregnancies in 2010 was $790 per woman aged 15–44 in Alaska, compared with $201 per woman nationally.(7)

Preventing Unintended Pregnancy in Alaska

- In 2013, 250 Alaska women aged 13–44 were in need of publicly funded family planning services.(6)
- Publicly supported family planning centers in Alaska served 22,140 female contraceptive clients in 2013. Those centers met 254% of Alaska women's need for contraceptive services and supplies, compared with 29% met by family planning centers nationally.(6)
- In 2010, the reported public expenditures for family planning client services in Alaska totaled $5.5 million; this includes $2.1 million through Medicaid and $1.9 million through Title X.

  Most states also use some of their own money (in addition to funds required to match federal grants) for family planning services; in 2010, Alaska contributed $1.4 million. (11)
- Publicly funded family planning centers in Alaska helped avert 5,400% unintended pregnancies in 2013, which would likely have resulted in 2,700 unplanned births and 1,800 abortions.(6)
- By averting unintended pregnancies and other negative reproductive health outcomes, publicly funded family planning services provided by safety-net health centers in Alaska helped save the federal and state governments $65.4 million in 2010.(8)

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Unintended Pregnancy Prevention

An unintended pregnancy is a pregnancy that is reported to have been either unwanted (that is, the pregnancy occurred when no children, or no more children, were desired) or mistimed (that is, the pregnancy occurred earlier than desired). Unintended pregnancy is a core concept that is used to better understand the fertility of populations and the unmet need for contraception (birth control) and family planning. Unintended pregnancy mainly results from not using contraception, or inconsistent or incorrect use of effective contraceptive methods.

Unintended pregnancy is associated with an increased risk of problems for the mom and baby. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing. For example, women with an unintended pregnancy could delay prenatal care that may affect the health of the baby. Therefore, it is important for all women of reproductive age to adopt healthy behaviors such as—

- Taking folic acid.
- Maintaining a healthy diet and weight.
- Being physically active regularly.
- Quitting tobacco use.
- Abstaining from alcohol and drugs (http://www.cdc.gov/pwud/).
- Talking to your health care provider about screening and proper management of chronic diseases.
- Visiting your health care provider at the recommended scheduled time periods (http://www.cdc.gov/family/checkup/index.htm) for your age and discuss if or when you are considering becoming pregnant.
- Using effective contraception correctly and consistently if you are sexually active but wish to delay or avoid pregnancy.

In the United States

According to a study published in 2011—

- In 2006, 49% of pregnancies were unintended—a slight increase from 48% in 2001.
- Among women aged 19 years and younger, more than 4 out of 5 pregnancies were unintended.
- The proportion of pregnancies that were unintended was highest among teens younger than age 15 years, at 98%.
- Between 2001 and 2006, the proportion of pregnancies that were unintended—
  - Declined from 89% to 79% among teens aged 15–17 years.
  - Increased from 79% to 83% among women aged 18 and 19 years and from 59% to 64% among women aged 20–24 years.
- Large increases in unintended pregnancy rates were found among women with lower education, low income, and cohabiting women.

Source: Unintended pregnancy in the United States: incidence and disparities, 2006. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338192/) *Contraception.* 2011;84(5):478–485.

Recent data from the National Survey of Family Growth show no significant decline in the overall proportion of *unintended births* (live births to women who did not want to get pregnant when they did) between the 1982 and the 2006–2010 surveys. The proportion of births that were unintended did decline during these years among ever-married, non-Hispanic white women. Women more likely to experience unintended births include—

- Unmarried women.
- Black women.
- Women with less education or income.

Source: Intended and unintended births in the United States: 1982–2010. [PDF- 404KB] (http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf) *National Health Statistics Reports.* 2012;55.

The United States has established family planning goals in *Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx)* aimed at improving pregnancy planning, spacing, and preventing unintended pregnancy. An objective is to increase the proportion of pregnancies that are intended to 56%. Family planning efforts that can help reduce unintended pregnancy include increasing access to contraception, particularly to the more effective and longer acting reversible forms of contraception, and increasing correct and consistent use of contraceptive methods overall among those who are sexually active but wish to delay or avoid pregnancy. Research also has focused on better understanding pregnancy intention and how it is measured. As one study suggests, "A better understanding of the multiple dimensions of unintended pregnancy also may lead to a better understanding of the consequences of these pregnancies." (The measurement and meaning of unintended pregnancy. (http://www.guttmacher.org/pubs/journals/3509403.html) *Perspect Sex Reprod Health.* 2003;35 (2):94–101.)

Related Links

- Search PubMed for articles on Unintended Pregnancy (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Search&db=PubMed&term=CDC+unintended+pregnancy) This search is being conducted on PubMed an NLM/NIH service.

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Page last reviewed: January 22, 2015
Page last updated: January 22, 2015
Content source: Division of Reproductive Health (http://www.cdc.gov/reproductivehealth), National Center for Chronic Disease Prevention and Health Promotion (http://www.cdc.gov/nccdphp/)

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July 2015 | Issue Brief

Private Insurance Coverage of Contraception

Laurie Sobel, Adara Beamesderfer and Alina Salganicoff

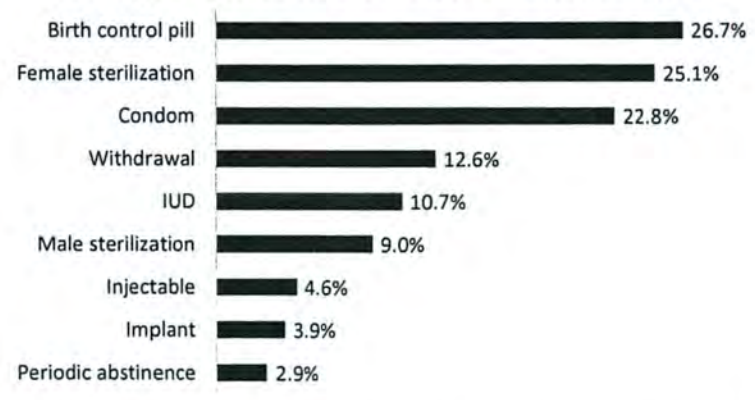
Insurance coverage of contraceptive services has been the focus of policy attention by state and federal policy makers as well as in the courts over the past two decades. In 2012, all new private plans were required to cover, without cost-sharing, the full range of contraceptives and services approved by the Food and Drug Administration (FDA) as prescribed for women.[1] For the first time, federal standards created a minimum set of benefits for most health plans regulated by the federal government (self-insured plans, federal employee plans) and states (individual, small and large group plans), including contraceptive coverage for women with no cost-sharing. This new requirement, however, has been at the center of a heated policy debate that culminated in the Supreme Court ruling on the religious rights of employers that object to contraception. At this time, the issue has not yet been resolved as additional cases are working their way through the courts, and may end up, yet again, at the Supreme Court. This issue brief explains the rules for private insurance coverage of contraceptives at the federal and state level and discusses key issues regarding the provision and coverage of contraception by private insurance plans.

