



**Testimony of Sharon L. Camp, Ph.D.
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**Before the
Committee on Preventive Services for Women
Institute of Medicine
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Read Dr. Camp's Written Testimony Submitted to the Committee

Good morning. I am Dr. Sharon Camp, president and CEO of the Guttmacher Institute.

Thank you for the opportunity to make a brief statement this morning and to submit fuller written testimony for the hearing record.

The Guttmacher Institute is a nonprofit, nonpartisan policy research organization with a broad scope of work in sexual and reproductive health.

Our research is supported in part by the National Institutes of Health, the Department of Health and Human Services, the Centers for Disease Control and Prevention, and a number of European governments and international organizations.

We are a World Health Organization Collaborating Centre on Reproductive Health Research, one of only three in the United States, and have institutional collaborations with the schools of public health at Columbia and Johns Hopkins universities.

For over 40 years, we have monitored public efforts to ensure that all American women, regardless of income, have the family planning services they need to make informed choices about the number and timing of their children.

Since the inception of public funding for family planning, Guttmacher has tracked unmet family planning needs; the coverage of services; public financing; private insurance coverage; and disparities in reproductive health outcomes by income, race and ethnicity.

On the basis of this accumulated expertise, we have come here today to urge the Committee on Preventive Services for Women to include the following in its recommended package of designated preventive services, exempt from cost-sharing:

- the full range of prescription and nonprescription contraceptives;
- the related clinical services necessary to supply them, such as IUD insertion and removal; and
- the patient education required to help women become successful contraceptive users over the 25–30 years they may need to avoid an unwanted or seriously mistimed pregnancy.

Contraceptive services and supplies fit any reasonable definition of preventive health care.

Indeed, family planning is one of the most cost-effective public health interventions available.

The ability to prevent an unintended pregnancy helps women and their partners ensure that the pregnancies they do have are planned and well spaced to maximize the likelihood of a healthy birth.

Family planning has well-documented benefits for mothers, newborns, families and communities.

Pregnancies that occur too early or too late in a woman's life, or that are too closely spaced, negatively affect maternal health and increase the risk of prematurity and low birth weight.

Unintended pregnancy is associated with other negative outcomes, such as delayed initiation of prenatal care and reduced breast-feeding.

Simply put, family planning protects family health.

But American women do not benefit equally from the positive health impacts of family planning.

Although 98% of American women who have ever had sex report the use of at least one contraceptive method, gaps in contraceptive use are common, particularly for low-income and young women.

At any point in time, 11% of sexually active U.S. women at risk of an unintended pregnancy are using no method of contraception, and nearly one-quarter of users experience one or more gaps in use of a month or more.

Many users of the pill, for instance, miss pills or start a new cycle late, when they are at high risk of pregnancy.

U.S. women who are not using contraceptives, or are using them inconsistently, represent one-third of all women at risk of unplanned pregnancy, and account for 95% of the three million unintended pregnancies that occur every year.

Other countries do much better.

Many western European countries have rates of unintended pregnancy and abortion that are less than half those of the United States.

While there can be a number of reasons for inconsistent contraceptive use, substantial evidence indicates that cost is a serious barrier for many low-income and young women.

This is particularly true of the most effective, long-acting methods, such as IUDs, the implant and contraceptive sterilization. These methods have failure rates of 1% or less, but have large up-front costs.

Compare this high level of efficacy to the fact that couples using no method of contraception have approximately an 85% chance of an unintended pregnancy over the course of a year.

It is critical to the health and well-being of American women and their families that effective contraception be readily available and affordable.

But for women currently without health insurance, the up-front costs of the most effective, long-acting methods— hundreds or thousands of dollars—can be prohibitive.

Brand-name versions of the pill, patch or ring can cost upward of \$60 per month if paid entirely out of pocket, not including the cost of a visit to a health care provider for a prescription.

Cost can be a barrier even for many women who are insured, but who typically cover more than half the cost of oral contraceptives.

A full year's worth of pills amounts to almost a third of insured women's annual out-of-pocket expenditures for all health services.

Making the most effective methods of contraception affordable for all women could dramatically improve contraceptive use in the United States and bring down our still high rate of unintended pregnancy.

Fully one-third of surveyed U.S. women indicate that they would switch contraceptive methods if cost were not an issue.

Typically, these women are using less-expensive and less-effective methods.

A recent study in St. Louis found that when women were offered the choice of any contraceptive method at no cost, two-thirds chose a highly effective, long-acting method, like an IUD.

When Kaiser Permanente of Northern California eliminated cost-sharing for IUDs and other highly effective methods, IUD use increased 137%.

In the general U.S. population, the IUD and contraceptive implant together represent only about 6% of current contraceptive use—a much lower rate than prevails in western Europe.

The Affordable Care Act—and, in particular, the Women's Health Amendment—gives us the chance to do better.

Indeed, the legislative history of the amendment makes it clear that Congress intended to make a full range of family planning services broadly available, without cost-sharing, as part of the expansion of health insurance coverage.

Fortunately, for both public and private health insurers, providing coverage for contraceptive services, even without cost-sharing, is cost-effective.

Every dollar invested in publicly supported family planning services, for example, returns almost four dollars in savings for pregnancy-related medical costs *in the first year alone*.

The federal government, the nation's largest employer, experienced *no* increase in costs after implementing congressionally mandated contraceptive coverage for federal employees.

Cost-benefit analyses by the National Business Group on Health concluded that it actually costs private employers 15–17% *more* not to provide contraceptive coverage in health plans, given the medical costs of an unintended pregnancy and related work loss.

The most recent analysis of the National Business Group on Health, drawing on actuarial estimates by PricewaterhouseCoopers, concludes that contraceptive coverage more than pays for itself, even when exempted from cost-sharing.

Over their 40-year history, publicly subsidized family planning programs have narrowed income disparities in reproductive health significantly. However, with the rising cost of contraception and inadequate levels of investment in subsidized services, the gaps are once again widening.

In recent years, rates of unintended pregnancy and abortion have increased for poor women while continuing to decline for better-off women.

Things could be worse, however.

In the absence of publicly funded family planning services, levels of unintended pregnancy would be nearly two-thirds higher among U.S. women overall and close to doubled among poor women.

Perhaps *most* impressive has been the impact of programs to make contraceptive services widely available to sexually active adolescents.

The teen pregnancy rate in the United States has dropped more than 40% since its high in 1991.

Improved contraceptive use was responsible for 84% of that decline; among older teens, it was responsible for *all* of the decline.

Family planning is unquestionably a critical part of women's preventive health care.

It protects women's health and makes wanted pregnancies safer.

It also saves money for public and private health payers.

The evidence is compelling.

Public and private health insurance must include coverage, without cost-sharing, of the full range of family planning methods and the patient education needed to ensure that women have the information and support they need to be successful long-term contraceptive users.

Recommending such coverage would be consistent with long-standing federal agency precedents and with the recommendations of leading associations of health and medical professionals.

And, of course, such a recommendation would be consistent with previous recommendations from the IOM itself, including those in its report *The Best Intentions*, which call for insurance coverage of contraception, free of cost-sharing.

Thank you for your attention.

I would be pleased to answer any questions.