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Restricted or Protected? An Analysis of American Contraception Policy and Its Effects

“My income fluctuates, and I often don’t have an extra $45 for a copay if there’s an emergency or I’m going through a dry spell financially. I’m not ready to be a parent—Aurora Kalispell, MT” (Planned Parenthood 2016).

Aurora, like millions of other women in the United States, struggles to afford the copays for contraception yet fears the consequences of an unintended pregnancy. Contraception has always been a heated debate in American politics, with religious conservative groups fighting in its opposition. So *should* the government protect contraception accessibility? Because contraception is key to decreasing unplanned pregnancies and abortions, increasing economic and educational opportunities, improving maternal and infant health, and strengthening family wellbeing, increasing accesses and affordability of birth control is necessary (The National Campaign 2016).

The United States’ recent policy protections for contraception, including the 2010 Patient Protection and Affordable Care Act (P.L. 111-148; commonly known as the ACA), and various state laws, have achieved their goal in decreasing out-of-pocket costs for birth control, compared to the restrictive policies of the 19th and 20th centuries. However, insurance loopholes, religious exemptions, and restrictive legislation have hindered their success. Yet socioeconomic benefits like decreased healthcare spending and decreased unplanned births continue to show the

necessity of accessible contraception. Increased education on birth control policies, stricter regulation of insurance companies, and penalties for states that do not comply with the ACA would all help the contraception accessibility problem.

The History of Contraception Policy

Throughout human history women have been attempting to limit the number of children they bare (May 2010). However, contraception policy in the United States has often been restrictive. The first blows to contraception were the 1872 Comstock Laws, also known as the "Chastity Laws." These laws made it illegal to ship birth control and birth control information through the U.S Postal Service, as they were considered "obscene and illicit" (PBS 2016). These laws remained unchallenged for four decades until birth control activist Margaret Sanger opened America's first birth control clinic in 1916. Two years later, the Crane Decision legalized birth control for "therapeutic purposes," and in 1960, the Food and Drug Administration (FDA) approved the first oral contraceptive, Envoid (PBS 2016; May 2010). The next major win for birth control did not come until 1965, when the Supreme Court declared contraception a constitutional right for married couples in *Griswold v. Connecticut*, and in 1971, when the Comstock laws were repealed (Powderly 1995). In addition, between 1965 to the 1990s, the federal government has introduced at least six federal statutes authorizing federal funds for family planning services (McFarlane and Meier 2001).

Despite improvements beginning in the 1960s, contraception policy has often been limited and not specifically addressed by federal legislation until the ACA in 2010. The central federal protection for contraception is the ACA's contraceptive mandate. Before the ACA, out-of-pocket costs for contraception were a significant barrier: in 2011, the mean total annual out-of-pocket cost was $298 for permanent contraceptives (sterilization methods) and $94 for non-

permanent contraceptives (the Pill, intrauterine devices, etc.). By 2013, the mean total annual out-of-pocket cost for permanent contraceptives was $82 and $20 respectively (Law et al. 2016). Additionally, The ACA has caused the percentage of pill-users with zero out-of-pocket costs to rise from 15 to 67% between 2012 and 2014 (Sonfield et al. 2014).

Current Protections of Contraception Access

Decreases in out-of-pocket costs for contraception can be attributed to Section 2713 of the ACA, which states that most private health plans must cover preventive services (including FDA-approved contraception) for women without charging a co-pay. Although the bill gives an exemption to religious employers (churches) and religious nonprofits (schools, hospitals, etc.), which are not required to provide, pay for, or make referrals for contraception, a woman's insurance company or a third-party administrator must offer her free contraceptive care directly (The White House 2012). An additional protection comes from Title VII of the Civil Rights Act, where an employer is in violation of protections against sex discrimination if they fail to cover contraception if they also cover prescription drugs and preventive care (Guttmacher Institute 2016a).

