

SB

53

<TARGET><BILL>SB 53</BILL><SUBJECT>SB
53</SUBJECT><COMM>SHSS30</COMM></TARGET>

ALASKA STATE LEGISLATURE

WORLD TRADE

RULES COMMITTEE

COMMUNITY & REGIONAL AFFAIRS

LABOR & COMMERCE



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

•
WHILE IN ANCHORAGE
1500 W BENSON BLVD ROOM 220
ANCHORAGE, AK 99503
(907) 269-0174

SENATOR BERTA GARDNER

SENATE DEMOCRATIC LEADER

SENATE DISTRICT I

Sponsor Statement

SB 53: An Act Expanding Access to Birth Control

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. SB 53 would require insurance companies to pay at the request of the consumer both private and Medicaid claims and reimburse health care providers for 12 month supply of contraceptives, including but not limited to birth control pills and hormonal contraceptive patches. Additionally, SB 53 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. Unintended pregnancy mainly results from not using contraception, or from 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.

I invited you to discuss this issue with me further and encourage you to support this legislation.

ALASKA STATE LEGISLATURE



WORLD TRADE

RULES COMMITTEE

COMMUNITY & REGIONAL AFFAIRS

LABOR & COMMERCE

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

•
WHILE IN ANCHORAGE
1500 W BENSON BLVD ROOM 220
ANCHORAGE, AK 99503
(907) 269-0174

SENATOR BERTA GARDNER
SENATE DEMOCRATIC LEADER
SENATE DISTRICT I

Sectional Analysis

SB 53: An Act Expanding Access to Birth Control

Section 1: Amends AS 21.42 by adding a new section, AS 21.42.427. AS 21.42.427 requires a health care insurer, in the group or individual market, that provides coverage for prescription contraceptives to provide reimbursement for dispensing prescription contraceptives for a 12-month period. AS 21.42.427(b)-(g) contain other related compliances 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 12-month period 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 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 for sec. 5 of this Act, provides for a January 1, 2018 effective date.

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: SB 53
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB053-DCCED-DOI-03-10-17
Title: INSURANCE COVERAGE FOR
CONTRACEPTIVES
Sponsor: GARDNER
Requester: (S) Health and Social Services

Department: Department of Commerce, Community and
Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues

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

	FY2018	Included in	Out-Year Cost Estimates				
	Appropriation Requested	Governor's FY2018 Request	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
OPERATING EXPENDITURES	FY 2018	FY 2018					
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Fund Source (Operating Only)

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Estimated SUPPLEMENTAL (FY2017) cost: 0.0 (separate supplemental appropriation required)
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2018) 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? No
If yes, by what date are the regulations to be adopted, amended or repealed? N/A

Why this fiscal note differs from previous version:

Not applicable, initial version.

Prepared By: Lori Wing-Heier, Director Phone: (907)465-2560
Division: Division of Insurance Date: 03/10/2017 05:00 PM
Approved By: Catherine Reardon, Director Date: 03/10/17
Agency: Division of Administrative Services, DCCED

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. SB 53

Analysis

SB 53 amends AS 21.42 and requires health care insurers that provide coverage for prescription contraceptives and related services to provide reimbursement for dispensing prescription contraceptives for a three-month period for the first dispensing, and a 12-month period for subsequent dispensing.

There is no anticipated fiscal impact to the Division of Insurance.

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: SB 53
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB053-DHSS-HCMS-03-03-17
Title: INSURANCE COVERAGE FOR
CONTRACEPTIVES
Sponsor: GARDNER
Requester: (S) 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)

	FY2018 Appropriation Requested	Included in Governor's FY2018 Request	Out-Year Cost Estimates					
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
OPERATING EXPENDITURES								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants & Benefits	(677.9)		(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)
Miscellaneous								
Total Operating	(677.9)	0.0	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)

Fund Source (Operating Only)

1002 Fed Rcpts (Fed)	(434.2)		(863.3)	(858.2)	(853.1)	(848.0)	(848.0)
1003 G/F Match (UGF)	(243.7)		(492.4)	(497.5)	(502.6)	(507.7)	(507.7)
Total	(677.9)	0.0	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)	(1,355.7)

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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

Estimated CAPITAL (FY2018) 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? **01/01/18**

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:	02/13/2017 12:00 PM
Approved By:	Shawnda O'Brien, Assistant Commissioner	Date:	03/03/17
Agency:	Health and Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. SB 53

Analysis

Administrative costs are captured in the Health Care Services Appropriation, Medical Assistance Administration Allocation in a separate fiscal note.

Benefits Costs

Oral Contraceptives: Duplication of Services

It is anticipated that there will be approximately 7,940 female Medicaid recipient oral contraceptive users annually (of which, 2,940 are through expansion). 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). 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 X 4 months X \$45) = \$142.9 (of which, \$52.9 is attributable to expansion)

Benefits Savings

Of the approximately 8,000 female Medicaid members who are contraceptive users, we assume that 75% or 6,000 plan to use the oral contraceptive long-term (i.e., longer than 12 months). 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 of contraceptives.

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 avoided 120 unintended pregnancies would have been complicated births, and the remaining 114.72 would have been non-complicated. The cost factor used for a complicated birth was \$110.0; the cost factor used for a non-complicated birth was \$8.0. Therefore, benefits savings is estimated at (5.28 X \$110.0) + (114.72 X \$8.0) = \$1,498.6 (of which, \$562.0 is attributable to expansion).

$\$142.9 + (\$1,498.6) = (\$1,355.7)$ net total annual projected savings in this component.

FUND SOURCE:

The Medicaid FMAP for contraceptives is 90%

The Medicaid FMAP for pregnancy-related services is 50%

FMAP for the Medicaid expansion population changes by federal fiscal year for several years, settling at 90% for all services by calendar year 2023. Prorated by state fiscal year, the expansion FMAP rates are:

FY2018	94.5%
FY2019	93.5%
FY2020	92.5%
FY2021	91.5%
FY2022	90.5%
FY2023	90.0%

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. SB 53

Analysis Continued

Applying these several FMAP rates generates the following fund source splits:

FY2018 Oral Contraceptives Costs

	Total	regular Medicaid @ 63%	expansion Medicaid @ 37%	Total
	\$142.9	\$90.0	\$52.9	
federal		\$81.0	\$50.0	\$131.0
GF match		\$9.0	\$2.9	\$11.9

FY2018 savings, unintended pregnancies avoided

	Total	regular Medicaid @ 62.5%	expansion Medicaid @ 37.5%	Total
	(\$1,498.6)	(\$936.6)	(\$562.0)	
federal		(\$468.3)	(\$531.1)	(\$999.4)
GF match		(\$468.3)	(\$30.9)	(\$499.2)

FY2018 Total

	Total	regular Medicaid	expansion Medicaid	Total
	(\$1,355.7)	(\$846.6)	(\$509.1)	
federal		(\$387.3)	(\$481.1)	(\$868.4)
GF match		(\$459.3)	(\$28.0)	(\$487.3)

Promulgation of associated regulations will take approximately six months following State Plan Amendment approval by the Centers for Medicare and Medicaid Services, with implementation effective January 1, 2018.

Since the regulations will only be in effect for six months of FY2018, cost savings have been adjusted to reflect one-half of the fiscal year. The department anticipates a net FY2018 savings of (\$434.2) federal (\$868.4 x .5 = \$434.2) and (\$243.7) GF match (\$487.3 x .5 = \$243.7). The logic of the calculations for FY2019 - 2023 is the same, except that the expansion FMAP rates are adjusted annually, as explained above.

