

***Griswold v. Connecticut* – The Impact of Legal Birth Control and the Challenges that Remain**

On June 7, 1965, the U.S. Supreme Court, in *Griswold v. Connecticut* (381 U.S. 479 (1965)), struck down a Connecticut law that had made the use of birth control by married couples illegal. The court's landmark decision – coming five years after oral contraceptives became available to American women and 49 years after Margaret Sanger opened the first birth control clinic in the U.S. – provided the first constitutional protection for birth control and paved the way for the nearly unanimous acceptance of contraception that now exists in this country.

The court's recognition of individuals' right to privacy in deciding when and whether to have a child in *Griswold* became the basis for later reproductive rights decisions. In *Eisenstadt v. Baird* (405 U.S. 438 (1972)), the court extended the constitutional protection to unmarried couples; in *Roe v. Wade* (410 U.S. 113 (1973)), the court recognized a woman's right to make her own health care decisions – including abortion; in *Carey v. Population Services International* (431 U.S. 678 (1977)), the court legalized not only the sale of nonprescription contraceptives by persons other than licensed pharmacists, but also the sale or distribution of contraceptives to minors under sixteen and the advertisement of contraception; and in *Planned Parenthood of Southeastern Pennsylvania v. Casey* (505 U.S. 833 (1992)), the court reaffirmed a woman has the right to make her own medical decisions, including whether or not to have an abortion. *Griswold* was also cited in the argument for the right to privacy in the court's 2003 decision in *Lawrence v. Texas* (539 U.S. 558 (2003)), which overturned Texas sodomy laws.

While challenges remain in the struggle to provide universal access to birth control, the court's 1965

decision in *Griswold* granted constitutional protection to the life-enhancing work of Planned Parenthood staff and volunteers and other advocates of reproductive rights in the U.S.

In the 50 years since birth control for married couples was first protected in the U.S., profound and beneficial social changes occurred, in large part because of women's relatively new freedom to control their fertility. Maternal and infant health have improved dramatically, the infant death rate has plummeted, and women have been able to fulfill increasingly diverse educational, social, political, and professional aspirations.

The ability to plan and space pregnancies has contributed to improved maternal, infant, and family health.

- In 1965, there were 31.6 maternal deaths per 100,000 live births (NCHS, 1967). In 2007, the rate had been reduced by 60 percent, to 12.7 maternal deaths per 100,000 live births (Xu et al, 2010).
- In 1965, 24.7 infants under one year of age died per 1,000 live births (NCHS, 1967). Preliminary data for 2011 shows that this figure had declined to 6.05 infant deaths per 1,000 live births, a 76 percent decline (MacDorman et al., 2013).

Since 1965, there has been a dramatic decline in unwanted births, the result of pregnancies that women wanted neither at the time they were conceived nor at any future time. This decline is particularly welcome because unwanted births are associated with delayed access to prenatal care and increased child abuse and neglect (Committee on Unintended Pregnancy, 1995; Piccinino, 1994).

- In 1961–1965, 20 percent of births to married women in the U.S. were unwanted (Mosher, 1988). By 2006–2010, only 8.9 percent of births to married women in the United States were unwanted (Mosher et al., 2012).

Mistimed births – those that happened sooner than the woman wanted them – have also declined markedly.

- In 1961–1965, 45 percent of births to married American women were mistimed (Mosher, 1988); in 2006–2010, only 16.4 percent of births to married women in the U.S. were mistimed (Mosher et al., 2012).

By enabling women to control their fertility, access to contraception broadens their ability to make other choices about their lives, including those related to education and employment.

Since 1965, the number of women in the U.S. labor force more than tripled, and women’s income now constitutes a growing proportion of family income.