Additionally, many states also have laws protecting contraception access. Twenty-six states currently have "contraceptive equity laws," which require private insurers to cover preventative services to women (NWLC 2016a). Twenty-eight states also require insurers that cover prescription drugs to also cover FDA-approved birth-control methods—17 of these states also require coverage of related outpatient services (Guttmacher Institute 2016a). These state laws help to strengthen the ACA's requirements while also filling in coverage gaps from religious or other exemptions.

Current Barriers to Contraception Access

Despite these federal protections, nearly 33% of women still pay for birth control (Sonfield et al. 2014). How has this happened? First, according to Human Rights and Services Administration (HRSA) guidelines, "plans may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs" (DOL 2016). Insurance companies can therefore refuse to cover name-brand contraceptives. For example, in a Kaiser Family Foundation study of 20 insurance carriers in five states, the "ella" emergency contraceptive (EC) pill was only covered by 11 of the providers. Although most of the carriers covered the progestin-based Plan-B EC pill, the ella EC pill has a different chemical formula, a longer effectiveness window, greater success for women with a higher body mass index, and no generic alternative (Sobel 2015). Likewise, because vaginal rings, such as NuvaRing, and other non-oral forms, such as the patch, contain the same chemical formulas as the already-covered oral contraceptives, providers do not need to cover their costs (Sobel 2015). This loophole restricts women's choices of birth control, especially when a name-brand or a non-oral contraceptive is medically their only option.

Secondly, recent legislation and legal restrictions have increased contraception barriers. One prominent example is *Burwell v. Hobby Lobby*, where three Christian for-profit corporations sued the U.S Department of Health and Human Services (HHS) for their "sincere Christian beliefs that life begins at conception and that it would violate their religion to facilitate access to contraceptive drugs or devices" (573 U.S. *Burwell v. Hobby Lobby Stores, INC* (2014)). After the Supreme Court ruled that for-profit companies *can* exclude contraception based on the owner's own religious beliefs, other employers can now deny their employees access to birth control or challenge the legality of state laws requiring such coverage (American College of

Obstetricians and Gynecologists 2015). Although the ACA is supposed to provide for employees of religious employers, this often becomes a grey-area, leading women to pay for their contraceptives when they should not be, largely because of ignorance or misinformation (Poppick 2015).

Legislative barriers also restrict access to EC. In 2016, nine states restrict access to EC. Arkansas and North Carolina exclude EC coverage from their contraception mandate; Texas excludes EC from its state's family planning program services; Arizona, Arkansas, Georgia, Idaho, Mississippi, and South Dakota allow pharmacists to refuse to dispense contraceptives; and Arizona, Illinois, and Mississippi allow pharmacies to refuse dispensing ECs (Guttmacher Institute 2016b). Although Section 2713 of the ACA requires insurers to cover ECs, state laws like these limit women's ability to physically obtain their ECs.

In addition to accessibility, affordability is also a problem. Although ECs can now be purchased without a prescription, per HRSA guidelines, insurers are only required to cover contraceptive methods (including EC) "as prescribed" (HRSA 2016). Therefore, EC may not be covered by insurers without a prescription. In 2013, the average price of the most commonly available EC, Plan B One-Step, was almost $48, with the generic version only being, on average, 14% lower (American Society for Emergency Contraception 2013). So, although EC has been moved to the shelf, its cost continues to be a significant barrier.

Another legislative barrier is the refusal of some states to expand Medicaid—as of October 2016, 19 states have not adopted the expansions (Kaiser Family Foundation 2016a). The expansion gives Medicaid coverage to "most low-income adults to 138% of the federal poverty level" (Healthcare.gov 2016). Expansion refusal, therefore, limits the number of women who can access free birth control via increased Medicaid coverage (family planning service coverage is

required under Medicaid). In addition, coverage requirements for Medicaid differ in states that have expanded it. For example, according to the Kaiser Family Foundation, "states have discretion in deciding whether they include EC in their traditional full scope Medicaid programs or family planning expansion programs" (Kaiser Family Foundation 2016b). Increased expansion of Medicaid *and* increased coverage of family planning services within Medicaid would increase accessibility and affordability of contraceptives for low-income women.

