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Rekindling Efforts to Prevent Unplanned Pregnancy: A Matter of 'Equity and Common Sense'

By Rachel Benson Gold

For nearly a quarter century, the divisive politics of abortion have tainted and virtually stymied meaningful discussion of family planning programs and policy in the United States. Funding for programs serving young and low-income women has lagged; expenditures stagnated or actually declined in more than half the states between 1994 and 2001. Meanwhile restrictions, especially at the state level, have multiplied. Now, however, research that casts in sharp relief the interrelationships among contraceptive use, unplanned pregnancy and abortion may be leading the way to a growing recognition of contraception as a critical prevention strategy. Already, this has led to calls to expand access to contraceptive services for all American women, but especially for low-income women through Medicaid—a move that a new analysis shows has the potential to reduce unplanned pregnancy and abortion considerably.

Progress Stalled

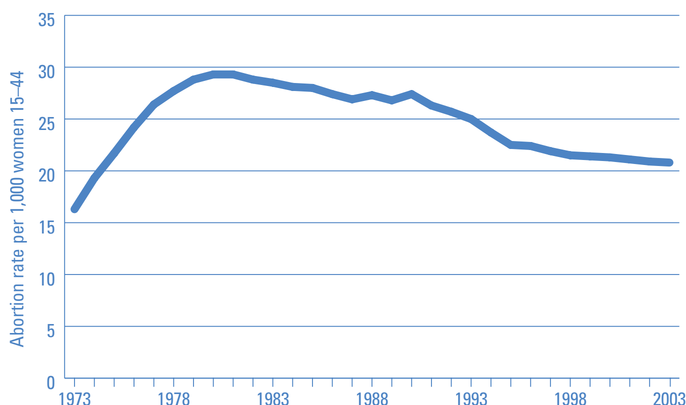
Unplanned pregnancy can have far-reaching consequences for women, families and society at large. According to numerous studies, closely spaced births and childbearing very early or late in a woman's reproductive life can have adverse health consequences for mothers and their children. And unplanned pregnancy—especially among teenagers—can hamper a young woman's ability to complete her education and participate effectively in the workforce. To be sure, being able to determine whether and when to bear children is one of the most basic aspects of self-determination, and it has become a prerequisite for women's full participation in modern life.

Between the early 1980s and the mid-1990s, contraceptive use among American women increased considerably, and the nation's unintended pregnancy rate—and the abortion rate—declined. But according to new research released by the Guttmacher Institute in May 2006, this progress has ground to a halt: Between 1994 and 2001, the steady decline in the U.S. unintended pregnancy rate stalled. If current levels continue, nearly half of all American women will face an unplanned pregnancy at some point in their lives.

And, as progress in reducing unplanned pregnancy has stalled, so has progress in reducing abortion. The U.S. abortion rate declined by 3.4% each year between 1992 and 1996, and by 1.2% each year between 1996 and 2000. Since then, the decline has slowed sharply (see chart).

LEVELING OFF

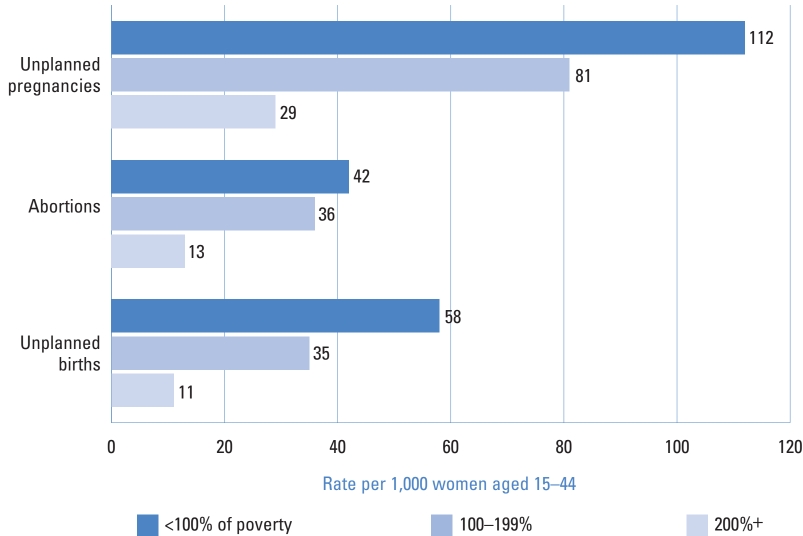
The decline in the U.S. abortion rate, especially steep during the early 1990s, has slowed to a crawl.



