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Wise Investment: Reducing the Steep Cost to Medicaid Of Unintended Pregnancy in the United States

By Rachel Benson Gold

Unintended pregnancy has long been known to substantially and negatively affect the health and well-being of individual women and their children. New research, however, shows that American taxpayers also pay a steep financial price because of unintended pregnancies. Half of all pregnancies in the United States are unintended, and reducing that proportion has been a long-standing national priority. Redoubling efforts to meet that goal by increasing federal and state investments in publicly funded family planning services would yield manifold benefits. It would help empower and enable women and couples to meet their own childbearing goals and better position themselves to be the kind of parents they want to be for the children they choose to have. And, it would also save precious dollars that could and should be used to shore up the beleaguered Medicaid program, so it can continue to provide the health care—including the reproductive health care—that low-income women and families need and to which they are legally entitled.

Costly National Problem

Unintended pregnancy has long been acknowledged as an important national health, social and economic problem. Every iteration of *Healthy People* since the series began in 1979 has set reducing unintended pregnancy as a national public health goal.[1] In fact, the federal government recently set the goal of reducing the proportion of pregnancies that are unintended by 10% by 2020.[2] This goal was echoed in the Surgeon General's National Prevention Strategy that was released this summer; the document reaffirmed that planning and having a healthy pregnancy is vital to the health of women, infants and families.[3] New data show the urgency of addressing this problem, especially for low-income women: 13% of women aged 15–44 with income below the poverty line had an unintended pregnancy in 2006, more than five times as many as among women at or above 200% of poverty.[4]

Unintended pregnancy can pose substantial health risks for women and their children, often by leading to poor birth spacing (related article, Winter 2011, page 7). Short intervals between births have been linked with numerous negative perinatal outcomes, including low birth weight and preterm birth—both of which are widely acknowledged risk factors for infant mortality.[5] Unintended pregnancy generally has also been linked with other negative outcomes, such as reduced breastfeeding and delayed initiation of prenatal care. Several studies also suggest an association with subsequent child abuse, maternal depression and marital instability. For these reasons, both the National Governors Association[6] and the March of Dimes[7] have long deemed expanded Medicaid coverage for contraceptive services an important strategy for improving maternal and child health.

Moreover, unintended pregnancy can create hardships for women that can impede their ability to reach their full potential. Unintended pregnancy deprives women and couples from being able to make purposeful and deeply personal decisions about childbearing, and to have children when they feel that they are ready and able to give their children the start in life they want them to have. It can also limit women's ability to

invest in the higher education they need to be full participants in the workforce.[5]

Two new studies show, for the first time, that unintended pregnancy also imposes a high financial burden on the nation. The first study, by researchers from the Brookings Institution, used 2001 national estimates of the publicly funded outcomes of unintended pregnancies—births, abortions, miscarriages and infant medical care.[8] It concluded that the estimated annual cost to taxpayers of providing medical services to women who experience unintended pregnancies—and to the infants who are born as a result—ranges from $9.6 billion to $12.6 billion, and averages $11.3 billion. Public savings from preventing these unintended pregnancies would range from $4.7 billion to $6.2 billion, and average $5.6 billion.

The second study, from researchers at the Guttmacher Institute, relied on first-ever calculations of unintended pregnancy at the state level.[9] It estimated the proportion of unintended pregnancies ending in publicly funded births in each state in 2006, as well as the resulting costs (see table, page 9).[10] The study found that in 2006, 1.6 million births resulted from unintended pregnancy nationally. Of these, 64% were paid for by Medicaid—and, to a much smaller extent, the Children's Health Insurance Program (CHIP)—at an average cost of $11,700 per birth. As a result, the total public cost of unintended pregnancy in 2006 was $11.1 billion, representing half of the total amount spent by Medicaid and CHIP for births and infant care that year (see chart).

