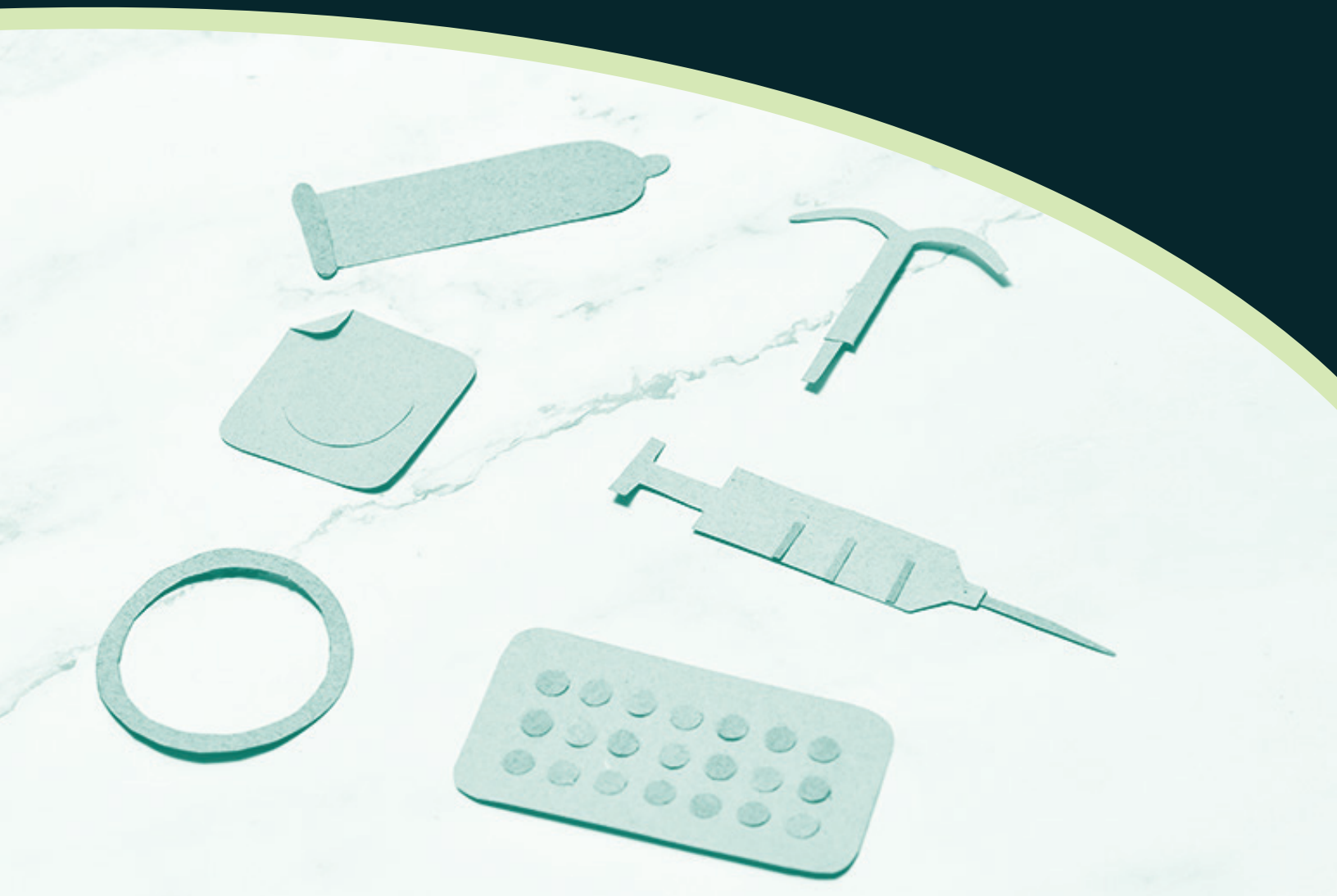
THE HAMILTON PROJECT

Increasing Financial Access to Contraception for Low-Income Americans

Martha J. Bailey



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MISSION STATEMENT

The Hamilton Project seeks to advance America's promise of opportunity, prosperity, and growth.

We believe that today's increasingly competitive global economy demands public policy ideas commensurate with the challenges of the 21st Century. The Project's economic strategy reflects a judgment that long-term prosperity is best achieved by fostering economic growth and broad participation in that growth, by enhancing individual economic security, and by embracing a role for effective government in making needed public investments.

Our strategy calls for combining public investment, a secure social safety net, and fiscal discipline. In that framework, the Project puts forward innovative proposals from leading economic thinkers—based on credible evidence and experience, not ideology or doctrine—to introduce new and effective policy options into the national debate.

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Abstract

Access to contraception is fundamental to reproductive autonomy and economic mobility for parents and their children. Today in the U.S., the cost of contraception severely limits access for those without health insurance. Although the Affordable Care Act eliminated cost-sharing for contraception for those with health insurance, substantial cost-sharing remains for uninsured individuals who seek care through Title X—a national family planning program that offers patient-centered, subsidized contraception and reproductive health services to low-income individuals. I propose two changes to Title X to increase the affordability of contraception for uninsured Americans: (1) make contraceptives free for low-income clients through a change to the guidelines issued by the Office of Population Affairs and Health and Human Services and (2) increase congressional appropriations for the Title X program to fund this change in guidelines. Similar to the Affordable Care Act's elimination of cost-sharing for contraception for Americans with health insurance, this proposal eliminates cost-sharing requirements for contraception for uninsured, low-income Americans through the Title X program. This policy proposal is supported by highly relevant evidence from a randomized control trial conducted at Title X providers. Eliminating cost-sharing for contraception through Title X would increase use of preferred contraceptive methods; reduce pregnancies that are mistimed or not desired, including those ending in abortion; and generate substantial enough savings in other government spending that the program would more than pay for itself.

Contents

Introduction

Inequities in access to contraception and reproductive health care have been well documented in the United States. In 2015, around 40% of pregnancies in the U.S. occurred either sooner than desired or when no pregnancy was desired at any point in the future. Mistimed or undesired pregnancies are significantly more common among low-income women as well as young and minority women (Kost, Zolna, and Murro 2023).[1] About two in five of these mistimed or undesired pregnancies end in abortion (Ibid). This means that the U.S. Supreme Court's 2022 decision, *Dobbs v. Jackson Women's Health Organization*, which has allowed states to restrict abortion access, is expected to send the number of mistimed or undesired pregnancies resulting in childbirth in the U.S. to levels not seen in decades.

Considerable research documents the relationship between mistimed and undesired pregnancies and adverse outcomes for mothers and their babies, including low infant birth weight, premature birth, and maternal morbidity and mortality (Gemmill and Lindberg 2013; Sonfield, Hasstedt, and Gold 2014). In addition to their direct consequences, mistimed and undesired pregnancies have indirect effects on all Americans because the prenatal and delivery costs for around two-thirds of births resulting from these pregnancies are funded by public dollars (Sonfield, Hasstedt, and Gold 2014). In addition to minimizing negative consequences, increasing access to contraception could have benefits as well. Studies of earlier periods show that increasing access to contraception can facilitate women's education and career advancement and improve the living circumstances and opportunities of children (Goldin and Katz 2002; Bailey 2006; Hock 2008; Bailey, Hershbein, and Miller 2012; Bailey, Malkova, and McLaren 2018).

Currently, the Affordable Care Act (ACA) mandates that health insurance cover contraception with no cost-sharing. Cost-sharing under the Title X program, however, is unaffected by the ACA. For uninsured women, the Title X program subsidizes contraceptives and reproductive health care but still requires substantial cost-sharing. In 2018, around 1.6 million Title X clients (or 40% of all Title X clients) were uninsured and faced substantial out-of-pocket costs for contraceptives after applying the Title X discounts. Importantly, no market mechanism or public program allows individuals wishing to delay or avoid pregnancy to finance these costs; these costs are paid upfront. Prohibitively high costs for contraception present difficult choices for many low-income Americans: pay for housing and groceries this month and chance unplanned pregnancy or use a preferred method of contraception. Given these choices, it is not surprising that too few low-income, uninsured individuals use their preferred contraceptive methods.

I propose two changes to Title X, which together eliminate cost-sharing for low-income, uninsured women: (1) make contraceptives free for low-income women through a change to the guidelines issued by the Office of Population Affairs (OPA) and Health and Human Services and (2) increase congressional appropriations for the Title X program to fund this change in guidelines. These changes would help equalize financial access to contraception for all women by extending the ACA's zero cost-sharing for contraception to the Title X program. This proposal also provides a benchmark for increasing equity in contraceptive access and reproductive health care through other federal programs, such as the Veteran's Administration, which also requires cost-sharing for contraception (Judge-Golden et al. 2019).

This policy proposal is supported by direct evidence from a randomized control trial (RCT) that my collaborators and I ran from 2017 to 2023 (Bailey et al. 2023). Extrapolating from this gold-standard evidence, making contraception free to all low-income Title X clients nationally would increase women's ability to choose their preferred contraceptive method; reduce the incidence of unplanned pregnancy, childbirth, and abortion; and more than pay for itself. Evidence from other research suggests that such a policy would increase women's education levels, labor market experience, and wages while increasing resources and opportunities for American children. Making contraceptives free through the Title X program may also increase access to contraceptives among low-income women who are not yet Title X clients and among women who have health insurance with incomplete coverage of contraception, suggesting broader effects of the policy proposal.

The Challenge

The national share of pregnancies that are either mistimed or undesired fell from 46% in 2009 to 40% in 2015 (Kost, Zolna, and Murro 2023). However, the share of unintended pregnancies among more economically disadvantaged women remains significantly higher today than the national average (101 compared to 36 per 1,000 women of childbearing age) (Bailey and Bart 2023). Inconsistent use of contraception or not using contraception at all are the most important proximate causes of unintended pregnancy. Over 95% of unintended pregnancies are driven by the 32% of women who use contraceptives inconsistently or not at all (Frost et al. 2014). I begin by documenting the groups more likely to experience undesired pregnancies.

The Demography of Unintended Pregnancy, Childbirth, and Abortion

A standard metric adopted by the Centers for Disease Control and Prevention (CDC) defines "unintended pregnancies" as those that occurred sooner than desired or occurred when no child was desired at the time or at any point in the future. In recent years, research has moved away from using "intention" with regard to pregnancy toward language more closely aligned with the questions asked on survey questionnaires (Auerbach et al. 2023). Because this review summarizes research over a longer period and because consensus alternatives are still in development, this proposal uses the term "unintended pregnancies" to correspond to the language used in most published research.

Unintended pregnancies occur for many reasons. Some occur among women using contraception, because inconsistent or inappropriate contraceptive method use results in method failures. Around 40% of unintended pregnancies occur among women who are using contraception in the month they become pregnant (Sonfield, Hasstedt, and Gold 2014). In addition, unintended pregnancies occur because women do not have access to their preferred methods of contraception, because primary care providers are not trained in providing counseling around contraception (Harper et al. 2015), or because contraceptive methods are prohibitively expensive. The cost of contraceptives in the U.S. for women without health insurance can be very high. For example, an intrauterine device (IUD) could cost more than $1,200 for a woman without health insurance.