BACKGROUND

Access to contraception is a key element in shaping women's health and well-being. Contraception is most notably used for family planning, but also to control symptoms associated with menstruation, endometriosis, and acne.[2] Nearly all women (99%) have used contraceptives at some point in their lives and 62% of women are currently using at least one method.[3] Of the more than 60 million women in their childbearing years (ages 15 to 44), 7 in 10 are sexually active and do not want to become pregnant.[4] The most common form of contraception among women currently using contraception is the pill (26.7%) followed by female sterilization (25.1%) and male condoms (22.8%) (**Figure 1**).[5] Use of long acting reversible contraception (LARCs) has been increasing over recent decades with the introduction of new

Figure 1

Contraceptive methods used by women ages 15-44, 2011-2013



Note: 61.7% of women ages 15-44 used contraception in previous 30 days. More than one method may be used by a woman., but these data only reflect most effective method used.
Source: CDC. (2015). *Health, United States, 2014: Table 9.*

intrauterine devices (IUDs) and implants.[6] Efficacy of various methods ranges from greater than 99% effective with IUDs, to 91% with oral contraceptive pills, and 82% with condoms.[7] According to the CDC, 6.9% of women of reproductive age are sexually active but are not using contraception, placing them at increased risk for unintended pregnancy.[8]

Unintended pregnancies account for almost half of all pregnancies in the US.[9] Women who use contraception incorrectly, experience gaps in contraceptive use, or do not use contraception are at particular risk for experiencing an unintended pregnancy, but no method is 100% effective. Approximately one quarter (23%) of women using contraception had a period of at least 1 month in the prior year when they were not using a contraceptive method.[10] Insurance coverage of contraception has been shown to increase utilization of contraception, increase use of more effective methods, and decrease out-of-pocket costs for women.

The ACA's Contraceptive Coverage Requirement

The ACA is the first law to set coverage requirement for health insurance across all markets – individual, small group, large group and self-insured plans. Individual, small and large group plans are regulated by the state, whereas self-insured plans are regulated by the federal government under the Employee Retirement Income Security Act (ERISA).

Before the ACA, coverage for prescription contraceptives was generally widespread in the private and public sectors, but not universal. Unless a state had a contraceptive coverage mandate, insurers and employers could choose whether or not to provide coverage for contraception. In 2000, a ruling by the Employment Equal Opportunity Commission found that employers that covered preventive prescription drugs and services, but did not cover prescription contraceptives were in violation of the Civil Rights Act.[11] Currently, 28 states require insurance plans to cover contraceptives, with a wide range of coverage and cost-sharing requirements, and exemptions among these mandates.[12] State laws, however, fell short of universal coverage as they only applied to state regulated plans, but not self-funded plans where 61% of covered workers are insured.[13] In addition, they did not place contraceptives in a special class that was protected from cost-sharing.

More than half of women in the United States are insured through an employer-sponsored plan, either as the primary beneficiary or as a spouse or dependent. The 2010 Kaiser/HRET survey of employers reported that 85% of large firms covered prescription contraceptives in their largest health plans[14], although they may have charged cost-sharing, the amount of which can vary greatly by employer and type of plan. Only a small share of women have historically purchased insurance directly from an insurance company on the individual market, but this share is growing as previously uninsured women can now purchase coverage through ACA Marketplaces.

The ACA made contraceptive coverage a national policy, by requiring most private health insurance plans to provide coverage for a broad range of preventive services including FDA-approved prescription contraceptives[15] and services for women without cost-sharing. While most health plans are now required to provide contraceptive methods and counseling to women with reproductive capacity with no out-of-pocket costs, there are certain conditions that must be met. Women must be enrolled in a non-grandfathered plan[16] and they must get services from an in-network provider. [17]

In addition, the federal regulations implementing the preventive services coverage requirement explicitly permit plans and issuers to use reasonable medical management to control cost and promote efficient delivery of care.[18] This applies to coverage of all preventive services, not just contraceptive care, but contraceptive services in particular had been documented as being unevenly covered by some plans because of how medical management was being interpreted by insurers.[19] Examples of medical management tactics include, but are not limited to, categorizing brand and generic drugs and devices in tiers based on either cost, type and or mode of delivery; steering consumers to generic equivalent drug options; requiring provider authorization to acquire a preferred brand drug; requiring a consumer to first try a lower tier formulary drug or therapy to treat a medical condition before they will pay for an alternative drug or therapy for that condition (step therapy); and limiting quantity and or supply.

In response to reports about gaps in contraceptive coverage attributable to medical management policies,[20] the Department of Health and Human Services (HHS) issued new guidance in May 2015 which clarifies that at least one form of all 18 FDA-approved methods of birth control must be covered without cost-sharing. If a provider recommends a specific option or product, plans must cover it without cost-sharing as well. Insurers may use reasonable medical management, however, to limit coverage to generic drugs when a generic version exists, and can impose cost-sharing for equivalent branded drugs. Plans are required to have a "waiver" process for women who have a medical need for contraceptives otherwise subject to cost-sharing or not covered.[21]

Exemptions and Accommodations

As mentioned above, women enrolled in "grandfathered" plans may not be covered for the full range of contraceptives without cost-sharing. In order to be classified as "grandfathered," plans must have been in existence prior to March 23, 2010, and cannot make significant changes to their coverage (for example, increasing patient cost-sharing, cutting benefits, or reducing employer contributions). In 2014, 26% of workers covered in employer sponsored plans were still in grandfathered plans,[22] and it is expected that over time almost all plans will lose their grandfathered status.

Certain religious employers have a religious objection to some or all contraceptive methods and may be "exempt" from the ACA contraceptive coverage mandate. Specifically "religious employers", primarily churches and other institutions of worship are exempt. Exempt employers do not have to include contraceptive coverage for their workers and their dependents in their health plan.

There is also an "accommodation" available to nonprofit religiously-affiliated organizations and closely held[23] for-profit corporations that object to contraceptive coverage on religious grounds[24] Under the accommodation, an eligible employer does not have to contract, arrange, pay or refer their employees for contraceptive coverage. The health carrier used by the nonprofit employer or closely held for-profit employer must notify the policyholders, and provide separate coverage of contraceptives, at no cost, to the policyholders. Unlike an exemption, female employees and the female dependents covered by the plans of a nonprofit or closely held for-profit employer choosing an accommodation are entitled to the full contraceptive coverage from their insurance carrier.

Looking Forward

Today, millions of women now have coverage for the full range of contraceptive methods without cost-sharing; however, some women will continue to experience gaps in coverage. Federal and state regulators have an important role to play in ensuring the federal standards are applied accurately and fairly, meaning all women can access contraceptive services. In addition, several cases are still working their way through the courts regarding the how this requirement will be applied to non-profit organization with religious objection to contraception.

Awareness of the Federal Standard Among Women and Providers

A recent HHS study estimates that 55 million women have private insurance coverage that includes no-cost coverage for contraceptive services and supplies.[25] While the number of individuals who have gained coverage for no-cost preventive services is large, public awareness of the preventive services requirement is relatively low. In March 2014, three and half years after the rule took effect, less than half the population (43%) reported they were aware that the ACA eliminated out-of-pocket expenses for preventive services.[26] A Kaiser Family Foundation study on plan coverage of contraceptives identified that some providers may not know how to correctly code all visits related to contraceptive services as a preventive service so the patient is not billed for the service.[27] For the contraceptive coverage requirement to reach all women enrolled in private plans, additional public and provider education is needed.