Because the two studies took different methodological approaches, it is striking that they arrive at a similar conclusion: Unintended pregnancy costs U.S. taxpayers roughly $11 billion each year. Dramatic though that price tag may be, it is itself a conservative estimate that is limited to publicly funded medical care for pregnancy and the first year of an infant's life; the true cost would actually be many times higher if other expenses, such as social supports or ongoing medical care, were considered.

Proven, Cost-Effective Strategy

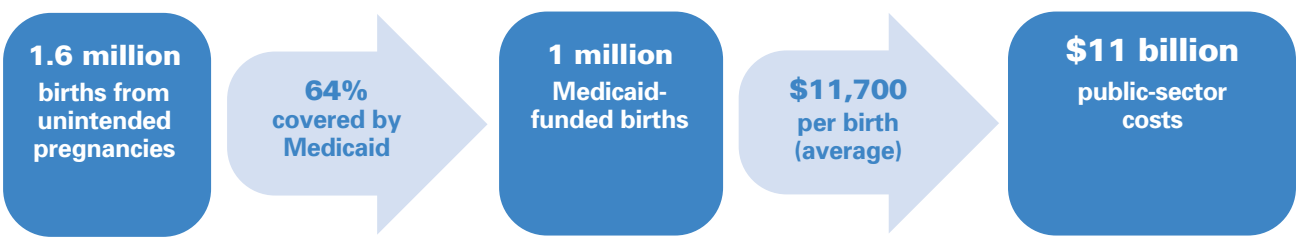
The typical American woman wants to have two children.[11] To meet this life goal, a woman will be pregnant, postpartum or attempting to become pregnant for only about five years of her life, but will need to spend three decades trying to avoid pregnancy.[12] Contraception is almost universally accepted as a way to reduce the risk of unintended pregnancy: More than 99% of U.S. women aged 15–44 who have ever had sex with a man have used contraceptives at some point in their lives.[13]

Contraceptive use reduces the risk of unintended pregnancy significantly, and consistent contraceptive use virtually eliminates it.[14] In fact, the two-thirds of U.S. women at risk of unintended pregnancy who use contraceptives consistently and correctly throughout the course of any given year account for only 5% of all unintended pregnancies. The smaller group of women who use contraception but who do so inconsistently account for 44% of unintended pregnancies, while the still smaller group who do not use contraception at all for a month or more during the year account for just over half (see chart, page 8).

Publicly funded family planning services bring the possibility of effective contraceptive use to

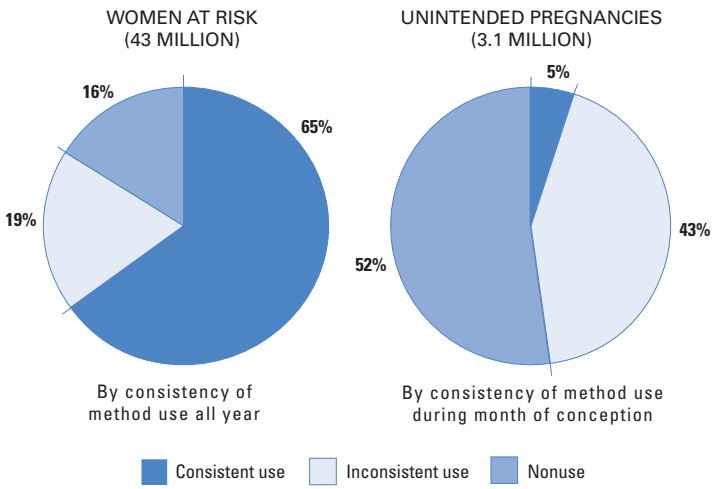
COSTS OF UNINTENDED PREGNANCY

Aside from the costs to women and families, taxpayers pay a steep price for unintended pregnancy.



CONTRACEPTION WORKS

The two-thirds of U.S. women at risk of unintended pregnancy who practice contraception consistently and correctly account for only 5% of unintended pregnancies.



Note: Nonuse includes women not using a method all year (6%) and those with an at-risk gap in use of at least one month (10%). *Source:* Reference 14.

more than nine million young and low-income women each year, enabling them to avoid almost two million unintended pregnancies.[14] Without these services, the number of unintended pregnancies occurring in the United States each year would be nearly two-thirds higher among women overall and among teens than it currently is; the number of unintended pregnancies among poor women would nearly double.