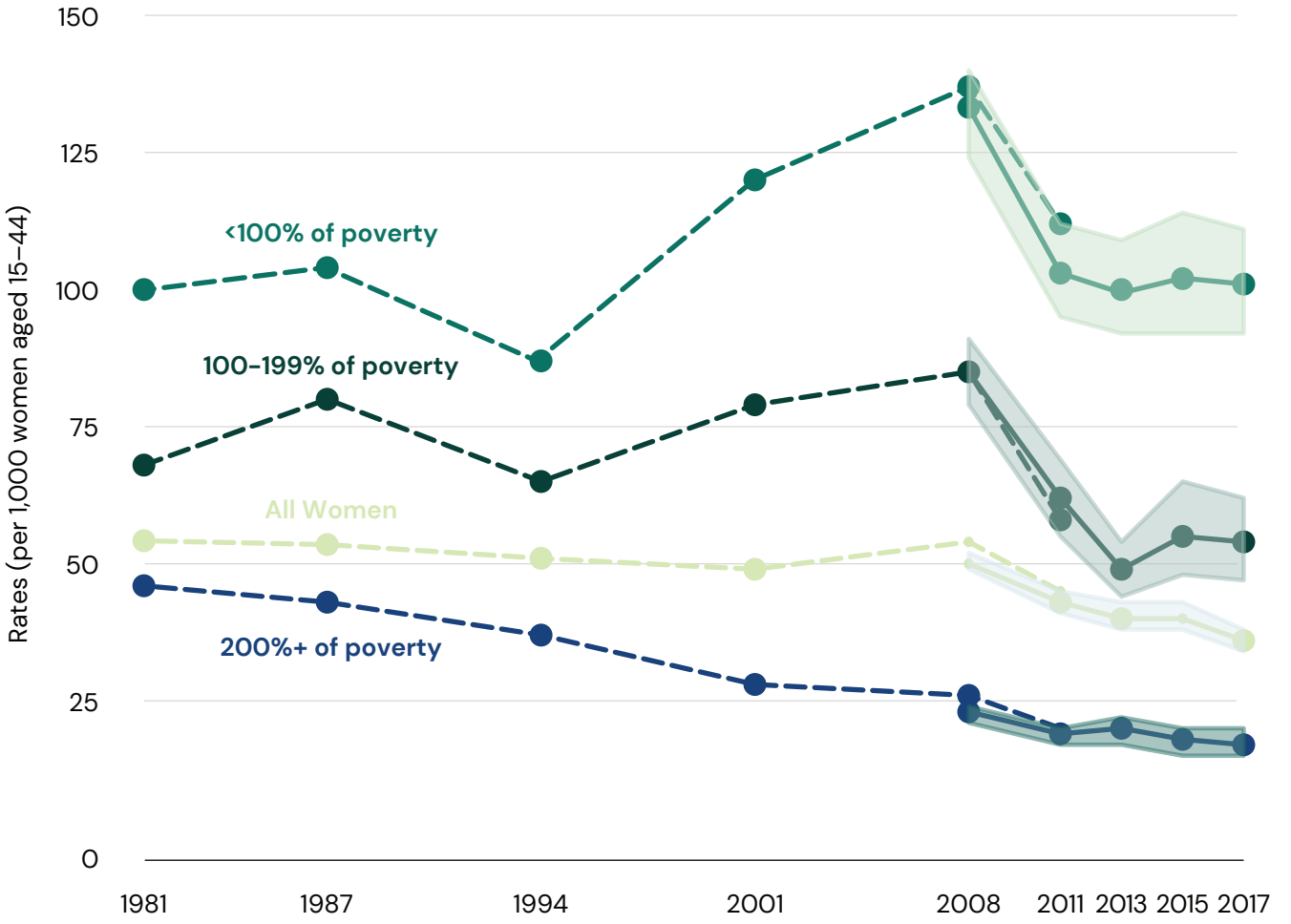
For these reasons, the rates of unintended pregnancies are not evenly spread across the population but exhibit striking racial, age, education, and income differences. The general patterns show that more economically or socially disadvantaged groups tend to have higher rates of unintended pregnancies. For example, Black non-Hispanic women were 66% more likely to have an unintended pregnancy than White non-Hispanic women, and teenagers were more than twice as likely than women older than 30 (Finer and Zolna 2016).

Unintended pregnancies are also disproportionately likely to occur to women with lower incomes. Figure 1 shows that rates among women below the federal poverty line (FPL) were five times higher than more affluent women with incomes at least two times the poverty line. From 1981 to 2008, the share of all women experiencing an unintended pregnancy remained roughly stable at 50 out of 1000 but then fell by roughly 25% through 2017. In contrast, the rates for women below 200% of the FPL rose on net through 2008. The rates fell sharply between 2008 and 2013 but were little changed between 2013 and 2017. As a result, in 2017, disparities in rates of unintended pregnancy by income remained roughly as large as in 2008.

Unintended pregnancies may result in childbirth or abortion, both of which occur unevenly in the population. Figure 2 shows the distribution of children born by education, race/ethnicity, marital status, and age group when the pregnancy was slightly mistimed (less than two years too soon), seriously mistimed (two or more years too soon), or not desired at any point in time. One in five children among women with bachelor's degrees or higher education resulted from unintended pregnancy, whereas the incidence was almost one in two among women with less than a high school education or GED and more than one in three among women with some college. Interestingly, the rate of childbirth resulting from slightly mistimed pregnancies was similar across all education groups (8–11%), but the differences were sharper for seriously mistimed and unwanted pregnancies. The rate of childbirth resulting from seriously mistimed or unwanted pregnancies

FIGURE 1

The Relationship of Poverty and Rates of Unintended Pregnancy, 1981–2017



Source: Henshaw 1998; Finer and Henshaw 2006; Finer and Zolna 2016; Bailey and Bart 2023.

Note: For 1981–1987, estimates are from Henshaw (all women) and Finer and Zolna (poverty). For 2001–11, all estimates are from Finer and Zolna. Estimates for 1994 are from Finer and Henshaw. Solid lines from 2008–2017 are from Bailey and Bart.

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was 4% among women with at least a bachelor's degree. However, the rates were almost five times higher among women with less than a high school education.

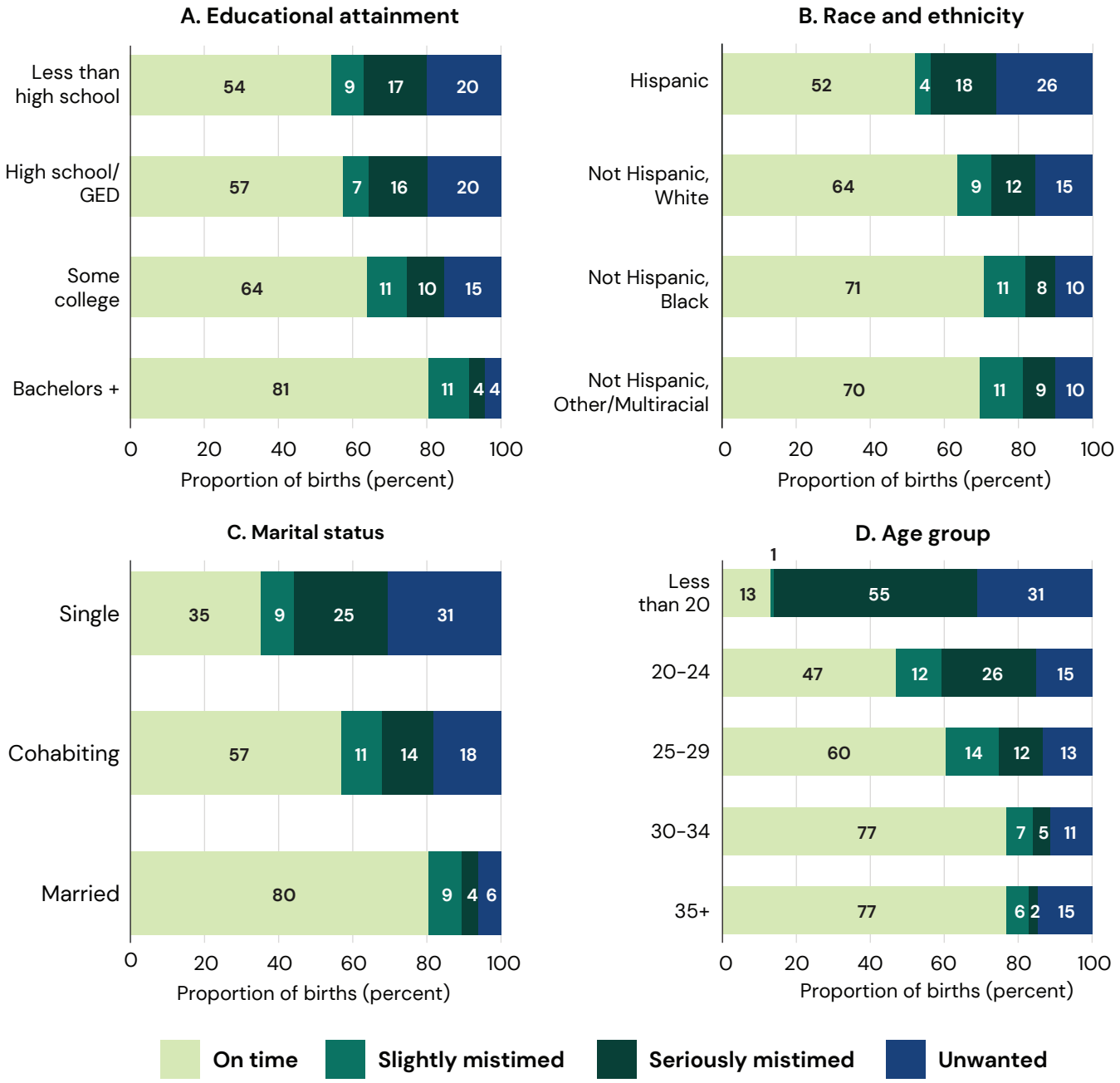
Racial disparities in unintended childbirth are also stark, as shown in figure 2: 30% of children born to White non-Hispanic women were from mistimed or unwanted pregnancies, whereas 37% and 48% of children born to Hispanic/Latina women and Black non-Hispanic women were from mistimed or unwanted pregnancies, respectively. These rates also differ by marital status at the time of childbirth and age group. Only 20% of married women's children result from unintended pregnancy versus 44% among cohabiting women and 66% among single, non-cohabiting women.