Role of States in Expanding Coverage

States have historically regulated insurance and many have mandated minimum benefits for decades. Contraceptive coverage is no exception. Since the passage of the ACA, some states have looked to strengthening and expanding the federal contraceptive coverage requirement. For example, in 2014 California passed the Contraceptive Coverage Equity Act of 2014 which requires plans to cover prescribed FDA-approved contraceptives for women without cost-sharing. The law specifies that a plan does not have to cover more than one therapeutic equivalent of a contraceptive drug, device, or product, as long as at least one is covered without cost-sharing. Contraceptives with the same chemical formulation and delivery mechanism are therapeutically equivalent. Starting in January 2016, plans in California will be required to cover the cooper IUD (Paragard) and all three hormonal IUDs (Mirena, Skyla and Liletta), because none of the IUDs are therapeutically equivalent. The ACA requires plans to cover Pargard, and only one hormonal IUD.

In 2015, Oregon passed a law that requires insurers to pay for a 3 month supply of contraceptives when first prescribed, followed by a 12 month supply of contraceptives regardless of whether the woman was insured by the same plan at the time of the first dispensing.[28] This law applies to oral contraceptive pills, the patch and the vaginal ring. In June 2015, the D.C. mayor signed a similar measure which would require health insurers that offer coverage of prescription birth control pills to cover a 12-month supply dispensed at one time. Congress has 30 days to review this bill.

Confidentiality and Consent for Minors and Young Adults

Prior to the ACA, young adults had the highest rates of uninsurance among all age groups.[29] A provision of the law allows young adults to remain covered through their parents' health insurance through age 26. While this expansion in coverage benefits young adults, young women and teens may face additional barriers to

contraceptive services as a result. Confidentiality is a priority for teens and young adults. In a national survey, 71% of women 18 to 25 rated confidentiality about use of health care such as family planning or mental health services as "important." Despite the importance of confidentiality, awareness of this practice was low among this age group, as only 37% of women knew that private insurers typically send an EOB to primary policy holders, often a parent. Awareness is even lower among teens ages 15 to 18, where only 24% reported knowing that EOBs were typically sent to the home.[30] Confidentiality also remains an issue for adult women who may be insured as a dependent through their spouse's insurance Concerns over confidentiality may prompt some women to not use their private insurance to cover the cost of contraception and instead seek contraceptive services from publicly funded clinics, or forgo their preferred contraceptive methods.[31] This creates additional barriers for women seeking contraception, placing them at increased risk for unintended pregnancy.

Some states have enacted laws aimed at protecting confidentiality for women and girls insured as dependents but they are limited to plans that are regulated by the state (small and large group and individual plans and not self-funded plans).[32] In 2013 California passed a law, effective January 2015, requiring insurance companies to honor requests for confidential communications when individuals receive sensitive health care services, including contraception, or when disclosure could lead to danger. Similarly, in 2013, Washington amended regulations that prohibit insurers from disclosing EOBs to policyholders for all services for which minor patients may consent, unless the patient expressly authorizes disclosure. Colorado also amended regulations effective in 2014 to require insurers to protect the privacy of adult dependents, but not minors. Insurers in Colorado must communicate directly with the adult child or adult dependent so that protected health information is not sent to the policyholder in the form of an EOB without prior consent. Other states have developed other strategies to try to protect the privacy of dependents insured by a primary policyholder.

State laws regarding minors' consent to contraceptive services pose another barrier.[33] Half the states (26 states and the District of Columbia) explicitly allow all minors ages 12 and older to consent to contraceptive services. An additional 20 states explicitly allow only certain categories of minors to consent to contraceptive services and 4 states have no relevant policy or case law. Private clinics and doctors need to abide by any state laws regarding parental notification or minor consent. However, federal Title X protections take precedence over state requirements for parental consent or notification, allowing minors to receive family planning services at Title X clinics without parental involvement.[34] So minors enrolled in plans that include Title X clinics in the network will be able to use their insurance and receive confidential services.

Access to Over the Counter Contraceptives without Doctor's Prescription

The ACA only requires insurance plans to cover prescribed female contraceptives without cost-sharing and has no requirement for plans to cover over the counter methods including condoms, spermicide, and progestin-based emergency contraception (which is only covered with a prescription). Proposals to extend over the counter (OTC) status for oral contraceptives to expand women's access to contraception, beyond progestin-based emergency contraceptive pills, have been gaining attention. FDA approval, however, is required to move more contraceptives over the counter, and members of Congress have introduced legislation addressing this issue.[35] One bill seeks to waive fees and give priority FDA review specifically for manufactures seeing over the counter status for oral contraceptives to women 18 and older. A different bill specifies that if the FDA approves

oral contraceptive for OTC, the ACA would be amended to include insurance coverage with no cost-sharing for these pills.

In addition, there have been efforts at the state level to broaden access to hormonal contraceptive. In 2013, California passed a law that allows pharmacists to prescribe pills, vaginal ring, and the patch for women. While this law does not change the OTC status for contraceptives, it allows women to access some prescription contraceptives without a doctor visit and still receive insurance coverage free of cost-sharing for these contraceptives. The law is expected to be fully implemented by the end of 2015. Oregon passed a similar law in July 2015 which allows pharmacists to prescribe hormonal oral contraceptives and the patch.

Coverage of Contraception for Men

While the ACA requires private insurance plans to cover FDA-approved contraceptives as prescribed for women without cost-sharing, this requirement does not include methods used by men: vasectomy and male condoms.[36] Because the ACA provisions on contraceptive coverage only address services for women, tubal ligation and tubal implant are covered without cost-sharing, but there is no equivalent requirement to cover vasectomies without cost-sharing. In their recommendations for the provision of high quality family planning service, the CDC and the Office of Population Affairs have clearly stated that offering women and men the full range of FDA-approved contraceptive methods is a critical element of high quality care and emphasize the importance of contraceptive choice in reducing couple's risk of unintended pregnancy.[37] In addition, for many women, condoms or a vasectomy may be their preferred method. Over 22% of women report that male condoms were their primary contraceptive method and 9% of women report relying on their partner's vasectomy.[38] (Figure 1) Furthermore, condoms are the only method that protect against STDs, including HIV. Federal or state legislation, or action by insurance plans to voluntarily expand coverage for men would be needed to address this gap.

Oversight

State regulators and the federal government have a role in the oversight of private plans including covered benefits, coverage appeals, and network adequacy.

Covered Benefits and Appeals

State regulators have the responsibility to oversee most private health insurance plans while the Department of Labor oversees self-funded plans. State regulators and the federal government can monitor contraceptive coverage as required by the ACA when reviewing plan documents for rate review. While most states have taken action to develop review processes that meet federal standards, CMS reviews plans in five states that have been determined not to have an adequate rate review process.[39]

At this time, this oversight does not appear to include review of the insurance carrier's waiver process for the coverage of contraceptive methods that are not included in the plans formulary for no-cost coverage. Federal guidance requires plans to have a "waiver" process for patients who have a medical need for contraceptives otherwise subject to cost-sharing or not covered.[40] A KFF study found that none of the insurance carriers reviewed had established a formal process for policy holders to file a waiver contesting limitations on coverage for preventive services beyond their usual appeal process.[41] The use of the standard appeal

process can create a time delay for women seeking timely contraceptive services which could increase women's risk of unintended pregnancy. This is particularly problematic for women who need timely access to emergency contraceptives not covered under the policy.