Fiscal Note

State of Alaska
2017 Legislative Session

Bill Version: SB 53
Fiscal Note Number: _____
() Publish Date: _____

Identifier: SB053-DHSS-MAA-03-03-17
Title: INSURANCE COVERAGE FOR
CONTRACEPTIVES
Sponsor: GARDNER
Requester: (S) HSS

Department: Department of Health and Social Services
Appropriation: Health Care Services
Allocation: Medical Assistance Administration
OMB Component Number: 242

Expenditures/Revenues

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

	FY2018 Appropriation Requested	Included in Governor's FY2018 Request	Out-Year Cost Estimates					
			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
OPERATING EXPENDITURES								
Personal Services	44.7		89.4	89.4	89.4	89.4	89.4	89.4
Travel								
Services	4.7		9.4	9.4	9.4	9.4	9.4	9.4
Commodities	8.6		2.0	2.0	2.0	2.0	2.0	2.0
Capital Outlay								
Grants & Benefits								
Miscellaneous								
Total Operating	58.0	0.0	100.8	100.8	100.8	100.8	100.8	100.8

Fund Source (Operating Only)

1002 Fed Rcpts (Fed)	29.0		50.4	50.4	50.4	50.4	50.4	50.4
1003 G/F Match (UGF)	29.0		50.4	50.4	50.4	50.4	50.4	50.4
Total	58.0	0.0	100.8	100.8	100.8	100.8	100.8	100.8

Positions

Full-time	1.0		1.0	1.0	1.0	1.0	1.0	1.0
Part-time								
Temporary								

Change in Revenues

None								
Total	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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

Estimated CAPITAL (FY2018) 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? 01/01/18

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: 02/13/2017 12:00 PM
Approved By: Shawnda O'Brien, Assistant Commissioner	Date: 03/03/17
Agency: Health and Social Services	

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2017 LEGISLATIVE SESSION

BILL NO. SB 53

Analysis

Personal Services

The Department will incur administrative costs to implement and manage a process that reviews patient eligibility in subsequent months, if the supply dispensed exceeds the months of eligibility. 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.

Medical Assistance Administrator I, Range 16, in Anchorage:

\$ 89.4 personal services

\$ 9.4 position support services

\$ 2.0 office supplies

\$100.8 annually

\$ 7.6 computer software and equipment (one-time)

Due to the effective date of proposed changes to regulations, the services of this position will only be needed for 6 months of FY2018. Therefore, the total cost FY2018 is \$58,000 (\$100.8 / 2, plus one-time costs)

These costs are anticipated to be offset by overall benefit savings captured in the Medicaid Services appropriation, Health Care Medicaid Services Allocation, in a separate fiscal note.



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)

References

1. Guttmacher Institute, *Testimony of Guttmacher Institute, Submitted to the Committee on Preventive Services for Women, Institute of Medicine*, 2011, <<http://www.guttmacher.org/pubs/CPSW-testimony.pdf>>, accessed Oct. 23, 2012.
2. Sonfield A et al., *The Social and Economic Benefits of Women’s Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013, <<http://www.guttmacher.org/pubs/social-economic-benefits.pdf>> accessed July 26, 2013.
3. Finer LB and Zolna MR, Shifts in intended and unintended pregnancies in the United States, 2001–2008, *American Journal of Public Health*, 2014, 104(S1): S44-S48.
4. Singh S, Sedgh G and Hussain R, Unintended pregnancy: worldwide levels, trends, and outcomes, *Studies in Family Planning*, 2010, 41(4):241–250.
5. Sonfield A, Hasstedt K and Gold RB, *Moving Forward, Family Planning in the Era of Health Reform*, New York: Guttmacher Institute, 2014.
6. Frost JJ, Frohwirth L and Zolna MR, *Contraceptive Needs and Services, 2013 Update*, New York: Guttmacher Institute, 2015, <<http://www.guttmacher.org/pubs/win/contraceptive-needs-2013.pdf>>, accessed July 15, 2015.
7. Sonfield A and Kost K, , New York: Guttmacher Institute, 2015, <<http://www.guttmacher.org/pubs/public-costs-of-UP-2010.pdf>>, accessed February 23, 2015.
8. Frost JJ, Sonfield A, Zolna MR and Finer LB, Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program, , 2014, doi: 10.1111/1468-0009.12080, <<http://onlinelibrary.wiley.com/enhanced/doi/10.1111/1468-0009.12080/>, accessed Oct. 15, 2014.
9. Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002* New York: Guttmacher Institute, 2015, <<http://www.guttmacher.org/pubs/StateUP10.pdf>>, accessed January 20, 2015.
10. Guttmacher Institute, *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity*, New York: Guttmacher Institute, 2014, <<http://www.guttmacher.org/pubs/USTPtrends10.pdf>>
11. Sonfield A and Gold RB, *Public Funding for Family Planning Sterilization and Abortion Services, FY 1980–2010*, New York: Guttmacher Institute, 2012, <<http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf>>.

Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies

Diana Greene Foster, PhD, Denis Hulett, Mary Bradsberry, Philip Darney, MD, MSc, and Michael Policar, MD, MPH

OBJECTIVE: To estimate how number of oral contraceptive pill packages dispensed relates to subsequent pregnancies and abortions.

METHODS: We linked 84,401 women who received oral contraceptives through the California family planning program in January 2006 to Medi-Cal pregnancy events and births conceived in 2006. We compared pregnancy rates for women who received a 1-year supply of oral contraceptive pills, three packs, and one pack.

RESULTS: Women who received a 1-year supply were less likely to have a pregnancy (1.2% compared with 3.3% of women getting three cycles of pills and 2.9% of women getting one cycle of pills). Dispensing a 1-year supply is associated with a 30% reduction in the odds of conceiving an unplanned pregnancy compared with dispensing just one or three packs (confidence interval [CI] 0.57–0.87) and a 46% reduction in the odds of an abortion (95% CI 0.32–0.93), controlling for age, race or ethnicity, and previous pill use.

CONCLUSION: Making oral contraceptives more accessible may reduce the incidence of unintended pregnancy and abortion. Health insurance programs and public health programs may avert costly unintended pregnancies by increasing dispensing limits on oral contraceptives to a 1-year supply.

(*Obstet Gynecol* 2011;117:566–72)

DOI: 10.1097/AOG.0b013e3182056309

LEVEL OF EVIDENCE: III

See related articles on pages 551 and 558.

From the Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology, and Reproductive Sciences, San Francisco General Hospital, University of California, San Francisco, San Francisco, California.

Corresponding author: Diana Greene Foster, PhD, 1330 Broadway, Suite 1100, Oakland, CA 94162; e-mail: greened@obgyn.ucsf.edu.

Financial Disclosure

The authors did not report any potential conflicts of interest.

© 2011 by The American College of Obstetricians and Gynecologists. Published by Lippincott Williams & Wilkins.

ISSN: 0029-7844/11

Oral contraceptive pills are the most commonly used reversible method of contraception in the United States.¹ Although oral contraceptive pills are highly effective when used perfectly (3 pregnancies per 1,000 users in the first year of use²), typical patterns of use, with approximately half of women regularly missing one or more pills per cycle,^{3,4} is associated with a much higher pregnancy rate (80 pregnancies per 1,000 users in the first year of use).⁵

Recent work has examined whether dispensing a greater number of oral contraceptive pill packs affects contraceptive continuation. Our previous work showed dispensing a 1-year supply at California family planning clinic visits was associated with lower health care costs and higher contraceptive continuation. In our first study, women who received a 1-year supply of pills were more likely to continue use at 15 months after the initial dispensing visit than women who received one or three packs (43% compared with 20%–22%).⁶ A study⁷ in Jamaica showed higher continuation at 1 month among women who received four cycles of pills at a visit compared with women who received one cycle of pills followed by three cycles of pills at the subsequent visit. However, women who received the larger initial quantity of packs in Jamaica did not show higher continuation at 5 months. Our objective was to estimate how the number of oral contraceptive pill packages dispensed relates to subsequent pregnancies and abortions.