A large part of these gaps is due to differences in seriously mistimed and unwanted pregnancies. The share of children associated with seriously mistimed or unwanted pregnancies was 18% combined among White non-Hispanic women, but 28% and 44%, respectively, among Hispanic/Latina and Black non-Hispanic women. Similarly, younger women experienced significantly more childbirth associated with seriously mistimed or unwanted pregnancy. Although 86% of the childbearing among women under 20 was unintended, keep in mind that births to young women are a very small share of all births in the U.S.

Many unintended pregnancies end in abortion. In 2011, around 40% of unintended pregnancies ended in abortion (Finer and Zolna 2016). Since then, the 2022 U.S. Supreme Court's decision, *Dobbs v. Jackson Women's Health Organization*, has triggered preexisting state laws or allowed states to pass new laws severely restricting access to abortion. Today, 14 U.S. states severely restrict access to abortion (McCann et al. 2023). These bans are expected to have large effects on the incidence of unintended childbirth and the

FIGURE 2

Unintended Childbirth by Education, Race, Marital Status, and Age Group, 2014–2018



Source: Guzzo 2021; NSFG 2015-19.

Note: Panels A-C are the author's replication of Guzzo 2021. Panel D presents author's calculations extending Guzzo 2021 using the 2015-2019 NSFG.

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related health consequences for low-income mothers and children. This is because around 75% of abortions in the U.S. occur to women below 200% of the FPL and this group is also much more likely to have unintended pregnancies (Jerman, Jones, and Onda 2016).

The Benefits of Increasing Access to Contraception on Lives and Livelihoods

The theoretical connection between access to contraception and economic outcomes is straightforward. Undesired pregnancy disrupts women's educations and careers and reduces their incomes. In addition, women are more likely to make different investments in their careers or stay attached to a job if they know they can avoid undesired childbearing in the future.

This argument finds support in research based in the 1960s and 1970s, which examines how changes in state laws allowing younger women to access the birth control pill—and reduce undesired pregnancies—affected childbearing and careers. Studies find that access to the birth control pill affected marital and birth timing and had lasting effects on women's and men's career investments (Bailey, Hershbein, and Miller 2012; Guldi 2008). With earlier legal access to the birth control pill, women and men were more likely to enroll in and complete college (Hock 2008; Bailey, Hershbein, and Miller 2012), and women were more likely to work for pay, invest in on-the-job training, and pursue nontraditional professional occupations (Goldin and Katz 2002; Bailey 2006; Bailey, Hershbein, and Miller 2012)—investments that resulted in higher wages for women later in adulthood (Bailey, Hershbein, and Miller 2012). More recently, the Colorado Family Planning Initiative's 2009 policy change—which made long-acting, reversible contraceptives LARCS such as IUDs or implants) free for all Colorado women through Title X providers—increased women's high school graduation rates by 14% (Stevenson et al. 2020).

Increasing access to contraception may also alter partnership decisions. For instance, a reduction in unintended pregnancies reduces the cost of delaying marriage, improves marital matching, and reduces marital stress, thereby reducing the likelihood of subsequent divorce (Goldin and Katz 2002; Rotz 2016; Christensen 2011). Related both to the direct effects of improvements in parents' education and earnings capacity as well as the indirect effects on resources through partnership decisions, reductions in unintended pregnancies are strongly correlated with a rise in the financial resources available to the average child (Ananat and Hungerman 2012; Bailey, Malkova, and McLaren 2018).

A closely related literature shows that increasing access to abortion services, which reduces childbirth associated with mistimed or unwanted pregnancy, has large and persistent effects on health. Two studies based on data from the Turnaway Study compare women who received an abortion to women who were denied one based on the gestational age of the pregnancy. Using this design, research shows that women who were denied an abortion experienced potentially life-threatening complications related to the pregnancy, such as eclampsia and postpartum hemorrhage (Gerdts et al. 2016). These health effects persisted past the immediate postpartum period, with women who were denied wanted abortions experiencing worse self-reported health than those who received abortions (Ralph et al. 2019). Notably, of the 292 women who participated in the Turnaway Study and were denied abortions, two died of childbirth-related complications.

In addition, childbirth associated with mistimed or unwanted pregnancy may negatively affect economic and financial well-being. Women who were denied an abortion experienced large and persistent increases in financial problems such as unpaid bills and bankruptcies (Miller, Wherry, and Foster 2020). These results suggest that access to reproductive healthcare substantially impacts a woman's financial and economic well-being, as measured with credit report data.

Access to Contraception Affects Pregnancy and Childbirth

A growing literature shows that costs can matter a great deal for women's choice of contraception. One study, the St. Louis Contraceptive Choice Project (CHOICE) examines whether giving no-cost LARCs to study participants affects birth rates. Because CHOICE had no control group, its research design compares outcomes for women who enrolled in the study (who wanted to start a new contraceptive method) to similarly aged women in the greater St. Louis area. Perhaps unsurprisingly, the group of women in CHOICE (whose enrollment in the study was conditioned on wanting to start a new contraceptive method) were less likely to give birth than the broader population (Secura et al. 2010; Mestad et al. 2011; McNicholas et al. 2014; Birgisson et al. 2015; Broughton et al. 2016). However, this study's design makes it difficult to interpret these findings as reflecting costs alone (Bailey and Lindo 2018). Although RCTs could provide better evidence, such trials in the U.S. have been limited to adolescents and have not included the broader population of women facing high costs of contraception (Kirby 1997; DiCenso et al. 2002).

In the last 15 years, other studies have made progress in showing a causal relationship between access to subsidized contraception and childbearing using natural experiments. Analysis of the expansion in federally funded family planning programs in the early

years of Title X finds a reduction in U.S. birth rates by 1.4–2.1% overall and by 19–30% among the most disadvantaged women who took up Title X services (Bailey 2012). State-level expansions in Medicaid eligibility for family planning services in the 1990s and 2000s increased the use of contraception and reduced childbearing by 8.9% among newly eligible women (Kearney and Levine 2009). After LARCs became free for all Colorado women in 2009, the teen birth rate fell by 6.4% (Packham 2017; Lindo and Packham 2017). Most recently, the ACA's requirement that private health insurance cover contraceptives has been shown to have decreased out-of-pocket costs and increased use of the most expensive and effective contraceptive methods (Becker 2018; Carlin, Fertig, and Dowd 2016; Dalton et al. 2020; Heisel, Kolenic, and Moniz 2018).

How U.S. Public Policy Shapes Access to Contraception in the United States

Before the ACA took effect, many U.S. insurers required patients to pay all or a significant part of the cost of birth control out of pocket. The costs for highly effective LARCs, such as IUDs and implants, were prohibitively high. Even women with insurance could be charged more than $1,200 (2022 dollars) out of pocket for an IUD. The ACA's "contraceptive coverage mandate" required insurance plans to cover FDA-approved forms of contraception with no cost-sharing starting in 2014. The ACA also increased the number of women with health insurance, both through private insurers and through the expansion in Medicaid. However, the ACA did not reduce the cost of contraception for U.S. women without health insurance, and not all health insurance providers cover all methods of contraception (Gemmill and Lindberg 2013).

The Title X Family Planning Program has helped to cover the cost of contraception for low-income individuals since 1970, when it was enacted as Title X of the Public Health Service Act. The program issues grants to public and nonprofit organizations to provide reproductive health services and all FDA-approved contraceptive methods on an ability-to-pay basis. For example, individuals with incomes at or below the FPL are not charged for services or contraceptives,[2] and those with higher incomes are charged to recover the reasonable costs of providing services on a sliding scale. Thus, Title X reduces the high costs of contraception for low-income Americans by subsidizing all FDA-approved methods. Importantly, the program disproportionately benefits low-income Americans at higher risk of unintended pregnancy and also aids women whose insurance plans do not fully cover their preferred contraceptive method. No Title X funds can be used for abortion (42 U.S.C. §300a-6).

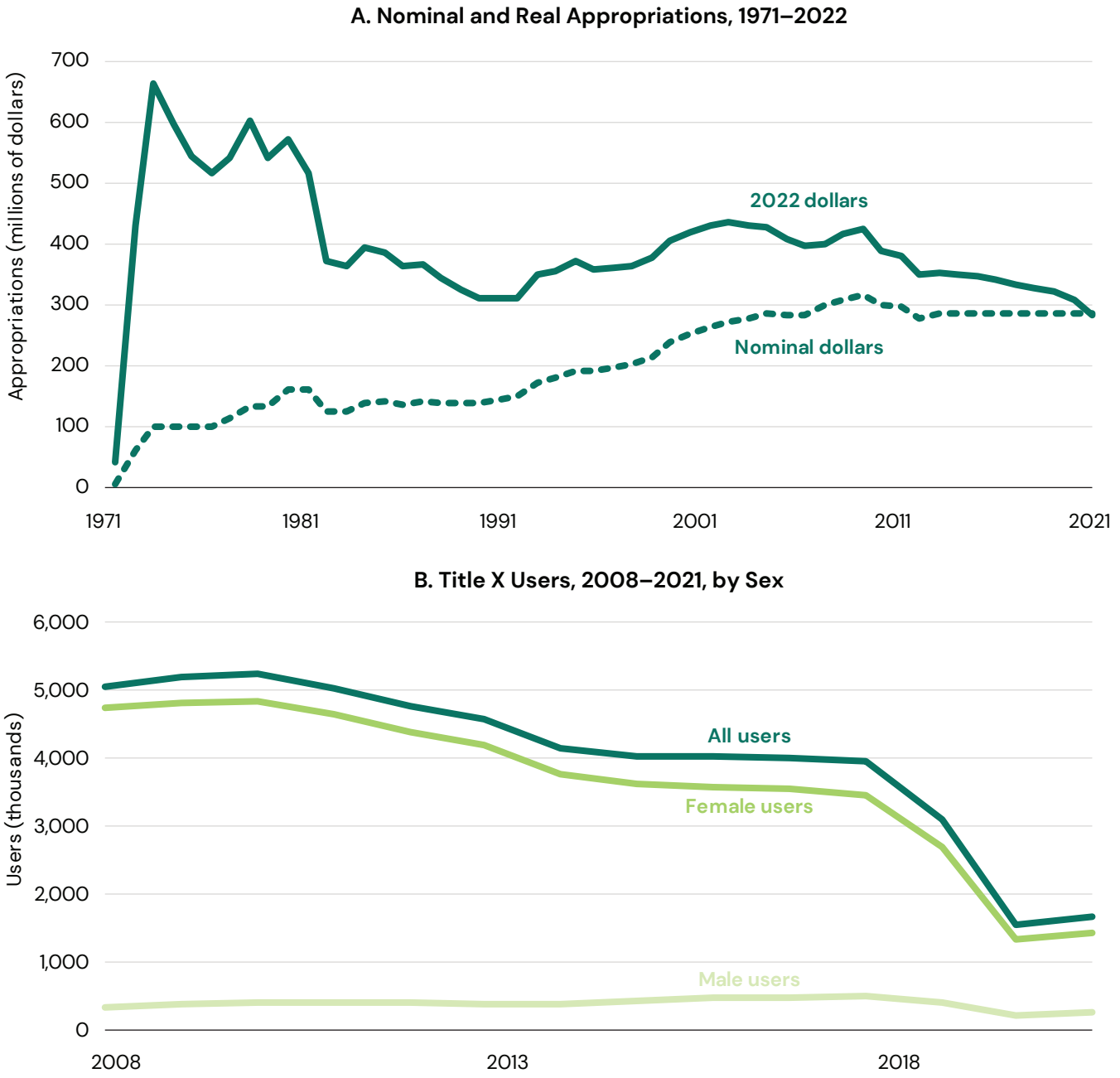
However, appropriations for Title X after adjusting for inflation have been falling since 2003. Although nominal funding has remained steady, inflation has increased, meaning that real funding levels have fallen by over 34% since 2010 (figure 3, panel A). Over the same period, Title X clients fell from around five million to four million in 2018, before dipping to under two million clients in 2020–2021 (figure 3, panel B).