In short, contraception is now protected under the ACA, yet HRSA loopholes, religious exemptions, state exemptions to EC coverage, and the lack of Medicaid expansion explain why almost a third of women still pay for birth control. Despite these restrictions, the ACA has been very effective at lowering contraception costs and increasing access. This increased affordability and accessibility then creates many positive socioeconomic benefits for women.

The Effects of Increased Accessibility

The ACA has led to many positive economic effects, including decreases in out-of-pocket sending and decreases in women's percentages of health-care costs going towards birth control. For all contraceptive methods, the ACA resulted in 67% of women paying nothing for birth control in 2014 (Sonfield et al. 2014). Likewise, one study estimated that women saved almost $1.4 billion in out-of-pocket birth control *pill* spending in 2013 due to the ACA (Becker 2015). Prior to the ACA, women spent on average 30-44% of their out-of-pocket health-care costs on birth control—this percentage dropped to 0% for the vast majority of women after its implementation (Becker 2015). In general, the ACA has been highly effective in reducing cost barriers for most women. With these cost barriers reduced, women can spend more money on other necessities like food, housing, and other health care.

In addition to decreasing costs, increasing access to contraception has positive social effects. According to the 2012 Contraceptive CHOICE Project at the Washington University School of Medicine, providing free long-acting reversible contraception (LARC; e.g., intrauterine devices and implants) and other reversible contraception significantly reduces abortion and unintended birth rates (Peipert et al. 2012). The study of 9,257 adolescents and women at risk for unintended pregnancy provided free reversible contraceptives (including LARCs) and analyzed the women's abortion rates and teenage birth rates over four years. The results were significant: the abortion rate at the CHOICE clinic was "less than half of the regional and national rates" and the rate of teenage birth was "6.3 per 1,000, compared to the U.S. rate of 34.1 per 1,000" (Peipert et al. 2012). Although this study does not directly measure the effects of the ACA, it does provide insight and support for the potential effects of the ACA's free contraception mandate.

Even considering the results of the CHOICE Project study, the effect of increased contraceptive access is largely unknown, due to a lack of research on contraceptive use trends after 2011. There are few studies that analyze the direct, non-economic impacts of the ACA. Although both abortion rates and unintended pregnancy rates have been in decline since 2011, one can only guess that this is, in part, due to the contraceptive mandate (Guttmacher Institute 2016c). A study by researchers at Brigham and Women's Hospital, however, found that in the year after the ACA's implementation, decreases in cost-sharing may have contributed to women taking generic birth control pills more consistently (Pace 2016). As the researchers mention, "inconsistent use of the pill is a contributor to high rates of unintended pregnancy" (Pace 2016). The Guttmacher Institute even found that publicly funded family planning services (including

contraception) helped reduce the number of unintended pregnancies, births, and abortions by almost 60% in 2013 (Guttmacher 2016d).

Given this information, it can be concluded that increased access and affordability to contraceptives has a positive economic, and possibly social, impact on women. Simply put, when women have access to free contraception, they are more likely to take it consistently, thus reducing unintended pregnancy. The only way to increase this use is government protections of contraception and its access. Further studies would be needed to see if the ACA, specifically, has had long-term, direct effects in social areas such as teenage pregnancy, abortion rates, and education levels. Additionally, states that have more restrictions (not covering EC or not expanding Medicaid) should be studied for negative socioeconomic impacts.

The Future of Contraception Policy

But what about the future of contraception policy? Because contraception accessibility reduces unintended pregnancies and has a positive socioeconomic effect on women, it should be protected by the government. Although the government has made great strides, the ACA's many loopholes cause almost 33% of women to still pay for birth control. Legislation requiring sex education to include information on the ACA's contraceptive mandate and stricter regulation on which methods insurance companies cover is needed to ensure that women can get the contraceptives they need.