In addition to the evidence of the benefits of reducing unintended pregnancy in general, 15 years of experience with expanded access to family planning services under Medicaid has shown specific benefits for low-income women and their families. According to evaluations of state programs, access to these services reduces the likelihood of short interbirth intervals, which raise the risk of poor birth outcomes. In Arkansas, repeat births within 12 months dropped 84% between 2001 and 2005 for women enrolled in the family planning expansion, and the proportion having a repeat delivery within 48 months fell by 31%.[15] And in Texas, 18% of expansion participants had a repeat birth within 24 months, compared with 29% of Medicaid-eligible women who did not participate in the program.[16]

Nine in 10 women who would have become pregnant in the absence of publicly subsidized family planning would be eligible for a Medicaid-covered birth if they were to become pregnant. Accordingly, family planning services subsidized through Medicaid, Title X and other federal and state funding streams are not only effective, they are highly cost-effective: Every dollar spent to provide these services not only helps women achieve their own childbearing goals, it also saves taxpayers almost $4 in Medicaid costs.[17] In the absence of the publicly funded family planning services already being provided, the already steep cost of unintended pregnancy would balloon by about 60%, to $18 billion a year.[10]

Safety Net Impact

Somewhat astonishingly, given this track record, family planning programs are under unprecedented attack. Some of these attacks appear purely ideological. For example, the House of Representatives earlier this year moved to strike all funding for Title X for the remainder of the current fiscal year (related article Spring 2011, page 20). Although the Senate blocked that move, funds for the program were eventually cut by $17 million. Such cuts were disproportionately higher than those made to other programs, ultimately leaving Title X at 64% below what the program had been funded at in 1980, when inflation is taken into account.[18] Similarly, in three states, cuts to state family planning funds were clearly disproportionate to the cuts taken by other health programs this year: Montana completely eliminated the family planning line item, and New Hampshire and Texas cut funding by 57% and 66% respectively.[19]

Moreover, both in Congress and in the states, opponents of family planning are taking aim at the network of family planning providers. The funding bill approved initially by the House would have denied federal funding to Planned Parenthood affiliates, a move that ultimately was also blocked. Nonetheless, opponents of family planning have tried to emulate this approach on the state level, with efforts (some of which currently are being litigated) in five states—Indiana, Kansas, North Carolina, Texas and Wisconsin—to either limit or deny funding to Planned

