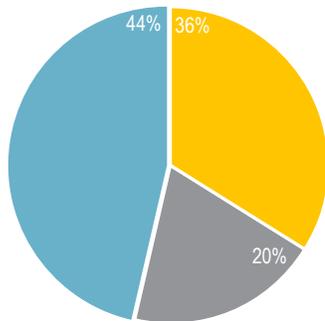


# PREVENTING UNINTENDED PREGNANCY IN MISSISSIPPI

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■ Mistimed ■ Intended ■ Unwanted  
Source: PRAMS. CDC (2009-2011).

Importantly, “unintended” does not always mean “unwanted” and refers to a mistimed pregnancy, as well as a pregnancy that was never intended. For the purposes of this brief, unintended refers to unwanted pregnancies and those that were wanted at a later time than they occurred. Pregnancies that were wanted sooner than they occurred are not included in the discussion or analysis presented here.

**Income:**  
Women relying on public insurance are 1.5 times as likely to report an unintended pregnancy as privately insured women, and almost 2 times as likely to report not wanting an unintended pregnancy.

**Race:**  
Black women report higher levels of unintended pregnancy than white women (72% v. 46%).

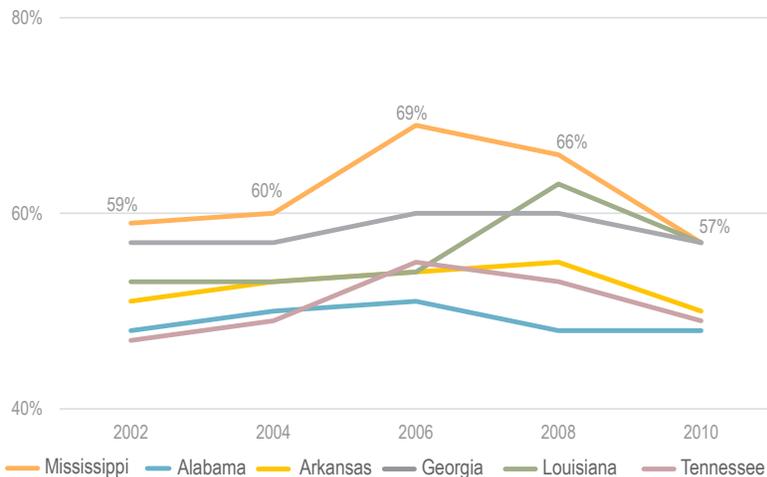
**Age:**  
75 percent of births to women under 20 are unintended.

Source: PRAMS. CDC (2009-2011).

Although it has been almost 60 years since the advent of the oral birth control pill and the development of a variety of forms of contraception, more than half of pregnancies among Mississippi women are unintended. Unintended pregnancy is associated with women prematurely leaving education and employment, as well as pre-term births and low birthweight babies, all of which create financial burdens for families and taxpayers.

Since 2008, the number of unintended pregnancies has declined significantly across the nation for all demographic groups. Nonetheless, Mississippi women experience higher percentages of unintended and unwanted pregnancies than women in other Southeastern states and nationally, with minorities and low-income populations at greatest risk (Figure 1). Teen pregnancy rates, long a concern in Mississippi, are also on the decline, but remain among the highest in the country at 39 births per 1,000 women 15-19 years compared to 22 per 1,000 nationally.

FIGURE 1. TRENDS IN UNINTENDED PREGNANCY IN MISSISSIPPI AND OTHER SOUTHEASTERN STATES (2002-2010)



Source: Guttmacher Institute. (2015).  
Note: Datapoints reflect all pregnancy categories, including pregnancies that were desired sooner than they occurred.

## Effective contraceptive methods reduce unintended pregnancies

Providing timely access to highly effective contraception for sexually active women who are not trying to get pregnant can lower rates of unintended pregnancy. Several states, including Iowa and Missouri, implemented policies and programs directed toward this goal and have seen decreased rates of teen births, abortions, and pre-term births. The Colorado Family Planning Initiative greatly increased the number of women using highly effective, long-acting reversible contraception (LARCs) in that state. That increase has been linked to a 35 percent decrease in abortion rates, a 40 percent decrease in babies born to teenage mothers, and a 12 percent decline in pre-term births that occurred between 2009 and 2014.

### RELATIVE COST OF LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS)

While LARCs have higher upfront costs than other birth control methods, these devices are highly cost effective and often cheaper over the lifetime of the device (3-12 years).

A typical prescription for oral birth control (the Pill) costs \$10-\$50 a month. The five-year Mirena IUD costs \$1,100 on average, while the most effective method, the implant, costs \$800 on average for four years of contraception.

Annual Cost:

The Pill @ \$25/month = \$300

Mirena IUD @ \$1,100/5 years = \$220

Nexplanon Implant @ \$800/4 years = \$200

Mississippians are not as likely to use the most effective forms of contraception. Statewide utilization of the most effective reversible birth control methods in publicly-funded clinics is less than half the national rate (seven percent compared to 18 percent). Public health surveys conducted among new Mississippi mothers in 2009 through 2011 suggest an inconsistent use of birth control and the use of less effective methods. Forty-five percent of respondents not actively seeking pregnancy reported using contraception, but still becoming pregnant. More than half of new mothers under age 18 reported that they became pregnant despite actively avoiding pregnancy and using contraception.

