ENDOCRINE SOCIETY
Hormone Science to Health

POSITION STATEMENT

ENSURING AFFORDABLE ACCESS TO HORMONAL CONTRACEPTION

MEDICAL BENEFITS OF HORMONAL CONTRACEPTION

The majority of women of reproductive age in the United States currently use at least one contraceptive method, with more than 99 percent having used contraception during their lifetime.[1] Hormonal contraception provides a myriad of benefits beyond the expected reproductive planning by decreasing the number of unintended pregnancies and pregnancy-related health risks such as preeclampsia, gestational diabetes, and complications of childbirth. Providing women with the ability to determine when they become pregnant has a positive impact on their family's socioeconomic and health status.[2] For instance, when a woman can plan her pregnancies, she can ensure that any underlying conditions that may affect her or her baby's health are addressed prior to becoming pregnant. Studies have shown that a causal link exists between the spacing of a birth and a subsequent pregnancy and three major birth outcomes measures: low birth weight, pre-term birth and small size for gestational age.[3]

Endocrinologists frequently prescribe hormonal contraception to treat a variety of conditions. Although the majority of women use contraception to prevent pregnancy, 58 percent of pill users also cite non-contraceptive health benefits such as treatment for excessive menstrual bleeding, menstrual pain, and acne as reasons for using the method.[4] Hormonal contraception can also reduce a woman's risk of developing ovarian and endometrial cancer.[5] In fact, fourteen percent of oral contraceptive users—1.5 million women—rely on this method exclusively for non-contraceptive purposes.[6]

Hormonal contraceptive options have expanded beyond oral contraceptives to long-acting options such as the levonorgestrel intrauterine device and the etonogestrel implant. New data supporting the effectiveness and cost-effectiveness of these options underscore the necessity of protecting the availability of contraception to women through provisions of the Affordable Care Act (ACA) and funding of women's health organizations.

COST CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) estimates that unintended pregnancies cost American taxpayers at least $21 billion each year.[7] Nationally, 68 percent of these unintended pregnancies were paid for by public insurance programs including Medicaid, Children's Health Insurance Program, and the Indian Health Service.[8] Offering affordable access to hormonal contraception can have a measurable impact on these costs. For every public dollar invested in contraception, short-term Medicaid expenditures are reduced by $7.09 for the pregnancy, delivery, and early childhood care related to births from unintended pregnancies.[9] Costs for employers have been found to be 15-17 percent higher when not offering contraception coverage due to the direct medical costs of pregnancy and indirect costs such as employee absence and reduced productivity.[10]

Texas provides a real-world example of the impact of limiting access to contraception and reproductive health services. In the years after funding was eliminated for providers in the Texas Women's Health Program, analysis shows that there was a 25 percent average decrease in the number of women served by these clinics[11] and, consequently, an increase in the rate of childbirth covered by Medicaid[12] and a significant increase in maternal mortality rates.[13]

Title X is an important source of funding for both contraceptive and preventive services to women. In 2015, a study found that Title X-funded health centers prevented 822,000 unintended pregnancies, resulting in savings of $7 billion to federal and state governments.[14] A recent analysis by Guttmacher Institute found that federally qualified health center (FQHC) sites in 27 states would need to at least double their contraceptive client caseloads if Title X funding is withheld from non-FQHCs. Nine of these states would need to at least triple their case load.[15] This would create an insurmountable access problem for women in need of contraceptive services.

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[1]Guttmacher Institute. Contraceptive Use in the United States. https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states. September 2016. Accessed April 28, 2017.

[2]Flucke N, O'Meara H, Coelho J. Colorado Policy Perspective: Breaking the Cycle of Poverty with Help of Long-Acting Reversible Contraceptives (LARCs). Colorado Nurse [serial online]. November 2016;116(4):11-19. Available from: CINAHL Plus with Full Text, Ipswich, MA. Accessed May 9, 2017.

[3]Guttmacher Institute. The Case for Insurance Coverage of Contraceptive Services and Supplies without Cost Sharing. Winter 2011. http://www.guttmacher.org/pubs/gpr/14/1/gpr140107.html

[4]Guttmacher Institute. Contraceptive Use in the United States. https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states. September 2016. Accessed April 28, 2017.

