

**EFFECTIVE CONTRACEPTIVE FOR ALL WOMEN:
A GUARANTEED INVESTMENT FOR GEORGIA**

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I. Abstract

Contraception is a component of basic health care. A woman's choice to use the most effective contraception to prevent an unintended pregnancy should not be based on her race, age or socio-economic status. There is no greater preventative measure that would improve both the health of Georgia's women and strength of the state's economy than to make all contraceptive options available on a voluntary basis to all Georgia women. The contraceptive option a woman chooses should be affordable or readily available without hidden charges on insurance plans and at every county health department in Georgia.

Because no one contraceptive method is likely to be consistently and continuously suitable for each man, woman or couple,¹ all contraceptive methods must be equally available to all women. No medical condition has a more disparate impact on women, particularly the young, minorities and uninsured women, than unplanned pregnancy. Contraception empowers women to control their reproductive and educational futures by preventing unintended pregnancies. Hormonal contraception also has multiple medical benefits; including easing the pain of a menstrual cycle, decreasing excessive bleeding, treating endometriosis, and to help lower Georgia's high hysterectomy rates.

This paper will highlight the new contraceptive methods available to women, the effectiveness (Tiers) and the cost-effectiveness of those new methods. This paper discusses the enormous benefits, both monetary and non-monetary, if all contraceptive options considered *The Best of the Best*, are available to each and every Georgia woman.

II. Overview of the Problem of Unintended Pregnancy

The Georgia General Assembly declared, "Maternal and infant health are greatly improved when women have access to contraceptive supplies to prevent unintended pregnancies."² The Assembly acknowledged that many women spend the majority of their reproductive lives trying to prevent pregnancy and that "the absence of prescription contraceptive coverage is largely responsible for the fact that women spend 68 percent more in out-of-pocket expenses for health care than men."³

Family planning professionals worldwide have seen rapid advances in contraceptive options available in the United States. Since 2000, the Food and Drug Administration (FDA) has approved several new, safe and very effective methods of contraception. But, despite the wide availability of so many contraceptive options, nearly half (49%) of the 6.4 million pregnancies each year remain unintended.⁴ In 2006, Georgia women had 182,431 pregnancies *and half of those pregnancies were unintended.*

At least 200 million women worldwide want to use safe and effective family planning methods, but are unable to do so because they lack access to information and services or the

¹ Healthy People, 2010, pp. 9-2&3, http://opa.osophs.dhhs.gov/pubs/hp2010/hp2010rh_sec2_famplan.pdf, accessed 9/21/07..

² Women's Access to Health Care Act, Ga. Code Ann. 33-24-59.6 (1996).

³ Id.

⁴ Trussell, J., *The cost of unintended pregnancy in the U.S.*, Contraception, Vol. 75, No. 3, pp. 168 -70.

support of their husbands and communities. The international community has agreed that reproductive choice is a basic human right. But, without access to relevant information and high-quality services, that right cannot be exercised.⁵

Georgia women are also greatly lacking in access to both information and services. Between 2000 and 2004, the number of women nationwide who are in need of publicly funded contraceptive services and supplies increased by over one million. Georgia experienced a 10.8% increase (from 472,120 to 522,940) of women who are in need of contraceptive services and supplies. These women need publicly supported contraceptive services because they have incomes below 250% of the federal poverty level or are sexually active teenagers.⁶ These trends point toward a rapid increase in need for family planning services among the nation's poorest women and a concomitant need for our agencies that administer the family planning programs to stay medically up-to-date.

Georgia has 338 publicly funded family planning clinics that provide contraceptive care to 199,840 women, but only 41% of Georgia women in need of publicly supported contraceptive services receive services.⁷ The Title X program is charged with promoting “public health and welfare by *expanding, improving and better coordinating the family planning services and population research activities.*” The purpose⁸ of the federal Title X grants is. . . “(1) to assist in making *comprehensive* voluntary family planning services readily available to all persons desiring such services.” Title X funding mandates that family planning projects *shall* offer a broad range⁹ of acceptable and effective family planning methods and services.

Many comprehensive studies have been published that demonstrate that the use of contraceptives save health care dollars. In the public sector setting, use of no method at all (calculating risks and costs of unintended pregnancy) costs \$720 at one year and \$3,272 at five years for all women, compared with \$677 and \$3,079 for teenagers.¹⁰

A small initial investment in family planning pays off quickly in dramatic savings to states that choose to invest in its women. A Wisconsin program that allows low-income women to access reproductive health care services, including contraceptives, saved the state more than \$3.3 million in the fourth quarter of 2003 by reducing the number of unplanned pregnancies in the state.¹¹ The GFPP announces “For every dollar spent on family planning services, \$4.40 is saved on medical care, welfare, and nutritional programs for babies up to

⁵ Family Planning: So that Every Pregnancy is Wanted, UNFPA, <<http://www.unfpa.org/rh/planning.htm>> (accessed 6/20/08).

⁶ *Contraception Counts: Georgia*, The Guttmacher Institute, 3/2006

⁷ *Id.*

⁸ Section 2 of Pub.L. 91-572, as amended Pub.L. 96-88, Title V, § 509(b), Oct. 17, 1979, 93 Stat. 695.

⁹ To date, there is no known case law interpreting the terms “a broad range of safe and effective contraceptives,” per e-mail from the Center for Reproductive Rights to Marilyn Ringstaff, personal 9.20.07 (copy on file with the author).

¹⁰ Trussell, J., et al, *Cost Savings from Adolescent Contraceptive Use*, Family Planning Perspectives, Vol. 29, Number 6, November/December 1997.

¹¹ Forster, Wisconsin Family Planning Program Saved State \$3.3M by Preventing Unplanned Pregnancies, *Milwaukee Journal Sentinel*, 3/12/07.

age two. In Georgia this could mean almost \$16 million saved over a two-year period,”¹² however, evidence shows that the state has not returned those savings into investment in the state’s family planning program.

The lack of access to effective contraceptives protection limits a woman's ability to plan their pregnancies. The aim of family planning programs must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children; to have the information and means to do so; to ensure informed choices; and to make available a full range of safe and effective methods.