LARCs (e.g. IUDs and implants) are highly effective methods (see sidebar) that require minimal on-going effort by the user. Usage of LARCS among Mississippi women has been low relative to other states but is growing among both publicly (Medicaid) and privately covered family planning users. LARC usage among women enrolled in the Mississippi Medicaid Family Planning Waiver program has increased by more than 400 percent since 2012, a utilization level that may have contributed to a 36 percent reduction in repeat births among teenage mothers and increased birth spacing intervals (a factor in healthy deliveries).

## Health Insurance Coverage

### MEDICAID FAMILY PLANNING WAIVER

Low-income, uninsured Mississippians are eligible to receive family planning services through a Medicaid program that is 90 percent federally funded.

Source: Mississippi Division of Medicaid. (2018).

All of the most effective methods of contraception, as well as several moderately effective methods, require treatment or prescription from a healthcare provider and are initially more costly but can be cost effective over time (see sidebar). Reduced out-of-pocket costs (such as through insurance coverage) have been linked to an increase in patients opting for prescription contraception, including the most effective, long-term methods.

### CONTRACEPTIVE METHODS BY EFFECTIVENESS\*

#### Most Effective Permanent Methods:

Vasectomy (0.15%)  
Female Sterilization (0.5%);

#### Most Effective Reversible Methods:

also called Long-Acting Reversible Contraceptives (LARCs).

Implants (0.05%);  
IUD (0.2-.0.8%)

#### Moderately Effective Methods:

Injectable Contraception (6%);  
Vaginal Ring (9%);  
Contraceptive Patch (9%);  
Oral Pill (9%),  
Diaphragm (12%)

#### Less Effective Methods:

Male Condoms (18%);  
Female Condoms (21%);  
Sponge (12-24%);  
Withdrawal (22%);  
Fertility-based Awareness (24%);  
Spermicide (28%)

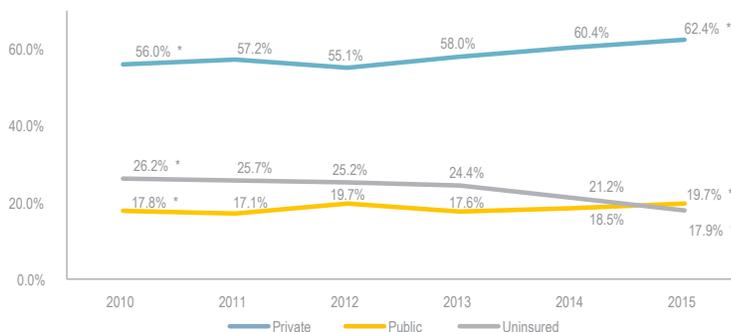
Note: Percentages indicate the number of pregnancies that result among 100 women users within the first year of typical use.

Source: Centers for Disease Control and Prevention. (2011).

Requiring private insurers to cover prescription contraception with no cost-sharing (prescription coverage mandate) is a strategy for improving access to birth control. A study of 11 states with prescription coverage mandates in place before the Affordable Care Act of 2010 required all states to do so determined that the likelihood of unintended pregnancy decreased by approximately five percent overall. A similar reduction in Mississippi's unintended pregnancy rate in 2010 would have averted approximately 1,700 unintended pregnancies.

Key policy developments have been associated with an increase in insurance enrollment for women of child-bearing age in Mississippi (Figure 2). These developments include the federally mandated coverage of contraception without cost-sharing, allowing adults under age 26 to remain on parents' insurance plans, and revisions in the Medicaid income eligibility.

FIGURE 2. HEALTH INSURANCE COVERAGE RATES FOR WOMEN 15-44 IN MISSISSIPPI, 2010-2015.



Source: American Community Survey. (2010-2015). United States Census Bureau. Note: Statistically Significant Difference (\*p<.01).

## Public programs are a safety net for low income and uninsured women

### TITLE X FAMILY PLANNING PROGRAM

Title X of the Public Health Service Act provides federal funding for family planning and reproductive health services for low income and uninsured men and women ages 13-44.

125 sites across Mississippi including public health departments and some Federally Qualified Health Centers (FQHCs) currently provide Title X funded services.

Source: US Department of Health and Human Services. (2017).