This sharp drop in clients reflected the 2019 Trump administration changes in national funding guidelines for Title X. Among these changes was a requirement for recipients of federal funds to physically separate sites that provide non-abortion reproductive health services from sites that provide abortion. In addition, the guidelines restricted counseling to exclude discussion of abortion as a family planning method. Rather than comply, many Title X providers withdrew from the program in 2019, including large Title X providers like Planned Parenthood. Even with the Trump administration guidelines in effect for only part of that year, 844,083 fewer clients received care through Title X in 2019 than in the previous year (Fowler et al. 2019). Throughout 2020, Title X served just 1.3 million women—half the number of women in 2019—and in 2021, the number increased to only 1.4 million (Fowler, Gable, and Lasater 2022).

Shortly after taking office in 2021, the Biden administration revoked the Trump administration changes and restored the Title X program's structure to its long-standing model (42 C.F.R.§59.5(a)(8)). Changes included *removing* the 2019 requirement for strict physical separation between Title X reproductive health care and abortion care and restrictions on the counseling of pregnant clients surrounding the discussion of abortion. Although the data for 2022 have not yet been released, the number of Title X clients are expected to approach their 2018 levels in 2023.

FIGURE 3

Title X Appropriations and Users



Source: BLS 2021; Fowler et al. 2019; Fowler, Gable, and Lasater 2022; Napili 2022; OPA 2023.

Note: Figure 3a plots funding data by fiscal year from 2008–19 Title X from OPA 2023 and 2020–2021 Congressional Research Service (CRS) from Napili 2022, adjusted using the Historical CPI-U from BLS 2021. Figure 3b is compiled from appendix exhibits in the Title X Family Planning Annual Report for 2018 and 2021.

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The Proposal

Expanding Title X is a straightforward and effective way to improve equitable access to contraception across the U.S. Title X has been administered at the federal level since 1970 with the goal of ensuring that every person has access to reproductive health care and services. Clients without health insurance currently pay out of pocket for contraceptives on a sliding scale. The governing statute for Title X of the Public Health Service Act (42 U.S.C. §300) dictates that charges will be made for services to clients in accordance with a schedule of discounts based on ability to pay for individuals from families whose annual income do not exceed 250% of the FPL set forth in the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2). I propose implementing two changes to the Title X program.

1. I propose changes to the program guidelines issued by the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 9902(2) specifying the schedules of discounts (i.e., the Title X sliding scale). My proposed change eliminates cost-sharing for contraceptives for low-income individuals, flattening the sliding scale.
2. I propose increasing congressional appropriations for the Title X program to fund the elimination of cost-sharing.

Together, these two changes would make contraceptives and related contraceptive services *free* to all clients with incomes below 250% of the FPL.[3] Making these changes at the federal level would help ensure that Title X meets its core objective and would better insulate people from restrictive and unpredictable reproductive health policies at the state level.

I begin by describing research findings from a novel RCT that provides direct evidence regarding the effects and costs of this policy proposal. Next, I summarize the proposal, its expected effects on contraceptive use and unplanned pregnancy, and its implications for federal spending.

Evidence from an RCT Regarding the Role of Cost in Reducing Access to Contraception for Low-Income Women

My research team ran an RCT at Planned Parenthood in Michigan (PPMI), which focused on the effects of making contraception affordable or free. By design, this RCT sets aside other aspects of access to contraception and abortion. However, PPMI is Michigan's largest Title X service provider, and Planned Parenthood affiliates served 40% of the 4 million Title X clients in the U.S. in 2018, making this study's context and focus on the costs of contraception highly policy relevant to Title X providers today. The goal of the Michigan Contraceptive Access Research and Evaluation Study (M-CARES) is to support participants' reproductive autonomy and eliminate cost barriers: the vouchers should make *any desired method of contraception* more financially accessible or free.

The ACA expanded Medicaid and mandates that health insurance policies pay for all FDA-approved contraceptive methods without cost-sharing. Consequently, fewer individuals are uninsured and insured women should not have out-of-pocket costs for contraception in most cases (Sonfield 2022). Title X providers bill services to a client's health insurance if the client has health insurance. However, uninsured individuals may face exorbitant costs for their preferred contraceptive method at Title X providers. Evidence from the past shows that such financial barriers reduced the use of contraception (see section II.C above), but little evidence speaks to the role of financial access to contraception today.

To fill this gap in the literature, we designed M-CARES. This RCT quantifies how cost-sharing at Title X clinics affects women's ability to use their preferred method of contraception. In addition, individual-level randomization uniquely allows the study to examine how similar cost-sharing may have different effects for different subgroups.

Between 2017 and 2023, M-CARES randomized individuals to receive a voucher with a dollar value equivalent to either 50% or 100% of the total out-of-pocket costs for an uninsured woman to have an IUD

inserted. This pricing scheme made any contraceptive either half price or free. Voucher values were determined by the costs of IUDs (one of the most expensive contraceptive methods available), but vouchers could be used for *any* contraceptive method at PPMI and related services for up to 100 days after enrollment. Study participants were recruited and randomized to receive vouchers in clinic waiting rooms. After they enrolled, study participants left the waiting room for their appointments.

To mitigate concerns that voucher recipients get stuck with a method that turns out not to be preferred (e.g., have an IUD or implant inserted and cannot afford to remove it), the study offered to pay for the removal of any device inserted with study funds up to one year after the individual enrolled—no questions asked. The control group received no voucher and the usual standard of care at Planned Parenthood, with prices based on the current Title X sliding scale.

The study did not nudge, advocate for, or compel individuals to use any method of contraception. The premise of the study was that individuals, in consultation with their physicians, know best which method of contraception is best suited for them. Methods may be preferred because of their efficacy, ease of use, or how long they last without requiring a return visit. For example, Depo Provera is highly effective, but it requires a return visit to the clinic every 90 days. Birth control pills are also highly effective. Existing patients can take home up to a 12-month supply, but they must remember to take a pill daily. An IUD is also highly effective and lasts from 3 to 10 years without a return visit, but this method may cause painful or very frequent menstruation in some women and is contraindicated in others with certain conditions.

Effects of Eliminating Cost-Sharing on Contraceptive Use and Expected Pregnancies

Bailey et al. (2023) report the findings of this study, which we summarize here. One finding is that voucher recipients were more likely to purchase contraceptives and spent more money on contraceptives (figure 4, panel A)—both indications that study participants wanted more contraceptives than they could afford. The 50% and 100% voucher increased the likelihood of any contraceptive purchase by 31% and 38%, respectively, both relative to the control group that paid for services on the usual Title X sliding scale. Voucher recipients also increased the value of contraception that they purchased by $176 (50% group) and $261 (100% group). The implication of these findings is that even the reduced cost of contraception through the Title X sliding scale limits clients' ability to purchase the quantity or type of contraceptives they prefer.

Eliminating cost-sharing allowed voucher recipients to purchase their preferred methods, which were often more effective methods. Over one-third of 100%-voucher recipients switched to a more effective method versus one-quarter in the control group. Additionally, almost two-thirds of the voucher group stayed on the same method or did not purchase any contraceptives at PPMI compared to three-quarters of the control group.

Figure 4, panel B summarizes changes in method choice among voucher recipients in two dimensions. Receiving a voucher allowed women to purchase contraception covering more days (181 and 317 days with the 50% and 100% vouchers, respectively), minimizing the need to return to clinics frequently to purchase more contraceptive supplies (returning to clinics often involves time off work or away from childcare). In addition, receiving a voucher also allowed women to purchase more expensive and effective LARC methods, if this was their preference. Making LARCs half price increased the use of this method by 75% (14 percentage points in the treatment group versus 8 percentage points in the control group), whereas making them free increased the use of LARCs by 274% (19 percentage points in the treatment group versus 5 percentage points in the control group).

