

Perspective: Current Threats to Contraceptive Access

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Unrestricted access to reliable and effective contraception empowers individuals to decide whether or not and when to become pregnant. The average desired family size in the United States is two children.¹ In order to accomplish that goal, the typical woman will spend close to three years pregnant, postpartum, or attempting to become pregnant, and nearly three decades – more than three quarters of her reproductive life – trying to avoid an unintended pregnancy. To control their reproductive future, individuals must have a comprehensive understanding of and reasonable access to a range of contraceptive options. In 2011, the latest data available, nearly half of the 6.1 million pregnancies in the United States were unintended, meaning mistimed or unwanted, and most of these could have been prevented with better access to contraception. Unintended pregnancy rates are highest among poor and low-income women, women aged 18 to 24, and cohabiting women and are directly related to contraceptive access.²

Effective, affordable contraception has immediate and long-term impacts on individuals' right to plan their future, allowing improved caretaking of themselves and their families, as well as the ability to meet their educational, career, and financial goals. Furthermore, births resulting from unintended or closely spaced pregnancies can be associated with adverse maternal and child health outcomes such as delayed prenatal care, premature birth, and decreased rates of breastfeeding.³ Individuals may elect to use a wide variety of contraceptive methods over the course of their life, and when people are satisfied with their choice of contraception, they are more likely to use it effectively.^{4,5} Patients need to have full health insurance coverage for counseling and obtaining any contraceptive method they may safely pursue. However, the guarantee of contraceptive coverage is one that fluctuates with the political landscape. Unfortunately, disparities in reproductive health access, as well as threats by policymakers to restrict adequate provision of contraception, remain at the forefront of recent political debate, making it difficult for patients to freely choose a method they can use effectively and consistently. In this article, we will

review the current state of contraceptive freedom in the U.S. and the myriad ways this human right is being threatened.

Since the mid-1990s, 28 states have required insurance plans to provide contraceptive coverage while federal rules applied in the remaining 22 states. This was expanded by the Affordable Care Act (ACA) in 2010; federal law now requires Medicaid, as well as most private health insurance, to cover comprehensive contraceptive care, as it was deemed a vital preventive health service for women by the Institute of Medicine.⁶ Importantly, this applies to coverage offered by employers that self-insure. Roughly 60% of insured workers in the U.S. are covered by self-insurers, and state laws are not allowed to regulate these employers, so the ACA's regulation of these insurers was a big step toward ensuring contraceptive access. Rhode Island law requires that if insurers cover prescription drugs, they also provide coverage for Food and Drug Administration (FDA)-approved contraceptives. The ACA's federal regulations are specific about requiring coverage for 18 different FDA-approved contraceptive methods, including emergency contraception and female sterilization.⁷ The ACA also stipulates that there can be no out-of-pocket costs to the patient. A major gap in these federal mandates is the lack of required coverage for male condoms and vasectomies. The ACA has spurred several states to not only match the federal regulations but to go further in requiring coverage for over-the-counter methods without a prescription, for extended supplies of contraceptives, and for male sterilization.

Despite these significant advances, the Trump administration attempted to pass regulations in October 2017 that would have made it much easier for employers to claim a religious or moral objection to providing contraceptive coverage for their employees. The courts blocked enforcement of these regulations based on the ruling that they are not in compliance with the ACA.⁸ Nonetheless, an older federal regulation still exists that does grant religious exemptions for a more strictly-defined group of employers. However, this does require that employees are able to receive contraceptive coverage from the same insurance company through alternative means.

Maintaining adequate, unrestricted access to contraception in the future is also uncertain due to threats to publicly funded family planning services. Title X is the only federal grant program solely dedicated to providing low-income

clients with affordable, much-needed reproductive health care. This includes annual exams, cervical and breast cancer screening, contraceptive education and provision, and testing and treatment for sexually transmitted infections, including HIV. Today, more than 4 million Americans rely on affordable family planning services that are provided through Title X.⁹ In recent months, some politicians have increased their efforts to deny public funding to Planned Parenthood, a Title X recipient. As an organization, Planned Parenthood serves 32% of the 6.2 million women who obtain contraceptive care through some type of safety-net family planning center, and 41% of the 3.8 million contraceptive clients served through Title X.⁹ Defunding Planned Parenthood would radically jeopardize access to family planning care. Many of the policy attacks have stemmed from anti-abortion politicians targeting organizations like Planned Parenthood that offer comprehensive contraceptive care in addition to abortion services, despite the fact that Title X funds have never been allowed to pay for abortion care. Furthermore, publicly funded contraception helped to avoid 1.3 million pregnancies in 2015 and these unintended pregnancies would have resulted in 453,400 abortions. Without publicly funded family planning services, rates of unintended pregnancy and abortion would have been 67% higher.¹⁰ According to an analysis by the Guttmacher Institute, if social conservatives were to succeed in cutting Planned Parenthood out of Title X, the remaining providers, such as health departments, hospitals and federally qualified health centers would need to increase their caseloads by nearly 70%, a herculean task.⁹