MATERIALS AND METHODS

Five attributes of publicly funded reproductive health care in California permit the comparison of data from the state family planning program on specific number of oral contraceptive packs dispensed and the deliveries and abortions of pregnancies that occur in the subsequent year. First, Medi-Cal, California's Medicaid program, is in one of only 17 states that



cover both abortion and birth.⁸ Second, Family Planning, Access, Care and Treatment (PACT), a Medicaid family planning waiver program that provides contraceptives at no cost to women at risk for pregnancy with incomes up to 200% of the federal poverty level, is a fee-for-service program that records how many packs of pills the women are dispensed. Third, nearly everyone who receives contraceptives under Family PACT would qualify for Medicaid pregnancy-related services if they became pregnant. Fourth, some Family PACT clinics have the authority to dispense pills on site. Those clinics are not bound by the 100-day supply limit at pharmacies and may dispense up to a 1-year supply. And finally, the number of women provided contraceptives within Family PACT is large—almost 1 million receive any contraceptive method each year and more than 80,000 women receive oral contraceptive pills each month, permitting the comparison of events such as births and abortions after contraceptive discontinuation.

We compared pregnancy rates between women who received a 1-year supply (12 or 13 packs) compared with one or three packs using a linkage between contraceptive dispensing claims in Family PACT and pregnancy events in Medi-Cal. We are particularly interested in whether providing a 1-year supply reduces unintended pregnancy rates, believing that it is a better outcome measure than the surrogate markers for pregnancy that have been used previously. To that end, we focused particular attention on abortions because abortions, unlike births, occur only rarely from intended pregnancies.

To identify pregnancy events among Family PACT clients, this study linked Family PACT client eligibility records with both the Medi-Cal beneficiary records in Medi-Cal Eligibility Data System and the California Birth Statistical Master File. A probabilistic linking algorithm was used because unique identifiers such as social security numbers are not available in many records.⁹ Consequently, approximately half of the Medi-Cal Eligibility Data System records, more than two-thirds of the Birth Statistical Master File records, and fewer than half of the Family PACT records contain a social security number. The probabilistic linking process linked individuals based on comparisons of birth date, name, gender, ethnicity, country of birth, language, county of residence, and postal code, as well as social security number, when available. We received approval from the University of California San Francisco Institutional Review Board to perform the claims data analysis and link to birth and Medi-Cal records (University of California

San Francisco Committee for Human Research H429-16233-12A).

The Fellegi-Sunter model of record linkage^{10,11} offers the ability to mathematically decide if a pair of records from two disparate data files belongs to the same person. A vector of weighted scores is created, indicating the levels of agreement and disagreement between corresponding variables within a record pair. This vector is used to create a composite score for the pair. The scores form a bimodal distribution of scores, one peak at the mean of the links and another at the mean of the non-links. Sensitivity and specificity analyses provide an optimal score threshold, above which the record pairs are considered links and below which are non-links. The threshold of the linking process for this analysis was set to obtain an equal number of errors among the links as among the non-links. Among the links, the error was estimated to be between 2% and 6%. Among the Family PACT to Medi-Cal Eligibility Data System links, 46% agreed fully on social security number. Among Family PACT to Medi-Cal Eligibility Data System links verified by social security number agreement, 95% agreed on seven or more other demographic variables. Among the links without benefit of social security number agreement, 86% agreed on seven or more variables. Among the Family PACT to Birth Statistical Master File links, 45% agreed fully on social security number. Among Family PACT to Birth Statistical Master File links verified by social security number agreement, 90% agreed on seven or more other variables. Among links without benefit of social security number agreement, 88% agreed on seven or more variables.

We ran a linkage from the 84,401 women who received oral contraceptive pills in January 2006 to 397,187 women whose Medi-Cal or Birth Statistical Master File pregnancy event (birth, miscarriage, abortion, or ectopic pregnancy) was conceived between January 2006 and January 2007. Exact dates of conception are not available in the Medi-Cal Eligibility Data System database. However, links made between Family PACT mothers and the Birth Statistical Master File births in 2006 and 2007 allowed us to obtain the date of last menses associated with 96% of linked births. In cases in which a matched record was found in the Birth Statistical Master File but no last menstrual period was recorded, we estimated the length of gestation by creating a linear model on birth weight and ethnicity. Conception for deliveries is set at 14 days after the date of last menses. For pregnancy events obtained from Medi-Cal Eligibility Data System when last menstrual period was not available, average gestation periods were used. Pregnancies



ending in surgical or spontaneous abortions were assumed to have been conceived 8 weeks before the abortion (10 weeks since last menstrual period). Pregnancies ending in medication abortion and ectopic pregnancies were assumed to have been conceived 5 weeks before the termination of the pregnancy (7 weeks since last menstrual period).

Women were considered to be continuously protected if they received enough pill cycles to continue pill use without a break. There was a 28-day grace period in our calculations of contraceptive protection to allow for the use of a remaining cycle from a previous visit for women not new to the pill and for new users to wait one menstrual cycle before initiating pill use. We assumed that women were not using oral contraceptive pills on an extended regimen in which they skip the inactive pills. We consider that a woman has switched to another contraceptive method if she receives an injectable, patch, ring, intrauterine device, or sterilization procedure. Women who receive condoms after having been dispensed oral contraceptive pills are not assumed to have switched methods because they may be using condoms concurrently as a back-up method or for prevention of sexually transmitted infections. A pack of oral contraceptive pills in this article refers to a supply sufficient for a 28-day period. A 1-year supply is considered to be 12 or 13 packs.

We use χ^2 tests to examine differences in continuation, method switching, and pregnancy rates by number of pill packs dispensed. We used multivariable logistic regression models to examine the effect of number of cycles of pills, controlling for other factors that may affect pregnancy rate such as age, parity, race or ethnicity, whether the woman is new to Family PACT (and may be more motivated to prevent pregnancy), and, if an established Family PACT client, whether they have received oral contraceptive pills in the previous year. Demographic data came from the client enrollment records. Women who reported being Hispanic were separated by primary language because English-speaking Latinas in California have been shown to have lower fertility and greater motivation to avoid pregnancy than Spanish-speaking Latinas.¹² At the time our analysis began, January 2006 was chosen as the index month because it was the latest month for which both Family PACT and Medi-Cal data were complete.

RESULTS

Table 1 describes the 84,401 women who were dispensed oral contraceptive pills through Family PACT in January 2006. Most women (58%) received three packs, one in five (20%) received one pack, 11% received 12 or 13 packs, and 10% received another quantity of pill packs. Young women (younger than age

Table 1. Characteristics of Women Receiving Oral Contraceptives in Family PACT in January 2006 by Number of Cycles Dispensed

	Number of Cycles Dispensed in January 2006					Other	n
	1	3	6	10	12 or 13		
Total	20	58	2	1	11	7	84,401
Age (y)							
10-19	17	47	4	2	18	11	15,180
20-29	20	57	2	1	12	7	45,201
30-39	21	66	2	1	5	6	18,904
40 or older	20	69	1	1	4	5	5,104
Race or ethnicity							
Missing	18	51	3	2	18	9	2,648
Asian or Pacific Islander	18	49	3	2	20	8	6,130
African American	19	54	3	1	15	8	2,965
Latina	22	51	3	2	14	9	13,140
Latina, Spanish	20	70	1	0	3	5	36,132
White, non-Latina	17	47	4	2	19	11	23,386
Parity							
0	18	50	3	2	17	9	45,558
1	21	64	2	1	6	6	14,400
2 or more	21	70	1	1	3	5	24,443
Type of provider dispensing							
Pharmacy	24	74	0	0	0	3	56,472
Clinic	11	27	7	4	34	17	27,929

PACT, Planning, Access, Care, and Treatment.
Data are % unless otherwise specified.



20) were most likely to receive a 1-year supply (18%) and women 40 and older were least likely (4%). Asians and white non-Latina women (20% and 19%, respectively) were more likely to get a 1-year supply; Spanish-speaking Latinas were least likely to get a 1-year supply (3%). Nulliparous women were more likely to get a 1-year supply than women with one or more children. Consistent with dispensing policy, pharmacies always dispensed a maximum of three packs of oral contraceptive pills, which is the maximum number allowable with a 100-day supply limitation. One-quarter (24%) of women receiving their pills at pharmacies received one cycle and three-quarters (74%) received three cycles. In January 2006, one-third of women received their pills at clinics that can dispense a 1-year supply. At these clinics, 11% of women got one cycle, 27% got three cycles, and 34% got a 1-year supply.