- In 1965, 26.2 million women participated in the U.S. labor force; by 2014, the number had risen to 73 million (U.S. Census Bureau, 2009; BLS, 2015a).
- The labor force participation rate of married women nearly doubled between 1960 and 2013 – from 31.9 to 58.9 percent (U.S. Census Bureau, 2009; BLS, 2014).
- By 2012, 29 percent of women in dual-income families earned more than their husbands (BLS, 2014).
- In 1960, women represented three percent of the lawyer population. By 2014, women represented 33 percent of all lawyers (BLS, 2015b; Epstein, 1981).
- Between 1960 and 2013 the percentage of women who had completed four or more years of college increased sixfold – from 5.8 percent to 37 percent (U.S. Department of Education, 1993; Kena et al., 2014).
- In 1960, only 10 percent of all doctorate degrees were awarded to women. Today, women are in parity with men – more than half (51.4 percent) of doctorates were awarded to women in 2012–

2013 (U.S. Department of Education, 1993; U.S. Department of Education, 2013).

Publicly funded contraception programs have increased the ability of lower-income women to exercise the right to control their fertility.

Family planning services available through Medicaid and Title X of the U.S. Public Health Service Act helped women prevent 2.2 million unintended pregnancies in 2010. Without these family planning services, the numbers of unintended pregnancies and abortions would be nearly two-thirds higher than they are now (Frost et al., 2013).

The reduction in unintended births since 1965 is largely a result of Americans’ shift to the more effective contraceptive methods that have become available.

- Among married women using contraception, the percentage relying on the most effective methods – the pill and other hormonal methods, the IUD, tubal sterilization, and vasectomy – grew from 38 percent in 1965 to 76.9 percent in 2006–2010 (Mosher, 1988; Jones et al., 2012).
- More than one-third of all women who use contraception rely on voluntary sterilization – 26.6 percent have had a tubal sterilization and 10.0 percent are protected by their partner’s vasectomy (Guttmacher Institute, 2014a).
- Oral contraception is the most commonly used reversible method – the choice of 27.5 percent of women who use contraception – followed by the condom, used by 16.3 percent of women using contraception (Guttmacher Institute, 2014a).

Investing in family planning is cost-effective.

A study that measured the cost of contraceptive methods compared to the cost of unintended pregnancies when no contraception was used found that the total savings to the health care system falls between \$9,000 and \$14,000 per woman over five years of contraceptive use (Trussell et al., 1995).

Publicly funded family planning services provided in 2010 resulted in a net savings to the federal and state governments of \$13.6 billion – in other words, every

\$1.00 invested in publicly funded family planning services saved \$7.09 in Medicaid and other public expenditures that otherwise would have been needed (Frost et al., 2014b).

The Challenges

In the last 50 years it has become clear that making informed reproductive health care decisions does not rest on the legalization of birth control alone – in order to make responsible decisions for themselves, women and men need access to reproductive health information and services.

Despite the overall reduction in unintended pregnancy during the last decades, American women still experience 3.4 million unintended pregnancies each year – 51 percent of all pregnancies (Finer & Zolna, 2014).

Forty percent of unintended pregnancies that do not end in miscarriage or stillbirth are ended via abortion (Finer & Zolna, 2014).

Unintended pregnancy is associated with a number of serious public health consequences, including delayed access to prenatal care, increased likelihood of alcohol and tobacco use during pregnancy, low birth weight, and child abuse and neglect (Committee on Unintended Pregnancy, 1995).

Cost is a major barrier against access to contraception.

Even though birth control is basic to women's health care, not all insurance plans cover the full range of contraceptive choices, and while funding for contraception for low-income women is provided through Title X and Medicaid, funding has not kept up with demand.

