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ACOG STATEMENT ON RESEARCH ABOUT FAMILY PLANNING SERVICES (FEBRUARY 23, 2016)

Washington, DC—Hal C. Lawrence, III, MD, Executive Vice President and CEO of the American College of Obstetricians and Gynecologists (ACOG), released the following statement regarding recent research showing the value of access to family planning clinics:

"As the medical society representing women's health physicians, the American College of Obstetricians and Gynecologists certainly recognizes the value of contraception to women and the importance of access to contraception to a woman's well-being.

"As an evidence-based organization, ACOG welcomes data that helps to quantify that value. The recent study by Texas researchers published in the New England Journal of Medicine demonstrates that access to long-acting reversible contraceptives (LARC) and availability of Planned Parenthood clinic services have a real impact on women's lives.

"We know that Planned Parenthood clinics provide important services to women, including access to effective birth control; that many of the women who use Planned Parenthood are otherwise underserved; and that our health care system is not equipped to simply replace Planned Parenthood clinics with other providers.

"It's not a surprise that reduced access to LARC methods is associated with an increase in childbirth. These birth control methods are among the most effective ways of preventing unplanned pregnancy. Excluding qualified clinics from being able to provide LARC

and other birth control methods can make family planning inaccessible for many low income women, inevitably driving up rates of unintended pregnancies, with all their attendant costs and concerns.

"This study is evidence that halting government reimbursement of health services provided by Planned Parenthood has a terrible impact on the ability of low income women to get the care that they need. Our patients need government policies that support and protect their access to care.

"Medical reimbursement decisions should be based on ensuring high quality care, not on political agendas. We thank the authors of this important study for their work in helping to demonstrate that restrictions on access to health care, including contraceptive care, ultimately hurts the patients who we are trying to help. We hope that future work in this field is not subject to the political pressures that might compromise the value of the data."

ACOG's Committee Opinion on Access to Contraception can be found here.

The American College of Obstetricians and Gynecologists (The College), a 501(c)(3) organization, is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization of approximately 58,000 members, The College strongly advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. The American Con-

gress of Obstetricians and Gynecologists (ACOG), a 501(c)(6) organization, is its companion organization. www.acog.org

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE OPINION (JANUARY, 2015)

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

COMMITTEE ON HEALTH CARE FOR UNDERSERVED WOMEN

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Access to Contraception

ABSTRACT: Nearly all U.S. women who have ever had sexual intercourse have used some form of contraception at some point during their reproductive lives. However, multiple barriers prevent women from obtaining contraceptives or using them effectively and consistently. All women should have unhindered and affordable access to all U.S. Food and Drug Administration-approved contraceptives. This Committee Opinion reviews barriers to contraceptive access and offers strategies to improve access.

Recommendations

The American College of Obstetricians and Gynecologists (the College) supports access to comprehensive contraceptive care and contraceptive methods as an integral component of women's health care and is committed to encouraging and upholding policies and

actions that ensure the availability of affordable and accessible contraceptive care and contraceptive methods. In order to accomplish this goal, the College recommends and supports the following:

- Full implementation of the Affordable Care Act (ACA) requirement that new and revised private health insurance plans cover all U.S. Food and Drug Administration (FDA)-approved contraceptives without cost sharing, including nonequivalent options from within one method category (e.g, levonorgestrel as well as copper intrauterine devices [IUDs])
- Easily accessible alternative contraceptive coverage for women who receive health insurance through employers and plans exempted from the contraceptive coverage requirement
- Medicaid expansion in all states, an action critical to the ability of low-income women to obtain improved access to contraceptives
- Adequate funding for the federal Title X family planning program and Medicaid family planning services to ensure contraceptive availability for low-income women, including the use of public funds for contraceptive provision at the time of abortion
- Sufficient compensation for contraceptive services by public and private payers to ensure access, including appropriate payment for clinician services and acquisition-cost reimbursement for supplies
- Age-appropriate, medically accurate, comprehensive sexuality education that includes infor-

mation on abstinence as well as the full range of FDA-approved contraceptives

- Confidential, comprehensive contraceptive care and access to contraceptive methods for adolescents without mandated parental notification or consent, including confidentiality in billing and insurance claims processing procedures
- The right of women to receive prescribed contraceptives or an immediate informed referral from all pharmacies
- Prompt referral to an appropriate health care provider by clinicians, religiously affiliated hospitals, and others who do not provide contraceptive services
- Evaluation of effects on contraceptive access in a community before hospital mergers and affiliations are considered or approved
- Efforts to increase access to emergency contraception, including removal of the age restriction for all levonorgestrel emergency contraception products, to create true over-the-counter access
- Over-the-counter access to oral contraceptives with accompanying full insurance coverage or cost supports
- Payment and practice policies that support provision of 3-13 month supplies of combined hormonal methods to improve contraceptive continuation
- Provision of medically accurate public and health care provider education regarding contraception