Network Adequacy

Another important provision related to all preventive services including contraceptive services is network adequacy. The provider networks of the Marketplace plans determine where enrollees can seek medical care. Many states have laws to help ensure that networks are adequate to meet consumers' needs.[42] The ACA also requires that consumers in Marketplace plans have a "sufficient choice of providers," defined in the regulations as a right to networks that are sufficient in the "number and types of providers, including providers that specialize in mental health and substance abuse services, to assure all services will be accessible without unreasonable delay." Narrow networks may make finding an available provider offering reproductive health services challenging for some women, especially if distance, time, and transportation barriers exist.

Marketplace plans must also include in their networks essential community providers (ECPs) that serve predominantly low-income, medically underserved individuals, including Title X clinics and Federally Qualified Health Centers. ECPs often provide services that are specifically developed to address the health needs of low income individuals, including language services, patient support services, coordination of health and social services, and location in a low-income community. As noted above, minors can receive family planning services without parental involvement at Title X clinics. For women, particularly low-income women and women of color, clinic-based providers, family planning clinics and health centers are important sources of reproductive and sexual health care. Over one-quarter (28%) of women enrolled in Medicaid and 43% of uninsured women reported they had their most recent gynecological visit at either a clinic or health center.[43] As many of these women gain insurance through Marketplace or employer-sponsored plans, community-based providers will continue to play an important role in reproductive health care.

It is unknown the extent to which state regulators and CMS are monitoring and enforcing federal and state network adequacy and ECP inclusion in Marketplace plans. As carriers are permitted to change networks during a plan year, the inclusion of ECPs in networks could change in the middle of a plan year. It is important to consider how federal and state oversight of the inclusion of ECPs can be ongoing and not just at the time of certification as a Qualified Health Plan.

Conclusion

The ACA has expanded contraceptive coverage without cost-sharing to millions of privately insured women across the nation. Ongoing consumer and provider education, continued oversight at the state and federal levels, and the resolution of the remaining legal challenges will determine how the ACA's contraceptive coverage requirement is fully implemented.

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Commentary

Let's work together against unintended pregnancy in Alaska, not low-income women's access to abortion services

Matt Davis November 17, 2015

istockphoto

When we talk about abortion in Alaska, the discussion often morphs into a pro-choice, pro-life debate that, by virtue of being grounded in personal beliefs, is unlikely to yield an answer that satisfies both sides. If we accept this stalemate, though, we miss an important point: the surest way to prevent abortions is to reduce the number of unintended pregnancies.

The good news is almost everyone agrees that allowing women to control whether or not they become pregnant is a good thing. Despite this consensus, however, according to the Guttmacher Institute, whose mission is to advance sexual and reproductive health worldwide, around half of pregnancies in the United States are unintended. **In 2011, this translated into 18 percent of pregnancies nationwide ending in abortions. In Alaska the figure was 12 percent.**

According to the Alaska Bureau of Vital Statistics, there were 1,629 abortions performed in Alaska in 2012. If we are serious about reducing that number, we will need to follow the lead of places like Colorado, where state officials say a state-run family planning initiative reduced the abortion rate of women ages 15-19 by 42 percent and of women 20-24 by 18 percent between 2009-2013. The secret behind this incredible success? Increased access to long-acting,

reversible contraceptives like intrauterine devices and implants. Fifty one percent of women in Alaska who received abortions in 2012 were under 25 years old, so we should pay close attention to these efforts and successes.

Sadly, our public officials have sometimes resorted to blocking broader health-care access as a means of restricting abortion access. For example, in 2010 Gov. Sean Parnell vetoed the expansion of Denali KidCare -- Alaska's version of the federal Children's Health Insurance Program that provides care to poor women and their children -- saying that, "My intention here today is to make sure we don't expand state government funding of abortions here in Alaska." That decision kept up to 1,300 children and 225 pregnant women from accessing the program.

At the beginning of November, the state of Alaska announced it will continue attempting to restrict low-income women's ability to access abortions via Medicaid funds by appealing a Superior Court ruling in Planned Parenthood v. Streur. In striking down a state regulation that severely narrowed the definition of 'medical necessity' as it relates to abortion provision, the court described how the regulation came to be in the first place: "Contrary to normal DHSS procedure, Commissioner William Streur developed the abortion regulation on his own. DHSS staff did not participate in the drafting of the regulation. The DHSS medical director played no role. No abortion providers were consulted." Of note, former Commissioner Streur is not a physician.

The American College of Obstetricians and Gynecologists states in its abortion policy statement, "Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties." Traditionally, the state has allowed patients and physicians to determine together what may or may not constitute a medical necessity. I suspect most Alaskans would prefer the government not interfere with that relationship.

If we are truly invested in women's health, let's support it by increasing access to primary care and family planning services rather than targeting low-income women's access to abortion services. As Judge Suddock wrote, "Women voluntarily assume the risks of pregnancy in the joyful context of a wanted child. But Alaskan women denied Medicaid abortions by a restrictive standard who are unable to beg, borrow, or earn $650 (or far more for an out-of-state second-trimester abortion) would be forced to carry to term without voluntarily assuming those risks."

I strongly urge Gov. Walker and Attorney General Richards to reconsider their appeal and to refrain from imposing their personal beliefs on low-income Alaskan women. Whether you are for or against abortion access, let's work together to reduce the need for it using evidence-based public health measures.

***Matt Davis** was born and raised in Anchorage and is currently attending medical school at the George Washington University School of Medicine & Health Sciences in Washington, D.C.*

***Correction:** An earlier version of this commentary mistakenly referred to a federal initiative as the "Children's Health Insurance Plan." The correct title is "Children's Health Insurance Program."*

The views expressed here are the writer's own and are not necessarily endorsed by Alaska Dispatch News, which welcomes a broad range of viewpoints. To submit a piece for consideration, email commentary(at) alaskadispatch.com.

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Unintended pregnancy rate high among active-duty military women

February 1, 2013
5:12 PM MST

A new study set out to determine the pregnancy rate among active-duty military women in 2008 and compare it to the rate in 2005 and the rate among the US population

Robin L Wulffson, M.D.

A new study set out to determine the pregnancy rate among active-duty military women in 2008 and compare it to the rate in 2005 and the rate among the US population. The study was conducted by researchers affiliated with the University of California, San Francisco. They published their findings in the February edition of the journal Obstetrics and Gynecology.