Women who are most at risk for pregnancy complications should have access to a broad range of the most effective contraceptives more than any other population; *however the opposite is true in Georgia*. Our state Medicaid programs and Georgia’s family planning program (GFPP) serve the state’s most vulnerable populations: minorities, the poor and teenagers, i.e., those women most likely to have pregnancy complications. These women are those who are currently most restricted in their contraceptive access and who are limited in their ability to make an informed choice about contraception. They are further limited both by burdensome co-pays, ‘tiers’ of payment, non-covered methods and limited family planning formularies.

III. COSTS OF UNINTENDED PREGNANCY

a. MONETARY COSTS OF UNINTENDED PREGNANCY

Unintended pregnancies are a costly problem in the United States and the costs can be measured in both monetary and non-monetary terms. In 1994, 3.04 million U.S. women experienced an unintended pregnancy, resulting in an average of \$3200 in medical costs per pregnancy.¹³ In 2002, the direct medical cost of unintended pregnancies was \$5 billion; in contrast, the direct medical cost *savings* due to contraceptive use was \$19 billion.¹⁴

The monetary costs of unplanned teen pregnancy are enormous. Nationally, between 1985 and 1990, the public cost of births to teenage mothers under the Aid to Families with Dependent Children (AFDC) program, the food stamp program, and the Medicaid program has been estimated at \$120,000,000,000.¹⁵

But, teen pregnancy is only a small part of the problem. Medicaid is one of the largest payers of reproductive-related services and Medicaid finances 41% of all births in the United States. Maternity costs comprise a quarter (27%) of all Medicaid inpatient charges.¹⁶ Medicaid also funds 61% of publicly funded family planning services. A *conservative estimate*¹⁷ of the cost of an uncomplicated pregnancy with vaginal delivery was \$9,660 and

¹² <<http://health.state.ga.us/programs/familyplanning/>> (accessed 9.19.07).

¹³ Chiou, C., et al, *Economic Analysis of contraceptives for Women*, Contraception, 68 (2003) 3-10.

¹⁴ Id.

¹⁵ 42 U.S.C.A. § 601.

¹⁶ Issues in Brief, *Medicaid’s Role for Women*, The Kaiser Family Foundation, 10/2007.

¹⁷ The Kaiser Family Foundation, *Maternity Care and Consumer-Driven Health Plans*, <http://www.kff.org/womenshealth/upload/7636ES.pdf>, accessed 9.20.07.

\$12,453 if a cesarean was required. A complicated pregnancy can easily cost hundreds of thousands of dollars. Women in the South are also more at risk of undergoing a cesarean section.¹⁸

In 2005, there were 176,235 pregnancies and 110,986 births to Georgia women; Medicaid financed nearly half of those births. Medicaid financed 41% of all births nationwide in 2002 (49% in Georgia).¹⁹ The Georgia Department of Human Resources (DHR) recognizes that a “woman with an unwanted pregnancy is less likely to get prenatal care, and her baby is more likely to be born dangerously underweight...these infants often require expensive hospital care (\$30,000 per month), and are more likely to have a lifelong disability, which could require care (possibly \$400,000 over a lifetime).”

As discussed below, the women accessing the GFPP services and Medicaid patients are most at risk for pregnancy complications. *In 1996, the estimated medical costs of caring for one low birth weight baby was \$151,956.00²⁰ (compare to the actual cost of one Implanon of \$289.00 /3 yrs and this method is close to 100% effective.)*

b. NON-MONETARY COSTS OF UNINTENDED PREGNANCY

i. TEENAGE PREGNANCY IN GEORGIA

Teen pregnancy and unplanned pregnancy among young adults is at the root cause of a number of important public health and social challenges. Children born to a teen mother who has dropped out of high school are ten times more likely to live in poverty than married women over age 20.²¹ Teenage mothers are less likely to complete school, less likely to go to college, more likely to have large families, and more likely to be single; all attributes which increase the likelihood that they and their children will live in poverty. Negative consequences are particularly severe for younger mothers and their children. The children of teenage mothers are less likely to have supportive and stimulating home environments resulting in lower cognitive development, less education, more behavior problems, and higher rates of both incarceration (for boys) and adolescent childbearing.²²

The Georgia DHR notes that state funds pay for special services for high-risk mothers and babies, including the costs of premature births, child abuse, day care, health care, foster care, education for children with mental and physical disabilities, and training for mothers who receive public assistance. Georgia’s First Lady, Mary Perdue states that every 30 minutes, a child in Georgia is the victim of abuse²³ and Georgia’s DHR notes that children born to teen mothers are twice as likely to be victims of abuse or neglect.²⁴

¹⁸ *Rates of Cesarean Delivery*, MMWR, April 21, 1995 / 44(15);303-307.

¹⁹ MCH Update 2005: *States Make Modest Expansions to Health Care Coverage*, National Governors Association, Table 1, Draft 6/9/06. <<http://www.nga.org/Files/pdf/0609MCHUPDATE.PDF>>

²⁰ Rogowski, J., 1998. "Cost-Effectiveness of Care for Very Low Birth Weight Infants." *Pediatrics* 102: 35-43.

²¹ *Unique Needs of children born to teen parents*, <www.healthyteennetwork.org> (accessed 6/1/08).

²² Id.

²³ First Lady's Our Children Campaign, http://www.gov.state.ga.us/summit_fl/index.shtml, accessed 11/08/07.

²⁴ Georgia DHR, Office of Communications, www.dhr.georgia.gov, January 2006.

There was a steady decline in teen pregnancy rates, birthrates and abortion rates nationwide between 1990 and 2004. Research showed that 86 to 88% of the decline was the result of improved contraceptive use among sexually active teens.²⁵ But during that time period, Georgia's rates of teen pregnancy did not drop as fast as the rest of the nation. In 1994, Georgia ranked 8th in the U.S., a decade later Georgia still ranked a very high 9th for teen pregnancy and 7th for repeat teen pregnancies.²⁶ In 2006, 12% percent of all Georgia births occurred to teenagers.