UNINTENDED PREGNANCY BY STATE

	Unintended pregnancies			Births resulting from unintended pregnancies				% increase in the absence of clinic services
	Number	Rate per 1,000 women 15–44	As % of all pregnancies	% publicly funded	Number publicly funded	Total public costs (in millions of dollars)	State-level public costs (in millions of dollars)	
Alabama	48,000	51	55	66	20,200	175	53	36
Alaska	8,000	55	53	64	3,100	68	29	96
Arizona	74,000	59	51	67	29,200	289	95	36
Arkansas	31,000	54	56	74	15,300	169	44	77
California	513,000	66	56	62	150,600	1,346	673	52
Colorado	48,000	48	48	60	16,700	161	80	59
Connecticut	37,000	53	51	47	6,400	84	42	47
Delaware	12,000	66	60	68	3,800	47	24	42
District of Columbia	10,000	67	59	75	1,900	23	7	43
Florida	223,000	64	59	63	69,000	642	264	32
Georgia	122,000	60	57	71	53,000	696	274	32
Hawaii	17,000	66	59	42	3,700	39	16	18
Idaho	13,000	43	41	56	4,600	67	20	70
Illinois	143,000	53	53	68	51,400	512	256	32
Indiana	58,000	45	48	61	22,700	252	93	50
Iowa	24,000	42	44	57	8,300	120	44	82
Kansas	27,000	49	48	55	9,400	94	37	38
Kentucky	35,000	40	45	78	18,600	248	76	79
Louisiana	49,000	55	58	81	27,900	406	123	28
Maine	10,000	37	50	66	3,600	31	12	83
Maryland	75,000	63	56	47	14,500	188	94	28
Massachusetts	59,000	43	47	59	14,200	182	91	52
Michigan	105,000	51	53	62	32,000	282	122	45
Minnesota	46,000	44	44	59	15,600	143	72	46
Mississippi	42,000	69	65	81	22,200	136	33	41
Missouri	61,000	51	53	65	24,500	262	100	39
Montana	9,000	48	53	53	2,900	33	10	82
Nebraska	16,000	44	46	65	6,900	92	37	52
Nevada	33,000	66	52	60	9,000	83	38	28
New Hampshire	9,000	36	43	46	2,300	27	14	77
New Jersey	112,000	63	55	50	20,100	283	142	27
New Mexico	24,000	59	56	65	8,900	91	26	82
New York	266,000	65	56	65	56,000	749	375	35
North Carolina	106,000	58	56	74	45,100	580	212	34
North Dakota	5,000	37	45	46	1,400	21	7	84
Ohio	118,000	51	54	62	43,300	479	192	34
Oklahoma	39,000	55	53	70	18,400	173	56	54
Oregon	35,000	47	49	61	11,300	72	28	87
Pennsylvania	121,000	49	55	51	33,600	321	144	50
Rhode Island	10,000	45	50	59	2,700	31	14	43
South Carolina	52,000	58	58	78	24,200	254	78	46
South Dakota	7,000	48	47	54	2,800	36	13	83
Tennessee	70,000	55	58	68	29,500	344	124	28
Texas	309,000	62	53	74	132,500	1,289	507	32
Utah	26,000	45	38	50	9,100	95	28	38
Vermont	5,000	38	50	67	1,600	22	9	116
Virginia	85,000	53	52	45	19,500	286	143	25
Washington	64,000	48	49	65	20,800	254	127	77
West Virginia	14,000	39	50	72	6,500	71	19	79
Wisconsin	45,000	40	45	52	14,300	157	67	55
Wyoming	5,000	54	45	60	2,000	40	18	78

Notes: All data are for 2006. Percentage increase in the absence of services provided at publicly funded family planning centers is calculated by dividing the number of unintended pregnancies averted (reference 14) by the total number of unintended pregnancies in the state (reference 9). *Sources:* Columns 1–3, reference 9. Columns 4–7, reference 10.

Parenthood affiliates specifically or specialized family planning providers more generally.[19]

Other moves seem driven less by an antipathy to family planning than by the sobering budget realities that continue to plague governments at all levels. For example, although legislatures in half of the 18 states with specific line items in their budgets for the year beginning in July cut family planning funding, most of those cuts were

proportional to cuts to other health programs.[19] During the fiscal year that ended in June, 43 states had taken steps to try to reduce Medicaid costs, most often by cutting provider reimbursement, lowering drug costs or reducing benefits; nearly all governors have proposed additional cuts for the fiscal year just beginning.[20] At the federal level, proposals abound to rein in Medicaid costs as well, moves that could have a profound impact on a program that has become the preeminent reproductive health program for low-income women, including the largest source of public funding for family planning services (related article, page 11).

Regardless of their motivation, moves that would cut family planning services are short-sighted, at best. If anything, difficult economic times such as these are precisely the most opportune moment to "double down" and support programs and services that enable low-income women to avoid pregnancies they do not want to have. Family planning services enable individuals to achieve fundamental childbearing goals, as well as economic security for themselves and their families. At the same time, reducing unintended pregnancy can save Medicaid costs that could be used to shore up the beleaguered Medicaid program. Medicaid is the bedrock of our national health care safety net, and a program through which low-income women receive the reproductive services they need to help prevent unintended pregnancies and obtain the health care they need during the pregnancies they do want. Ensuring that the program can continue this vital role going forward is essential for the well-being of low-income American women and their families.

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