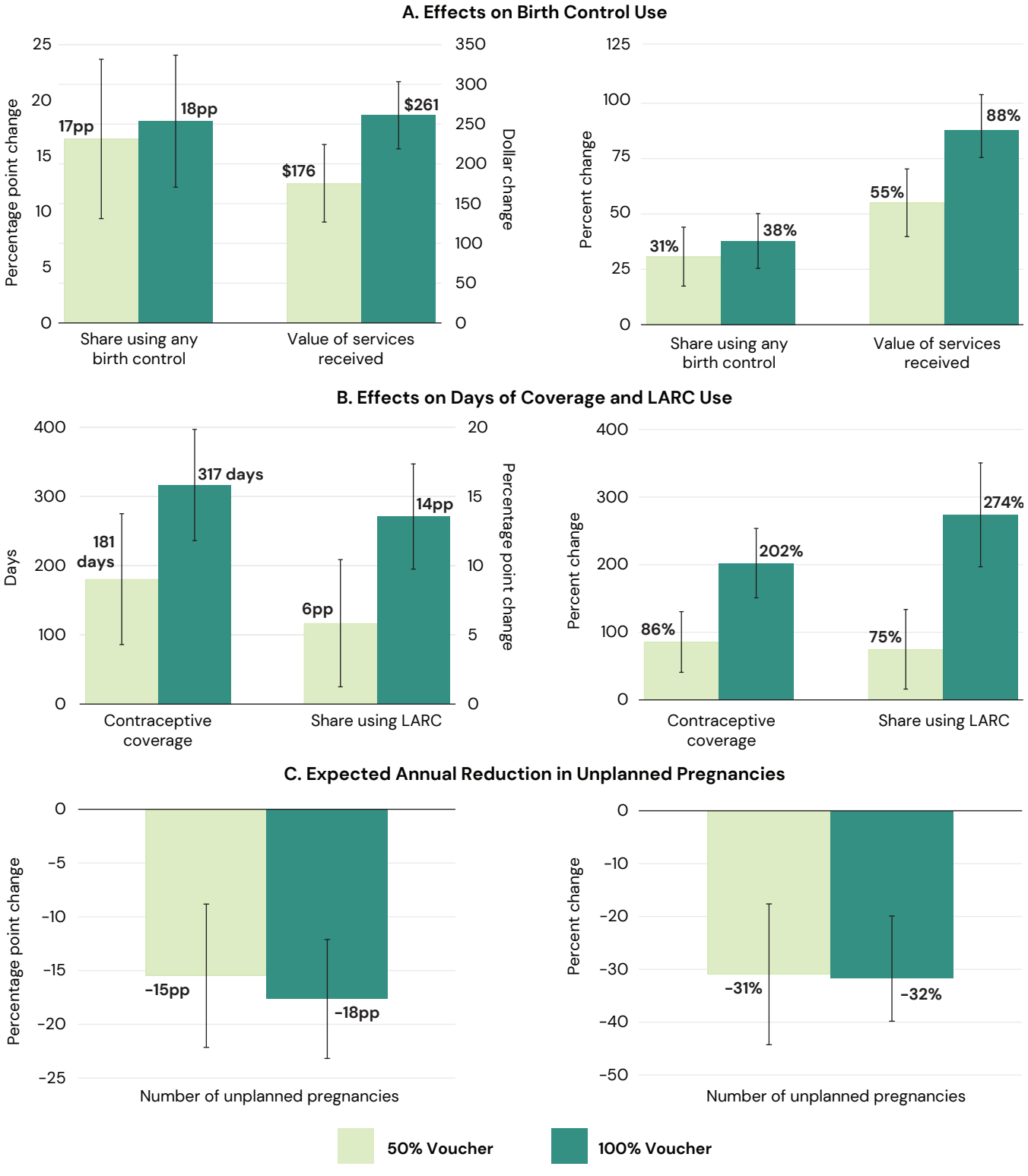
A comparison of the effects of the 50% and 100% vouchers also sheds light on a highly relevant public policy choice: how much the difference in the generosity of the subsidy matters. Doubling the voucher subsidy more than tripled the use of LARCs, from 75% to nearly 275%. This large increase in the relative effect shows that even 50% of the already discounted Title X price is still prohibitive. These findings show that eliminating cost-sharing—as with the 100% voucher—allows many more women to choose their preferred contraceptive method.

Another notable finding is that these effects persist for up to two years. A one-time voucher did not just induce clients to purchase a desired method sooner, they appear to have resolved a binding constraint on their ability to purchase a desired method in the longer term.

As a consequence of changes in the likelihood of using contraceptives as well as a shift in the types of methods chosen, figure 4, panel C shows that the one-year likelihood of an unplanned pregnancy decreased by 31% in the 50% voucher group (a fall of 15 per 100 women) and by 32% in the 100% voucher group (a fall of 18 per 100 women).[4]

FIGURE 4

The Effects of Receiving a Voucher on Different Measures of Contraceptive Efficacy



Source: Bailey et al. 2023.

Note: The column on the left presents the percentage point, dollar, or day change in the outcome among voucher recipients. The column on the right represents the change in the outcome for voucher recipients relative to the mean for the control group.

Subgroup Differences in the Effects of Eliminating Cost-Sharing for Contraception

Figure 5 breaks down the estimated effects for three outcomes into different demographic subgroups: the value of services received at PPMI (panel A), the use of LARCs (panel B), and the expected annual reduction in unplanned pregnancies (panel C). One remarkable finding across all outcomes is the similarity in the relative effect sizes. Receiving a voucher increased the value of services received among all subgroups, and the 100% voucher increased spending by considerably more for all but one group (mothers).

Different subgroups, however, show considerable differences in the use of LARCs. For example, eliminating cost-sharing for LARCs had little effect on their use among Black non-Hispanic women but had sizable effects (a 1042% increase) among Latinas. Similarly, receiving a voucher increased LARC use among women with less than an associate's degree by 499% versus only 220% among women with at least an associate's degree. Mothers' choices of contraceptive methods also appear constrained by the costs of LARCs. Eliminating cost-sharing for mothers increased their LARC use by 610%.

But differences in LARC take-up did not translate into similar variability in expected unplanned pregnancies, which fell for every subgroup. This finding suggests that even though different women chose different methods according to their own personal circumstances, values, and medical histories, they all choose methods that limited their risk of unplanned pregnancies.

A Proposal for Increasing Access to Contraception by Strengthening Title X

This policy proposal flattens the sliding scale so that uninsured women have the same cost-sharing (zero out-of-pocket costs) for contraception as insured women by

1. changing the governing statute described above to eliminate the stipulated schedule of discounts based on the ability to pay and
2. increasing federal discretionary funding for the Title X program to fund this more generous schedule of discounts so that all Title X clients have the financial freedom to choose their preferred contraceptive.

Making contraception free for uninsured individuals from families with incomes at or above 250% of the FPL would require changing the Title X statute, which is beyond the scope of this proposal. Note that only 5.9% of women ages 15–44 with incomes above 250% of the FPL are uninsured, meaning that this proposal eliminates cost-sharing for over 94% of uninsured women of reproductive age. This proposal is consistent with Title X funds continuing to be directed toward the individuals most in need of contraceptive services.

Moving from an RCT in Michigan to Evidence on a National Policy

The sample of M-CARES participants differs from the national Title X population, largely because the population of Michigan differs from the national population of Title X clients. To characterize the effects of free contraception on the outcomes for Title X clients across the U.S., we adjusted the M-CARES sample to reflect the age, race/ethnicity, and income of the national Title X population who were seeking care at Title X providers using entropy balancing (Hainmueller 2012; Bailey et al. 2023). This reweighting ensures that the M-CARES sample resembles the age, race, insurance, and income characteristics of all Title X clients nationwide. (See the Technical Appendix for more information.)

Effects of Eliminating Cost-Sharing for Contraception through Title X

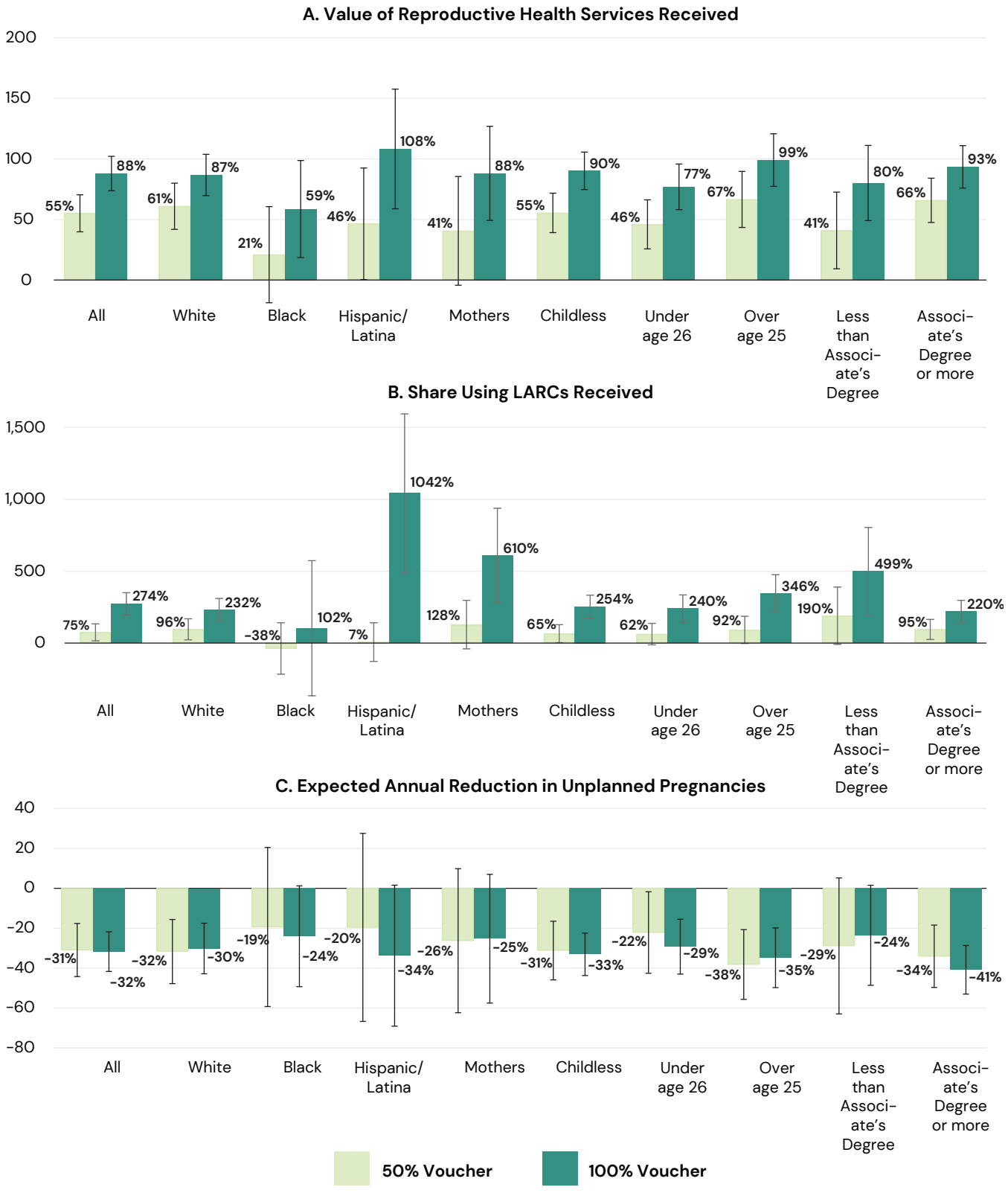
If every Title X patient in the U.S. received free contraception up to the price of the lowest-cost LARC, we project that pregnancies would fall by around 22 per 100. Based on the number of 2021 pregnancies, this policy is expected to reduce unplanned pregnancies by around 301,000 (5.3%) within one year.

Using previously published estimates of the share of pregnancies that result in childbirth, these numbers imply a reduction in births of 144,000, or 3.9%, from the 2021 level (Bailey, Bart, and Lang 2022).[5] Another consequence of eliminating cost-sharing for contraception for Title X clients is that the number of abortions would fall by around 77,000, or 8.3%, relative to the 2020 level (Diamant and Mohamed 2023). The number of births and abortions would continue to be reduced to some degree in later years, although these reductions in later years are less certain and are not included in these calculations.

States would see different effects as a result of the policy due largely to differences in their number of Title X clients, which reflect a combination of state policies and client needs. Figure 6, panel A illustrates the predicted effect of making all contraception free to uninsured Title X clients by state, using the 2018

FIGURE 5

The Effects of Reduced-Price Contraceptives on Contraceptive Efficacy



Source: Bailey et al. 2023.

Note: Figure 5 plots percent change in the outcome for voucher recipients, or the effect in dollars, percentage points, or pregnancies relative to the mean for the same outcome in the control group.