In Family PACT as a whole, teenagers are more likely than older women to receive a 1-year supply because they disproportionately receive care in clinics that are able to dispense a 1-year supply. However, at these clinics, teenagers are less likely than older women to receive the full 1-year supply (odds ratio [OR], .76). Women in their 20s and 30s are more likely than teenagers and women in their 40s to receive a 1-year supply. Racial ethnic differences are prominent. Asians are more likely (OR 1.15) and Latinas, particularly Spanish-speaking Latinas (OR .66), are less likely to receive a 1-year supply compared with white non-Latina

women in the program as a whole and within clinics that are able to dispense a 1-year supply. Independent of age, ethnicity, and language, women who have no children are more likely than women with one or more children to get a 1-year supply (OR 2.04). Women who were dispensed oral contraceptive pills in the previous year are less likely to get a 1-year supply, even at clinics that can dispense a 1-year supply on site (OR .69). New clients to the Family PACT Program are more likely to get a 1-year supply of oral contraceptive pills than established clients (OR 1.48; Table 2).

Women who receive a 1-year supply of oral contraceptive pills are more likely to continue to use them than women who get one or three packs of pills. Just more than one in five (21%) of women who received one pack in January 2006, 25% of women who received three packs, and 40% of women who receive a 1-year supply had received sufficient packs of pills in time to continuously use oral contraceptive pills for the subsequent 15-month period. Women who received a 1-year supply were less likely (7%) to switch to another method of contraception than women who received one cycle (11%) or three cycles (10%) in the next 18 months (Table 3).

An estimated 2.8% of women who were dispensed oral contraceptive pills in January 2006 conceived a pregnancy in the subsequent year and the resolution (birth, induced abortion, ectopic pregnancy, or spontaneous abortion) was paid for by Medi-Cal. Women who received a 1-year supply

Table 2. Odds of Receiving a 1-Year Supply of Oral Contraceptives: Results of Multivariable Logistics Models

	All Family PACT	Only Providers Who Can Dispense 1-Year Supply
Age (y)		
10–19	1.33* (1.13–1.57)	0.76* (.63–0.92)
20–29	1.58* (1.35–1.86)	1.21* (1.01–1.45)
30–39	1.33* (1.12–1.57)	1.23* (1.02–1.48)
40 or older	Reference	Reference
Missing race or ethnicity	0.94 (0.85–1.05)	1.10 (.97–1.24)
Asian or Pacific Islander	1.09* (1.02–1.18)	1.15* (1.06–1.25)
African American	.73* (.66–.82)	.93 (.82–1.05)
English-speaking Latina	.70* (.65–.74)	.86* (.80–.92)
Spanish-speaking Latina	.23* (.21–.24)	0.66* (0.60–.72)
White, non-Latina	Reference	Reference
Nulliparous	2.39* (2.17–2.62)	2.04* (1.83–2.27)
1 child	1.36* (1.23–1.52)	1.42* (1.26–1.60)
2 or more children	Reference	Reference
Received pills in 2005	.38* (.36–.40)	.69* (.65–.73)
New client in January 2006	1.80* (1.68–1.92)	1.48* (1.38–1.60)
Established client, new pill user	Reference	Reference
n	84,389	27,927

PACT, Planning, Access, Care, and Treatment.

Data are odds ratio (95%) confidence interval unless otherwise specified.

* $p < 0.05$.



Table 3. Contraceptive Continuation and Pregnancies Conceived in the Subsequent Year by Number of Oral Contraceptive Packs Dispensed in January 2006

No. of Cycles Received at First Visit in January 2006	n	Continuation at 15 mo	Switch to Another Primary Method	Pregnancy Conceived*	Induced Abortion*
1	16,471	21	11	2.9	.52
3	49,024	25	10	3.3	.63
12-13	9,549	40	7	1.2	.18
Other	9,357	38	10	2.0	.35
Total	84,401	27	10	2.8	.53

Data are % unless otherwise specified.

All differences by number of packs dispensed are significant at the .05 level using χ^2 test.

*Includes only those pregnancies in which medical care for the pregnancy outcomes were paid for by Medi-Cal.

were less likely to have a pregnancy (1.2% compared with 2.9% of women getting one cycle and 3.3% of women getting three cycles; $P < .05$). Almost one-fifth (19%) of pregnancies ended in an induced abortion. The rate of Medi-Cal-funded induced abortions ranged from 0.18% among women who received a 1-year supply to 0.63% among women who received three cycles ($P < .05$; Table 3).

Results of a multivariable analysis of the pregnancy rate and abortion rate in the context of client demographics, family planning history, and number

of cycles dispensed are shown in Table 4. Dispensing a 1-year supply is associated with a 30% reduction in the odds of conceiving a pregnancy in the subsequent year and a 46% reduction in the odds of an abortion, controlling for age, race or ethnicity, and previous pill use.

DISCUSSION

Dispensing a 1-year supply is associated with a significant reduction in the odds of conceiving an unplanned pregnancy compared with dispensing just

Table 4. Predictors of Conceiving a Pregnancy and Terminating a Pregnancy in the Subsequent Year by Number of Oral Contraceptive Packs Dispensed in January 2006: Results of a Multivariable Model

	Odds of Conceiving a Pregnancy in the Subsequent 12 mo	Odds of Terminating a Pregnancy Conceived in the Subsequent 12 mo
Race or ethnicity		
Missing	2.15* (1.59-2.90)	2.23* (1.11-4.48)
Asian or Pacific Islander	1.56* (1.22-1.99)	2.06* (1.21-3.52)
African American	1.87* (1.38-2.53)	2.15* (1.10-4.22)
Latina	2.46* (2.07-2.93)	2.55* (1.69-3.85)
Latina, Spanish	4.65* (4.01-5.39)	4.35* (3.06-6.19)
White, non-Latina	Reference	Reference
Number of pill packs dispensed		
1	Reference	Reference
3	1.08 (.97-1.20)	1.16 (.91-1.47)
12-13	.70* (.57-0.87)	.54* (.32-0.93)
Other	.91 (.76-1.08)	.91 (.61-1.37)
Age (y)		
10-19	1.46* (1.16-1.83)	1.74 (.96-3.13)
20-29	1.78* (1.47-2.16)	2.24* (1.35-3.74)
30-39	1.65* (1.35-2.01)	2.43* (1.45-4.07)
40 or older	Reference	Reference
Client status		
Established client, new pill user	Reference	Reference
Established client, established pill user	.96 (.87-1.06)	.86 (.69-1.06)
First visit to Family PACT (n=84,389)	.57* (.45-.72)	.55* (.32-0.96)

PACT, Planning, Access, Care, and Treatment.

Data are odds ratio (95% confidence interval).

* $p < 0.05$.



one or three packs. The cause of this reduction in pregnancies cannot be determined from these data. Most obviously, a greater supply of oral contraceptive pills may facilitate continuation of use by obviating the need for repeated time-consuming visits to a clinic or pharmacy for resupply; improved access and convenience may explain higher continuation among women given a 1-year supply. There is also a psychological explanation: each resupply visit is an opportunity to reconsider continuation of use. Being given a 1-year supply may enhance the expectation that the method is acceptable and safe, whereas fewer packs may suggest that the woman is likely to experience side effects and needs to reconsider use of the method at each resupply visit.

Our results are likely affected by a selection effect whereby more compliant users are given a larger supply of oral contraceptive pills. The women receiving oral contraceptive pills in Family PACT were not randomized to receiving one, three, or 13 packs. We cannot control for strength of intentions to avoid pregnancy or continue oral contraceptive pill use. However, we have controlled for factors that may be related to pill continuation, including age, race or ethnicity, and pill use in the previous year. We were not able to control for educational attainment; however, the population served by Family PACT has low income and likely has disproportionately low educational attainment as well. The effect of a 1-year supply of oral contraceptive pills on abortion rates controlling for demographic and previous use does indicate that not all pregnancies were planned in advance, and dispensing a greater supply of pills may reduce unintended pregnancy.