Notes: Data for 2001–2003 are preliminary. Data for 1983, 1986, 1989, 1990, 1993, 1994, 1997 and 1998 are estimated by interpolation of numbers of abortions. *Source:* Guttmacher Institute, 2006.

GROSS DISPARITIES

Compared with higher-income women, poor women are four times as likely to have an unplanned pregnancy, three times as likely to have an abortion and five times as likely to have an unplanned birth.



Source: Guttmacher Institute, 2006.

Progress Turned Back

If the picture for American women overall is one of progress stalled, the picture for poor women is one of progress turned back. The newest data paint a disturbing picture of two very different Americas—one in which middle- and upper-class women are continuing decades of progress in reducing unplanned pregnancy and abortion, and the other in which poor women are facing more unplanned pregnancies and growing rates of abortion.

The newest data paint a disturbing picture of two very different Americas.

From 1982 to 1995, as contraceptive use increased among women of all income groups, historical disparities in contraceptive use patterns between richer and poorer Americans also narrowed considerably. Between 1995 and 2002, contraceptive use fell slightly among all women at risk of unintended pregnancy (i.e., women who are sexually active and able to become pregnant, but who are not seeking a pregnancy). But the drop among poor women was significantly larger, from 92% to 86%. And contraceptive use is critical to being able to avoid unplanned pregnancy: The 11% of at-risk women who do not use contraception account for half of all unplanned pregnancies.

With contraceptive use falling sharply among low-income women, it is no surprise that their rate of unplanned pregnancy has been rising. Between 1994 and 2001, the unintended pregnancy rate for poor women shot up by 29%, even as it fell 20% for more affluent women. A poor woman in the United States is now nearly four times as likely as a more affluent woman to have an unplanned pregnancy (see chart). As a result, unplanned pregnancy is becoming ever more concentrated among poor women: The 16% of women at risk of unplanned pregnancy who are poor account for 30% of all unplanned pregnancies.

Higher levels of unplanned pregnancy inevitably lead to higher levels of both unplanned birth and abortion. When faced with an unplanned pregnancy, a low-income woman is more likely than an affluent woman to continue the pregnancy. In fact, poor women are five times as likely as more affluent women to have an unplanned birth—an event that can have serious consequences for both the woman and her family. (Overwhelmingly, women who opt to continue an unplanned pregnancy also opt to keep the child. According to the National Center for Health Statistics, only 1% of babies born to never-married women are placed for adoption.)

Abortions levels show a similar trend: From 1994 to 2000, abortion rates decreased among higher-income women, but increased among poor

women. Because of high levels of unplanned pregnancy, a poor woman is now more than three times as likely as a more affluent woman to have an abortion. In 2000, the 13% of reproductive-age women who are poor accounted for 27% of all abortions.

Expanding Contraceptive Access

These findings quickly struck a chord in the policy arena. The United States Conference of Catholic Bishops immediately issued a press release disclaiming the potential of improved access to contraceptive services to help women avoid unplanned pregnancy and abortion. But others made the connection instantly. The "most effective way to prevent unintended pregnancy and reduce abortions is to improve access to safe, affordable, and effective contraceptive methods," declared Sens. Hillary Rodham Clinton (D-NY) and Harry Reid (D-NV) in a May 11 letter to their Senate colleagues.

