Preventing Unintended Pregnancy: The Need And the Means

In 2000, 34 million women—half of all U.S. women of reproductive age—were in need of contraceptive services and supplies to help prevent unintended pregnancy, and half of those were in need of public support for such care. In the absence of a national health insurance program, the United States relies on a patchwork system of public insurance and subsidized clinics to provide care to those in need. Holes in this patchwork, however, are becoming increasingly evident, threatening the system's ability to provide needed services and heightening political interest in more comprehensive solutions.

By Adam Sonfield

The typical American woman has intercourse for the first time at age 17 and reaches menopause at age 51. If she wants only two children, as most American women do, she will spend three decades being sexually active but trying to avoid unintended pregnancy. This is not an easy goal for an individual woman to meet.

Even though the Centers for Disease Control and Prevention in 1999 declared family planning to be one of the 10 most significant U.S. public health achievements of the 20th century, half of all pregnancies in the United States are still unintended. And the consequences of unintended pregnancy can be serious, even life-altering, particularly for women who are young or unmarried, have just recently given birth or already have the number of children they want. An unplanned pregnancy can be a barrier to obtaining timely prenatal care because it may take weeks or months for a woman to realize or accept that she is pregnant. Lack of prenatal care—along with poor birth-spacing, or giving birth before or after one's childbearing prime—can pose health risks for the woman and for her newborn. In addition, an unintended pregnancy can interfere with a young woman's education, limiting her employment possibilities and her ability to support herself and her family. Largely for reasons such as these, half of women who become pregnant unintentionally decide to have an abortion, which can be a serious decision in itself.

Assessing the Need

Contraceptive use drastically reduces the chances of unintended pregnancy. Over the course of a year, only 8% of women using the pill will become pregnant, compared with 85% of sexually active women not using contraceptives. This fact alone helps explain why the 7% of U.S. women at risk of unintended pregnancy who do not practice contraception account for almost half of the country's unintended pregnancies.

According to new data from The Alan Guttmacher Institute (AGI), 34 million U.S. women in 2000 were in need of contraceptive services and supplies—that is, they were of reproductive age, sexually active, able to have children and not pregnant or seeking to become pregnant (see table, page 8). These women constituted just over half of all U.S. women aged 13–44.

For individual women who need contraception over long periods of their life, the costs can be significant. According to Planned Parenthood Federation of America, oral contraceptives can cost $15–35 per month, not counting an annual exam; the contraceptive patch, contraceptive ring and the one-month injectable have costs at the high end of that range. Some of the most effective methods require concentrated payments: $50–115 for the three-month injectable and $175–400 to insert an IUD. Not all women in need can afford to purchase these services and supplies on their own. This is problematic because it may dissuade women from using the method that is most effective or appropriate for them. Also, cost may lead women to delay getting a refill or an injection, which in turn could lead to unintended pregnancy among those nominally using a method (see related story, page 4).

Private health insurance helps to lower and limit the cost of many women's medical care. Yet, 12.1 million U.S. women—20% of all women aged 15 to 44—were uninsured in 2002, and that proportion has increased by 10% since 1999. At the state level, the rate of being uninsured ranged from about 9% in Wisconsin to about 31% in Texas in 2001–2002 (see table, page 9). Moreover, researchers have found serious gaps in private coverage of prescription contraceptive methods; policymakers and advocates have worked over the past decade through legislatures, government agencies, the courts, the media and employers to improve this coverage ("Federal Law Urged as Culmination of Contraceptive Insurance Coverage Campaign," *TGR,* October 2001, page 10). And even when private insurance does pay for contraception, women may be required to contribute high copayments: According to the Kaiser Family