Another potential source of bias lies in which providers are permitted to dispense a 1-year supply. Only providers who dispense on-site, typically Planned Parenthood clinics, county health departments, student health clinics, and privately owned family planning clinics, can dispense a 1-year supply of oral contraceptive pills. For a variety of reasons, private practice providers do not stock and dispense oral contraceptive pills and instead write prescriptions that are transmitted to pharmacies. To the extent that the first group of providers takes more care in contraceptive counseling, differences in observed pregnancy rates may be attributable to differences in counseling rather than number of packs dispensed. However, there is no formal evidence that, even if the quality of counseling was higher at the first provider group, contraceptive counseling is associated with higher continuation.

Our study is limited to only those pregnancies with a resolution covered by the Medi-Cal program. The

total pregnancy rate of 2.8% is significantly lower than we would have expected based on typical use failure rates of the oral contraception of 8%.¹³ Induced abortions appear to be particularly undercounted; if there were no planned pregnancies in this group, then we would have expected to see an equal ratio of births to abortions rather than a ratio of 5 to 1.¹⁴ Pregnancies ending in induced abortion may have been paid out of pocket because women may not know that Medi-Cal covers abortion, they may have been unable to find a provider who accepts Medi-Cal, or they may have decided to pay cash to maintain confidentiality. Even if induced abortions are undercounted in these data, the extent of abortion undercounting is unlikely to vary by number of packs dispensed.

Making oral contraceptive pills more accessible may reduce the incidence of unintended pregnancy and abortion. If all 65,000 women who received only one or three packs of pills experienced the same pregnancy and abortion rates as women who received a 1-year supply, then almost 1,300 publicly funded pregnancies and 300 abortions would have been averted. Health insurance programs and public health programs may avert costly unintended pregnancies by increasing dispensing limits on oral contraceptive pills to a 1-year supply.

REFERENCES

1. Mosher WD, Martinez GM, Chandra A, Abma JC, Willson SJ. Use of contraception and use of family planning services in the United States: 1982–2002. *Adv Data* 2004;350:1–36.
2. Hatcher R, Trussell J, Stewart F, Cates W, Stewart GK, Guest F, et al. *Contraceptive technology*. 18th ed. New York (NY): Ardent Media; 2004.
3. Rosenberg MJ, Waugh MS, Burnhill MS. Compliance, Counseling and satisfaction with oral contraceptives: A prospective evaluation. *Fam Plann Perspect* 1988;30:89–92,104.
4. Potter L, Oakley D, de Leon-Wong E, Cañamar R. Measuring compliance among oral contraceptive users. *Fam Plann Perspect* 1996;28:154–8.
5. Hatcher R, Trussell J, Stewart F, Cates W, Stewart GK, Guest F, et al. *Contraceptive technology*. 19th ed. New York (NY): Ardent Media; 2007.
6. Foster DG, Parvataneni R, de Bocanegra HT, Lewis C, Bradberry M, Darney P. Number of oral contraceptive pill packages dispensed, method continuation, and costs. *Obstet Gynecol* 2006;108:1107–14.
7. Chin-Quee D, Otterness C, Wedderburn M, McDonald O, Janowitz B. One compared with multiple packs for women starting oral contraceptive pills: a comparison of two distribution regimens. *Contraception* 2009;79:369–74.
8. Guttmacher Institute State Policies in Brief. State Funding of Abortion Under Medicaid. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf. Retrieved January 6, 2010.
9. California Department of Health Care Services. Presumptive eligibility for pregnant women. Available at: <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx>. Retrieved January 6, 2010.



10. Fellegi IP, Sunter AB. A theory for record linkage. *J Am Stat Assoc* 1969;64:1183-210.
11. Winkler WE. Frequency-based matching in Fellegi-Sunter model of record linkage. Statistical research report series No. RR2000/06; Report issued October 4, 2000.
12. Foster DG, Arons A, Lauren R, Biggs A, Brindis C. Reproductive intentions: the social and personal benefits of pregnancy prevention. *Women's Health Issues* 2008;18:351-9.
13. Hatcher R, Trussell J, Stewart F, Cates W, Stewart GK, Guest F, et al. *Contraceptive technology*. 18th ed. New York (NY): Ardent Media; 2004.
14. Henshaw S. Unintended pregnancy in the United States. *Fam Plann Perspect* 1998;30:24-9,46.



Online Access to *Obstetrics & Gynecology*

Activate Your Online Subscription by Following These Steps:

1. On www.greenjournal.org, click **Register** at the top right corner of the screen.
2. On the registration screen, choose a username and password and enter your e-mail address. (Usernames must be at least 6 characters in length and contain no spaces or symbols; passwords must be at least 8 characters in length and contain at least one number and one letter.)
3. Click **Continue** to go to the next step of user registration.
4. On the next screen, enter your name and address and click **Continue**.
5. The next registration screen asks for additional information about you and your practice to help us recommend articles and rich media that suit your area of specialty. After entering this information, indicate your acceptance of the End User License Agreement and click **Complete Registration**.
6. After you complete the registration, you will receive an e-mail from the site asking you to confirm your registration. Click on the link in the e-mail within 48 hours.
7. The link in the e-mail leads to a web page where you will be asked if you want to activate your online subscription. Click on **Yes! I am a subscriber and want to activate my online subscription(s)**.
8. At the bottom of the next screen, there is a field for activating your subscription. *Enter your ACOG Member ID or your subscriber ID, which can be found on the top left corner of the mailing label for your journal.* Be sure to enter all characters into this form field. Then click on **Activate Subscription**.

Your account will now be active, and you will have full access to all content in the journal. Read full-text articles, download an epub file for your e-reader, listen to podcasts, watch videos, and take advantage of personalized features that allow you to save searches and create personal collections.

REV 10/2010





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

- 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

CONTENTS

Introduction..... 3

Methodology..... 4

Findings 8

TABLE 1. Number of births, and percentage and number that were publicly funded, by pregnancy intention status, 2010 11

TABLE 2. Cost per publicly funded birth and miscarriage, 2010 ... 12

TABLE 3. Total public costs for and potential savings from preventing unintended pregnancies, 2010 13

TABLE 4. Costs for all publicly funded pregnancies and for publicly funded intended pregnancies, 2010..... 14

Conclusions 15

References 16

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.

© Guttmacher Institute, 2015

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 (RlTe 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 R² 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.