Citing both the recent decrease in contraceptive use among low-income women and the fact that contraceptive use reduces the probability of having an abortion by 85%, Clinton and Reid introduced legislation that would expand eligibility for Medicaid-covered contraceptive services. Their proposal would require all states that have not yet done so to extend coverage for contraceptive services and supplies to all women in the state who would be entitled to Medicaid-funded prenatal, labor, delivery and postpartum care in the event they became pregnant. This would effectively give low-income women across the country equal access to contraceptive services to help prevent an unplanned pregnancy and to pregnancy-related care if they do become pregnant—something that is a basic issue of "equity and common sense," according to Clinton and Reid.

The Clinton-Reid proposal builds on two distinct but closely related sets of Medicaid expansions that together have greatly improved the ability of low-income women to obtain the reproductive health care they need. The first of these innovations began in the 1980s, when Congress did away with the long-standing requirement that a low-income family needed to be eligible for welfare to be covered under Medicaid. In a series of incremental moves, Congress first allowed and later required states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care to all women with an income up to 133% of the federal poverty level—a level far above the regular income-eligibility ceiling set by most states (which averages 67% of poverty nationwide and goes as low as 20% in Alabama, Arkansas and Louisiana). Moreover, Congress allowed states to expand eligibility for pregnancy-related services to women with a significantly higher income.

The Clinton-Reid legislation would effectively give low-income women equal access to contraceptive services to help prevent an unplanned pregnancy and to pregnancy-related care if they do become pregnant.

These expansions had a substantial impact. Most states now cover women with an income up to 185% of the federal poverty level, and a few go well above that. Medicaid pays for nearly four in 10 of the births that occur in the United States each year, and in some states, the program funds over half.

To date, 24 states have built on these early expansions by also broadening eligibility for Medicaid-covered contraceptive services and supplies. Most of these efforts directly parallel the earlier initiatives for pregnancy-related care and extend coverage for contraceptive services to women with an income up to 185% or 200% of poverty, regardless of whether they have ever been a Medicaid recipient (related article, March 2004, page 1). Some of the programs are more narrow, only extending coverage for contraceptive services to certain previously eligible women who are leaving the Medicaid program.

The Clinton-Reid legislation would effectively merge these two waves of expansions and establish parity between coverage of pregnancy-

related care and coverage of contraceptive services under Medicaid. Significantly, of the 24 states that have already expanded eligibility for Medicaid-covered contraceptive services, 15 extend coverage to women with an income up to the same level used to determine eligibility for pregnancy-related care.

Reviving Progress

A new analysis by the Guttmacher Institute shows how potent this approach would be in restarting the nation's stalled progress in reducing unplanned pregnancy and, thereby, abortion. The analysis, published in August 2006 as part of the Institute's *Occasional Report* series, looked at the potential impact of four scenarios for expanding eligibility for Medicaid-covered contraceptive services: establishing parity between contraceptive services and pregnancy-related care, instituting a nationwide expansion of eligibility to women with an income of either 200% or 250% of poverty and giving each state the option to extend eligibility to women with an income up to 200%. This last approach would remove current bureaucratic hurdles in the path of states seeking to expand, but whether an expansion would be implemented in each state would be at the state's option.

All four of these scenarios would have a significant impact on women's access to contraception (see table). In some cases, women who were unable to access services at all would be able to obtain them; in other cases, women who were using less effective contraceptive methods would be able to use more effective methods. By doing so, all of these approaches would improve women's ability to avoid unplanned pregnancy or birth, as well as abortion. Moreover, all would result in significant cost savings to the federal and state governments.

EXPANSION IMPACT

Any of four scenarios for expanding women's eligibility for Medicaid-covered contraceptive services would significantly reduce unplanned pregnancies, abortions, unplanned births and public-sector costs.