- Improved access to postpartum sterilization, including revision of federal consent requirements for women covered by Medicaid, the Indian Health Service, the U.S. military, or other government health insurance
- Institutional and payment policies that support immediate postpartum and post-abortion provision of contraception, including reimbursement for long-acting reversible contraception (LARC) devices separate from the global fee for delivery, and coverage for contraceptive care and contraceptive methods provided on the same day as an abortion procedure
- Inclusion of all contraceptive methods, including LARC, on all payer and hospital formularies
- Funding for research to identify effective strategies to reduce health inequities in unintended pregnancy and access to contraception

Background

The benefits of contraception, named as one of the 10 great public health achievements of the 20th century by the Centers for Disease Control and Prevention, are widely recognized and include improved health and wellbeing, reduced global maternal mortality, health benefits of pregnancy spacing for maternal and child health, female engagement in the work force, and economic self-sufficiency for women (1). Ninety-nine percent of U.S. women who have been sexually active report having used some form of contraception, and 87.5% report use of a highly effective reversible method (2). Universal coverage of contraceptives is cost effective and reduces unintended pre-

gnancy and abortion rates (3). Additionally, non-contraceptive benefits may include decreased bleeding and pain with menstrual periods and reduced risk of gynecologic disorders, including a decreased risk of endometrial and ovarian cancer.

Unintended Pregnancy in the United States and the Case for Contraceptive Access

The College supports women's right to decide whether to have children, to determine the number and spacing of their children, and to have the information, education, and access to health services to make those choices (4). Women must have access to reproductive health care, including the full range of contraceptive choices, to fulfill these rights.

Unintended pregnancy and abortion rates are higher in the United States than in most other developed countries, and low-income women have disproportionately high rates (5). Currently, 49% of pregnancies are unintended (5). Reducing this high rate is a national priority reflected in the Healthy People 2020 goal to decrease the rate of unintended pregnancies from 49% to 44% (6). The human cost of unintended pregnancy is high: women must either carry an unplanned pregnancy to term and keep the baby or make a decision for adoption, or choose to undergo abortion. Women and their families may struggle with this challenge for medical, ethical, social, legal, and financial reasons. Additionally, U.S. births from unintended pregnancies resulted in approximately $12.5 billion in government expenditures in 2008 (7). Facilitating affordable access to contraceptives would not only improve health but also would reduce health care costs, as each dollar spent on publicly funded contra-

ceptive services saves the U.S. health care system nearly $6 (8). The most effective way to reduce abortion rates is to prevent unintended pregnancy by improving access to consistent, effective, and affordable contraception.

Knowledge Deficits

Lack of knowledge, misperceptions, and exaggerated concerns about the safety of contraceptive methods are major barriers to contraceptive use. There has been a focus on abstinence-only sexuality education for young people in the United States despite research demonstrating its ineffectiveness in increasing age of sexual debut and decreasing number of partners and other risky behavior (9, 10). In contrast, data suggest the effectiveness of comprehensive sexuality education in achieving these outcomes (10). The emphasis on abstinence-only education may have in part led to widespread misperceptions of contraceptive effectiveness, mechanisms of action, and safety that can have an effect on contraceptive use and method selection (11). For example, many individuals have unfounded concerns that oral contraceptives are linked to major health problems or that IUDs carry a high risk of infection (12, 13). Many individuals also incorrectly believe certain types of contraception to be abortifacients (14). None of the FDA-approved contraceptive methods are abortifa-cients because they do not interfere with a pregnancy and are not effective after a fertilized egg has implanted successfully in the uterus (15).

Health care providers also may have knowledge deficits that can hamper their ability to offer appropriate contraceptive methods to their patients. For example, many clinicians are uncertain about the risks

and benefits of IUDs and lack knowledge about correct patient selection and contraindications (16-18). Improving health care provider and patient knowledge about contraceptive methods would improve access and allow for safer use.

Restrictive Legal and Legislative Climate

Unfavorable legal rulings and restrictive legislative measures can impede access to contraceptives for minors and adults and interfere with the patient-physician relationship by impeding contraceptive counseling, coverage, and provision. With the U.S. Supreme Court's *Burwell v. Hobby Lobby* ruling that a closely held corporation can exclude contraceptive coverage from workers' insurance benefits based on the company owner's religious beliefs, additional employers may now refuse to comply with federal birth control coverage requirements. Some corporations also may use the legal process to challenge laws in states that ensure equitable contraceptive coverage.