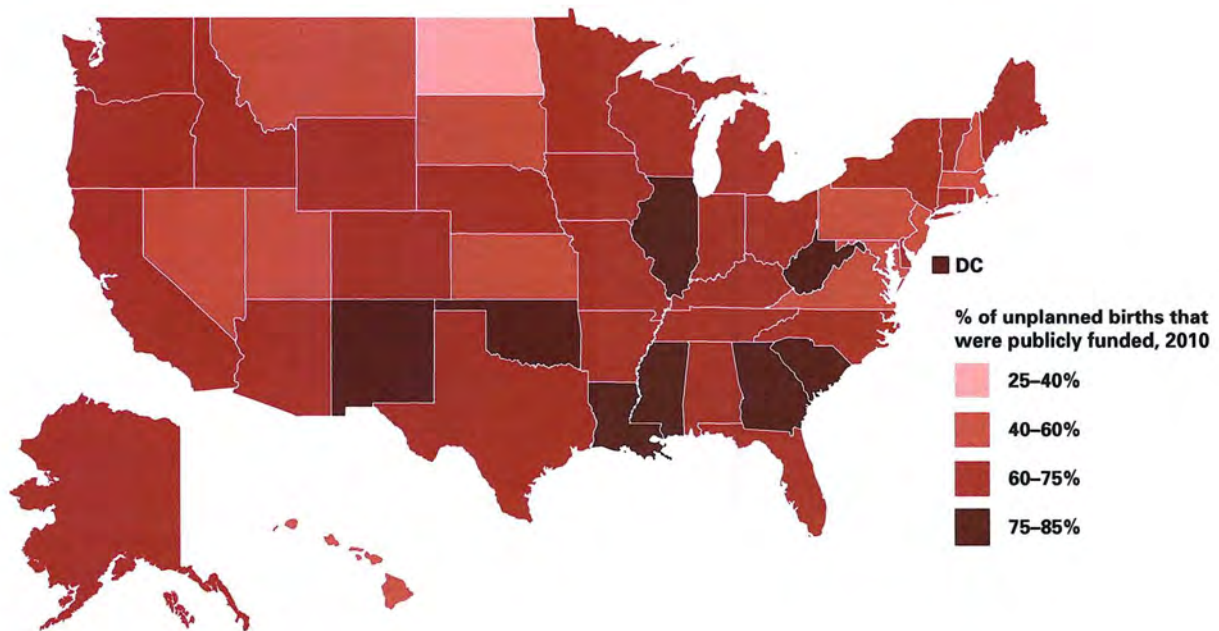
Public-Sector Costs

- 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),

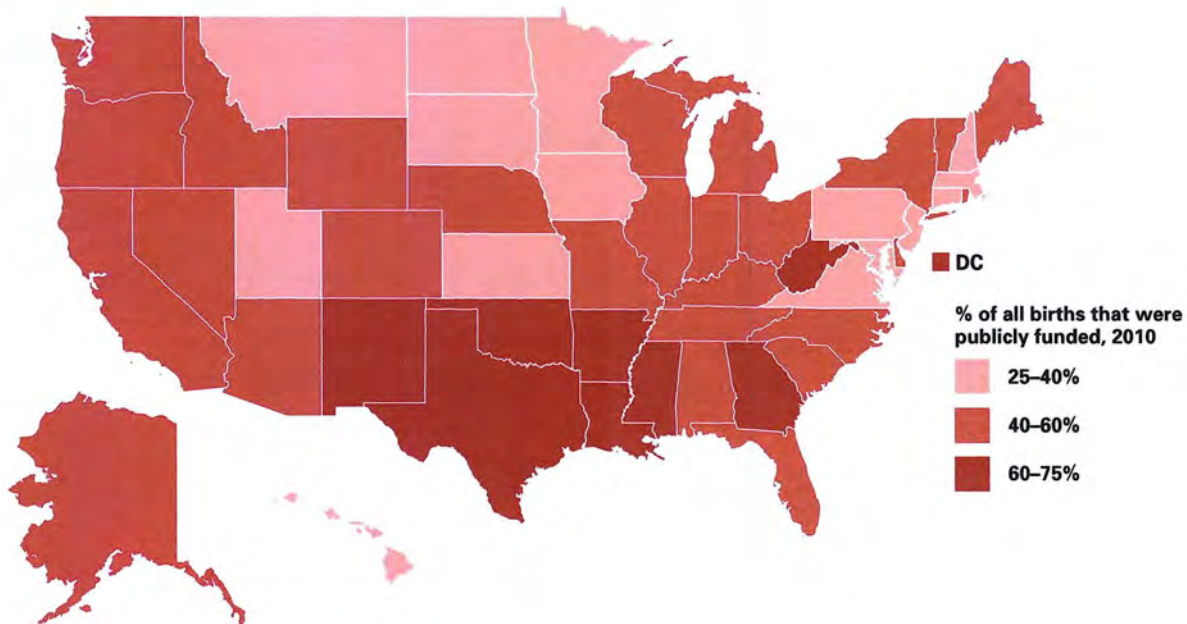
New York (\$1.5 billion) and Florida (\$1.3 billion). (Those four states are the nation's most populous.)

- 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

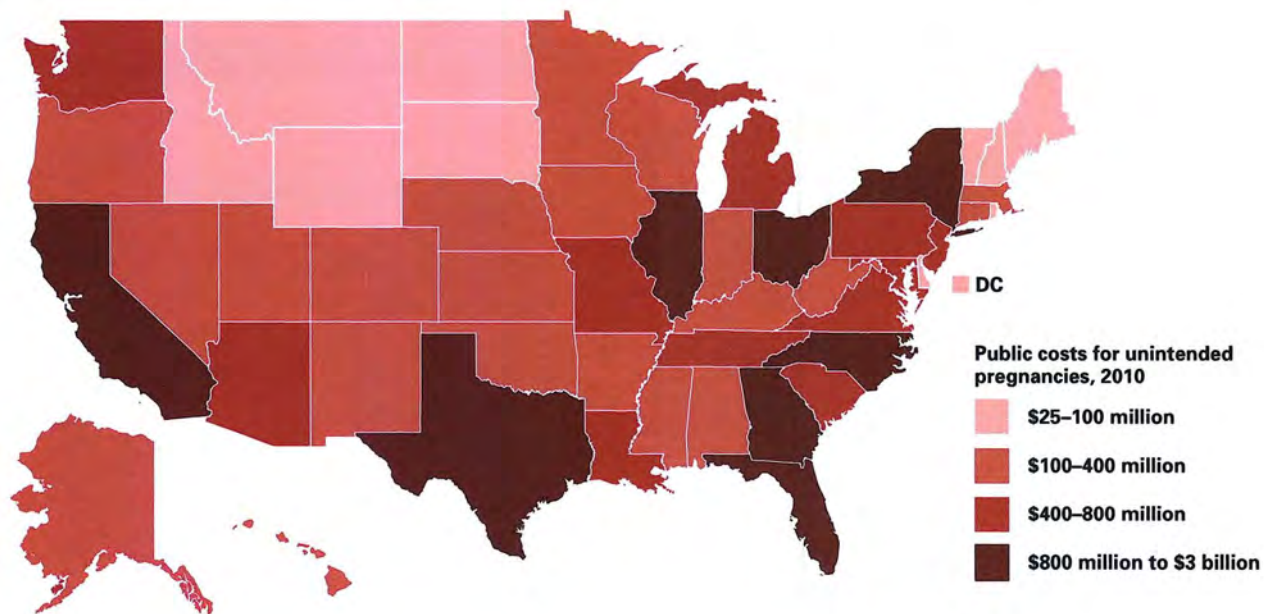


TABLE 1. Number of births, and percentage and number that were publicly funded, by pregnancy intention status, 2010

	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.

References

1. Brown SS and Eisenberg L, eds., *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Washington, DC: Institute of Medicine, 1995.
2. Sonfield A et al., *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*, New York: Guttmacher Institute, 2013, <www.guttmacher.org/pubs/social-economic-benefits.pdf>, accessed Nov. 19, 2014.
3. Kavanaugh ML and Anderson RM, *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers*, New York: Guttmacher Institute, 2013, <<http://www.guttmacher.org/pubs/health-benefits.pdf>>, accessed Nov. 19, 2014.
4. HealthyPeople.gov, Healthy People 2020, Family planning, 2011, <<http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13>>, accessed Nov. 19, 2014.
5. Finer LB and Zolna MR, Shifts in intended and unintended pregnancies in the United States, 2001–2008, *American Journal of Public Health*, 2014, 104(S1):S44–S48.
6. Guttmacher Institute, Unintended pregnancy in the United States, *Fact Sheet*, New York: Guttmacher Institute, 2013, <<http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html>>, accessed Nov. 19, 2014.
7. Sonfield A et al., The public costs of births resulting from unintended pregnancies: national and state-level estimates, *Perspectives on Sexual and Reproductive Health*, 2011, 43(2):94–102.
8. Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008*, New York: Guttmacher Institute, 2013, <<http://www.guttmacher.org/pubs/public-costs-of-UP.pdf>>, accessed Nov. 19, 2014.
9. Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2014, <<http://www.guttmacher.org/pubs/StateUP10.pdf>>, accessed Jan. 26, 2015.
10. Markus AR et al., Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform, *Women's Health Issues*, 2013, 23(5):e273–e280.
11. Frost JJ et al., *Contraceptive Needs and Services, 2010: Methodological Appendix*, New York: Guttmacher Institute, 2013, <www.guttmacher.org/pubs/win/winmethods2010.pdf>, accessed Nov. 19, 2014.
12. Sonfield A and Gold RB, *Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2010*, New York: Guttmacher Institute, 2012, <<http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf>>, accessed Aug. 23, 2013.
13. Frost JJ et al., Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program, *The Milbank Quarterly*, 2014, doi: 10.1111/1468-0009.12080, <<http://onlinelibrary.wiley.com/enhanced/doi/10.1111/1468-0009.12080/>>, accessed Oct. 22, 2014.
14. Henry J. Kaiser Family Foundation, Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, <<http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>>, accessed Nov. 19, 2014.
15. Finer LB and Zolna M, Guttmacher Institute, special tabulations of data from the 2006–2010 National Survey of Family Growth.
16. Frost JJ, Sonfield A and Gold RB, Estimating the impact of expanding Medicaid eligibility for family planning services, *Occasional Report*, New York: Guttmacher Institute, 2006, No. 28.
17. Finer LB and Kost K, Unintended pregnancy rates at the state level, *Perspectives on Sexual and Reproductive Health*, 2011, 43(2):78–87.
18. Singh S, Gold RB and Frost JJ, Impact of the Medicaid eligibility expansions on coverage of deliveries, *Family Planning Perspectives*, 1994, 26(1):31–33.