	Scenarios for Expanding Eligibility for Medicaid Coverage of Contraceptive Services			
	Nationwide, women up to 200% FPL	Optional, women up to 200% FPL	Nationwide, women up to 250% FPL	Nationwide, parity with eligibility for pregnancy-related care
Unplanned Pregnancies Averted				
Number	521,700	375,100	722,600	471,100
Percent	16.7	12.0	23.2	15.1
Abortions Averted				
Number	210,300	151,200	291,200	189,900
Percent	16.3	11.7	22.5	14.7
Unplanned Births Averted				
Total	248,900	178,900	344,700	224,700
Medicaid-funded	238,200	174,300	271,300	224,700
Costs and Savings				
Medicaid costs averted (in billions of $)	$2.47B	$1.76B	$2.81B	$2.34B
Cost of expansion (in billions of $)	$0.91B	$0.63B	$1.25B	$0.82B
Net savings (in billions of $)	$1.56B	$1.13B	$1.56B	$1.53B
Cost savings ($ saved per $ spent)	$2.70	$2.80	$2.20	$2.90

Notes: FPL=federal poverty level. Estimates are for the annual impact in the third year of program operation. *Source:* Guttmacher Institute, 2006.

But by providing access to contraceptive services and supplies to all women who would be eligible for a Medicaid-funded birth if they became pregnant, the equity strategy would be the most cost-effective. Although the impact would differ from state to state (see table, page 6), this approach would cost $800 million but avert $2.3 billion in costs from unplanned births for a net savings of $1.5 billion in Medicaid costs in the third year of the program's operation. It would enable nearly 500,000 women to avoid an unplanned pregnancy, reducing the number of unplanned pregnancies nationwide by 15%. Doing so would prevent nearly 200,000 abortions, cutting the number of abortions by 15% as well. Moreover, the

effort would help 225,000 women avoid an unplanned birth each year.*

Connecting the Dots

More than 35 years ago, the United States embarked on a large-scale effort to provide access to contraceptive services to low-income women. Congress established the Title X national family planning program in 1970; two years later, it revisited the issue, guaranteeing that family planning services would be covered under all states' Medicaid programs. That early effort was driven both by a growing awareness of the impact of unplanned pregnancy on women and families and by the realization that low-income women lacked access to the contraceptive services and supplies without which they could not make or act on responsible decisions about their childbearing.

For two decades, steady progress was made, and by the mid-1990s, the income and racial disparities in contraceptive use that had spurred the gov-

ESTABLISHING PARITY

Equalizing eligibility levels for Medicaid-covered contraceptive services and pregnancy-related care would help women avoid unplanned pregnancy, abortion and unplanned birth, while yielding considerable savings.

	Unplanned pregnancies averted	Abortions averted	Unplanned births averted	Medicaid costs averted (in 000s)	Cost of expansion (in 000s)	Net savings (in 000s)
U.S. TOTAL	**471,100**	**189,900**	**224,700**	**$2,341,700**	**$816,300**	**$1,525,500**
Alaska	1,300	500	600	14,500	3,300	11,200
Arizona	14,200	5,700	6,800	65,700	39,100	26,500
Colorado	13,700	5,500	6,500	66,700	54,700	12,000
Connecticut	5,800	2,300	2,700	33,200	7,700	25,500
Delaware	1,500	600	700	8,100	2,200	5,900
District of Columbia	1,400	600	700	7,300	1,900	5,300
Florida	50,100	20,200	23,900	244,500	31,800	212,700
Georgia	27,500	11,100	13,100	149,200	26,100	123,100
Hawaii	1,600	700	800	8,200	2,600	5,600
Idaho	2,900	1,200	1,400	16,800	3,300	13,600
Illinois	32,500	13,100	15,500	137,100	86,100	51,000
Indiana	13,400	5,400	6,400	63,500	19,600	43,900
Kansas	5,200	2,100	2,500	25,500	8,900	16,600
Kentucky	11,400	4,600	5,400	60,300	13,200	47,100
Louisiana	19,100	7,700	9,100	127,100	36,500	90,600
Maine	2,400	1,000	1,100	10,200	6,000	4,200
Maryland	16,400	6,600	7,800	96,400	32,500	63,900
Massachusetts	10,900	4,400	5,200	66,900	24,800	42,100
Minnesota*	3,400	1,400	1,600	19,900	4,400	15,400
Missouri	12,800	5,200	6,100	55,200	25,400	29,900
Montana	2,200	900	1,100	12,100	4,000	8,000
Nebraska	4,000	1,600	1,900	23,200	7,000	16,200
Nevada	6,200	2,500	3,000	37,500	14,400	23,100
New Hampshire	2,400	1,000	1,100	12,400	4,500	7,900
New Jersey	19,300	7,800	9,200	75,000	28,000	47,000
North Dakota	900	400	400	5,400	1,700	3,700
Ohio	20,300	8,200	9,700	100,300	63,200	37,000
Pennsylvania	27,700	11,200	13,200	64,000	42,300	21,600
Rhode Island	2,800	1,100	1,300	16,500	3,100	13,400
South Dakota	1,300	500	600	6,700	2,000	4,700
Tennessee	10,600	4,300	5,100	55,400	18,900	36,500
Texas	101,200	40,800	48,300	535,300	145,800	389,400
Utah	3,700	1,500	1,800	17,600	4,300	13,300
Vermont	900	400	400	5,000	1,400	3,600
Virginia	14,600	5,900	6,900	65,200	38,400	26,800
West Virginia	4,600	1,900	2,200	27,000	2,800	24,200
Wyoming	1,100	400	500	7,100	4,300	2,800