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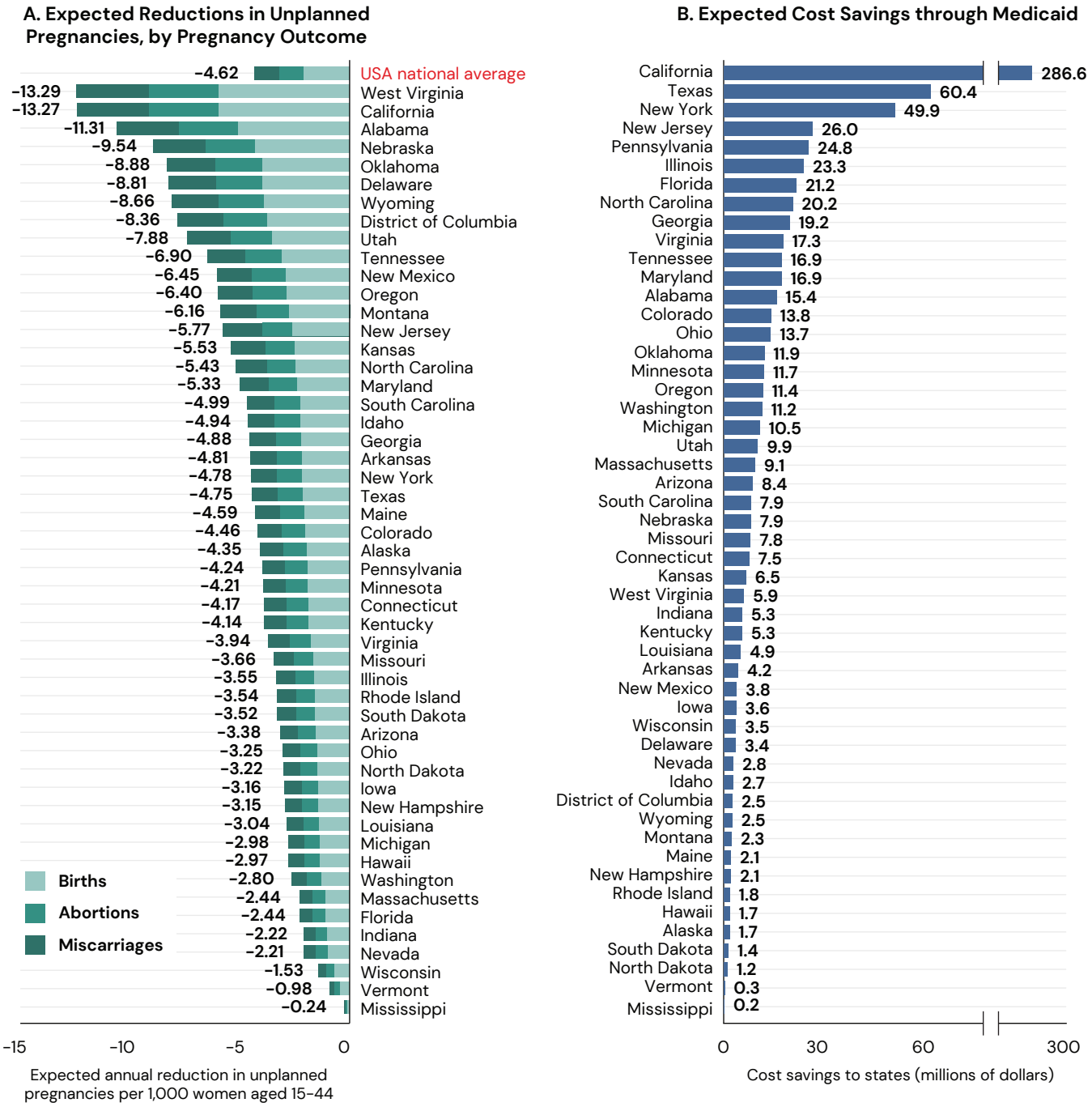
FIGURE 6

Projected Effects of Free Contraception for Title X Clients, Nationally and by State



Source: Author's calculations based on the following sources: Bailey et al. 2023; Bailey, Bart and Lang 2022; Fowler, Wang, Gable, Lasater, and Wilson 2019; CDC 2016-2021; Kortsmit et al. 2020; Guttmacher Institute; and Kaiser Family Foundation (KFF) 2023.

Note: Panel A shows the estimated change in the number of pregnancies relative to the population of reproductive-aged women in each state. Panel B shows the anticipated Medicaid savings to states based on their Federal Medical Assistance Percentage (FMAP) (KFF 2023). The FMAP determines how much states are reimbursed by the federal government for their spending on Medicaid, ranging from 50% to 83% depending on the average income in each state. States are ordered from largest to smallest predicted change in pregnancies or cost savings. Different colors in panel A project how the reduction in unplanned pregnancies is expected to translate into miscarriages, abortions, and births. The number at the end of each bar indicates the total change in expected unplanned pregnancies for each state in panel A, and total cost savings to states in millions of 2022 U.S. dollars in panel B.

data on Title X clients (Fowler et al. 2019).[6] It shows that West Virginia and California would likely experience the largest change in unplanned pregnancies as a result of this proposed policy. In contrast, Mississippi and Vermont had very low rates of uninsured Title X clients among their reproductive-aged female population and relatively few Title X users, which would result in smaller changes in unplanned pregnancies because of the proposed policy.

Effects of Eliminating Cost-Sharing for Contraception through Title X on Appropriations

I estimate that a national policy eliminating cost-sharing for contraception under Title X would cost an additional $178 million annually—an increase of around 62% over current funding levels.[7] This estimate is based on the historical distribution of Title X patient incomes as well as costs based on voucher use from the clinical trial, reweighted to estimate the cost of making all contraception free for Title X clients across the U.S. with incomes under 250% of the FPL. Around 1.4 million individuals—36% of Title X clients nationally who are female, are uninsured, and have out-of-pocket costs—would be immediately affected by eliminating cost-sharing for contraceptives (Fowler, Gable, and Lasater 2022).

The reduction in unplanned pregnancies resulting from the policy would also have immediate budgetary implications. As noted above, this policy is expected to reduce the number of births in the first year of the program by 144,000. Assuming that around 62% of these births would be funded through Medicaid implies a reduction in Medicaid costs of more than $1.61 billion in the first year of the policy.[8]

In short, eliminating Title X cost-sharing for contraception would cost the federal government $178 million per year and reduce federal and state government spending by $1.61 billion in the first year of the program, for a net savings to taxpayers of around $1.43 billion in the first year of the program. Around 50% of the $1.6 billion in total savings, or $804 million, less $178 million in additional Title X appropriations would accrue to the federal government under the FY 2024 Federal Medical Assistance Percentage (FMAP) rates (Kaiser Family Foundation (KFF) 2023). In short, the first year's savings to the federal government through the reduction in Medicaid spending alone could fund free contraception through Title X for around four years. While the actual reduction in childbirth in the first year of the program could be more or less than what we estimate, this estimate would have to be too high by an order of magnitude to change the conclusion that a policy making contraception free to Title X clients would more than pay for itself in its first year. This calculation ignores likely revenue gains from more women remaining in the labor force (and paying taxes) rather than taking maternity leave. In addition, state governments would save the remaining $812 million, which figure 6, panel B breaks down by state.[9]

These estimates of cost savings are conservative because they do not account for the fact that some unplanned pregnancies will be deferred for more than one year and that some unplanned pregnancies are undesired, meaning that they may never occur in the future. Moreover, given the significant increase in unplanned childbirth expected in the aftermath of the *Dobbs* decision, free contraception could reduce births resulting from unplanned pregnancies by more than we estimate. Thus, the reduction in costs by expanding access to contraception could be more substantial.

Questions and Concerns

Should the federal government be implementing policies that reduce childbearing given that fertility rates are below replacement levels?

Below-replacement fertility rates are almost universal in developed countries, and many policies target creating family-friendly environments to encourage childbearing (e.g., paid leave for parents, child tax credits, and child-care subsidies). Minimizing choice over contraceptive methods to encourage undesired childbearing may raise birth rates in the short run. However, disempowering individuals will not maintain higher birth rates in the long run. Increasing undesired childbearing tends to limit the financial resources of families, which tends to reduce childbearing in the medium to long term.

Does this proposal solve all issues with access to contraception in the U.S.?

This proposal solves issues surrounding financial access to contraception in the U.S., which is one important dimension of reproductive autonomy. However, equal access to contraception depends upon many other factors as well. Future policy proposals should focus on addressing misinformation about contraceptives and their side effects; improving physician training around reproductive health care, including sensitivity to concerns and preferences of different groups; and improving the integration of reproductive health care as part of holistic health services.

Endnotes

1. We understand and acknowledge that people of all genders give birth. For parsimony, this proposal uses the word "woman," "mother," and female pronouns when discussing individuals who become pregnant or give birth.
2. The FPL for an individual was $13,590 in annual income in 2022; $4,720 is added to the annual income level for each additional person in the family.
3. 250% of FPL is in the statutory maximum income for the sliding scale. See the Code of Federal Regulations in Title 42 CFR 59.5(a)(8).
4. "Unplanned" is not reported on a survey but is inferred from contraceptive method choice. I define unplanned pregnancies as those that would not have occurred if one had access to her desired contraceptive method.
5. We use estimates by Bailey, Bart and Lang 2022 from the NSFG, which find that 48% of Title X pregnancies result in childbirth, 25.5% in abortion, and 26.6% in miscarriages. Bailey, Bart and Lang 2022 inflate reported abortions and miscarriages to arrive at these estimates to account for underreporting in the CDC and the NSFG. The pregnancy-to-birth transition rate for the Title X population is slightly lower than estimates for the overall population.
6. As outlined in section I.D., the number of clients in Title X dropped by more than half after 2018, even as Planned Parenthood and other former Title X grantees continued to provide family planning services outside the purview of the federal program. The "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services" final rule revoked the previous rule and went into effect late in 2021, and Planned Parenthood and other former grantees returned to the program in 2022. Given these policy changes and the fact that Planned Parenthood served 40% of all Title X clients before 2019, we present these projections using the 2018 numbers (which should be closer to the number of Title X users in 2022).
7. This assumes that the number of Title X clients remains at the 2018 level, with the cost increase calculated over the FY 2022 Title X funding levels.
8. This calculation uses Guttmacher's estimate of $12,770 in 2010, which includes the costs of delaying prenatal care, labor and delivery, postpartum care, and 12 months of infant care and inflates this estimate using the health care inflation index (Sonfield et al. 2011). This inflation yields $17,987 in 2022 dollars. Fowler et al. 2019 show that around 38% of Title X clients have private health insurance, implying that 62% of births to Title X clients will be paid by public insurance (i.e., Medicaid). We obtain $1.59 billion by multiplying $17,987 per birth by the reduction of 62% of the 142,000 unplanned births.
9. KFF reports that an average of 69% of Medicaid spending was funded by the federal government with the remaining 30.7% of spending funded by the states (KFF 2022).