In 2006, the CDC reported that there was a 3% increase nationwide in teen birthrates, the first increase in over a decade, *but Georgia's increase was larger.*²⁷ Some 16,500 Georgia women under the age of 20 gave birth in 2004, but by 2006, the numbers had increased to 17,990. Over one thousand of those births were repeat births to Georgia teenagers. But, as noted above, declines were apparent when contraceptives were readily available. One Georgia teen clinic which offered every FDA approved method of contraception which was medically appropriate for the young woman demonstrated no repeat teen pregnancies in 2006.²⁸

Eighty percent of teen pregnancies in the U.S. are unintended. Nationwide in 2004, the public costs of teen childbearing cost taxpayers \$9.1 billion²⁹ and these births to adolescents cost more than \$1.3 billion a year in direct health care expenditures in the U.S.³⁰ Medicaid pays the costs of pregnancy care for approximately 90% of Georgia teens³¹ and teen childbearing in cost Georgia taxpayers \$344 million in 2004.³² In 2004, when teen births were still declining, the estimated cost savings to Georgia taxpayers was \$227,000,000.³³

Ten years ago, an analysis done under the most conservative assumptions showed that the average annual cost per adolescent at risk of unintended pregnancy who used no contraceptive method was \$1,267 (\$1,079 for unintended pregnancy and \$188 for STDs) in

²⁵ "Explaining Recent Declines in Adolescent Pregnancy in the United States: The Contribution of Abstinence and Improved Contraceptive Use" by Santelli, J., et al., American Journal of Public Health and Guttmacher Institute, http://www.guttmacher.org/pubs/fb_ATSRH.html, accessed 6/30/08.

²⁶ Martin JA, et. al., Births: Final Data for 2004, Table 11, National Vital Statistics Report, Vol. 55, No. 1, September 29, 2006, Division of Vital Statistics, National Center for Health Statistics, http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_01.pdf.

²⁷ Birth rate =the number of live births per 1,000 mothers, rates decreased from 70.6 for 15-19 year olds in 1994 (1st year data available) to 52.3 in 2005, 26% decline, followed by a 4% increase from 2005 to 2006, <<http://oasis.state.ga.us/oasis/qryMCH.aspx>>

²⁸ Provided by Marilyn Ringstaff, CNM/nurse manager of the Floyd County Teen Plus Center from 1997-2008, statistics presented to the Floyd County Board of Health 3/13/08 and on file.

²⁹ (Costs include increased public sector health care costs, child welfare costs, increased costs of incarceration, lost revenue due to lower taxes as a result of lower education and earnings). *The Public Costs of Teen Childbearing*, The National Campaign to Prevent Teen Pregnancy, http://www.thenationalcampaign.org/costs/pdf/resources/key_data.pdf, accessed 7/1/08.

³⁰ Trussell, J., *Medical Care Cost Savings from Adolescent Contraceptive Use*, Family Planning Perspectives, 29:248.255 & 295, 1997.

³¹ Births to Teenagers in Georgia, Georgia DHR, Office of Communications, March 1998.

³² GCAPP Fast Facts, <http://www.gcapp.org/teenPregnancy/fastFacts.htm>.

³³ *Teen Childbearing in Georgia Costs Taxpayers \$344 Million Annually*, Georgia Campaign for Adolescent Pregnancy Prevention, <<http://www.gcapp.org/teenPregnancy/fastFacts.htm>> (accessed 7/14/08).

the private sector and \$677 (\$541 for unintended pregnancy and \$137 for STDs) in the public sector.³⁴

ii. UNINTENDED PREGNANCY AND HIGH SCHOOL GRADUATION

Georgia remains one of the worst in the nation for high school dropout rates for girls.³⁵ The United Health Care Foundation notes that Georgia is a very unhealthy state.³⁶ Georgia's primary identified challenge is our low high school graduation rate. A high school diploma is an indication of the consumer's ability to learn about, create and maintain a healthy lifestyle and to understand and access needed health care, but only 59-60 of every 100 girls will graduate from high school in Georgia. One in four girls overall do not finish high school, and graduation rates are worse for girls of color. Four in ten black female students and nearly four in ten Hispanic female students fail to graduate with a diploma each year.

Approximately 1,000 high school students will drop out with each hour that passes in a school day in America. Studies show that pregnancy plays a role in from 33-44% of the girls' decision to drop out and this pattern also holds across racial and ethnic lines. Additionally, 40% of girls who drop out for other reasons will give birth before age 20; this probably accounts for the very high rates of births to 18-19 year olds in Georgia. In one Georgia County in the year 2000, 211 teen girls delivered a baby at the local Medical Center, but during the same year only 220 total teens, both male and female, graduated from the city high school.³⁷

Girls who fail to graduate from high school have higher rates of unemployment; make significantly lower wages; and are more likely to need to rely on public support programs to provide for their families. Poorer mothers with less education are at a significantly higher risk of early delivery.³⁸ Because one in two female high school dropouts aged 25-64 are unemployed, all levels of government would benefit from the increased tax revenues that would flow from increasing the number of taxpayers who graduate from high school.

It is estimated that every student who graduates from high school can save a state as much as an average of \$40,500 in total public health and \$3,000 in welfare expenditures over his or her lifetime. If the 1.2 million students of the Class of 2007 predicted to have dropped out instead earned their high school diplomas, states could save more than \$17 billion in Medicaid and other expenses for uninsured care alone.

Georgia must address the root causes of high school dropouts, particularly for girls. Educated women are more likely to marry and give birth later in life, to seek health care and

³⁴ Trussell, J., et al, *Medical Care Cost Savings from Adolescent Contraceptive Use*, Family Planning Perspectives, 29:248.255 & 295, 1997.

³⁵ All statistics from this section derived from, *When Girls Don't Graduate We All Fail*, The National Women's Law Center, <http://nwlcc.org/pdf/DropoutReport.pdf> (accessed 11/09/07).

³⁶ <<http://www.unitedhealthfoundation.org>>

³⁷ Fact sheet Floyd County Teen Plus Center, (2000).

³⁸ *Healthy Women, Healthy Babies*, Trust for America's Health

to encourage education for their children.³⁹ Skilled and knowledgeable employees fuel businesses in Georgia. Georgia's workforce development website states, "in Georgia, we're committed to providing you the best, most skilled workforce in the nation."⁴⁰ Georgia will not meet the goal of providing the best or most skilled workforce when our teenagers have babies but not high school diplomas.

iii. THE POVERTY BURDEN AND DISPARITIES IN HEALTH CARE

Because women are often the sole provider and caregiver for families they carry a disproportionate burden of poverty. They are not able to make a living wage, are disenfranchised, and have limited access to credit. Because their basic needs for food, clothing, and shelter are not being met, their children are more vulnerable to disease and premature death from preventable causes. The children that survive then continue the cycle of poverty, being uneducated and unemployed.

