The Impact of Contraceptive Subsidies for Individuals in the United States

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Sector(s): Health

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Sample: 1,597 Planned Parenthood of Michigan patients

Target group: Mothers and pregnant women Women and girls

Outcome of interest: Sexual and reproductive health Women's/girls' decision-making

Intervention type: Health care delivery

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Research Papers: How Costs Limit Contraceptive Use among Low-Income Women in the U.S.: A Randomi...

Partner organization(s): Arnold Ventures, Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), Planned Parenthood of Michigan

Low-income and uninsured individuals in the United States continue to face high out-of-pocket costs for accessing contraceptives. In this randomized evaluation, researchers partnered with Planned Parenthood of Michigan to give vouchers for contraception to evaluate the impact of contraceptive costs on method choice. Those who received the vouchers were more likely to buy contraceptives and buy more expensive methods than those who did not receive vouchers. They also chose longer-lasting and more effective methods. The effects were more pronounced for the group who received larger vouchers. The results indicate that individuals' decision-making about contraceptives is highly cost sensitive which limits individuals from purchasing their desired methods and may lead to undesired pregnancies.

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Access to contraceptives has become even more important in the wake of the *Dobbs vs. Jackson* decision in 2022.[1] Out-of-pocket costs may impede many low-income and uninsured individuals from using their preferred method. Not being able to access

contraceptives can lead to undesired pregnancies—a figure topping 46 percent in 2015 to 2019 for the whole United States.[2] Undesired pregnancies can decrease workforce participation and employment opportunities,[3] and also worsen maternal and newborn health outcomes.[4], [5] However, some researchers argue that the use of contraceptives is not dependent on its price, but rather on a person's preferences.

Is it possible for public policy to reduce barriers associated with choosing a contraceptive method and, more broadly, help reduce the rate of undesired pregnancies? Researchers evaluated how greater financial access to contraception affects choice of contraceptive method, future unintended pregnancy, and childbearing.

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Title X, a national family planning program, has provided low-income individuals with subsidized access to contraceptives and reproductive health care since 1970. In 2018, Title X providers served over 4 million individuals in the United States, 40 percent of whom did not have health insurance to cover contraception. Although the Affordable Care Act (ACA) eliminated cost-sharing for contraceptives for individuals with health insurance, those who were uninsured did not receive this expanded coverage. Title X's cost-sharing policies were not affected by the ACA's policy change, so uninsured individuals still face high out-of-pocket costs to access contraception.

Until 2019, Planned Parenthood of Michigan (PPMI) served as Michigan's largest Title X provider. PPMI provided free contraceptives to those below the poverty line. Those above it had an out-of-pocket cost based on a sliding scale related to their income. PPMI offers all FDA-approved contraceptive methods, including more affordable, but shorter-lasting injections of Depo-Provera or birth control pills, to the more expensive and longer-lasting IUDs and implants (long-acting reversible contraceptives or LARCs).



A woman talks to her doctor in the United States.

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To evaluate the impact that contraceptive price has on decision-making, researchers conducted a randomized evaluation where eligible individuals were randomly assigned to receive vouchers. These vouchers could be used for *any* type of contraceptive and would be valid for 100 days. To be eligible, participants had to meet four criteria: 1) be between 18-35 years old; 2) not desire to become pregnant and be able to become pregnant; 3) have out-of-pocket costs for contraceptives; and 4) be visiting PPMI to see a health care professional, regardless of the purpose of the visit.

While patients waited for their appointments at PPMI, they had the option to take a screening survey to see if they were eligible for the study. If they were eligible and consented to participate in the study, they were randomly assigned into one of three groups:

1. **50 percent voucher group (321 participants)**: This group received vouchers between August 2018 and March 2019 that covered 50 percent of their out-of-pocket cost for a name-brand LARC.
2. **100 percent voucher group (496 participants)**: This group received vouchers between March 2019 and November 2019 that covered 100 percent of their out-of-pocket cost for a name-brand LARC.
3. **Comparison group (total of 780 participants, with 318 participants in the 50 percent comparison group, and 462 participants in the 100 percent comparison group)**: This group would not receive a voucher.

All study participants, no matter their group, also received an information sheet that described the different types of contraceptives and method efficacy and the different types of contraceptives at PPMI.

In order to measure short and long-term impacts, researchers used billing records from Planned Parenthood of Michigan to measure outcomes within 100 days of recruitment and up to two years post-recruitment.

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In both the short and long term, those who received the vouchers bought contraceptives at a higher rate, chose more expensive and longer-lasting methods, and also chose LARCs more than those who did not receive the vouchers. The individuals who received the 100 percent vouchers also chose more expensive contraceptives, longer-lasting methods, and LARCs more than those who received 50 percent vouchers.

After 100 days, the researchers found that cost can be a major component for decision-making to buy contraceptives. Participants in the 50 percent voucher group on average bought any type of birth control 18 percentage points more than the comparison group average of 52 percent (a 35 percent increase). In the 100 percent voucher group, there was a 19 percentage point increase from the comparison group average of 48 percent (a 40 percent increase).

The method chosen was also affected by the vouchers. People in the 50 percent voucher group, on average, chose methods that were $181 more than the comparison group average of $300 (a 60 percent increase). In the 100 percent voucher group, they spent $270 more than the comparison group average of $287 (a 94 percent increase).

Similarly, the temporal coverage—the time period a person is covered by their chosen contraceptive—was also affected by the vouchers. Those in the 50 percent group chose methods that lasted 186 days more than the comparison group average of 184 days (a 101 percent increase). In the 100 percent group, participants chose methods that on average covered them for 328 more days than the 145 days the comparison group were covered for (a 226 percent increase).

Researchers were also interested in seeing how cost affected the purchase of LARCs. For the 50 percent voucher group, there was a 5 percentage point increase in choosing a LARC from the 7 percent baseline (a 71 percent increase). The 100 percent voucher group purchased LARCs 14 percentage points more than the 4 percent baseline (a 350 percent increase).

PPMI billing records measuring contraceptive outcomes up to two years after enrollment showed there was a slight decrease in the measured outcomes, indicating that the voucher did speed up contraceptive purchases, but the effects experienced by both voucher groups were still present.

The results indicated that low-income and uninsured individuals' decision-making when purchasing contraceptives was highly sensitive to out-of-pocket costs. Making contraceptives more affordable to low-income and uninsured individuals can allow them to have higher take-up of contraceptives and to choose their preferred method which may ultimately reduce undesired pregnancies.

With these findings, the researchers estimated that making all contraceptives free through Title X would reduce pregnancies by 5.3 percent, birth rates by 3.9 percent, and abortions by 8.3 percent. Higher costs associated with this expanded contraceptive coverage would be offset by decreases in federal health care spending through Medicaid, resulting in net savings of $1.43 billion just in the first year of this policy's enactment.

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