*Advancing sexual and reproductive health worldwide
through research, policy analysis and public education*

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



The Voice of Small Business®

ALASKA

February 20, 2017

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

RE: Senate Bill 53

Dear Senator Gardner,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 53. 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 last 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 53 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 specifically 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.

Honorable Berta Gardner
February 20, 2017
Page 2

SB 53 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 or unions providing federally regulated health plans. Thus it creates a less fair business environment for small employers.

At a minimum, SB 53 should be amended by adding the following to proposed section 21.42.427 (g)(1), "and plans provided under AS 39.30.090 or 39.30.091." This would specifically include the state employee programs.

Sincerely yours,



Dennis L. DeWitt
Alaska State Director

cc: NFIB Alaska Leadership Council
Senator David Wilson, Chair, Senate Health & Social Services Committee



Planned Parenthood Votes Northwest and Hawaii

Senator Gardner
Alaska State Capitol
Juneau, AK 99801

Re: Senate Bill 53

February 15th, 2017

Dear Senator Gardner,

On behalf of Planned Parenthood Votes Northwest and Hawaii, I write today to thank you for your leadership and for introducing legislation to expand birth control access in Alaska. As a health care provider that serves thousands of low-income individuals every year, we have long supported sincere efforts to expand access to birth control.

For more than 100 years, Planned Parenthood has provided birth control and other high-quality health care across the nation. In Alaska alone we serve more than 7,700 patients, which includes providing birth control to nearly 3,000 women. We believe that every woman should have full access to the birth control method that works best for her, without barriers based on cost or availability. Senate Bill 53 would remove such barriers and give women more career and education opportunities, encourage healthier pregnancies, and make them less likely to depend on government programs.

Providing a year's supply of birth control at a time is a solution that works for women. For many women who live in rural communities, lack reliable access to transportation, or struggle to balance work and family, a monthly trip to the pharmacy can be an insurmountable barrier to using birth control consistently. Consistent use of birth control is the best way to prevent unintended pregnancy, but one in four women say they have missed pills because they could not get the next pack in time. Getting a full year's supply at one time dramatically improves consistent use. According to a study published in *Obstetrics & Gynecology*, dispensing a full 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. It is also cost effective for both public and private insurance plans, which lower their direct costs on follow-up visits, pregnancy tests, and long-term costs associated with unintended pregnancies.

Women's consistent access to birth control should not depend on her insurance carrier. We appreciate your leadership and hard work to expand birth control access for Alaska women and look forward to supporting your efforts.

Sincerely,

A handwritten signature in black ink that reads 'Alyson Currey'.

Alyson Currey
Legislative Liaison

Planned Parenthood Votes Northwest & Hawaii
3231 Glacier Hwy, Juneau, AK 99801
907.957.8708 | alyson.currey@ppvnh.org



Alaska Nurses Association

3701 E. Tudor Road, Suite 208
Anchorage, Alaska 99507
(907) 274-0827
www.aknurse.org

March 6, 2017

Senator Berta Gardner
State Capitol
Juneau, Alaska 99801

Dear Senator Gardner,

We are writing on behalf of the Alaska Nurses Association in strong support of SB 53: "An Act relating to insurance coverage for contraceptives and related services; relating to medical assistance coverage for contraceptives and related services." This bill will provide for consistent contraceptive coverage for the women and families of our state.

Supporting women's and family healthcare is a long-standing priority of the Alaska Nurses Association. We believe that every woman should have full access to the birth control method that works best for her, without barriers related to cost or availability. Senate Bill 53 would remove such barriers and give women more career and education opportunities, encourage healthier pregnancies, and make women and families less likely to be dependent on government programs.

- With perfect use, hormonal birth control has a failure rate of less than 5%, but for people who lack access to transportation, move frequently, or struggle to balance work and family, monthly trips to the pharmacy make perfect use of contraceptives challenging.
- One in four women say they have missed contraceptive pills because they could not receive the next pack in time; dispensing a one-year 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 help women avoid unintended pregnancies; 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%.
- Publicly-funded or private insurance plans that dispense a one-year supply of birth control (instead of limiting dispensing to one or three cycles) lower their direct costs on follow-up visits and pregnancy tests, as well as on long-term unintended pregnancy management.
- Forty-six percent of women who unintentionally became pregnant report that they were using some form of contraceptive; providing a one-year supply of birth control will increase consistent use and reduce frequency of unintended pregnancy.

Access to reliable, consistent contraceptives should not depend on your insurance carrier. By requiring insurance to allow dispensing of a one-year supply of birth control, we can remove barriers to contraceptives, help women plan their families, and avoid unintended pregnancies and save money for Alaskan families and Alaska's government.

The Alaska Nurses Association certainly appreciates your support on behalf of women and families in our state.

Sincerely,

Arlene Briscoe, RN-BC
Legislative Chair
Alaska Nurses Association

Jane Erickson, RN, CCRN
President, Board of Directors
Alaska Nurses Association

The Alaska Nurses Association strongly endorses SB 53, recognizing our shared interest in removing barriers to consistent access to contraceptives for Alaskan women and families.

The Alaska Nurses Association serves to advance and support the profession of nursing. The Alaska Nurses Association's core purpose includes working for improvement of health standards and promoting access to health care services for all Alaskans.



Alaska Pharmacists Association

Board of Directors

Della Cutchins
President
Anchorage

Michelle Vaughn
President Elect
Juneau

Tara Ruffner
Past President
Soldotna

Piper Machamer
Treasurer
Anchorage

Michelle Locke
Secretary
Chugiak

Eric Burke
Metlakatla

Adele Davis
Juneau

Robert Gruszynski
Chugiak

Brittany Karns
Fairbanks

Eutonna Kirk
Anchorage

Kathryn Sawyer
Nome

Ashley Schaber
Anchorage

Sara Supe
Anchorage

March 2, 2017

Senator Berta Gardner
State Capitol Room 9
Juneau, AK 99801

Dear Senator Gardner:

Thank you for introducing SB 53. The Alaska Pharmacists Association (AKPhA) appreciates your efforts and leadership on this issue. AKPhA represents over 250 pharmacists and pharmacy technicians in the State of Alaska. Our mission is to preserve, promote, and lead the profession of pharmacy in Alaska.

SB 53 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.

The bill will add Alaska to the 7 other states that already require insurers that cover prescription drugs to provide coverage of FDA-approved prescription contraceptive drugs and devices; and to join states such as Illinois, Oregon, Vermont and California that allow women to get 12 months of birth control pills at one time. It will be important for women to understand appropriate storage methods for their contraception and we will work to ensure that they do.