Unintended pregnancies occur among women of all socioeconomic levels and all marital status and age groups, but females under age 20, the poor and African American women are especially likely to become pregnant unintentionally.⁴¹ But, unfortunately, these are the women who are relying on Georgia Medicaid and the GFPP for contraceptive assistance. Nearly three quarters (70 percent) of Title X family planning users in Georgia have incomes at or below the federal poverty level.⁴¹ Even though less than 30% of Georgia's population is Black,⁴² 50% of the GFPP program patients are minorities and one-third are teenagers. In Georgia, 14% of women aged 15–44 have incomes below the federal poverty level, and 22% of all women in this age group are uninsured.

Women who live in poverty have a decreased life expectancy and life expectancy is also falling for women in rural and low-income areas, especially in the Deep South.⁴³ African Americans and Latinos in Georgia are more than twice as likely to live below the poverty line as whites.⁴⁴

iv. MATERNAL HEALTH RISKS OF UNPLANNED PREGNANCY

Georgia's women are unhealthy⁴⁵ and unplanned pregnancy increases the health risks of both mother and baby. No medical condition evidences a more disparate impact than unintended pregnancy. Sadly, maternal mortality is the leading killer of women of reproductive age throughout the world and the single greatest indicator of the inequities faced by poor and minority women in industrialized and developing nations.

³⁹ CNN, 5/10/06 <http://www.cnn.com/2006/HEALTH/parenting/05/08/mothers.index>

⁴⁰ WorkForce, <http://www.georgia.org/Business/Workforce/>, accessed 11/10/07.

⁴¹ Georgia DHR, http://health.state.ga.us/pdfs/familyplanning/DHR_FamPlan05FINAL_12-21-05.pdf, accessed 11/08/07.

⁴² <http://factfinder.census.gov/>, accessed 6/28/08.

⁴³ *The Washington Post* (4/22/08).

⁴⁴ [9] <http://www.advocatesforyouth.org/PUBLICATIONS/factsheet/fsgeorgia.htm>,

⁴⁵ Georgia ranked 45th for overall health status in _____⁴⁵

In 2008, the United States fell four more places in ranking of preventable deaths due to treatable conditions and is now the worst of 19 leading industrialized nations.⁴⁶ The U.S. ranks 41st among them for maternal deaths. Poor American women die in childbirth at twice the rate of middle-class women and bear more than twice as many low birth weight babies.⁴⁷ In 2005, thirty women in Georgia died during pregnancy or delivery and over the last 10 years, 242 Georgia women have lost their lives because of pregnancy.⁴⁸ The inequities in health care are no more evident than in Georgia where less than 30% of Georgia's 9,363,941 citizens are black,⁴⁹ but 74% of the 23 Georgia women who died because of pregnancy in 2006 were black women. Black infants also fare much worse than white, 50% of the 1,241 fetal deaths in 2006 were black.⁵⁰

Georgia's Council on Maternal and Infant Health (MIH) recognizes that there still are many preventable maternal deaths among Georgia's women and that Georgia has one of the highest infant mortality rates of all the states.⁵¹ The Council recognized family planning efforts as a strategy to lower the risk of poor pregnancy outcomes. The Council on MIH stated, "women of child-bearing age should have . . . timely access to family planning services."⁵²

The universal attainment of a level of health that permits all people to lead socially and economically productive lives will require equity in access to contraceptive services with focus on poor and vulnerable people.

v. PREMATURITY, LOW BIRTH WEIGHT AND INFANT MORTALITY

The United States is experiencing an epidemic of preterm birth. One in every eight births, or nearly 500,000 babies, is born prematurely every year in the U.S. and the numbers continue to rise. But in Georgia, 1 in 7 babies (13.6% of live births) were born preterm in 2005 and the numbers increased to 14.2% of live births in 2006.

Approximately 30% of women who give birth have some form of pregnancy complications which cost the U.S. at least \$26.2 billion in 2005. Prematurity and low birth weight are often associated with these health issues, such as diabetes, high blood pressure, or obesity in the mother.⁵³

Preterm birth is a major cause of infant death and places infants at increased risk for serious lifelong health and developmental problems compared with the risk for infants born

⁴⁶ Dunham, W., *France best, U.S. worst in preventable death ranking*, (Reuters) AP, 1/10/08.

⁴⁷ Nelson, H., *Feminist Therapies for Low-Birthweight Babies*, <<http://www.bioethics.msu.edu/mhr/00f/feministtherapies.htm>> (accessed 6/18/04).

⁴⁸ <<http://oasis.state.ga.us/>> (accessed 11/08/07).

⁴⁹ <<http://quickfacts.census.gov/qfd/states/13000.html>> (accessed 7/1/08).

⁵⁰ <<http://oasis.state.ga.us/oasis/qryMCH.aspx>>, (accessed 7/7/08).

⁵¹ The Council on Maternal and Infant Health of the State of Georgia, *Recommended Guidelines for Perinatal Care in Georgia*, 2d ed., 5/99.

⁵² *Id.* at 1:2.

⁵³ *Healthy Women, Healthy Babies*, Trust for America's Health. *See also, Obesity is an independent risk factor for neonatal mortality among blacks but not whites*, *Obstetrics and Gynecology* (6/08).

at term.⁵⁴ The annual increase in total health care costs due to preterm birth in the United States is estimated to be \$426 billion. In 2005, the medical costs for preterm births cost the United States at least \$26.2 billion, or \$51,600 for every infant born preterm.⁵⁵

The cost of one baby in a neonatal intensive care unit is approximately \$30,000 per month. The Grady Special Care Nurseries alone admits approximately 550 infants each year⁵⁶ and all of Georgia society pays these bills.