The researchers note that in the US, 49% of pregnancies are unintended, meaning that they are mistimed, unplanned, or unwanted. Unintended pregnancy is an important public health issue, because it may lead to negative maternal and child health outcomes, including low birth weight and preterm birth, lower rates of breastfeeding, and postpartum depression. For these reasons, the US Department of Health and Human Services identified reducing unintended pregnancy as a national goal in its Healthy People campaign, a set of 10-year national benchmarks and objectives for health promotion and disease prevention. The authors note that unintended pregnancy among women in the US military may have additional consequences, affecting both women's careers and negatively affecting troop readiness because pregnant women cannot be deployed and must be evacuated from theater if already overseas. With 97% of women in the US military of reproductive age and a growing proportion of active-duty personnel that is female, these issues are of major importance.

For the study, the researchers accessed cross-sectional data came from the 2008 Department of Defense Survey of Health Related Behaviors among Active Duty Military Personnel (Health Related Behaviors Survey). Unintended pregnancy rates per 1,000 women were calculated and compared with rates reported in the 2005 Health Related Behaviors Survey. The age-standardized unintended pregnancy rate was calculated to adjust for differences in age composition between the military and US populations for better comparison with the general U.S. rate.

The researchers found that 11% of women reported an unintended pregnancy in the prior 12 months. The 2008 self-reported unintended pregnancy rate was 105 per 1,000 women, an increase from 2005 (97/1,000 women). Younger, less educated, nonwhite, and married or cohabitating women had significantly higher rates of unintended pregnancy compared with their counterparts. Rates did not differ between women deployed in the prior 12 months and non-deployed women. The age-standardized rate was 78 per 1,000 women, which is 50% higher than the general U.S. population (52/1,000 women).

The authors concluded that unintended pregnancy rates in the military are high and have increased in most key subgroups since the 2005 survey. They noted that efforts are needed to help servicewomen prevent unintended pregnancy, including during deployment.

The authors noted that the majority of respondents to the survey were not counseled on contraception for pregnancy prevention or menstrual suppression as part of their pre-deployment preparations, and some faced barriers to accessing a method while overseas. These overseas barriers included care-seeking stigma and logistic obstacles that made it

challenging to visit a healthcare provider as well as a limited amount of contraceptive supplies given at a time to women for deployment. Another factor deterring some women from seeking contraception was confusion about prohibition of sexual activity. Although consensual sexual activity among members of the same rank is legal, current military regulations make sexual relationships a chargeable offense in a number of circumstances. Confusion or concern about these laws led some women to believe they could not access contraception or would not need contraception. Another factor that may contribute to the high rates is the high prevalence of sexual assault. An estimated 20–43% of servicewomen experience rape or attempted rape during their military career.

SUGGESTED LINKS

- **Healthcare found lacking for military women**
- **VA extends maternity benefits to women veterans**
- **An injustice to military women: healthcare restrictions**
- **New videos feature women veterans**
- **VA promotes women veterans with public service announcement**

Robin Wulffson, M.D.
LA Veterans Affairs Examiner

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Unintended Pregnancy Prevention

An unintended pregnancy is a pregnancy that is reported to have been either unwanted (that is, the pregnancy occurred when no children, or no more children, were desired) or mistimed (that is, the pregnancy occurred earlier than desired). Unintended pregnancy is a core concept that is used to better understand the fertility of populations and the unmet need for contraception (birth control) and family planning. Unintended pregnancy mainly results from not using contraception, or inconsistent or incorrect use of effective contraceptive methods.

Unintended pregnancy is associated with an increased risk of problems for the mom and baby. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing. For example, women with an unintended pregnancy could delay prenatal care that may affect the health of the baby. Therefore, it is important for all women of reproductive age to adopt healthy behaviors such as—

- Taking folic acid.
- Maintaining a healthy diet and weight.
- Being physically active regularly.
- Quitting tobacco use.
- Abstaining from alcohol and drugs (http://www.cdc.gov/pwud/).
- Talking to your health care provider about screening and proper management of chronic diseases.
- Visiting your health care provider at the recommended scheduled time periods (http://www.cdc.gov/family/checkup/index.htm) for your age and discuss if or when you are considering becoming pregnant.
- Using effective contraception correctly and consistently if you are sexually active but wish to delay or avoid pregnancy.

In the United States

According to a study published in 2011—

- In 2006, 49% of pregnancies were unintended—a slight increase from 48% in 2001.
- Among women aged 19 years and younger, more than 4 out of 5 pregnancies were unintended.
- The proportion of pregnancies that were unintended was highest among teens younger than age 15 years, at 98%.
- Between 2001 and 2006, the proportion of pregnancies that were unintended—
  - Declined from 89% to 79% among teens aged 15–17 years.
  - Increased from 79% to 83% among women aged 18 and 19 years and from 59% to 64% among women aged 20–24 years.
- Large increases in unintended pregnancy rates were found among women with lower education, low income, and cohabiting women.

Source: Unintended pregnancy in the United States: incidence and disparities, 2006. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338192/) *Contraception.* 2011;84(5):478–485.

Recent data from the National Survey of Family Growth show no significant decline in the overall proportion of *unintended births* (live births to women who did not want to get pregnant when they did) between the 1982 and the 2006–2010 surveys. The proportion of births that were unintended did decline during these years among ever-married, non-Hispanic white women. Women more likely to experience unintended births include—

- Unmarried women.
- Black women.
- Women with less education or income.

Source: Intended and unintended births in the United States: 1982–2010. [PDF- 404KB] (http://www.cdc.gov/nchs/data/nhsr/nhsr055.pdf) *National Health Statistics Reports.* 2012;55.

The United States has established family planning goals in *Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx)* aimed at improving pregnancy planning, spacing, and preventing unintended pregnancy. An objective is to increase the proportion of pregnancies that are intended to 56%. Family planning efforts that can help reduce unintended pregnancy include increasing access to contraception, particularly to the more effective and longer acting reversible forms of contraception, and increasing correct and consistent use of contraceptive methods overall among those who are sexually active but wish to delay or avoid pregnancy. Research also has focused on better understanding pregnancy intention and how it is measured. As one study suggests, "A better understanding of the multiple dimensions of unintended pregnancy also may lead to a better understanding of the consequences of these pregnancies." (The measurement and meaning of unintended pregnancy. (http://www.guttmacher.org/pubs/journals/3509403.html) *Perspect Sex Reprod Health.* 2003;35 (2):94–101.)

Related Links

- Search PubMed for articles on Unintended Pregnancy (http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Search&db=PubMed&term=CDC+unintended+pregnancy) This search is being conducted on PubMed an NLM/NIH service.

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Page last updated: January 22, 2015
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GUTTMACHER INSTITUTE

STATE POLICIES IN BRIEF

As of APRIL 1, 2013

Medicaid Family Planning Eligibility Expansions

BACKGROUND: In recent years, several states have expanded eligibility for Medicaid coverage of family planning services. Historically, states have expanded their programs by securing approval of a "waiver" of federal policy from the Centers for Medicare and Medicaid Services. Most of the expansion states grant coverage for family planning solely on the basis of income to individuals not previously covered under Medicaid. A handful of states have received federal approval for more limited expansions that continue coverage for family planning for individuals who are leaving the Medicaid program. The passage of health care reform gave states a new and more expeditious option for expanding eligibility for family planning. Under this law, states may expand their programs by amending their state Medicaid plan. Unlike a waiver, which is time-limited, a State Plan Amendment is a permanent change to the state's Medicaid program. However, in June 2012, the U.S. Supreme Court ruled that the federal government could not force states to accept a major element of the health care reform law—its large-scale expansion to the Medicaid program. This decision adds a major new piece of uncertainty to the law's implementation and coverage for millions of the poorest Americans could be jeopardized if states decide to opt out of that expansion.