WOMEN IN NEED OF CONTRACEPTION, 2000

State	Overall, # in 000s	With public support	
		% of all	# in 000s
U.S. Total	**33,983**	**48.2**	**16,396**
Alabama	496	55.6	276
Alaska	72	44.4	32
Arizona	606	52.0	315
Arkansas	280	58.9	165
California	4,281	49.3	2,111
Colorado	537	42.6	229
Connecticut	438	36.8	161
Delaware	93	43.0	40
District of Columbia	85	48.2	41
Florida	1,699	49.9	848
Georgia	988	47.8	472
Hawaii	138	44.2	61
Idaho	141	56.7	80
Illinois	1,568	44.3	694
Indiana	735	48.6	357
Iowa	325	52.0	169
Kansas	309	50.8	157
Kentucky	442	54.3	240
Louisiana	520	59.4	309
Maine	152	52.0	79
Maryland	637	38.1	243
Massachusetts	880	38.0	334
Michigan	1,215	46.3	562
Minnesota	598	42.3	253
Mississippi	310	62.6	194
Missouri	665	51.4	342
Montana	89	61.8	55
Nebraska	197	51.8	102
Nevada	239	46.0	110
New Hampshire	158	39.9	63
New Jersey	1,101	35.9	395
New Mexico	207	61.4	127
New York	2,557	46.7	1,195
North Carolina	924	49.2	455
North Dakota	72	58.3	42
Ohio	1,369	48.1	658
Oklahoma	372	58.3	217
Oregon	390	50.5	197
Pennsylvania	1,528	46.8	715
Rhode Island	143	46.2	66
South Carolina	458	53.3	244
South Dakota	82	57.3	47
Tennessee	646	51.2	331
Texas	2,469	52.8	1,304
Utah	292	50.3	147
Vermont	72	52.8	38
Virginia	835	43.8	366
Washington	708	45.1	319
West Virginia	182	60.4	110
Wisconsin	634	46.4	294
Wyoming	51	56.9	29

Source: The Alan Guttmacher Institute (AGI), *Women in Need of Contraceptive Services and Supplies, 2000*, AGI, 2003, <www.guttmacher.org/pubs/win/index.html>.

Foundation, the average copayment for a "nonpreferred" drug (such as a brand-name drug that has generic substitutes) averaged $29 per refill in 2003, up from $17 in 2000.

Poor and low-income women (those below 250% of poverty) are particularly unlikely to have the out-of-pocket resources to pay for contraception. Private health insurance (if it covers contraception) might help, yet among poor women, such coverage is especially rare: Only 23% of women 15–44 with incomes below the poverty level had any private insurance in 2002 (see chart, page 10). Poor and low-income women are also especially likely to find the required cost-sharing to be unaffordable. Adolescent women have all of these problems and more, because they are more likely than older women to have a need and desire for confidentiality that precludes use of their family's resources or insurance.

For these reasons, low-income and adolescent women in need of contraception are also in need of public support for that care. In 2000, 16.4 million U.S. women needed publicly supported contraceptive services and supplies, including 11.5 million poor and low-income adult women and 4.9 million women younger than 20. Nationally, 48% of women in need of contraceptive services and supplies also need public support; however, the proportion varies widely by state: from 36% in New Jersey to 63% in Mississippi (see table).

Meeting the Need

Rather than having a well-structured, nationwide system that guarantees insurance coverage for all Americans, the United States relies on a patchwork system in which most people obtain private insurance through their employer, while some of those without private insurance obtain government-subsidized care. The federal and state governments attempt to provide this care in two primary ways: by extending publicly funded health insurance coverage to specific categories of low-income individuals (primarily through Medicaid) and by providing grants, either through state and local health departments or directly to community-based "safety-net" providers.

Medicaid and the State Children's Health Insurance Program (SCHIP) together covered 6.5 million women 15–44 in 2002, 11% of the age-group. That proportion was an 18% increase from just two years earlier. Coverage at the state level ranged from about 4% in Nevada to about 19% in Tennessee in 2001–2002 (see table, page 9). Medicaid is especially important for poor women, covering 35% of those who are of reproductive age.

Medicaid has been required to cover family planning services and supplies since 1972. Moreover, Congress

has prohibited states from imposing cost-sharing on family planning services under Medicaid and has guaranteed most enrollees—even those in Medicaid managed care plans—freedom in their choice of family planning providers. The requirements for SCHIP are not always as strict, but almost every state covers a broad range of contraceptive services and supplies. Over the past decade, 18 states have extended the role of Medicaid in providing contraception by creating special family planning initiatives for women who are ineligible for the broader Medicaid program ("Medicaid Family Planning Expansions Hit Stride," *TGR,* October 2003, page 11).