### NEED FOR CONTRACEPTION AMONG MISSISSIPPI WOMEN 13-44, 2014

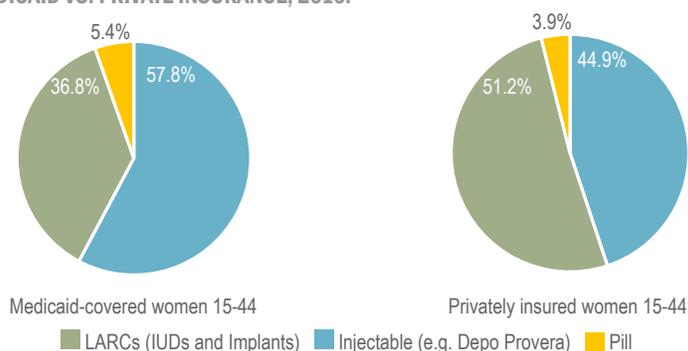
Need Contraception	337,800
Need Publicly Supported Contraception	213,930
Uninsured and in Need of Publicly Supported Contraception	55,180

Source: Guttmacher Institute Data Center. (2014).

Since 2012, the total number of family planning users at Mississippi's Title X facilities has dropped by 42 percent, possibly due to expanded access to private insurance. However, publicly funded family planning and contraception continue to be important for Mississippi women from low income households. As of 2014, approximately 214,000 women were estimated to have been in need; one-third of those women were also uninsured. Without publicly supported family planning, it is estimated that the rate of unintended pregnancy in Mississippi could be higher by as much as 41 percent.

Importantly, women in Mississippi's publicly funded clinics are less likely to use the most effective methods of birth control. Since 2010, the most frequently used methods in Mississippi's Title X clinics have been the pill, the male condom, Depo Provera injections, and the patch, all considered to be less or moderately effective methods. This disparity can also be observed in the private setting (Figure 3). In 2016, women covered by Medicaid who sought services in physician offices were more likely to use moderately effective methods over the most effective reversible methods (LARCs) and less likely to use LARCs than privately insured women.

FIGURE 3. DISTRIBUTION OF USERS OF THREE COMMON METHODS PRESCRIBED IN PRIVATE PHYSICIANS' OFFICES, MEDICAID VS. PRIVATE INSURANCE, 2016.



Source: Amino. All-payor healthcare claim database. (2017). Sample: 26,912 Mississippi women 15-44 with medical claims for contraceptive management services in 2016.

## Payment and service provision barriers limit effective contraceptive use

Providing contraception on the same day a woman first requests it has been a key strategy in the reduction of unintended pregnancy rates in Colorado and Missouri. The experience of these and other states has shown that clear reimbursement policies across third party payors as well as streamlined provider workflow are important to support timely access to the most effective family planning methods. For LARCs in particular, the expense of maintaining those devices in inventory and confusion over insurance billing policies and procedures can deter physicians from providing same-day services.

Providers' knowledge and attitudes about various birth control methods may limit the methods they are willing to prescribe and may even impact patient choice and awareness of available methods. The American College of Obstetricians and Gynecologists (ACOG) recommends that obstetrician-gynecologists include contraceptive counseling in every visit with adolescents and that they discuss LARCs for all women at risk of pregnancy. However, a lack of training on LARC insertion has been cited by providers as an additional barrier to recommending these highly effective methods.



In 2010, \$13 million spent on family planning services in Mississippi's public health centers is estimated to have saved 8 times as much by averting unintentional pregnancies (based on the costs for Medicaid to provide prenatal care, delivery, post-partum care and infant care for one year).

Source: Guttmacher Institute Data Center. (2014).

## Policy Considerations

Because Mississippi has a substantial population of low-income women who are sexually active and avoiding pregnancy, the Medicaid Family Planning Waiver plays an important role in supporting intentional family planning. This population is less likely to have private coverage and must rely on public family planning services. In 2017, Mississippi Medicaid, which has had success increasing use of effective contraception for participants, received a ten-year extension of the Family Planning Waiver Program that provides services to low income women avoiding pregnancy. Ensuring timely access to effective forms of contraception for women relying on publicly funded family planning is key to achieving higher rates of intended and well-timed pregnancies.

In light of possible changes to the federally mandated contraception coverage, several states have taken steps to preserve broadened access to family planning services for women in their states. Maine, Hawaii, Maryland, Illinois, Oregon, and Vermont have enacted legislation requiring insurance companies to cover contraception at no cost-sharing for patients.

## Summary

Despite the wide availability of a broad range of birth control methods, the majority of new mothers in Mississippi report that their most recent pregnancy was unintended, which can be costly for families as well as taxpayers. Using methods of highly effective birth control reduces unintended pregnancy, but use of these more effective methods has been low in Mississippi, particularly for low-income populations. Other states have successfully reduced the rates of unintended pregnancy by providing timely access to highly effective birth control methods through health system delivery improvements and provider and patient education. Federal policy changes have resulted in more health insurance coverage for women of child-bearing age and a shift from publicly supported family planning services to increased privately insured services.

Mandating private insurance to include contraception with no cost-sharing may have significantly shifted coverage of family planning from public providers to the private setting. However, as long as more than half of Mississippi women who need contraception rely on public support to obtain family planning services, safety-net and public providers will remain important. Additional work is needed to ensure that women in Mississippi have access to more effective birth control methods in both the public and private sectors. Mississippi can learn from other states who have succeeded in reaching this goal and achieve similar declines in preterm births, abortions, and teenage pregnancies.

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