HIGHLIGHTS:

- 31 states have obtained federal approval to extend Medicaid eligibility for family planning services to individuals who would otherwise not be eligible. (Texas operates a similar, but entirely state-funded, program that provides family planning services to women at least 18 years of age with incomes up to 185% of the federal poverty line)
  - 26 states provide family planning benefits to individuals based on income; most states set the income ceiling at or near 200% of poverty.
  - 2 states provide family planning benefits for women losing Medicaid for any reason.
  - 3 states have extended eligibility for family planning services to women losing Medicaid postpartum.
- 15 states provide family planning benefits to men and women.
- 22 states include individuals who are younger than 19 years of age; 3 additional states include 18 year olds but not younger individuals.
- 21 states operate their programs under a waiver from the federal government; 10 states operate their programs through a State Plan Amendment.

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125 Maiden Lane
New York, NY 10038
212.248.1111
www.guttmacher.org
info@guttmacher.org

1301 Connecticut Avenue, N.W.
Washington, DC 20036
202.296.4012
www.guttmacher.org
policyworks@guttmacher.org

CONTINUED

MEDICAID FAMILY PLANNING ELIGIBILITY EXPANSIONS

STATE	BASIS FOR ELIGIBILITY			ELIGIBLE POPULATION INCLUDES		ORGANIZED AS A:		WAIVER EXPIRATION DATE
	Based Solely on Income	Losing Coverage for Any Reason	Losing Coverage Postpartum	Men	Individuals <19	State Plan Amendment	Waiver	
Alabama	133%						X	12/31/13
Arizona			2 years		X		X	9/30/16
Arkansas	200%				X		X	12/31/13
California	200%			X	X	X		N/A
Connecticut	250%			X	X	X		N/A
Delaware		2 years			X		X	12/31/13
Florida		2 years			X		X	12/31/13
Georgia	200%		*		†		X	12/31/13
Illinois	200%	*					X	5/31/13
Indiana	133%			X	X	X		N/A
Iowa	300%		*	X	X		X	12/31/13
Louisiana	200%						X	6/30/13
Maryland	200%		*		X		X	12/31/13
Michigan	185%						X	6/30/13
Minnesota	200%			X	X		X	12/31/13
Mississippi	185%				X		X	4/30/13
Missouri	185%						X	12/31/13
Montana	200%		*				X	12/31/13
New Mexico	185%			X	X	X		N/A
New York	200%		*	X	X		X	12/31/13
North Carolina	185%			X	X	X		N/A
Ohio	200%			X	X	X		N/A
Oklahoma	250%		*	X	X	X		N/A
Oregon	250%			X	X		X	4/30/13
Pennsylvania	185%				†		X	6/30/13
Rhode Island			2 years		X		X	12/31/13
South Carolina	185%			X	X	X		N/A
Texas‡								
Virginia	200%		*	X	X	X		N/A
Washington	200%			X	X		X	12/31/13
Wisconsin	300%			X	X	X		N/A
Wyoming			Unlimited				X	8/31/13
TOTAL	26	2	3	15	22	10	21	

* State also extends Medicaid eligibility for family planning services to these individuals.

† Includes 18 year olds but not younger individuals.

‡ Texas operates an entirely state-funded program that provides family planning services to women at least 18 years of age with incomes up to 185% of the federal poverty line.

For state-specific Medicaid family planning fact sheets, including the Medicaid expansions, see State Facts About Medicaid and Family Planning

CONTINUED

FOR MORE INFORMATION:

For information on state legislative and policy activity, click on Guttmacher's Monthly State Update, for state-level policy information see Guttmacher's State Policies in Brief series, and for information and data on reproductive health issues, go to Guttmacher's State Center. To see state-specific reproductive health information go to Guttmacher's Data Center, and for abortion specific information click on State Facts About Abortion. To keep up with new state relevant data and analysis sign up for the State News Quarterly Listserv.

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carolyn V Brown MD MPH
1640 Second Street
Douglas Alaska 99824

Obstetrics-Gynecology
Public Health-Preventive Medicine

907-364-2726
907-364-2727 fax
907-321-0784 cellular
cvbrown1937@yahoo.com

Memorandum

To: *Senators Bert Stedman, Cathy Giessel, Pete Kelly, Bill Stoltze, Johnny Ellis, Berta Gardner*
Re: *SB 156. Insurance Coverage for Contraception*

I have reviewed SB 156 a number of times. This issue is of serious importance for the health and safety of Alaskans and deserves a reasoned and informed discussion from health care providers, citizens, and policy makers.

That said, I have the following comments for your consideration:

1. *It is important to clearly define what is meant by "contraception" and what is meant by "prescriptive contraception". These terms appear to be used interchangeably in the proposed legislation. They are definitely not the same.*
2. *Does this bill really intend for all (including over-the-counter) contraception to be covered by health insurance plans? Think about that... and the usefulness (and not so useful) plethora of over-the-counter products. It is valuable to delineate just which contraceptive products (prescriptive and otherwise) are being considered.*
3. *Most oral prescriptive pharmaceuticals are ordered for three month intervals with an expiration of one year. What are the justifications for this difference? Life changes and so do people and their ever-changing contraception use. Where is the oversight? Have other options been considered?*
4. *It may be entirely appropriate that additional consultation be sought from medical, public health and pharmacy health care professionals.*

It is my view that contraception (prescriptive or otherwise) can decrease unintended pregnancies with its potential associated morbidity, quality of life issues, and/or mortality.

While my career in obstetrics and gynecology has led me to firmly believe in contraception, I believe this proposed legislation will require some continued work and consideration to address the issues raised so that there is a win-win for patients, health care providers and society. We must continue this work.

Please let me know if I can answer questions or provide additional information.

I ask that these comments be introduced into the public record.

Thank you for this consideration.

Information from Your Family Doctor

Side Effects of Hormonal Contraceptives

What are hormonal contraceptives?

Hormonal contraceptives are medicines or devices that can reduce your risk of getting pregnant. They contain hormones called estrogen (ESS-tro-jen) and progestin (pro-JEST-tin). Some contraceptives contain a combination of these hormones, and others contain only progestin. Some types of combination methods are contraceptive pills (also called birth-control pills or "the pill"), a patch that is worn on the skin, and a ring that is placed in the vagina. Progestin-only methods include pills, shots, implants that are placed under the skin, and intrauterine devices (also called IUDs).

What are the side effects?

Most women do not have serious side effects from hormonal contraceptives. If you do have side effects, they will probably go away on their own after a few months. You might have:

- Weight gain
- Headaches
- Sore breasts
- Irregular periods
- Mood changes
- Decreased sexual desire
- Acne
- Nausea

Some types of hormonal contraception are more likely to cause certain side effects than others.

What should I do if I have side effects?

If you have side effects that last more than three months, talk to your doctor about switching to another method.

How can I lower my chances of having side effects?