Technical Appendix

The M-CARES trial protocol has been approved by the University of Michigan's Health Sciences and Behavioral Sciences Institutional Review Board (HUM00132909) and is registered at clinicaltrials.gov (NCT03673007). The pre-analysis plan includes a detailed research protocol relating to recruitment, enrollment, consent, survey instruments, administrative data collection, primary outcomes, and planned analyses.

Recruitment and Inclusion Criteria

M-CARES partnered with NORC, an internationally recognized firm in survey research, to recruit participants in the waiting rooms of 12 clinics. Enrollment is conducted on an electronic tablet. If a patient elects to participate, the electronic tablet walks them through an eligibility screen and, if eligible, an informed consent process, with assistance from a field interviewer as needed. For participants, the tablet encodes personal information (e.g., name, Social Security Number, date of birth, and contact information) and answers to survey questions.

M-CARES includes individuals ages 18–35 who have out-of-pocket costs for contraception at PPMI and are at risk of becoming pregnant. The study excludes individuals who are pregnant at the time of enrollment or wish to become pregnant in the next 12 months. We also exclude individuals with no out-of-pocket costs for contraceptives, because the voucher should not affect their costs for contraceptives or, by extension, choice of contraceptive method. Following enrollment, participants are invited to complete a baseline survey after their clinic visit on the same day. Participants consent to take two follow-up surveys and release their administrative data to the study.

The Sliding Scale and Voucher Values

As with other Title X providers, PPMI determines clients' out-of-pocket costs using a sliding scale. Clients are assigned fee scale 2/B if their incomes range from 101–150% of the FPL, 3/C if their incomes are 151–200% of the FPL, 4/D if their incomes are 201-250% of the FPL, and 5/E if their incomes are 250%+ of the FPL. Unless they have insurance to cover their visit (which most do not), clients with fee scales 2–5 will be charged 25%, 50%, 75% or 100%, respectively, for the services they receive from PPMI.

The M-CARES voucher amounts reflect either 50% or 100% of the total out-of-pocket costs for an uninsured woman to have an IUD inserted, after applying the PPMI sliding scale. However, vouchers can be used for ANY contraceptive method at PPMI and related services. Except for the period between November 2019 and September 2021, clients with family income below the FPL are assigned fee scale 1/A and are not charged for contraceptive services, regardless of their insurance coverage. For all periods except for November 2019 to September 2021 when they experienced costs, 1/A women are excluded from the study because the voucher should not affect their choices of contraceptive methods. Participants randomly assigned to receive vouchers are handed the voucher amount before their appointments. After this, the M-CARES participant proceeds with her appointment as planned. All contraceptive decisions and discussions with health care providers occur after recruitment to M-CARES.

Outcomes

Using information up to two years after enrollment from PPMI records, we examined how reducing out-of-pocket costs changed five pre-specified contraceptive outcomes capturing different dimensions of contraceptive use and efficacy: (1) the dollar value of services purchased; (2) a binary measure for whether any contraceptives were purchased; (3) a binary measure of LARC insertion; (4) a continuous measure of method success, defined by one minus the CDC failure rate with typical use of the most effective method purchased; and (5) the expected days of coverage of the most effective method purchased. We also create an index of contraceptive efficacy that combines these five outcomes to summarize the overall effect of receiving a voucher and to limit the number of statistical tests (Katz and Krueger 1992). Our methods compare individuals who were randomly assigned to receive a voucher for contraceptives versus individuals who received the usual standard of care at PPMI and were paid on the usual sliding scale.

TABLE A-1.

Final Sample, Weight, and Representativeness

	M-CARES Sample	Title X Patient Characteristics	M-CARES Reweighted
Age 18-19	0.096	0.135	0.135
Age 20-24	0.393	0.354	0.354
Age 25-29	0.326	0.304	0.304
Age 30-34	0.186	0.207	0.207
Non-Hispanic White	0.673	0.333	0.333
Non-Hispanic Black	0.135	0.195	0.195
Hispanic any race	0.099	0.340	0.340
Other/Not reported	0.093	0.132	0.132
Les than 100% FPL	0.080	0.667	0.667
101-150% FPL	0.398	0.149	0.149
151-200% FPL	0.246	0.073	0.073
201-250% FPL	0.124	0.035	0.035
251+% FPL	0.151	0.076	0.075
Insured	0.073	0.583	0.583
Uninsured	0.927	0.417	0.417

Source: Bailey, Bart and Lang 2022.

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Generalizing Findings from M-CARES to the National Title X Population

Given the differences between the M-CARES sample and the national Title X population, we use entropy balancing to reweight the M-CARES sample such that the age, race/ethnicity, insurance, and income characteristics match those in the 2018 national Title X population (Hainmueller 2012). The rebalanced M-CARES sample is shown in Bailey et al. 2023. This reweighting ensures that the M-CARES sample resembles the age, race, insurance, and income characteristics of all Title X clients nationwide.

An important caveat is that reweighting does not account for differences in the treatment effects due to other factors. For instance, treatment effects for Title X clients nationally may differ due to different state reproductive health-care programs or policies, or to states' decisions to expand Medicaid coverage under the ACA (as Michigan did). In addition, these results may misstate the intervention's true effects on pregnancies if (1) low-income, uninsured women obtain contraception from other providers not observed in our data; (2) women do not use the most effective method purchased for the entirety of one year (we use the one-year method failure rate as a summary metric); or (3) women adjust their sexual behavior when using a less effective method (e.g., abstain from intercourse). The first issue is not likely important in practice, because PPMI served 70% of all Michigan Title X clients in 2018, and Title X clients have few other options for affordable care. The quantitative importance of the second and third issues is harder to gauge, so they remain important caveats to the interpretation of the results.

Regarding the similarity of Michigan's other characteristics (not in table A-1) and policies to other states, one key piece of evidence is that Michigan falls around the national median of many key behaviors related to contraceptive use, such as cohabitation, marriage, age at first birth, nonmarital childbearing, and teenage childbearing (Lesthaeghe and Neidert 2006). Michigan offers a 6% state Earned Income Tax Credit and has per capita spending on public welfare close to the national average (U.S. Department of Commerce 2020).

Michigan's reproductive health policies are also shared with many other states. Its Medicaid expansion program, Healthy Michigan, supplements the state's Medicaid program and covers women who are not pregnant and with household income up to 138% of the FPL. This is similar to 40 states and the District of Columbia that have expanded eligibility for Medicaid under the

ACA. However, residents of the 10 states that have not expanded Medicaid (Alabama, Georgia, Florida, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming) would likely experience larger effects of eliminating cost-sharing for contraceptives.

Michigan has not banned abortion in the aftermath of the *Dobbs* decision, which makes it similar to the 36 states without abortion bans. The effects of eliminating cost-sharing for contraceptives for residents of the 14 states that have effectively banned abortion as of February 2023 could be more far-reaching than in Michigan (McCann et al. 2023).

A final consideration is how similar PPMI is to national Title X providers. Importantly, Planned Parenthood as an organization serves around 40% of the nation's estimated four million Title X clients, which alleviates some concern about generalizing the findings from clients recruited at this organization to other Title X providers. However, other Title X providers such as federal qualified health centers are less focused on reproductive health care, so the generalizability of these findings may be more limited at these locations.

References

2021. Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services. In *42 C.F.R. § 59.5(a)(8)*, edited by Health and Human Services Department.

Ananat, Elizabeth Oltmans, and Daniel Hungerman. 2012. "The Power of the Pill for the Next Generation: Oral Contraception's Effects on Fertility, Abortion, and Maternal and Child Characteristics." *Review of Economics and Statistics* 94 (1):37-51.

Auerbach, S. L., K. Coleman-Minahan, A. Alspaugh, E. A. Aztlan, L. Stern, and K. Simmonds. 2023. "Critiquing the Unintended Pregnancy Framework." *J Midwifery Womens Health* 68 (2):170-178. doi: 10.1111/jmwh.13457.

Bailey, Martha J. 2006. "More Power to the Pill: The Impact of Contraceptive Freedom on Women's Lifecycle Labor Supply." *Quarterly Journal of Economics* 121 (1):289-320.

Bailey, Martha J. 2012. "Reexamining the Impact of U.S. Family Planning Programs on Fertility: Evidence from the War on Poverty and the Early Years of Title X." *American Economic Journal: Applied Economics* 4 (2):62-97.

Bailey, Martha J., and Lea J. Bart. 2023. "Trends in Mistimed and Undesired Pregnancies, 2011-2019." *UCLA Working Paper*.

Bailey, Martha J., Lea Bart, and Vanessa Wanner Lang. 2022. "The Missing Baby Bust: The Consequences of the COVID-19 Pandemic for Contraceptive Use, Pregnancy, and Childbirth Among Low-Income Women." *Population Research and Policy Review* 41 (4):1549-1569. doi: 10.1007/s11113-022-09703-9.

Bailey, Martha J., Brad J. Hershbein, and Amalia R. Miller. 2012. "The Opt-In Revolution? Contraception and the Gender Gap in Wages." *American Economic Journal: Applied Economics* 4 (3):225-54.

Bailey, Martha J., Vanessa Wanner Lang, Alexa Prettyman, Iris Vrioni, Lea Bart, Daniel Eisenberg, Paula Fomby, Jennifer Barber, and Vanessa K. Dalton. 2023. "How Subsidies Affect Contraceptive Use among Low-Income Women in the U.S. A Randomized Control Trial." *NBER Working Paper. Accessed March 26, 2021*.

Bailey, Martha J., and Jason M. Lindo. 2018. "Access and Use of Contraception and Its Effects on Women's Outcomes in the U.S." In *Oxford Handbook of Women and the Economy*, edited by Susan L. Averett, Laura M. Argys, and Saul D. Hoffman. Oxford: Oxford University Press.

Bailey, Martha J., Olga Malkova, and Zoë McLaren. 2018. "Do Family Planning Programs Increase Children's Opportunities? Evidence from the War on Poverty and the Early Years of Title X." *Journal of Human Resources*.

Becker, Nora. 2018. "The Impact of Insurance Coverage on Utilization of Prescription Contraceptives: Evidence from the Affordable Care Act." *Journal of Policy Analysis and Management* 37 (3):571-601.

Birgisson, Natalia E., Qiuhong Zhao, Gina M. Secura, Tessa Madden, and Jeffrey F. Peipert. 2015. "Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review." *Journal of Women's Health* 24 (5):349-53.

Bureau of Labor Statistics (BLS). 2021. "Historical Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, all items, by month." Table. Bureau of Labor Statistics, Washington D.C.

Broughton, Hilary O., Christina M. Buckel, Karen J. Omvig, Jennifer L. Mullersman, Jeffrey F. Peipert, and Gina M. Secura. 2016. "From research to practice: dissemination of the Contraceptive CHOICE Project." *Translational Behavioral Medicine*:1-9. doi: 10.1007/s13142-016-0404-x.