Additionally, state lawmakers may be emboldened to further restrict access to contraception. For example, in 2012, Arizona revisited its decade-old law that ensures equitable insurance coverage for birth control and authorized a much broader class of employers to exclude this coverage from employee health insurance plans. In 2013, bills designed to weaken existing contraceptive equity laws or to allow employers—secular and religious—to deny contraceptive coverage to their workers were introduced in more than a dozen states.

Measures that define life as beginning at fertilization and, thereby, conferring the legal status of "personhood" on fertilized eggs also pose a significant risk to contraceptive access. Supporters of "personhood"

measures argue erroneously that most methods of contraception act as abortifacients because they may prevent a fertilized egg from implanting; if these "personhood" measures were to be implemented, contraception opponents may assert that hormonal contraceptive methods and IUDs are illegal.

Currently, 20 states restrict some minors' ability to consent to contraceptive services (19). Although the Title X family planning program and Medicaid require that minors receive confidential health services, state and federal legislation requiring parental notification, parental consent, or both for minors who receive contraceptive care has been increasingly proposed (20). Even though policies should encourage and facilitate communication between a minor and her parent or guardian when appropriate, legal barriers and deference to parental involvement should not stand in the way of needed contraceptive care for adolescents who request confidential services.

Cost and Insurance Coverage

More than one half of the 37 million U.S. women who needed contraceptive services in 2010 were in need of publicly funded services, either because they had an income below 250% of the federal poverty level or because they were younger than 20 years (8). One in four women in the United States who obtain contraceptive services seek these services at publicly funded family planning clinics (21). The number of women in need of publicly funded contraceptive services increased by 17%, or nearly three million women, from 2000 to 2010 (8). Expanding access to publicly funded family planning services produces cost savings by reducing unintended pregnancy. In 2010, federal and state

governments saved an estimated $7.6 billion because of contraceptive services provided at publicly funded centers (8). As the ACA goes into effect, obstetrician-gynecologists can be strong advocates for continued expansion of affordable contraceptive access, which has been shown to be cost neutral at worst and cost saving at best (22, 23).

High out-of-pocket costs, deductibles, and copayments for contraception also limit contraceptive access even for those with private health insurance. Most private health plans cover prescription contraception, but cost sharing and formularies vary (24). In 2000, the federal Equal Employment Opportunity Commission concluded that a company's failure to cover contraception is sex discrimination under Title VII of the Civil Rights Act as amended by the 1978 Pregnancy Discrimination Act (25). However, even when contraception is covered, women pay approximately 60% of the cost out of pocket compared with the typical out-of-pocket cost of only 33% for non-contraceptive drugs (26).

Under the ACA, all FDA-approved contraceptive methods, sterilization procedures, and patient contraceptive education and counseling are covered for women without cost sharing by all new and revised health plans and issuers as of the first full plan year beginning on or after August 1, 2012. This requirement also applies to those enrolled in Medicaid expansion programs. However, many employers are now exempt from these requirements because of regulatory and court decisions. Women covered through exempted employers, as well as women such as unauthorized immigrants who remain uninsured in spite of the ACA, will not benefit from coverage introduced by the ACA. For

these women, cost barriers will persist and the most effective methods, such as IUDs and the contraceptive implant, likely will remain out of reach.

Other insurance barriers include limits on the number of contraceptive products dispensed. Data show that provision of a year's supply of contraceptives is cost effective and improves adherence and continuation rates (27). Insurance plan restrictions prevent 73% of women from receiving more than a single month's supply of contraception at a time, yet most women are unable to obtain contraceptive refills on a timely basis (26, 28, 29).

Some insurers, clinic systems, or pharmacy and therapeutics committees also require women to "fail" certain contraceptive methods before a more expensive method, such as an IUD or implant, will be covered. All FDA-approved contraceptive methods should be available to all insured women without cost sharing and without the need to "fail" certain methods first. In the absence of contraindications, patient choice and efficacy should be the principal factors in choosing one method of contraception over another.

Another strategy for improving access to contraception is to allow over-the-counter access to oral contraceptive pills (30). However, over-the-counter provision may improve access only if over-the-counter products also are covered by insurance or other cost supports in order to make them financially accessible to low-income women.

Objection to Contraception

Efforts to frame access as an issue of conscience or religious belief rather than as essential health

care have grave consequences for women and can create major obstacles to obtaining insurance coverage, receiving prescriptions from health care providers, obtaining medications from pharmacists, and receiving care at hospitals. Ten of the 25 largest health systems in the country are Catholic sponsored facilities (31). Mergers between religious (predominantly Catholic) health care facilities and other hospitals are common and often result in decreased access to reproductive health services, including contraception (31). Advocacy by clinicians and community leaders has been effective in preserving access in some communities (32, 33).