If you are taking the pill, be sure to take one every day. This lowers your risk of bleeding between periods. Progestin-only pills must be taken at the same time each day. The contraceptive patch and ring should be changed according to the schedule given by your doctor.

Where can I get more information?

Your doctor

AAFP's Patient Education Resource
Web site: http://familydoctor.org

Association of Reproductive Health Professionals
Web site: http://www.arhp.org/methodmatch/

Bridging the Gap Foundation
Web site: http://www.managingcontraception.com

Planned Parenthood
Web site: http://www.plannedparenthood.org/health-topics/birth-control-4211.htm

Princeton University's Emergency Contraception Website
Web site: http://ec.princeton.edu/

December 2010

APRN
ALLIANCE

February 21, 2016

Senator Berta Gardner
State Capitol Room 9
Juneau AK 99801

RE: SB 156
"An act relating to insurance coverage for contraceptives..."

Dear Senator Gardner:

I am writing on behalf of the Alaska Advanced Practice Registered Nurse (APRN) Alliance **in strong support of SB 156**. The APRN Alliance is a group of nurse leaders representing nurse practitioners (CNPs), nurse-midwives (CNMs), nurse anesthetists (CRNAs), and clinical nurse specialists (CNSs) throughout Alaska. The Alliance is actively engaged in advocacy and policy issues which affect the interests of APRNs in Alaska.

The APRN Alliance strongly supports this common sense bill which provides women with a full year of contraceptive coverage following an initial three-month dispensing.

Sincerely,

Laura Sarcone CNM

Laura Sarcone MS, ANP-BC, CNM
Immediate past co-chair, APRN Alliance
1444 Hillcrest Drive
Anchorage AK 99503
907-230-7068 (cell)
sarconecnm@yahoo.com

cc: Katherine Hardy MSN, FNP-BC
Co-chair, APRN Alliance

Tracey Wiese ANP, DNP, PMHNP-BC, FNP-BC
Co-chair, APRN Alliance

Alaska State Legislature

Please enter into the record my testimony to the Health and Social Services
Committee name

Committee on SB 156, dated 2-24-16
Bill/Subject

I very much support this bill and hope it will be moved forward and passed. It makes sense. Reducing unintended pregnancies is a good thing. Affordable, accessible contraceptives will help do that. This bill will help women and men better manage their family planning.

Signed: Barbara McDaniel
Testifier

Representing (Optional)

1040 N Craig Stadler Lp, Wasilla, Ak 99623
Address

907-373-6977
Phone number

Catriona Reynolds
Clinic Manager
Kachemak Bay Family Planning Clinic
Homer, Alaska 99603

SB 156

I have been the Clinic Manager at Kachemak Bay Family Planning Clinic for 13 years and I represent my organization when I speak today. I also serve on the Alaska Medicaid Care Advisory Committee (MCAC) and I am a Homer City Councilmember but I am not speaking on their behalf. I have two teenage children who have greatly benefitted from participating in comprehensive reproductive and sexual health curricula at Homer Middle and High Schools.

I am here to provide my opinion about expanded access to cyclical birth control methods which has been formed by both my own experiences and from evidence based studies, which I will include references to.

With perfect use, hormonal birth control has a failure rate of less than 5%, but for women who lack access to transportation, move frequently, or struggle to balance work and family, monthly trips to the pharmacy make perfect use challenging. This is especially a concern in rural areas. While our clinic is in Homer we serve clients as far away as Ninilchik, Nikolaevsk, Vosnesenka and across the Bay in Seldovia and Halibut Cove. We also serve women who work or fish in remote areas for months at a time.

About one in four women say they have missed pills because they could not get the next pack in time; dispensing one-year's supply at a time reduces the odds of experiencing an unintended pregnancy by 30% and is associated with a 46% drop in the chance of needing an abortion.

Consistent use of birth control is the best way to prevent unintended pregnancy; 19% of women who inconsistently use birth control account for 43% of unintended pregnancies whereas the two-thirds of women who use birth control consistently only make up 5%. When we talk about the timing of inconsistent contraceptive use, most often the reason is given that the next cycle wasn't on hand to start on time.

Women without reliable access to transportation or living in rural areas have more barriers to dependable access to birth control, leaving them at a greater risk for unintended pregnancies.

Insurance plans that dispense one-year's supply of birth control instead of limit dispensing to one or three cycles lower their direct costs on follow-up visits and pregnancy tests, as well as long-term unintended pregnancy management.

Forty-six percent of women who unintentionally became pregnant report that they were using some form of contraceptives; providing one year of birth control at a time will increase consistent use and reduce unintended pregnancy.

Women's consistent access to birth control should not depend on her insurance carrier. By requiring that women get 12 months of birth control at a time, we can reduce barriers to contraceptives, prevent unintended pregnancy, and save money. A supply for 12 months may require up to 17 packs/cycles of a contraceptive method, depending on the instructions for use.

Background

- Research from California's family planning Medicaid expansion program, Family PACT, has demonstrated the impact of contraceptive coverage policies encouraging expanded dispensing practices. Specifically, researchers found that dispensing a 1-year supply of oral contraceptives was associated with a significant reduction (30%) in the odds of conceiving an unplanned pregnancy compared with dispensing just one or three packs. *Foster DG, Hulett D, Bradsberry M, Darney P, & Policar M. Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies. Obstetrics and Gynecology, 2011: 117(3), 566-572.*

- The recently released Centers for Disease Control report, "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs" reinforces this standard. The report explicitly recommends providing or prescribing multiple cycles (ideally a full year's supply) of oral contraceptive pills, the patch, or the ring to minimize the number of times a client has to return to the service site. *Gavin L, Moskosky MS, Carter M, et al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs. MMWR 2014: 63(4).*

Considerations

- It is unclear how a health benefit plan/prescription benefit program would determine whether an insured member had previously received the same contraceptive under a different program, plan, or policy. Decisions regarding how many cycles of contraceptives to prescribe are made by the insured's health care provider. If the health care provider determines that a 12-month cycle of contraceptives for a new member is warranted, the health benefit plan/prescription benefit program would have no way of determining whether this was the first dispensing of the contraceptive or a subsequent dispensing.

And, thinking about money and associated costs, you might have concerns about whether 12 month supplies would result in wastage. Anecdotal experience from my clinic is that after an initial 3 or 4 month trial period clients are confident whether or not they tolerate, like and will continue to use a method.

This anecdote is supported by analysis conducted by Rachel Linz, Epidemiologist for the Public Health Division of the Oregon Health Authority. Ms. Linz conducted a 2 year analysis of data from a program in Oregon that dispensed 12 months of contraception at a time.

Overall, she found that fewer than 2% of the clients received more than 35 cycles of the pill, patch, and/or ring within a 2-year period. The analysis used 35 units as the cut-off because for those clients taking continuous use birth control, 34 packs are needed over a 2-year period. Regardless of whether a client received one method (e.g. pill only) or multiple methods (e.g. pill, then ring) over the 2-year period, the overall percentage of clients receiving an excessive quantity was almost negligible (1.2%). This data indicates that receiving more than a 12-month supply over a 1-year period is extremely rare.