Again, the disparities in health care are apparent; it is the population who are most likely to be seen in GFPP clinics that are most at risk. Black women continue to experience a much higher proportion of preterm births. Only 17 percent of all U.S. births were to African-American families, but 33 percent of all low-birthweight babies were African-American.⁵⁷ Georgia had 21,007 babies (14.2 of all births) born prematurely in 2006. 18.5 percent of black women had a baby born prematurely versus 12.1 percent for white women. A study of Georgia women on Medicaid found that poor women also suffer. Poor women experienced not only a higher risk of preterm birth, but they also had a poorer quality of prenatal care as compared to Fee for Service patients.⁵⁸

The Georgia Department of Human Resources (DHR) states “in Georgia, nearly 9 out of 100 born, are born low birth weight. These babies are about *twenty times more likely to die* during their first year of life or to have a disability than a normal weight baby.”⁵⁹ Birth defects alone lead to more than \$2.5 billion a year in hospital costs.⁶⁰

Low birth weight (LBW =<2500 gm) and Very Low Birthweight (VLBW= <1500 grams) births) are also increasing in Georgia. Of the 110,986 births to Georgia women in 2005, 13,301 (9.4%) were low birth weight babies. The rate of LBW babies is directly proportional to the age of the mother and young mothers are most at risk. Young girls, ages 10-14 years old, gave birth to 326 babies in Georgia in 2005 and 14.8 percent (49) of these babies were LBW versus only 7.5 percent of babies born to 25-29 year old women.⁶¹

Racial disparities are also present with low birth weight babies. More than fourteen (14.4%) percent of the LBW babies were born to black women versus 7.1% of white women. **For VLBW births, the numbers are almost tripled for black women;** 3.1% of births to black women are VLBW versus 1.2% to white women.⁶²

⁵⁴ Berman, E. & Butler, A, (eds), *Preterm Birth: Causes, Consequences, and Prevention*, IOM, The National Academies Press, <http://books.nap.edu/catalog/11622.html>, accessed 6/22/08.

⁵⁵ *Preterm Birth: Causes, Consequences, and Prevention*, Institute of Medicine (2006).

⁵⁶ Emory University, Neonatal Services at Grady Hospital, <<http://www.pediatrics.emory.edu/divisions/neonatology/ghcs.html>>, accessed 11/06/07.

⁵⁷ *Healthy Women, Healthy Babies*, Trust for America's Health, <<http://healthyamericans.org/>>, accessed 09/06/08.

⁵⁸ Samadi A., Preterm Birth among Medicaid Beneficiaries in Georgia by Healthcare Plans. *Abstr Academy Health Meeting*; 20: abstract no. 252. (2003: Nashville, Tenn).

⁵⁹ DHR, Babies Born Healthy, Fact Sheet (revised 2/2006).

⁶⁰ Associated Press, [CDC] Studies Count Costs of Birth Defects (January 19, 2007).

⁶¹ <<http://oasis.state.ga.us/oasis/qryMCH.aspx>> (accessed 11.09.07).

⁶² Id.

The U.S. has the second worst newborn death rate in the modern world,⁶³ and Georgia is among the worst in the United States. The United Health Care Foundation notes that Georgia's high infant mortality rate (8.3 deaths per 1,000 live births) is another primary challenge for the state. Babies born to teenagers in Georgia are much more likely to die. There were 49 fetal deaths for 15-17 year old women in 2005 (9.2%) versus 7.6% for 25-29 year old mothers.

Babies born to black mothers in Georgia die at two and a half times the rate of those born to white mothers.⁶⁴ The broad disparities are likely due to the lack of access to health care among racial and income groups.

vi. THE HIV/AIDS EPIDEMIC IN GEORGIA

The HIV/AIDS epidemic continues to grow in Georgia. The total number of cumulative Georgia AIDS cases reported by the end of 2004 was 27,821. The state had the seventh highest number of AIDS cases in the United States in 2004.⁶⁵ Further, a recent report by the Southern AIDS Coalition shows that the number of deaths from AIDS in the rest of the nation dropped between 2001 and 2005, *but rose in the South*.⁶⁶ The lifetime costs of care and treatment for one HIV-infected person is estimated to be \$154,402.⁶⁷

The Georgia DHR states that the HIV/AIDS epidemic now affects many Georgia women and "as more women become infected with HIV, more children may be born with HIV."⁶⁸ From 1984 to 2004, the cumulative proportion of AIDS cases among women increased from four percent to 24 percent. Again, minority women are disproportionately affected. Georgia's DHR recognizes that as more women become infected with HIV, more children may be born with HIV. Without treatment, HIV-infected mothers transmit their infection to their babies 25-30 percent of the time.

Treatment reduces the transmission rates, but **the only known 100% method to prevent AIDS in infants of HIV positive mothers is prevention of unplanned pregnancy.** The significant contribution of contraception in reducing the perinatal transmission of HIV is called the "best-kept secret in HIV prevention" because the benefits of preventing unintended pregnancies have gone virtually unrecognized.⁶⁹ Programs that provide HIV services or prevention to Georgia's highest risk populations for HIV infection must allow these women voluntary access to Tier One methods of contraception.

⁶³ Green, J., CNN (5/10/06).

⁶⁴ Associated Press, *US Among Worst in World for Infant Death* (Nov 10, 2007).

⁶⁵ http://dhr.georgia.gov/DHR/DHR_FactSheets/AIDS%20in%20Georgia%20Jan%2006%20rev.pdf (accessed 6/23/08).

⁶⁶ Associated Press, *HIV On Rise In South*, (7/20/08.) (available at <<http://www.11alive.com/news/health/story.aspx?storyid=118826&catid=13>>).

⁶⁷ <<http://www.kff.org/hivaids/upload/HIV-AIDS-Policy-in-Georgia.pdf>> (accessed 12/01/07).

⁶⁸ Aids in Georgia, DHR Office of Communications, <<http://dhr.georgia.gov>> (January, 2006).

⁶⁹ *Hiding in Plain Sight: The Role of Contraception in Preventing HIV*, Guttmacher Policy Review, Vol. 11, No. 1, Winter 2008.

vii. FAMILY STRENGTH

In 1980, 33 % of all Georgia births were to unwed mothers and by 2006 that number has increased to 42 % (62,887 births) (compare to 31% nationwide). In 2000, out-of-wedlock births represented 83% of all teen births, 44% of births to women in their early twenties, but only 13% of births among women over the age of 29.