Medicaid's reach, however, is limited. People may think of Medicaid as covering "the poor," but it only covers a subset of the poor, both by design and in practice. Medicaid coverage is available in all states to very young children and to pregnant women up to 133% of poverty, and to older children up to 100% of poverty; many states cover children and pregnant women at higher incomes, through Medicaid or SCHIP. Yet, parents of Medicaid-enrolled children are only eligible at state-set income levels that are typically far lower, averaging 71% of poverty in 2003, according to the Center on Budget and Policy Priorities. Medicaid also includes other eligibility tests, including one that prohibits coverage for many immigrants. Even if they are eligible for coverage, low-income Americans may not enroll because of a perceived social stigma, lack of knowledge about the program or bureaucratic hassles in applying for and maintaining coverage. For all of these reasons, poor women are more likely to be uninsured than on Medicaid (40% vs. 35%).

Although some poor women obtain their contraceptive and other health care from private doctors, as a group, they are heavily dependent on local clinics. There are more than 7,000 clinics located in 85% of U.S. counties that provide free or subsidized family planning services and supplies. These clinics are typically designed to meet the needs of low-income members of their communities and to link their clients with other public health and social services programs.

The federal and state governments provide funding for these clinics through a wide variety of sources. Medicaid is the largest public source of funding, as it pays for the services its enrollees receive from clinics. Yet, much of clinic funding—and the most flexible portion of it—is through grants to providers. The largest federal source of such grants is the Title X program, which was appropriated $273 million in FY 2003. State governments collectively spend a similar amount of their own money in grants, and they spend smaller sums from several federal health and social services block grants.

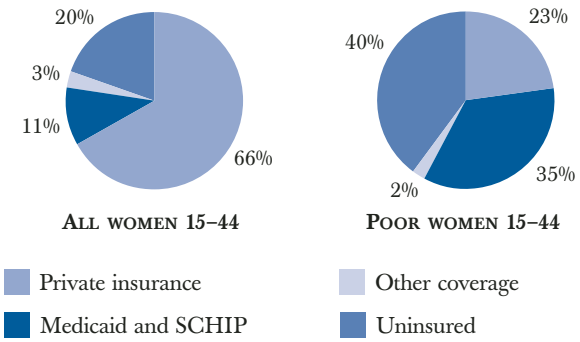
WOMEN ON MEDICAID AND UNINSURED

State	% of women 15–44, 2001–2002	
	Medicaid or SCHIP	Uninsured
U.S. Total	**10.3**	**19.2**
Alabama	9.9	16.9
Alaska	11.9	19.3
Arizona	11.7	20.9
Arkansas	10.8	24.8
California	11.3	22.9
Colorado	4.6	19.1
Connecticut	8.5	13.7
Delaware	10.7	11.1
District of Columbia	18.6	14.0
Florida	8.3	23.7
Georgia	7.3	21.9
Hawaii	10.3	12.2
Idaho	11.2	20.8
Illinois	8.8	17.6
Indiana	5.9	16.2
Iowa	7.8	11.5
Kansas	6.9	16.2
Kentucky	10.7	17.0
Louisiana	11.6	28.2
Maine	16.9	12.8
Maryland	4.7	15.0
Massachusetts	15.2	10.1
Michigan	10.7	15.4
Minnesota	9.6	9.5
Mississippi	17.6	21.2
Missouri	12.0	15.8
Montana	10.8	18.6
Nebraska	9.3	11.1
Nevada	3.9	21.8
New Hampshire	4.6	12.9
New Jersey	8.7	16.4
New Mexico	14.4	30.6
New York	14.5	20.3
North Carolina	10.5	21.6
North Dakota	10.6	11.4
Ohio	9.7	14.1
Oklahoma	8.3	22.8
Oregon	13.6	18.4
Pennsylvania	10.3	13.3
Rhode Island	16.8	11.3
South Carolina	14.2	17.6
South Dakota	7.8	14.5
Tennessee	19.3	13.0
Texas	7.5	31.4
Utah	8.8	15.0
Vermont	17.8	12.3
Virginia	5.4	15.4
Washington	12.9	17.6
West Virginia	15.6	21.9
Wisconsin	11.2	9.3
Wyoming	6.5	23.8

Source: The Alan Guttmacher Institute, special tabulations of data from the Current Population Survey, 2002 and 2003.