I realize that you may have already heard much of this officially researched data. I want to also share with you the unique way that working at KBFPC allows me to see the benefits of providing 12 month supplies in action. KBFPC is a Title X clinic, as such we are able to provide contraceptive supplies directly to clients on a sliding scale that goes as low as 100% discount. We serve some clients that have no other coverage, or are unable to use it because of confidentiality reasons. For many years now we have provided clients with up to a 12 month supply after they have established that a method works for them. We have other clients that use their insurance or Medicaid as primary coverage and revert to our sliding scale for elements that insurance doesn't cover. All Medicaid clients and some of the private insurance clients have to get their supplies from a regular pharmacy, usually in 1 or 3 month quantities. Clients that have to make repetitive trips to the pharmacy are more often the ones that discontinue use of the method or use it inconsistently.

SB156 is important and will positively impact the health of Alaska's women, while providing a substantial saving by reducing unplanned pregnancies.

I apologize for running over during my testimony today, I had prepared for about four minutes of testimony and didn't condense it enough.

Yours,

Catriona Reynolds

Alaska State Legislature

Please enter into the record my testimony to the Health and Human Services
Committee name

Committee on SB 156, dated 2-24-16
Bill/Subject

This is a common sense bill. I sincerely hope that you will pass it.

Signed: Pamela Jo Rahn
Testifier

Representing (Optional)

PO Box 879723 Wasilla AK 99687
Address

357-9151
Phone number

Alaska Pharmacists Association

February 23, 2016

Senator Berta Gardner
Alaska State Capitol Building
Room 9
Juneau, AK 99801

Dear Senator Gardner:

On behalf of the Alaska Pharmacists Association (AKPhA), I am writing in support of SB 156. I would like to personally thank you for introducing this piece of legislation, as having access to affordable contraception is very important in our state. The only caveat we would make is the section requiring a 90 day first fill for oral contraceptives. We see this requirement potentially creating multiple insurance issues that could be avoided by simply leaving this section out of the final bill. I believe this section has already been removed from the companion bill in the House.

AKPhA represents over 200 pharmacists and pharmacy technicians in the State of Alaska. Our mission is to preserve, promote, and lead the profession of pharmacy in Alaska. Alaska SB 156 strongly aligns with our mission to provide the best possible care to all of our patients, and to make needed medications, including contraceptives, readily available to these patients.

Again, we appreciate your efforts and leadership on this issue. Should there be anything that I, or the Alaska Pharmacists Association can do to help ensure passage of this legislation, please let me know.

Sincerely,

Tara Ruffner, Pharm D
President
Alaska Pharmacists Association

E-mail: akphrmcy@alaska.net
203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

Katie Bruggeman

From: Dr Tomsen <ttomsen@awcp.net>
Sent: Tuesday, February 23, 2016 10:55 AM
To: Katie Bruggeman
Subject: in support of contraceptive access

Katie,

I am more than happy to lend my support to your and Senator Gardner's efforts to improve women's access to contraception.

The bill being considered in the HESS committee tomorrow seeks to expand access for women in the year after delivery, so that they can 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 woman 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 or damaging parenting by young 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 more financially secure 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, mission trips, remote living or 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.

Please consider expanding your efforts to EXPAND this bill to cover **all** women seeking to fill their prescriptions for contraception **and other medications** that are prescribed to them for lengthy periods. The

only reason not to do this is to support pharmaceutical and insurance company profits at the expense of the individual, the family, and even the state.

I am sorry I will not be there to testify this time.

Tina Tomsen, MD

Anchorage Women's Clinic

The League of Women Voters

c/o P.O. Box 90079, Anchorage, AK 99509-0079

February 16, 2016

Dear Senator Stedman, HSS Chair:

The League of Women Voters of Alaska strongly supports SB 156, a bill related to insurance coverage for contraceptives and other services that reduce the risk of unintended pregnancies. At the national level, the League of Women Voters of the United States supports primary care for all, care that includes "prenatal and reproductive health" (*Impact on Issues* 72). When women have the consistent ability to plan their pregnancies, their families benefit through greater financial well-being, healthier living conditions, healthier children, greater opportunities, and a myriad of additional benefits.

While improving the quality of life for families, the ability to avoid unintended pregnancies also reduces costs for state and federal governments. In 2010 according to the Guttmacher Institute, the State of Alaska spent nearly $43 million on health costs related to unintended pregnancies while the federal government added another $71 million for a total cost of $114 million. Guttmacher reports that 48% of all pregnancies in Alaska in 2010 were unplanned and 64% of Alaska's unplanned pregnancies were publicly funded, representing the $43 million cost.

In addition, the cost benefits of supporting women in their efforts to plan their pregnancies goes far beyond the cost of the pregnancy itself. A woman who is able to plan a pregnancy can better guarantee that her health is at optimum level prior to pregnancy, reducing the risk of a difficult pregnancy and trauma to the child. Such planning reduces the possibility of increased health problems for the child, problems which can follow the child for years and require increased health and education costs for the State. A planned pregnancy increases a woman's ability to manage her role as income provider for a family and allows that family the best opportunity to remain as financially independent as possible. Supporting affordable contraceptives prescribed on a 12-month basis will undoubtedly reduce the number of unintended pregnancies in Alaska, thereby increasing family well-being and reducing State costs.

SB 156 can assist women and families to plan pregnancies so they are ready for the added responsibility of a child. In addition, costs to the State for unintended pregnancies can be reduced. This is a win-win bill that deserves consideration by the Legislature especially as it struggles with the budget crisis. Thank you for your consideration.

Sincerely,

Hetty Barthel

Hetty Barthel, Secretary
League of Women Voters of Alaska

The League of Women Voters is a nonpartisan political organization that encourages the informed and active participation of citizens in government and influences public policy through education and advocacy.

NFIB

The Voice of Small Business

ALASKA

February 18, 2016

The Honorable Berta Gardner
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 156

Dear Senator Gardner,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 156. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues, not additional mandates.

For many small employers in Alaska insurance premiums for small groups or single coverage have increased again this year by 30 to 40 percent, a jaw-dropping statistic on top of double-digit increases in the past few years. This is completely unsustainable over the long-term. Much of the increase is driven by the additions to coverage by state mandates

Unfortunately, SB 156 mandates specified drug coverage that may not fit employee's needs but for which small employers providing health insurance bear the cost. Increased mandates force employers to consider whether they can afford to continue coverage or are forced by increased prices to eliminate health insurance for their employees. Mandates prevent small employers from providing affordable insurance programs tailored to its specific work force.

While this measure includes the state Medicaid program, it does not include the state employee programs. In fairness, if the state legislature does not believe it is a benefit important enough to mandate on its own programs, how can it be fair to mandate it on small employers and individual policy purchasers.

SB 156 is discriminatory against small employers as the mandate applies to those who provide coverage regulated by state insurance statutes, but not programs offered by the state and other governmental entities or large employers who typically offer ERISA programs. Thus it creates a less fair business environment for small employers.

Sincerely yours,

Dennis L. DeWitt
Alaska State Director

cc: NFIB Alaska Leadership Council
Senator Bert Stedman, Chair, Senate Health & Social Services Committee