One reason why many women are still paying for birth control is lack of education on contraception policy. A Kaiser Family Foundation survey found that, in 2013, 32% of respondents had heard "nothing at all," and 25% had heard "only a little" about "the new federal requirement that private health insurance plans cover the full cost of birth control and other

preventive services for their female patients" (Kaiser Family Foundation 2014). Clearly, when more than half of the population is unaware that they should be getting free birth control, there is a gross lack of education. Young women need to be made aware that, under the ACA's contraceptive mandate, they should not be paying for birth control. Although there are currently only 18 states plus the District of Colombia that require education on contraception, schools should also be required to educate high school students on the contraceptive mandate and its provisions (Guttmacher 2016e). This education would hopefully give women the knowledge needed to recognize if their insurance provider is illegally not providing coverage and the resources to needed to challenge their providers if they are acting illegally (per HHS appeal guidelines). In general, a more accessible HHS appeal process would be beneficial for most insurance-related copay problems, such as issues with religious exemptions.

Because of the ACA, the HHS appeal process allows women to challenge their insurer's decision to deny payment for a claim. An "internal appeal" is done first to ask the insurance company to review their decision; an "external appeal" is done next by an independent third-party if the insurance company still denies payment (HHS.gov 2016). However, this process is complicated and daunting for the average women because of the many technical rules and regulations Luckily, organizations like the CoverHer by the National Women's Law Center work to help women through the appeal process. Providing calling scripts, letter-writing instructions, and educational materials for college campuses, CoverHer makes the appeal process more accessible (NWLC 2016b). Increased publicity for programs like this in sex-education classes and health centers would give more women the knowledge to appeal their insurer's decisions, making the HHS appeal process more accessible.

Another way to reduce the percentage of women paying for birth control would be to introduce stricter regulation on insurance companies. First, the "reasonable medical management" federal regulation code (Coverage of Certain Preventive Services Under the Affordable Care Act) states that "nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1)" (29 CFR 2590.715-2713(a)(4)). This should be changed to make "reasonable medical management" illegal when it comes to contraception because this allows insurers to pick and choose which specific contraceptives they cover for each of the FDA's 20 approved methods, as it is economically beneficial to them. Some consequences of "reasonable medical management" thus include "categorizing brand and generic drugs and devices in tiers based on either cost, type and or mode of delivery; steering consumers to generic equivalent drug options; requiring provider authorization to acquire a preferred brand drug; and limiting quantity and or supply" (Kaiser Family Foundation 2016c). These techniques limit women's choices of free contraception and impose barriers to finding the right birth-control methods. A Centers for Disease Control and Prevention (CDC) report emphasizes that "contraceptive services should include consideration of a full range of FDA-approved contraceptive methods" for reducing risk of unintended pregnancy (Gavin et al. 2014).

In general, policy proposals should increase awareness of the contraceptive mandate and should require insurance providers to cover *all* FDA-approved methods without cost sharing. Eventually, state legislation needs to also be adjusted; refusing to cover ECs without a prescription, allowing pharmacies to refuse dispensing contraceptives, and refusing to expand Medicaid will continue to be a problem unless the (largely Republican- controlled) state legislatures change their restrictive laws. Unfortunately, the future of these policy proposals look

bleak under a Trump Administration (president-elect Donald Trump has promised to repeal the ACA) and a Republican-controlled congress, where repealing the ACA is a "high item on the list" according to the Senate Majority leader Mitch McConnell (Howard 2016). Perhaps state-level adjustments in Democrat-controlled states would be needed first to show the positive benefits of increasing contraception accessibility.

In describing the introduction of the pill, Professor Elaine May said, "for the first time, women had access to an effective form of birth control that did not require men's cooperation or even their knowledge" (May 2010). However, contraception policy has always been a struggle between protection and restriction—it was not until the ACA that women were guaranteed access to affordable birth control. Yet despite the many benefits of accessible contraception (like decreased out-of-pocket costs, decreased unintended pregnancies, and the subsequent life-quality improvements), policymakers, corporations, and insurance companies have continuously fought to restrict its accessibility and affordability. New legislation for contraception-law education, insurance regulation, and state compliance is necessary to make birth control free for all women. The government needs to *guarantee* no-cost contraception for all FDA-approved methods, for it is a woman's right to decide if they have children, if they finish their education, and if they participate in the workforce on the same playing field as men. Breaking down the barriers to affordable and accessible contraception empowers women; the government must protect this right.

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