Additionally, threats posed to restructuring Medicaid, including granting states greater authority to choose eligibility criteria, deciding what services to cover, limiting enrollees' provider options, and imposing paternalistic restrictions on enrollee's behavior, have significant consequences for family planning.¹¹ Medicaid is central to the family planning effort in the U.S., not only because it accounts for three quarters of all public dollars invested in family planning, but also because it ensures enrollees access to qualified providers and advocates for reproductive health. In all states, if a woman is pregnant, she is eligible for Medicaid coverage of maternity care services, including prenatal and postpartum care until 60 days post-delivery. In many states, once those 60 days expire, a woman is no longer eligible for Medicaid coverage, and thus, no longer has access to family planning care and FDA-approved contraceptives.¹² Often, this limited time frame of insurance coverage means providers must equip women with contraception either immediately or early in the postpartum period.

Because some patients are not able to attend their postpartum visit, providers frequently offer long acting reversible contraceptive (LARC) methods, including hormonal implants and intrauterine devices (IUDs), during the postpartum hospital stay – called “immediate postpartum contraception”. In order to ensure that women are able to

make an informed decision and understand available alternatives, conversations regarding postpartum birth control plans should be initiated early and revisited often during the prenatal period. Despite its high efficacy and convenience, significant barriers exist for individuals seeking access to LARC. Only 23%-60% of women requesting an immediate postpartum IUD actually receive it.¹³ Part of the challenge to providing patients with LARC in the immediate postpartum period revolves around reimbursement. Before 2012, the majority of insurance carriers bundled obstetric reimbursement (prenatal care, delivery, and postpartum care) without providing extra reimbursement for immediate postpartum LARC insertion. This is in contrast to other methods of postpartum contraception that are prescription-based. However, due to increasing data supporting the benefits of immediate postpartum LARC, many states have begun providing extra compensation; however, this typically only applies to patients on Medicaid.¹⁴ Another important barrier to immediate postpartum LARC uptake stems from religiously affiliated hospitals. One out of every six hospital beds in the United States are in Catholic hospitals that do not allow placement of LARC for contraceptive purposes or postpartum sterilization.¹⁵ Clearly, more work is needed to ensure access to immediate postpartum LARC if patients desire it.

The federal policy requiring 30-day consent for Medicaid funded sterilization procedures puts forth yet another barrier to reproductive autonomy. In 1978, the U.S. Department of Health, Education and Welfare created new legislation that required a 30-day waiting period prior to surgical sterilization for women receiving Medicaid.¹⁶ It also prohibited pregnant women in labor and women under the age of 21 to consent to sterilization. This legislation was drafted in response to coercion and forced sterilization of minorities and women of low-socioeconomic status. Although well-intentioned, this mandate has actually resulted in new barriers to contraceptive access for low-income women.

Because the 30-day waiting period is only mandated for those patients receiving Medicaid, it predominantly affects those women whose lives are already filled with obstacles to free choice. It impacts an already vulnerable population and patronizes these individuals with the assumption that their choices about their own bodies are flippant and must be chaperoned.¹⁷ Not only is it morally indefensible, it has become clear that this mandated waiting period negatively affects a woman's ability to receive a desired sterilization procedure. In one study, only 52% of women desiring postpartum sterilization procedure were granted their request, and the primary reason women were unable to undergo postpartum sterilization was due to an inability to complete the federally mandated consent form at least 30 days prior to delivery.¹⁸ The American College of Obstetricians and Gynecologists states that postpartum sterilization is an “urgent surgical procedure” given the narrow window during which it may be performed and the serious consequences of failing to complete it.¹⁹⁻²⁰

For those patients who do not elect or are unable to receive immediate postpartum contraception, many must wait until the postpartum visit for initiation of contraception. However, reliance on the postpartum appointment to provide contraception creates a significant gap in the ability to provide egalitarian and effective contraceptive care. Approximately a third of women will not attend their postpartum visit, and non-attendance is associated with social and economic disadvantage.²¹ A recent study showed that 43% of women will resume intercourse within six weeks of delivery, indicating that waiting until the postpartum visit to provide contraception may be too late.²² Our healthcare culture must move towards an increased awareness on the postpartum period as a critical time in a woman's life. In addition to being a time of joy and excitement, this "fourth trimester" is a period marked with considerable challenges. Truly supporting women during the postpartum period, rather than only offering a single visit almost two months after delivery, would undoubtedly have a positive impact on the number of women able to stay connected to health services and receive appropriate contraceptive care.

It is a personal decision and human right to decide when one would like to have a child. It is important for advocates of reproductive health to protect unrestricted access to contraception and ensure that personal choices about childbearing can be made freely and without coercion. There is a war being waged against contraception in this country. All health care providers must step up to the plate to protect patients' rights to access contraception. This work can start with having regular, open discussions about reproductive life plans, contacting local, state and national representatives, and testifying at hearings for new legislation. Let us realize our power to create change and join the ranks of those fighting for reproductive justice.

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