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,

Della Cutchins, PharmD
President, Alaska Pharmacists Association
dcutchins@anthc.org

E-mail: akphrmcy@alaska.net

203 W. 15th Ave., Suite 100 • Anchorage, Alaska 99501 • (907) 563-8880 • (907) 563-7880

Jody Simpson

From: Shanah Stone <shanah.stone@gci.net>
Sent: Wednesday, March 08, 2017 11:13 AM
To: Senate Health and Social Services
Subject: Senate bill 53

Access to birth control is extremely important. You should give women a choice.

The average cost of non subsidized birth control in the USA without insurance is \$1,200 a year. That is for pills, implant, or IUD. Implants and IUD have a much higher success rate at preventing pregnancy. An IUD for the same cost as pills for a year may prevent pregnancies for up to five years.

So I hope this bill would give women all the choices available and support Planned Parenthood.

Sincerely,

Shoshanah Stone, ANP



The League of Women Voters

A Voice For Citizens, A Force For Change

P.O. Box 101345, Anchorage, AK 99510-1345

March 9, 2017

Dear Senator Gardner:

The League of Women Voters of Alaska strongly supports SB 53, 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." 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 53 can assist women and families to plan pregnancies so they are ready for the added responsibility of a child. It is time to accept birth control as an important and normal part of health care and make that care more easily available. In addition, costs to the State for unintended pregnancies can be reduced. This is a win-win bill that deserves serious consideration by the Legislature. The League fully supports the passage of SB 53.

Sincerely,

League of Women Voters of Alaska, Board of Directors

Pat Redmond, President; Judy Andree, Vice-President; Carol Dickason, Treasurer; Gail Knobf, Secretary; Marianne Mills, Past President; Directors Lois Pillifant, Hetty Barthel, Phyllis Tugman-Alexander, & Diane Mathisen.

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.

Jody Simpson

From: Paul Crews <pbcrews@alaska.net>
Sent: Thursday, March 09, 2017 11:05 AM
To: Senate Health and Social Services
Subject: SB 53

I support the passage of SB 53.

Improved family planning supports family and community well being, improves family economic situations, saves society money and prevents unwanted pregnancies and abortions.

Please pass SB 53.

Paul Crews
Girdwood

Jody Simpson

From: Cat Coward <travelncat@gmail.com>
Sent: Saturday, March 11, 2017 10:35 AM
To: Senate Health and Social Services
Cc: Sen. Berta Gardner
Subject: In support of SB 53

Dear Alaska State Legislators,

I'm am writing in support of SB 53, legislation that would require insurance companies to cover one full year of birth control rather than simply one month or quarter.

The necessity of getting to the pharmacy once per month or quarterly, especially when one is working a full time job, has one or more children to take care of, and/or lives rurally, is challenging at best. Birth control functions only when taken consistently and properly and any help that we can give parents to ease their family planning makes sense. It also is better for our economy as it decreases the costs of unintended pregnancy. It is good news that the rate of abortions is decreasing. It is even better news that we can help decrease it even more by allowing parents, and women, the ability to purchase birth control for an entire year, thus eliminating gaps in service when they have to purchase it more often.

Thank you for your support of this bill.

Catherine Coward
6221 Farpoint Dr
Anchorage, AK
99507

March 12, 2017

Dear Chairman Stedman, Vice Chair Giessel, and members of the Senate Health and Social Services Committee,

I live in Anchorage, Senate District L, I represent myself, and I am writing to you to express my support for SB 53, "12 Months of Birth Control." By far, prescription birth control, when used as directed, is the most effective method of pregnancy prevention. I spent over 20 years on prescription birth control, which means I've gone to the doctor 80 times in those 20 years to get my prescription refilled. This is an unnecessary time sink and financial burden born only by women.

I am thrilled to be married to a man who was willing to get a vasectomy after our marriage. Our insurance covered his vasectomy. And our insurance would have covered a pregnancy. But our insurance would not have allowed more than 3 months-worth of birth control.

I have been on two long-term medications, one for over 20 years and another for over 10 years. As long as I see my doctor once per year, I can renew my prescriptions for up to one year. I see no reason why birth control should be looked upon any differently.

I ask the committee to give women, men and families the gifts of time, money, and planned pregnancies by supporting 12-months of birth control with only one doctor's visit each year.

Thank you for considering my personal experience in your decision.

Sincerely,



Cathy Girard
3841 Chiniak Bay Drive
Anchorage, AK 99515-2230
cgirard@gci.net
907-538-5232

Jody Simpson

From: Traci Ferguson-Hayes <tracijoyferguson@gmail.com>
Sent: Monday, March 13, 2017 6:55 AM
To: Senate Health and Social Services; John Church
Subject: Support of SB 53

Hello,

My name is Traci Ferguson Hayes and I live in Juneau, AK in Senate District Q. I am writing in support of SB 53.

As a young woman of the age of 30 and as a mom of two children already, I support full access of birth control. My last pregnancy has it's complications and I was told by numerous doctors that if I was to ever get pregnant again, I or the baby would not be able to make it. Personally, it is important to me that I have access to birth control for a long period of time. If I were able to obtain birth control for an entire year, that would benefit myself and my family. It would reduce the risk of getting pregnant again and worrying about not only my life, but the life of an unborn child.

Thank you,
Traci Ferguson Hayes

--
Traci Ferguson Hayes
(907) 723-7066

"No Matter What Happens, Always Keep Your Childish Innocence"

Jody Simpson

From: lauterbacht <lauterbacht@aol.com>
Sent: Monday, March 13, 2017 9:17 AM
To: Senate Health and Social Services
Subject: Supporting SB 53

Dear Senate HSS committee:

I stand in STRONG SUPPORT of SB 53. I hold Life, Family, and Health very dear. I can think of no better single avenue to prevent abortions, support loving families, and provide for healthy women than to make contraception more widely available and covered by insurance (and Medicaid) for 12-month prescriptions, as required under SB 53. Thank you for holding a public hearing on it. Please pass it out of committee with resounding "Do Pass" recommendations.

Theresa Lauterbach
800 F Street, Unit N-6
Juneau, AK 99801


From: [Lou Gagne](#)
To: [John Church](#)
Subject: SB 53
Date: Monday, March 13, 2017 10:04:45 AM

Dear Senate HES committee:

I stand in STRONG SUPPORT of SB 53. I hold Life, Family, and Health very dear. I can think of no better single avenue to prevent abortions, support loving families, and provide for healthy women than to make contraception more widely available and covered by insurance (and Medicaid) for 12-month prescriptions, as required under SB 53. Thank you for proposing the bill and holding a public hearing on it. Please pass it out of committee with resounding "Do Pass" recommendations.

Thank you.

LouAnn Gagne'


Douglas, AK 99824

Sent from my iPad

Jody Simpson

From: Mike Coons <mcoons@mtaonline.net>
Sent: Monday, March 13, 2017 9:32 AM
To: Senate Health and Social Services
Subject: Oppose SB 53

My name is Mike Coons from Palmer and speaking for myself.

I oppose SB 53 for the following reasons.

Cost of pill per Fred Meyer Pharmacy ranges \$4-200 per month. Most popular is \$25 per month Injection for 3 months is \$97 or \$32.33 per month. Sean Hannity during the Obamacare legislation said the average cost of \$9 a month, per Fred Meyer, that is still correct. If an insurance company wants to cover this minor cost, that should be up to the insurance company. Most if not all women can afford the pill without insurance. This is just an attempt to replace Obamacare at our state level.

Section 1 will be mute once Obamacare is repealed and replaced with strong conservative economic values! Under Obamacare, insurance has to cover a bunch of stuff, like this for all, men included! So all this legislation does is tries to extend a requirement to insurance companies to insure the pill and sterilization. I'm betting if a doctor came up with a diagnosis that would cause the need for a hysterectomy, that would be covered under most if not all existing insurance. If this is elective, that is up to the insurance policy. This again is big government demanding business' to do something that is not sound economics for them!

Vote no and do not pass out of committee.

Mike Coons
5200 Dorothy Drive
Palmer AK 99645

--

Using Opera's mail client: <http://www.opera.com/mail/>