Pharmacist refusals to fill contraceptive prescriptions or provide emergency contraception, as well as pharmacies that refuse to stock contraceptives, are considerable barriers. Although some women have access to an alternative pharmacy, women in areas where pharmacies and pharmacists are limited, such as rural areas, may find insurmountable obstacles to obtaining prescribed contraception. In eight states, laws specifically prohibit pharmacy or pharmacist refusal; seven states allow refusal but prohibit pharmacist obstruction of patients' receipt of medications; and six states specifically allow pharmacists to refuse to dispense legally prescribed medications without protections for patients, such as a referral requirement (34). The American Pharmacists Association supports the establishment of systems to ensure patient access to contraception when individual pharmacists refuse provision (35). The College supports unhindered access to contraception for all women and opposes health care provider and institutional refusals that create obstacles to contraceptive access.

Unnecessary Medical Practices

Common medical practices prevent easy initiation of contraception. There is no medical or safety benefit to requiring routine pelvic examination or cervical cytology before initiating hormonal contraception. The prospect of such an examination may deter a woman, especially an adolescent, from having a clinical visit that could facilitate her use of a more effective contraceptive method than those available over the counter (36).

Another common practice is requiring one medical appointment to discuss initiation of a LARC method and a second for placement of the device or requiring two visits to perform and obtain results from sexually transmitted infection testing. Clinicians are encouraged to initiate and place LARC in a single visit as long as pregnancy may be reasonably excluded. Sexually transmitted infection testing can occur on the same day as LARC placement, and women do not require cervical preparation for insertion (37, 38). Insurer payment policies should support same-day provision by providing appropriate payment and reimbursement for multiple services performed during a single visit. Similarly, health care providers should encourage patients initiating combined hormonal contraceptives to start on the day of the medical visit (38).

Institutional and Payment Barriers

Appropriate compensation for contraceptive services enables health care providers to provide the full range of contraceptive options, which improves quality of care and optimizes health outcomes. Public and private payers can contribute to efforts to improve contraceptive access by working with health care pro-

viders to ensure appropriate payment for clinician services and to provide reimbursement for contraceptive devices at acquisition cost levels.

Twenty-seven percent of reproductive-aged women choose to undergo permanent sterilization once they have completed childbearing (39). Institutional and payment barriers often prevent women from receiving this desired procedure. Many sterilization procedures are planned immediately postpartum, which is an advantageous time because the woman is not pregnant, is within a medical facility, and often has insurance coverage. However, many women do not obtain their planned postpartum sterilization because of limited operating room availability, lack of motivation or coordination on the part of the health care team (obstetricians, nurses, and anesthesiologists), perceived increased risk because of the postpartum state, or misplaced or incomplete sterilization consent forms. In one study, almost 50% of women who did not receive a requested postpartum sterilization were pregnant again within 1 year (40). Federal regulations require a specific sterilization consent form to be signed 30 days before sterilization for women enrolled in Medicaid or covered by other government insurance (41). This requirement eliminates immediate postpartum sterilization as an option if the paperwork is not completed in advance and available at the time of delivery. This regulation, created to protect women from coerced sterilization, also can pose a barrier to a desired sterilization. Women with commercial or private insurance who desire sterilization are not mandated to follow the same consent rules. Revision of the federal consent mandate in order to create fair and equitable access to sterilization services for women enrolled in

Medicaid or covered by other government insurance would improve access. These revisions can be balanced by educating patients and obtaining informed consent to address concerns of coercion (41).

Highly effective LARC methods are underutilized, and promoting affordable access to LARC methods for current low-use populations, including adolescents and nulliparous women, may help reduce unintended pregnancy (37). In addition to the high up-front costs associated with these methods, another common barrier is inadequate reimbursement for LARC devices in certain settings. Providing effective contraception postpartum and post-abortion can be ideal because the patient is often highly motivated to avoid pregnancy, is within the health care system, and is not pregnant. Appropriate reimbursement for LARC methods immediately postpartum or post-abortion can be difficult to obtain.

Health Care Inequities

Rates of adverse reproductive health outcomes are higher among low-income and minority women. Unintended pregnancy rates are highest among those least able to afford contraception and have increased substantially over the past decade (5). The unintended pregnancy rate for poor women is more than five times the rate for women in the highest income bracket (5). Low-income minority women have higher rates of nonuse of contraceptives and are more likely to use less effective reversible methods such as condoms (42). Additionally, low-income women face health system barriers to contraceptive access because they are more likely to be uninsured, a major risk factor for nonuse of prescription contraceptives (42). Publicly

funded programs that support family planning services, including Title X and Medicaid, are increasingly underfunded and cannot bridge the gap in access for vulnerable women. To address these barriers, the ACA has encouraged states to expand Medicaid eligibility for family planning services to greater numbers of low-income women. Also, in states that choose to expand Medicaid under the ACA, fewer poor women will lose Medicaid eligibility postpartum.

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