- Public funding for family planning has been inconsistent over the years and has decreased in many states. Although federal funding for family planning rose 18 percent between 1980 and 2006, when inflation is taken into account, funding decreased or stagnated in 18 states and the District of Columbia between 1994 and 2006 (Sonfield et al., 2008).
- Steps to remove economic barriers impeding access to contraception are succeeding, however, at both the state and federal levels. As of May 2015, 28 states now have contraceptive equity laws requiring health plans to provide coverage for all FDA-approved contraceptives (Guttmacher Institute, 2015a). In 1998, a contraceptive coverage requirement was added to the Federal Employees Health Benefits Plan (PL 106-58). This coverage remains in effect today (NCSL, 2010).
- On August 1, 2011, the U.S. Department of Health and Human Services (HHS) announced that the full range of FDA-approved contraceptive methods would be included as one of eight women's preventive health services that would be available without copays or cost sharing as part of the Affordable Care Act (ACA). The HHS announcement followed a strong recommendation from the Institute of Medicine (IOM), an independent, nonpartisan medical body (HHS, 2011). The provision went into effect on August 1, 2012.
- However, the ACA's birth control benefit only works if enforced. Following reports that some insurance companies were still denying coverage or requiring women to pay out-of-pocket for their birth control, the Obama administration issued clarifying guidance on May 11, 2015, stating that insurance companies must cover all 18 FDA-approved birth control methods for women without a copay – not a curated selection (National Women's Law Center, 2015; Sobel et al., 2015; U.S. Department of Labor, 2015). Importantly, the guidance also clarifies that plans must provide coverage for contraceptive-related clinical services, including education and counseling. As of May 2015, more than 55 million women are now eligible for this benefit (HHS, 2015).
- The ACA's birth control benefit saves women money and makes it easier for women to use the birth control method of choice. For instance, in 2013, 24 million more prescriptions for the birth control pill were filled with no copay than in 2012, saving women \$483 million on their out-of-pocket costs on birth control – an average of \$269 per woman – in one year alone. According to this same report, the share of women with no out-of-pocket costs for these forms of birth control increased to 56 percent from 14 percent one year ago (IMS, 2014).

- Dispensed hormonal contraceptive prescriptions increased by 2 million in 2014 over 2013, for a total of 97 million dispensed prescriptions. This represents a two percent increase over the previous year and a six percent increase since 2012. Hormonal contraceptives rank within the top 12 therapy classes by the number of prescriptions dispensed (IMS, 2015).

Improved contraceptive use has contributed to the lowest U.S. teenage pregnancy rate in nearly 40 years, though it still remains one of the highest in the developed world.

Between 1990 and 2010, the national teen pregnancy rate fell 51 percent to its lowest level in nearly 40 years (Kost and Henshaw, 2014). The teen pregnancy rate in the U.S. is still one of the highest among the most developed countries in the world (Guttmacher Institute, 2014b). Each year, nearly 615,000 American teenagers become pregnant (Kost and Henshaw, 2014). The majority of these pregnancies – 82 percent – are unintended (Finer & Zolna, 2014).

- Eighty-six percent of the decline in the teen pregnancy rate through 2005 resulted from improved contraceptive use among sexually active teenagers, and another 14 percent was attributable to increased abstinence (Santelli et al., 2007). An earlier study pointed out that another cause for the reduction of teen pregnancy is that adolescents are increasingly substituting other kinds of sex play for vaginal intercourse (Weiss & Bullough, 2004).

Studies have confirmed that the results of teenage parenting are often discouraging for both mother and child.

- Pregnant teenagers are more likely than women who delay childbearing to experience maternal illness, miscarriage, stillbirth, and neonatal death (Luker, 1996).
- Teen mothers are less likely to graduate from high school and more likely than their peers who delay childbearing to live in poverty and to rely on welfare (Hoffman, 2006).
- The children of teenage mothers are often born at low birth weight, experience health and developmental problems, and are frequently poor,

abused, and/or neglected (Hoffman & Maynard, 2008; Martin et al., 2009; NCPTUP, n.d.).

Teenage pregnancy poses a substantial financial burden to society, estimated at \$9.4 billion annually in public assistance, child health care, foster care, and involvement with the criminal justice system (NCPTUP, 2013).

Access to birth control is still too hard for far too many people.

Increasingly, women and men no longer need to abstain from sex for fear of having more children than they can afford or in terror of endangering a woman's health with a high-risk pregnancy. In 1965, 35 percent of married women in the U.S. used a safe and effective method of family planning. Only one out of 10 women in the developing world did so. Today 56 percent of couples worldwide rely on modern methods of birth control to maintain the health and well-being of their families (PRB, 2014; Ryder & Westoff, 1971).