Carlin, Caroline S., Angela R. Fertig, Bryan E. Dowd. 2016. "Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices Of Women With Employer Coverage." *Health Affairs*. 35 (9):1608-15.

Christensen, Finn. 2011. "The Pill and Partnerships: The Impact of the Birth Control Pill on Cohabitation." *Journal of Population Economics* 25 (1):29-52.

Dalton, Vanessa K., Michelle H. Moniz, Martha J. Bailey, Lindsay K. Admon, Giselle E. Kolenic, Anca Tilea, and A. Mark Fendrick. 2020. "The Impact of Eliminating Out-of-Pocket Costs for Contraception on Births following the Affordable Care Act." *Journal of the American Medical Association Network Open*.

Diamant, Jeff, and Besheer Mohamed. 2023. "What the data says about abortion in the U.S." Pew Research Center, Washington, D.C.

DiCenso, Alba, Gordon Guyatt, Andrew Willan, and Lauren Griffith. 2002. "Interventions to reduce unintended pregnancies among adolescents: Systematic review of randomized controlled trials." *British Medical Journal* 324 (7351):1426-1434.

Finer, Lawrence B, and Stanley K Henshaw. 2006. "Disparities in rates of unintended pregnancy in the United States, 1994 and 2001." *Perspectives on Sexual and Reproductive Health* 38 (2):90-96.

Finer, Lawrence B, and Mia R. Zolna. 2016. "Declines in unintended pregnancy in the United States, 2008–2011." *New England Journal of Medicine* 374 (9):843-852.

Fowler, C.I., J. Gable, and B. Lasater. 2022. Family Planning Annual Report: 2021 National Summary. Office of Population Affairs, Office of the Assistant Secretary for Health, Department of Health and Human Services, Washington, D.C.

Fowler, C.I., J. Gable, J. Wang, B. Lasater, and E. Wilson. 2019. *Family Planning Annual Report: 2018 National Summary*. RTI International, Research Triangle Park.

Frost, Jennifer J., Adam Sonfield, Mia R. Zolna, and Lawrence B. Finer. 2014. "Return on investment: a fuller assessment of the benefits and cost savings of the US publicly funded family planning program." *Milbank Quarterly* 92 (4):696-749.

Gemmill, Alison, and Laura Duberstein Lindberg. 2013. "Short interpregnancy intervals in the United States." *Obstet Gynecol* 122 (1):64-71. doi: 10.1097/AOG.0b013e3182955e58.

Gerdts, Caitlin, Liza Fuentes, Daniel Grossman, Kari White, Brianna Keefe-Oates, Sarah E. Baum, Kristine Hopkins, Chandler W. Stolp, and Joseph E. Potter. 2016. "Impact of Clinic Closures on Women Obtaining Abortion Services after Implementation of a Restrictive Law in Texas." *American Journal of Public Health* 106 (5):857-864.

Goldin, Claudia, and Lawrence F. Katz. 2002. "The Power of the Pill: Oral Contraceptives and Women's Career and Marriage Decisions." *Journal of Political Economy* 110 (4):730-770.

Guldi, Melanie. 2008. "Fertility Effects of Abortion and Pill Access for Minors." *Demography* 45 (4):817-827.

Guzzo, Karen Benjamin. 2021. "FP-21-01 Twenty Years of Change in Unintended Births." *National Center for Marriage and Family and Marriage Research Family Profiles* 245.
Hainmueller, J. 2012. "Entropy Balancing for Causal Effects: A Multivariate Reweighting Model to Produce Balanced Samples in Observational Studies." *Political Analysis* 20:25-46.
Harper, Cynthia C., Corinne H. Rocca, Kirsten M. Thompson, Johanna Morfesis, Suzan Goodman, Philip D. Darney, Carolyn L. Westoff, and J. Joseph Speidel. 2015. "Reductions in Pregnancy Rates in the USA with Long-Acting Reversible Contraception: a Cluster Randomised Trial." *The Lancet* 386 (9993):562-568.
Heisel, Erica, Giselle E. Kolenic, Michelle E. Moniz, Emily K. Kobernik, Leah Minadeo, Neil S. Kamdar, Vanessa K. Dalton. 2018. "Intrauterine Device Insertion Before and After Mandated Health Care Coverage: The Importance of Baseline Costs." *Obstetric Gynecology* 131 (5):843-9.
Henshaw, Stanley K. 1998. "Unintended Pregnancy in the United States." *Family Planning Perspectives* 30:24-29.
Hock, Heinrich. 2008. "The Pill and the College Attainment of American Women and Men." *Florida State University Working Paper*.
Jerman, Jenna, Rachel K. Jones, and Tsuyoshi Onda. 2016. "Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008." Guttmacher Institute, New York.
Judge-Golden, Colleen P., Kenneth J. Smith, Maria K. Mor, and Sonya Borrero. 2019. "Financial Implications of 12-Month Dispensing of Oral Contraceptive Pills in the Veterans Affairs Health Care System." *JAMA Internal Medicine* 179 (9):1201-1208. doi: 10.1001/jamainternmed.2019.1678.
Kaiser Family Foundation (KFF). 2022. "Federal and State Share of Medicaid Spending: FY 2021." Kaiser Family Foundation, San Francisco. Accessed April 29, 2023.
Kaiser Family Foundation (KFF). 2023. "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." Kaiser Family Foundation, San Francisco. Accessed May 30, 2023.
Katz, Lawrence, and Alan B. Krueger. 1992. "The Effect of the Minimum Wage on the Fast-Food Industry." *Industrial and Labor Relations Review* 46 (1):6-21.
Kearney, Melissa S., and Phillip Levine. 2009. "Subsidized Contraception, Fertility, and Sexual Behavior." *Review of Economics and Statistics* 91 (1):137-151.
Kirby, Douglas. 1997. "No easy answers: Research findings on programs to reduce teen pregnancy." The National Campaign to Prevent Teen Pregnancy, Washington, D.C.
Kost, Kathryn, Mia R. Zolna, and Rachel Murro. 2023. "Pregnancies in the United States by Desire for Pregnancy: Estimates for 2009, 2011, 2013, and 2015." *Demography*. doi: 10.1215/00703370-10690005.
Lesthaeghe, Ron J., and Lisa Neidert. 2006. "The Second Demographic Transition in the United States: Exception or Textbook Example?" *Population and Development Review* 32 (4):669-698.
Lindo, Jason M., and Analisa Packham. 2017. "How Much Can Expanding Access To Long-Acting Reversible Contraceptives Reduce Teen Birth Rates." *American Economic Journal: Economic Policy* 9 (3):348-76.
McCann, Allison, Amy Schoenfeld Walker, Ava Sasani, Taylor Johnston, Larry Buchanan and Jon Huang. 2023. "Tracking the States Where Abortion is Now Banned." *The New York Times*. Updated May 26, 2023, originally published October 13, 2022.
McNicholas, Colleen, Tessa Madden, Gina Secura, and Jeffrey F. Peipert. 2014. "The Contraceptive CHOICE Project Round Up: What we Did and What we Learned." *Clinical Obstetrics and Gynecology* 57 (4):635-643.
Mestad, Renee, Gina Secura, Jenifer Allsworth, Tessa Madden, Qiuhong Zhao, and Jeffrey Peipert. 2011. "Acceptance of long-acting reversible contraceptive methods by adolescent participants in the Contraceptive CHOICE Project." *Contraception* 84 (5):493-498.
Miller, Sarah, Laura R. Wherry, and Diana Greene Foster. 2020. "The Economic Consequences of Being Denied an Abortion." *National Bureau of Economic Research Working Paper No. 26662*.
Napili, Angela. 2022. "Title X Family Planning Program." In Focus, Congressional Research Service. V. 24. Accessed June 2, 2023.
Packham, Analisa. 2017. "Family Planning Funding Cuts and Teen Childbearing." *Journal of Health Economics* 55:168-185.
Office of Population Affairs (OPA). 2023. "Title X Program Funding History." U.S. Department of Health & Human Services, Washington D.C. Accessed June 2, 2023.
Ralph, Lauren J., Eleanor Bimla Schwarz, Daniel Grossman, and Diana Greene Foster. 2019. "Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services." *Annals of Internal Medicine* 171 (4):238-247. doi: 10.7326/M18-1666.
Rotz, Dana. 2016. "Why Have Divorce Rates Fallen? The Role of Women's Age at Marriage." *Journal of Human Resources* 51 (4):961-1002.
Secura, Gina M., Jenifer E. Allsworth, Tessa Madden, Jennifer Mullersman, and Jeffrey F. Peipert. 2010. "The Contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception." *American Journal of Obstetrics and Gynecology* 203 (2):115.e1–115.e7.
Sonfield, Adam. 2022. When Your Birth Control Isn't Covered: Health Plan Non-Compliance with the Federal Contraceptive Coverage Requirement. In *Power to Decide*. Accessed May 30, 2023.
Sonfield, Adam, Kinsey Hasstedt, and Rachel Benson Gold. 2014. *Moving Forward: Family Planning in the Era of Health Reform*. Guttmacher Institute, New York.
Sonfield, Adam, Kathryn Kost, Rachel Benson Gold, and Lawrence B Finer. 2011. "The public costs of births resulting from unintended pregnancies: national and state-level estimates." *Perspectives on Sexual and Reproductive Health* 43 (2):94-102.
Stevenson, Amanda J., Katie R. Genadek, Sara E. Yeatman, Stefanie Mollborn, and Jane A. Menken. 2020. "The Educational Impact of Contraceptive Access." *University of Colorado Working Paper*.
U.S. Department of Commerce, Census Bureau. 2020. Current Population Reports: Consumer Income. Government Printing Office, Washington, D.C.

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Access to contraception is fundamental to reproductive autonomy and economic mobility for parents and their children. Today in the U.S., the cost of contraception severely limits access for those without health insurance. Although the Affordable Care Act eliminated cost-sharing for contraception for those with health insurance, substantial cost-sharing remains for uninsured individuals who seek care through Title X—a national family planning program that offers patient-centered, subsidized contraception and reproductive health services to low-income individuals. I propose two changes to Title X to increase the affordability of contraception for uninsured Americans: (1) make contraceptives free for low-income clients through a change to the guidelines issued by the Office of Population Affairs and Health and Human Services and (2) increase congressional appropriations for the Title X program to fund this change in guidelines. Similar to the Affordable Care Act's elimination of cost-sharing for contraception for Americans with health insurance, this proposal eliminates cost-sharing requirements for contraception for uninsured, low-income Americans through the Title X program. This policy proposal is supported by highly relevant evidence from a randomized control trial conducted at Title X providers. Eliminating cost-sharing for contraception through Title X would increase use of preferred contraceptive methods; reduce pregnancies that are mistimed or not desired, including those ending in abortion; and generate substantial enough savings in other government spending that the program would more than pay for itself.

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