There is an inverse relationship between educational achievement and out-of-wedlock births. Fifty-four percent of women who had not completed high school give birth out of wedlock, compared to only 4% of women who had attained a bachelors or professional degree.⁷⁰ Georgia is last in the nation for its girls dropping out of high school and these uneducated young women, who most likely will be uninsured, will be most in need of effective contraception. The stated mission of Georgia's Department of Human Services, is to strengthen Georgia families and help them become self-sustaining.⁷¹ But, by denying the most effective contraception to our most at risk population, the Georgia DHR itself may be contributing to the high rate of single parent homes and the breakdown of Georgia families.

viii. ABORTION

The United States is making progress, but we continue to have very high rates of unintended pregnancy and subsequently have among the highest number of abortions of all the developed nations. Nearly four in 10 unintended pregnancies are terminated by abortion. In 2005, one in five pregnancies still ended in abortion, emphasizing the need for a national emphasis on better sex education and broader access to contraception.

Though the number of abortions performed yearly in the U.S. has dropped to 1.2 million, *two-thirds of this decline can be traced to only eight states that have shown a commitment to comprehensive sex education and to helping women avoid unintended pregnancies by making contraception widely available.*⁷² In 2006, 27,642 Georgia women terminated a pregnancy and once again, the rates were highest for black women. Georgia could greatly reduce its abortion rates by committing to providing effective contraception to all women, regardless of race, socioeconomic or insurance status.

IV. New Contraceptive Methods and Effectiveness Classes

Remarkable advances in family planning methods have occurred in the last few years. Since the year 2000, the FDA has approved several new safe and very effective methods of birth control, including the Mirena intrauterine system (a hormonal IUD), the Implanon implant, Ortho Evra Patch, the vaginal Nuvaring, and Essure sterilization (see Appendix A for more detailed description of the new methods).⁷³

⁷⁰ U.S. Census Bureau (October 2001).

⁷¹ <<http://www.dhr.state.ga.us/portal/site/DHR/>> (accessed 11/10/07).

⁷² NYT, *Behind the Abortion Decline* (1/26/08).

⁷³ Appendix A, if not attached, is available from the author or at <http://docs.google.com/Doc?id=ddkvh34b_23gsz294cq&hl=en> posted 9/27/08.

The main characteristic of all of these new methods of birth control is that they are long-acting and all extremely effective. No daily usage requirement allows a woman to be more compliant with the method. The Implanon is a single rod implant about the size of a match that is inserted under the skin of the upper arm and the device is effective for at least three years. The procedure is done in the office and uses only local anesthesia. The Mirena IUS is an IUD that is inserted only once every five years. Essure sterilization is a permanent contraceptive method.

The World Health Organization now classifies birth control methods by how effective the method is at preventing unintended pregnancy (i.e. “**Tiers of Effectiveness,**” see Appendix B)⁷⁴. The **Tier One reversible** methods of birth control in the United States include the new Implanon implant and two IUD’s: the ParaGard (a copper IUD) or the Mirena (a hormonal IUD). Either IUD is inserted into the uterus and can remain there for from five to ten years. For the number of years that they are recommended, the three reversible methods Tier One methods (both IUDs and the Implanon implant) **are more effective than tubal sterilization for women.** Male sterilization (vasectomy) and female sterilization (tubal ligation or Essure) are also Tier One methods, but they are **only** recommended as permanent methods of contraception.

All of the new methods have an increased upfront cost, but the costs are easily offset by improved patient satisfaction that results in better compliance and decreased unplanned pregnancy rates. **Over time they are the most cost-effective approaches to family planning.** Each of the Tier One methods of contraception has a first year failure rate that is close to zero (one in one thousand).

The Tier Two contraceptives are very effective methods, but only if used correctly and consistently. In actual use they lead to about *25 times as many failures* and far higher discontinuation rates. The Tier Two methods of birth control include oral contraceptives, Depo-Provera, Ortho Evra patch, and the NuvaRing. The pill is taken daily, the Ortho Evra patch is changed once weekly, and the Nuvaring is used monthly. All of these methods require a monthly prescription or require repetitive efforts by a woman at home or they require a regular return to her health care provider or pharmacy. Because of the known high failure rates of Tier Two methods, the current family planning recommendation is to encourage women to use Tier One contraceptive methods if they do not desire a pregnancy.

Georgia law precludes “the use of closed formularies” and states that formularies shall include oral, implant, and injectable contraceptive drugs, and intrauterine devices (plural).⁷⁵ Despite that fact, in 2007 the GFPP transitioned to a limited state family planning formulary that limits all women served by the program to the use of contraceptive methods developed

⁷⁴ Appendix B, if not attached, is available at Comparing effectiveness of family planning methods, Family Health International, <<http://www.fhi.org/NR/rdonlyres/ebrix34v4ltkpve23ajfowame5hqgdm2youb6puzqqbblfj3vmtgdgsiazhaylskjepy oehpjgee4ab/EffectivenessChart1.pdf>>, accessed 9/27/08

⁷⁵ Women's Access to Health Care Act, Ga. Code Ann. 33-24-59.6 (1996).

in the previous century. The GFPP formulary now contains a very narrow range of contraceptive methods. Patients are able to choose only traditional birth control pills, Depo-Provera injections and only one IUD (Paragard) as the only effective reversible birth control methods available to Georgia's poorest citizens.^{76,77} The **only** reversible Tier one method a woman in the GFPP may now choose is the Paragard IUD.

The current range of new contraceptive methods available include 1) non-surgical sterilization, 2) subdermal implants, 3) an extended use vaginal contraceptive, 4) a hormonal IUD, and 5) extended use and 6) low dose [20 mcg.] oral contraceptives. The current GFPP contains **none** of these contraceptive methods and its range of choice in methods that are provided is very narrow.