But access is not universal. Worldwide, 225 million women who want to use modern contraceptive methods cannot access them (Singh et al., 2014). There were 20 million U.S. women in 2012 in need of publicly funded family planning services, an increase of more than three million (22 percent) between 2000 and 2012. All the growth in the need for publicly funded contraceptive was among low-income adults (Frost et al., 2014a).

Inability to pay is not the only block to access for women seeking modern methods of contraception. As of May 2015, 46 states now have refusal statutes written into their state legislation. The majority refer only to abortion. However, 13 of these states have statutes that pertain to both abortion and contraception. Ten of the 13 explicitly allow health care providers to refuse to provide birth control, contraception, and/or family planning services. There are six states with existing laws or regulations which explicitly permit pharmacists to refuse to dispense contraception – six additional states have broadly written refusal clauses that may also pertain to pharmacists (Guttmacher Institute, 2015b).

The ACA's birth control benefit includes an expansive religious exemption, allowing churches, religious schools, and houses of worship to refuse to provide this benefit to their employees, under their right to religious freedom under the First Amendment. Corporations and other for-profit businesses were not exempt. More than 40 for-profit corporations whose owners had personal objections to contraception filed litigation in various federal courts challenging the ACA's contraceptive coverage provision, asserting that it violated their religious beliefs (ACLU, 2015). Specifically, these for-profit companies claimed that requiring their employer health insurance plans to include coverage of contraception violated the Religious Freedom Restoration Act (RFRA) and the Free Exercise Clause of the First Amendment. The Free Exercise Clause of the First Amendment protects an individual's religious exercise from laws that target religion specifically, and RFRA is a federal law that provides greater protection for an individual's religious exercise by prohibiting the federal government from placing a substantial burden on an individual's religious practice, unless there is a compelling reason for the government action and the government action is implemented in the least restrictive way possible.

In the 5-4 *Burwell v. Hobby Lobby* decision issued on June 30, 2014, the Supreme Court set a new precedent by asserting for the first time in American history that private for-profit corporations have religious rights, and that employers have the right to interfere with medical decisions of their employees based on their personal beliefs (134 S.Ct. 2751 (2014)). The implications of this ruling potentially impact much more than women's access to birth control. The Supreme Court decision has created a very slippery slope, giving private, for-profit employers the right to impose their own medical preferences on their employees.

Planned Parenthood believes that all well-woman exam visits and all FDA-approved prescription contraception methods, including emergency contraception when prescribed, should be covered under private health insurance plans as preventive

care with no cost sharing. The HHS decision to include contraception as a women's preventive health service available without copays or cost sharing as part of the Affordable Care Act is a historic victory for women's health.

The prescription status of some forms of birth control can itself be a barrier to access, which is why Planned Parenthood supports making some forms of birth control available over-the-counter (OTC). In 2012, the American College of Obstetricians and Gynecologists (ACOG) recommended increasing access to birth control by approving oral contraceptives for OTC use (ACOG, 2012). A study on the potential public sector cost-savings from over-the-counter access to oral contraceptives found that the rate of unintended pregnancies among low-income women could drop by as much as 25 percent if birth control pills were made available over-the-counter while still being covered by insurance with no copay. The study also found that the number of women using oral contraception could increase by as much as 21 percent (Foster et al., 2015). Making birth control pills available over-the-counter is not adequate, however – because over-the-counter products are not often covered by health insurance, moving some forms of birth control OTC would not eliminate the fundamental need for the women's preventive benefit and for all forms of birth control to be both accessible and covered by insurance. While leading women's health experts agree that some forms of birth control should be made available OTC, currently zero manufacturers have applications in to the FDA to do so. Furthermore, the most effective forms of birth control, such as the IUD, will never be available OTC because they require the involvement of a trained health care provider.

The bottom line is, in a post-Griswold world, much work remains to ensure every woman in America has full access to the birth control method of her choosing – without barriers based on cost, availability, stigma, or other factors.

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