[5]National Institutes of Health/National Cancer Institute. Oral Contraceptives and Cancer Risk. https://www.cancer.gov/about-cancer/causes-prevention/risk/hormones/oral-contraceptives-fact-sheet. Reviewed March 2012. Accessed April 28, 2017.

[6]Jones RK, *Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills*, New York: Guttmacher Institute, 2011.

[7]Centers for Disease Control and Prevention. *Women's Reproductive Health*; 2016. https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/aag-reproductive-health.pdf. Accessed April 28, 2017.

[8]Guttmacher Institute. Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care. February 2015. https://www.guttmacher.org/sites/default/files/report_pdf/public-costs-of-up-2010.pdf.

[9]Guttmacher Institute. Contraceptive Use in the United States. https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states. September 2016. Accessed April 28, 2017.

[10]Guttmacher Institute. Contraceptive Use in the United States. https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states. September 2016. Accessed April 28, 2017.

Critics of expanding access to free contraception argue that the benefit increases insurance costs. Estimates show that the cost to provide contraception per year ranges from $100-$600[16] while the cost for prenatal care, delivery, and newborn care averages $18,000-28,000 under private insurance.[17] As 45 percent of pregnancies are unintended, access to contraception has significant potential to improve women's health, reduce the number of elective pregnancy terminations, and lower health care costs.[18,19]

POLICY SOLUTIONS

Since the implementation of the ACA, access to no-cost, hormonal contraception in the United States has increased dramatically. Reverting to pre-ACA cost-sharing requirements would result in a dramatic increase in the number of women who are unable to afford contraception. Surveys conducted prior to the implementation of the ACA found that 34 percent of women voters reported having struggled with the cost of prescription birth control.[20] Among young adult women who are at most risk for having unintended pregnancies, 55 percent struggled with the cost of prescription birth control and reported times when they were unable to afford it.[21]

The passage of the ACA provided no-cost access to hormonal contraceptive services for all women. American voters have been highly supportive of this provision; 77 percent of women and 64 percent of men support such access.[22] The Endocrine Society believes that future health reform efforts should include continued access to no-cost contraception as it:

- Allows a woman to effectively plan when and if she becomes pregnant;
- Provides additional health benefits beyond reproductive planning;
- Positively impacts health care costs by reducing the number of unintended pregnancies and a woman's risk of developing ovarian or endometrial cancer.

[11]Weinberg, A. Planned Parenthood was Defunded by Texas: Here's What Congress Can Learn. *ABC News Online*. August 3, 2015

[12]Stevenson, A. et al. Effects of Removal of Planned Parenthood from the Texas Women's Health Program. *N Engl J Med* 2016; 374:853-860.

[13]MacDorman MF, et al. Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. *Obstet Gynecol* 2016;128:447-52.

[14]Guttmacher Institute. Federally Qualified Health Centers: Vital Sources of Care, No Substitute for the Family Planning Safety Net. Guttmacher Policy Review. Volume 20: 2017. https://www.guttmacher.org/gpr/2017/05/federally-qualified-health-centers-vital-sources-care-no-substitute-family-planning.

[15]*Ibid.*

[16]Guttmacher Institute. Good for Business: Covering Contraceptive Care Without Cost-Sharing is Cost-Neutral or Even Saves Money. July 16, 2014. https://www.guttmacher.org/article/2014/07/good-business-covering-contraceptive-care-without-cost-sharing-cost-neutral-or-even

[17]Truven Health Analytics MarketScan Study. The Cost of Having a Baby in the United States. January 2013. http://transform.childbirthconnection.org/reports/cost/

[18]Gutmacher Institute. New Clarity for the U.S. Abortion Debate. A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines. https://www.guttmacher.org/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent-abortion. March 2016. Accessed June 22, 2017.

[19]Guttmacher Institute. Unintended Pregnancy in the United States. https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states. September 2016.

[20]Planned Parenthood. Survey: Nearly Three in Four Voters in America Support Fully Covering Prescription Birth Control. http://www.plannedparenthood.org/about-us/newsroom/press-releases/survey-nearly-three-four-voters-america-support-fully-covering-prescription-birth-control-33863.htm. May 14, 2014.

[21]*Ibid.*

[22]Sobel L, Salganicoff A. The Future of Contraceptive Coverage. The Future of Contraceptive Coverage. http://www.kff.org/womens-health-policy/issue-brief/the-future-of-contraceptive-coverage/. Published January 17, 2017. Accessed June 2, 2017.