V. Women Need a Broad Range of Contraceptive Options

The United States continues to have one of the highest unintended pregnancy rates in the developed world. There are currently many options in contraception and 98 percent of sexually active women U.S. women have used a method of contraception.⁷⁸ It is imperative that we look closely at *why* nearly half of the pregnancies in the U.S. remain unintended. One of the major contributing factors is simply a lack of access to effective contraception; further, economic gaps, age, racial disparities and insurance status all are factors that play a role in determining women's access to birth control. Many women have a lack of access to health care or could not afford birth control.⁷⁹

Over one-half of U.S. women who had at least a one-month gap in contraceptive use had experienced a major life event, such as the end of a relationship, or a move, job change or personal crisis. Women who are satisfied with their method and have a good relationship with their health care provider are more likely to be compliant with their method. But, studies show that nearly four in 10 contraceptive users are not very satisfied with their current method.⁸⁰

Further, nearly one in four women who are not trying to become pregnant are ambivalent about becoming pregnant, and many women are reassured by the fact that they would qualify for Medicaid (under Right from the Start Medicaid) in Georgia, the day that they found out they were pregnant.⁸¹

⁷⁶ The GFPP states that a goal is to "Maintain the guarantee of full contraceptive choice in the face of rapidly escalating costs," <http://health.state.ga.us/pdfs/familyplanning/DHR_FamPlan05FINAL_12-21-05.pdf> (p. 13).

⁷⁷ Paper available from the author, or at <http://docs.google.com/Doc?id=ddkvh34b_21c4q6f6f5>, posted 9/27/08.

⁷⁸ *Use of Contraception and Use of Family Planning Services in the United States: 1982-2002*. National Center for Health Statistics, Advance Data No. 350. 35 pp. (PHS) 2005-1250

⁷⁹ Valenti, V., *The Contraception Failure*, AlterNet.org June 16, 2008.

⁸⁰ Frost, J., *Factors Associated with Contraceptive Choice and Inconsistent Method Use*, United States, <<http://www.guttmacher.org>>, 2004.

⁸¹ Personal observation of the author, through 11 years of clinical experience at Floyd County Teen Plus, in Rome, GA.

There is new and disappointing evidence that many women do not continue any of the frequent user (Tier Two) methods (the pill, Depo-Provera, patch, or Nuvaring) for long periods of time. Thus, **the current standard of care in family planning** is to encourage the use of more effective and long-term contraceptive (Tier One) methods.

Of all hormonal contraceptive methods, the birth control pill is the least effective because of the daily usage requirement. Virtually all pill users (98%) reported needing a reminder system to help them remember to take their pill every day, even then 38% reported having missed at least one active pill in the prior three months. Further, a large number of women who begin the pill do not continue it. **The birth control pill is the least effective of the Tier Two methods and yet it is the most likely method to be utilized in Georgia family planning clinics.**⁸²

There are about 1 million women who become pregnant each year in the U.S. who are depending upon birth control pills. Oral contraceptives require usage 365 days a year and thus are easy to forget.⁸³ Because of the realities of use, about 7–9% of either the pill or injectable (Depo-Provera) users become pregnant during the first year of typical use.⁸⁴ For example, if 100 women start birth control pills, in one year eight of them will become pregnant. Of every 25 pregnancies which occur in women on birth control pills, 24 were due to the errors that women made taking the pills. Among 15- to 19-year-old girls relying upon oral contraceptives, only 70 percent take a pill every day.⁸⁵

The Ortho Evra patch or Nuvaring methods are both longer acting, one week or for one month and patients are highly satisfied with the method and are more likely to continue it, yet both of these Tier Two methods are being denied to Georgia’s women who need access to the most effective birth control.

VI. Costs of Contraception

1. Monetary costs to the GFPP to provide a broad range of contraceptives

The GFPP, through special pricing programs available to Title X grantees are able to provide contraceptives at steeply reduced prices. The price the GFPP could provide each new contraceptive which is currently not on the GFPP formulary⁸⁶ is shown in the table below.

	Effectiveness Tier	Monthly cost*
Mirena (\$345/five** years)	ONE	\$5.75
Implanon*** (\$289/3 years)	ONE	\$8.06
Ortho Evra Patch	TWO	\$15.00

⁸² Georgia Family Planning program (GFPP), page 10.
<http://health.state.ga.us/pdfs/familyplanning/DHR_FamPlan05FINAL_12-21-05.pdf>(accessed 9/1/08).

⁸³ Personal correspondence, Dr. Bob Hatcher, Emory University, 5/2008.

⁸⁴ For effectiveness rates of all methods, see Table 1, p. 43. Hatcher, R., et al, *Pocket Guide to Managing Contraception*, 2007-2009 Ed., Bridging the Gap Foundation.

⁸⁵ Trussell, Id.

⁸⁶ Table provided by Marilyn Ringstaff, CNM, JD as a health care provider in the GFPP (ordering pharmaceuticals off-formulary/costs are accurate through 6/2008).

Nuvaring	TWO	\$14.64
20 mcg pill	TWO	\$11.36 Avianne; ~\$7.50 Lutera

* Compare to the cost of 1 baby in NICU for 1 month \$30,000

** The Mirena is likely effective for 7 years = \$4.10/month

*** The implant cost more than no method at one year, but by year two the savings exceeded costs.⁸⁷

For private pay patients in Georgia, there are now two higher dose oral contraceptives on Wal-Mart and Kroger's generic program for \$9.00 per cycle, but most pills cost significantly more. Ortho TriCyclen-Lo is \$55.99/month, the Ortho Evra patch is \$56.99/month, one Depo-Provera vial is \$75.59 (plus the cost of an office visit and injection fees), and the Nuvaring costs 64.99/month.⁸⁸

2. Non-monetary concerns with limiting the GFPP formulary

If the GFPP does not provide up-to-date contraceptive methods, health departments will lose income, not just in lost billing for providing contraceptive methods for their Medicaid clients, but they risk losing current Medicaid clients who have the option of seeking more progressive health care in a private practice. The GFPP, already suffering a shortage of nursing staff and a shortage of medical oversight, is also at risk of maintaining a poorly trained workforce and a decreased ability to recruit new providers. Nurses working in an expanded-role in public health will see patients who are using new methods of contraception that have been prescribed by private providers. These nurses will be inexperienced and unable to properly evaluate or counsel clients if their family planning skills are not required to be current. Those skills can only be current through education and experience with the new methods.

The GFPP states, "any interruption in women's access to contraception may mean an interruption in contraceptive use. And that, in turn, may translate into unintended pregnancy."⁸⁹ If the GFPP or Medicaid formularies remain limited, women may be forced to change methods when they suffer a change in insurance and lapses in method use will result. The GFPP correctly recognizes the danger of limiting a woman's contraceptive options; however the GFPP has not translated that statement into action.