Coverage Gaps

While two-thirds of American reproductive-age women have private insurance, those who are poor tend to be on Medicaid or uninsured.



Source: The Alan Guttmacher Institute (AGI), special tabulations of data from the Current Population Survey, 2003.

This public funding has a demonstrable impact. Publicly funded clinics provided contraceptive services and supplies to 6.5 million women in 1997, serving about one-quarter of women who obtain family planning services from a medical provider, and half of such women who are poor or adolescent. These clinics provide women with a broad choice of methods on a confidential basis. Moreover, they do so at a price that women can afford; for Title X–supported clinics, this means providing services for free to poor women and on a sliding scale for low-income women.

The contraceptive services and supplies provided by Title X–supported clinics have prevented 20 million pregnancies and nine million abortions over the past two decades. Publicly funded family planning clinics also provide their clients with other vital reproductive health services, including prenatal care, cervical cancer screening, and screening and treatment for sexually transmitted diseases. Furthermore, publicly funded contraceptive services are cost-effective: Every $1 spent saves an estimated $3 in expenditures for pregnancy-related and newborn care for Medicaid alone.

Challenges to Public Funding

Despite these successes, the need for publicly supported contraceptive services and supplies goes unmet for many women. The nation's official health goals, *Healthy People 2010,* include 13 objectives for future progress in this area, toward the overall goal of improving pregnancy planning and preventing unintended pregnancy. Given the patchwork system of care that exists in this country, however, progress will be difficult.

Medicaid costs have been rising rapidly, and the program now accounts for two of every 10 dollars spent by the states. Part of this increase is due to higher prices for medical services and supplies, a trend that has affected private insurance coverage as well. Yet, much is the result of increased enrollment in Medicaid (and in SCHIP) that is the natural consequence of the recent economic stagnation. Medicaid is designed as a safety-net program—there to catch people who fall out of work and off of their insurance plans. However, because the federal and state governments are struggling with low revenue and tight budgets, policymakers have been forced to make tough decisions about containing costs ("States Eye Medicaid Cuts as Cure for Fiscal Woes," *TGR,* August 2002, page 6). A September 2003 analysis by the Kaiser Commission on Medicaid and the Uninsured found that every state imposed cost-containment measures in FY 2003 and planned to do so again in FY 2004. These measures ranged from freezing or cutting provider payments (in all 50 states in FY 2003) to restricting eligibility (25 states) to increasing copayments (17 states).

Publicly funded clinics are feeling these cost pressures. According to a 2002 AGI investigation, clinics are facing serious problems paying for even their current caseloads because of the rising costs of contraceptive supplies and other medical care, new and more expensive contraceptive and screening technologies, inadequate reimbursement from Medicaid, rising staff salaries and the need for multilingual services ("Nowhere But Up: Rising Costs for Title X Clinics," *TGR,* December 2002, page 6). These problems have been compounded by the cost of caring for new clients driven to the clinics by the sluggish economy.

These circumstances have helped to illuminate the limitations of our nation's patchwork approach to health care and to revive the movement for more universal health coverage. Many of the 2004 Democratic contenders for president have released detailed proposals to substantially decrease, if not eliminate, the number of uninsured Americans. Maine enacted a law in June designed to provide universal health care in the state by 2009, and California enacted a law in October that will require large employers to provide health insurance or pay into a state insurance fund. It is, of course, uncertain whether universal health care will ever become a reality in the United States, and whether it will include contraceptive and other reproductive health services. In the meantime, the programs that are struggling to provide assistance to needy Americans today are increasingly in need of assistance themselves.

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