*Minnesota extends eligibility for contraceptive services to women with an income up to 200% of poverty, but eligibility for pregnancy-related services to 275%; the impact estimated here would be that of expanding eligibility for contraceptive services from 200% to 275% of poverty. *Note:* States not included in this table have already expanded their income-eligibility level for contraceptive services to the level used to determine eligibility for pregnancy-related care, so no impact would be expected; those states are Alabama, Arkansas, California, Iowa, Michigan, Mississippi, New Mexico, New York, North Carolina, Oklahoma, Oregon, South Carolina, Washington and Wisconsin. *Source:* Guttmacher Institute, 2006.

ernment's involvement were all but eliminated. But these disparities have widened again. Moreover, the number of women in need of publicly subsidized contraceptive services increased by more than one million from just 2000 to 2004 (related article, page 20).

Might the very politics of abortion that have tied up our national family planning effort for decades ironically now be setting it free? To be sure, increased recognition of the inherent relationship between unplanned pregnancy and abortion, and of the critical role played by contraceptive services in avoiding both, is leading to a fresh look at the importance of prevention. Connecting these dots earlier this summer, Sen. Clinton urged us to "unite around a common goal of reducing the amount of abortions, not by making them illegal as many are attempting to do or overturning *Roe v. Wade* and undermining the constitutional protections that decision provided, but by preventing unintended pregnancies in the first place through education, contraception, accessible health care and services, empowering women to make decisions…." Clinton—who also has introduced with Rep. Nita M. Lowey (D-NY) a resolution calling on Congress to express its support for expanded access to contraception for women of all income levels—went on to say, "this is not just about family planning or contraceptives…it's about the kind of country we believe in, what kind of obligations we owe one another. We have a very high value placed on individual choice and individual responsibility. But we don't often empower people to be able to make those choices in a responsible way."

Clinton's statement tacitly recognizes that meaningfully reducing unintended pregnancy in the United States is a goal that will not be achieved merely by increasing the availability of contraceptives. Much more needs to be understood about why people who presumably have "access" nonetheless have difficulties in using contraceptives properly and consistently. And much more attention should be paid to the constructive role society and public policy might play in better supporting people as they try to exercise "individual responsibility" in their sexual and reproductive lives. Identifying and addressing these factors and obstacles, along with establishing a firm foundation of access to services for all who need them, are critically important components of a much-needed national effort to rekindle progress in reducing unintended pregnancy. www.guttmacher.org

*Clarification: A number of states have already established "equity" by equalizing eligibility levels for Medicaid-covered contraceptive services and pregnancy-related care. When determining whether a woman is eligible for pregnancy-related care, however, states use a specialized methodology that considers her family size as what it would be if she gave birth. If states applied this methodology to determining eligibility for family planning under the parity scenario, additional women would be eligible and the estimated impact would be roughly 20% greater than what is presented here.