The only Tier One reversible method available under the GFPP currently is a ParaGard IUD. Georgia is also experiencing an epidemic of sexually transmitted diseases and a woman who is high risk for the acquisition of an STD or currently has one is not a good IUD candidate. As a result, many GFPP clients are not safe IUD candidates. Under the current formulary that excludes Implanon implants, high-risk patients will not have access to any reversible Tier One method. Instead our highest risk women can only choose between either daily pills or the Depo-Provera injection or she may be forced to choose permanent sterilization.⁹⁰ Georgia leads the nation in both unplanned pregnancies and

⁸⁷ Trussell, J., et al, *Cost Savings from Adolescent Contraceptive Use*, Family Planning Perspectives, Vol. 29, Number 6, Nov./Dec. 1997.

⁸⁸ CVS pharmacy, *online prescription drug costs*, <www.cvs.com>, accessed 6/25/08.

⁸⁹ The GFPP, <<http://health.state.ga.us/programs/familyplanning/>> (accessed 6/21/08).

⁹⁰ See Appendix C for documented case examples. Appendix C, if not attached, is available from the author http://docs.google.com/Doc?id=ddkvh34b_22cg93n2d4, posted 9/27/08.

obesity. Given the known high method failure rates and weight gain side-effect of Depo-Provera, neither of these could be classified as a completely “safe or effective” methods and certainly they do not represent a “broad range” of contraceptives, since none of the newest methods ore represented.

A primary benefit of the new Tier One methods of contraception is the decreased need for frequent office visits. For example, the Implanon is considered a ‘set and forget’ method that requires no monitoring for three years once it is placed. The Mirena IUS requires no clinician monitoring other than routine annual health screenings. Conversely, a patient on Depo-Provera during the same length of time would have required either 12-13 office visits (if using Implanon) or 20 office visits (if patient uses Mirena). Public health is already experiencing a severe nursing shortage, and mandating the usage of a method which requires frequent nursing follow-up can severely overtax its nursing staff.

2. The insured women’s cost of contraception- Are the cost of contraceptives prohibitive? Hidden charges (i.e. “tiers of coverage”)

The Centers for Disease Control reported in 2007 that more than 40 million people in the U.S. cannot afford adequate health care and even those that are fortunate enough to have health insurance are now feeling the burden of rising medical costs and limited coverage.⁹¹ More disposable income is being spent on higher premiums and bigger out-of-pocket deductibles and co-payments. Since 2001, the average cost of healthcare for a family has doubled, but incomes have not kept up.⁹² Another survey found that health care costs now outranked housing costs, rising food prices and credit card bills as a source of concern.⁹³

The nation’s concern extends to contraceptive coverage and the problems of unplanned pregnancies cross all segments of society. Due to prohibitive up-front costs, many women delay in filling prescriptions. Three-fourths of women say cost is a factor in deciding what birth control method to use when they do not have comprehensive insurance coverage.⁹⁴ Many women report difficulty accessing contraceptive services or say they cannot afford the more effective, prescription methods of contraception.⁹⁵ Twenty two percent of Georgia women are uninsured; but even for the well-insured, contraceptive costs can be prohibitively expensive.

Only 39 percent of Health Maintenance Organizations (HMOs) cover all methods, and 7 percent cover no prescription contraceptives at all.⁹⁶ Georgia law mandates that if insurance policy includes prescription drugs it must include contraceptives.⁹⁷ However, the

⁹¹ Reuters (12/3/07).

⁹² Abelson, R., *The New York Times*, 05/04/2008.

⁹³ *Los Angeles Times*, April 29, 2008.

⁹⁴ *Facts about Contraceptive Coverage*, National Partnership for Women & Families, <<http://www.nationalpartnership.org/site/DocServer/EPICCFactsheet.pdf?docID=1076>> (accessed 7/19/08).

⁹⁵ Frost, J., *Improving Contraceptive Use In the U.S.*, *Guttmacher Institute*, 2008 Series, No. 1.

⁹⁶ “U.S. Policy Can Reduce Costs Barriers to Contraception,” *The Alan Guttmacher Institute, Issues in Brief* 1999 Series, No. 2, p. 2.

⁹⁷ Women's Access to Health Care Act, Ga. Code Ann. 33-24-59.6 (1996).

‘mandate’ does not specify what the ‘tier’ of coverage should be provided. For example, the Nuvaring and the Ortho Evra patch are ‘Tier 2’ methods on Well Care, Amerigroup and Peach State (meaning its cost is \$45.00 per prescription). Only Peachcare covers these two methods as a Tier 1 (limited co-pay) method.⁹⁸ Thus, the actual cost of a ‘covered’ product, while appearing to be compliant with the statute, approaches the cost a woman would pay if she had no contraceptive coverage at all.

V. SUMMARY

Every baby in Georgia deserves to be planned and wanted. Children of unintended pregnancies are more likely to be unwanted, abused, die before their first birthday. The monetary and non-monetary costs of unintended pregnancy are enormous. Their mothers are more likely to be unwed, live in poverty and are more likely to have complicated pregnancies and their children grow up to be a costly burden on multiple social welfare programs.

Prevention works. Family Planning is called one of the "Ten Great Public Health Achievements" of the 20th century because of its opportunity for prevention and the impact on morbidity and mortality. Prevention of unintended pregnancy works to prevent prematurity, prevent maternal and infant deaths, works to prevent HIV in newborns and reduce the strain on our social welfare programs, reduce the wide disparity in health status for minorities

This paper discussed the multiple new options for women to help them plan their families. These contraceptive methods are much more effective at preventing pregnancy and are more cost-effective in the long term.

The Georgia family planning program’s stated goals are to lower the incidence of unintended pregnancy, improve maternal and infant health, and to reduce the incidence of abortion. That goal could be met by committing to providing effective contraception to all women, regardless of race, socioeconomic or insurance status. The contraceptive option a woman chooses should be affordable or readily available without hidden charges on insurance plans and at every county health department in Georgia.

Helping women who do not want to become pregnant to use contraceptives more effectively is sound public policy that will reduce unintended pregnancy.

⁹⁸ <<http://www.fingertipformulary.com/Home/>>, accessed 7/7/08.