Pregnancy, Preventive Services and Cost Savings: An Ethical and Economic Mirage

On March 21, 2012 the U.S. Department of Health and Human Services (HHS) published the final version of its advanced notice of proposed rule-making (ANPRM) for mandatory preventive services coverage under the Affordable Care Act (77 Fed. Reg. 16501). The rule requires that U.S. employers with 50 or more workers provide zero-dollar (no copay, deductible or premium impact) coverage of a range of disease-preventive medical care, but includes within the ambit of such care both sterilization and birth control drugs and devices certified as "contraceptives" by the Food and Drug Administration. Only a narrow set of religious organizations, mainly houses of worship, are exempted from the rule. In so doing, HHS argues that the cost-savings to insurers resulting from the application of these drugs and devices, which include some that actually cause early abortions, will result in premium reductions for non-exempt employers, thereby nullifying their expressed concerns about subsidizing medicines and procedures they hold to be morally repugnant.

Specifically, the ANPRM states:

> *Issuers would pay for contraceptive coverage from the estimated savings from the elimination of the need to pay for services that would otherwise be used if contraceptives were not covered.*[1]

In other words, savings would accrue to the issuer of a covered employer's health plan by virtue of lower expenses under the plan for prenatal care, complications of pregnancy and, presumably, health services delivered to a child born in the absence of contraception or sterilization. The ANPRM essentially argues that these savings will achieve premium savings or, at worst, "cost-neutrality," thereby alleviating concerns by an employing entity that it is paying for the services to which it conscientiously objects. This argument is specious on at least four grounds.

1. Actual cost-savings are contentious and may not ensue. The cost of some forms of contraception covered by the proposed rule are small (e.g., contraceptive pills at $15 to $50 per month), especially relative to other types of drugs which can range into the hundreds and thousands of dollars per prescription. Other types of contraceptives mandated for zero-cost to the consumer, as well as surgical sterilization to end reproductive potential, are significantly more expensive[2] in terms of upfront costs. The following costs for various methods of pregnancy prevention or abortifacient action illustrate this point:

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[1] "Certain Preventive Services under the Affordable Care Act," at https://www.federalregister.gov/articles/2012/03/21/2012-6689/certain-preventive-services-under-the-affordable-care-act#p-40 (June 20, 2012).

[2] Price list, various web pages, online at http://www.plannedparenthood.org/health-topics/birth-control-4211.htm (June 20, 2012)

Depo-Provera	$35-75 plus exam fees (over three months)
IUD insertion	$500-$1,000 up front (12-year potential), additional charge for removal
Nuva Ring	$15-80 per month
Female sterilization	$1,500-$6,000 (potentially permanent)
Implanon	$400-$800 (up to 3 years)
Birth control patch	$15-80 per month

In addition to the specific possibility that employee use of this coverage could increase insurer costs with no means of recouping those costs, insurers question how similar analyses might be used in the future. As Robert Zirkelbach, a spokesman for America's Health Insurance Plans, a leading trade association, remarked, "We are concerned about the precedent this proposed rule would set."[3] In addition, many employers affected by these provisions are self-insured and utilize third-party administrators, not insurance companies, to handle claims. These entities have no funds of their own with which to process claims and the ANPRM speculates that they might designate funds received from other sources including, presumably, nonprofit groups willing to underwrite sterilizations and abortion-inducing drugs. Such a process would set a similarly disturbing precedent and deprive self-insured employers of the ability to choose ethically compatible third-party administrators to process their claims.

2. Cost-savings are life-cycle driven, essentially incalculable and frequently illusory. Advocates of cost-free distribution of family planning methods frequently assert that every $1 in expenditures for these items "saves $3.80" in yearly net government expenditures.[4] This figure is based on predictions and formulas regarding prenatal care, treatment of complications of pregnancy, and delivery of children of women eligible for public assistance. The frame of reference of this calculation is self-evidently narrow and prejudicial. While predictions of future use of public services and benefits may be sound for an initial period, the net cost-benefit of any particular human life transcends the pregnancy and birth period and is unrepresented in these numbers. Any parent, for example, can reasonably say that he or she averts personal and public "costs" by delaying or avoiding pregnancy. In fact, the "savings" from such a decision likely amount not to $3.80 per dollar expended but to tens of thousands of dollars over the course of every human being's birth, childhood, and adolescence. Clearly, however, the avoidance of any particular birth may not be a financial boon to either a family or to society. Positive returns from human lives in the form of taxation to pay for public services and productivity to increase private sector growth occur later in life, and the pattern of highest "return" is subject to many influences, including broad questions of public policy, character and dependency, and the strength of civil society. Without the ability to track the value of investment in human capital and the return on an individualized basis, the presumed cost-savings of family planning even to government is a pseudo-statistic that depends on an extremely narrow frame of reference and a deterministic, faintly eugenic theory of human development. Numerous nations that have experienced sharp drops in fertility are facing crises of aging that threaten the viability of their economies and government services across the board.[5]

None of these factors addresses, of course, the far more important matter of the inherent value of every human life, irrespective of its apparent or measurable utilitarian value. As Thomas Jefferson noted, "The

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[3] Lewis Krauskopf, "Update 1-Health Insurers Question Obama Birth Control Plan," Reuters, February 10, 2012, at http://www.reuters.com/article/2012/02/10/usa-contraceptives-aetna-idUSL2E8DAEKD20120210 (June 20, 2012).

[4] "Each $1 Invested in Title X Family Planning Program Saves $3.80," Press Release, The Guttmacher Institute, November 16, 2006; at http://www.guttmacher.org/media/nr/2006/11/16/index.html (viewed June 19, 2012).

[5] Douglas Rediker and David Gordon, "12 Signs of the Europocalypse," Foreign Policy, June 12, 2012, at http://www.foreignpolicy.com/articles/2012/06/12/12_signs_of_the_europocalypse?page=0,2 (June 20, 2012).

care of human life and happiness, and not their destruction, is the first and only legitimate object of good government."[6]

3. Cost-savings are not the sole object of health policies and means to achieve them may be objectionable per se. Achieving health care savings is a laudable and primary goal of health insurance reform. The cost of health care as a portion of U.S. GDP, especially relative to other nations' experience, is a valid and growing concern.[7] Cutting costs by such reforms as eliminating wasteful and unnecessary tests, decreasing bureaucracy, improving coordination of care, reforming malpractice laws, and promoting wellness and disease-preventive health care are important steps in slowing health care cost increases. Employers and providers alike, however, may reasonably oppose and refuse to implement a variety of steps to reduce health care costs where such reductions compete or conflict with other values embodied in their decision to provide insurance in the first place. Employers, especially but not exclusively religious employers, may decline to limit the number of dependents included in family coverage; they may welcome a family's decision to protect a child affected by Down Syndrome; they may encourage employees to provide compassionate care for the elderly even if lesser measures could save the plan money. In short, they may see health care benefits as a portion of the compensation they provide that is designed to improve the conditions of life and provide the employed with options they may otherwise have lacked. Like any other component of wages, the meaning and value of this benefit may increase to the employee even as its cost increases to the employer.

4. Equating cost-savings with non-participation opens an ethical Pandora's Box. During her testimony on the preventive services mandate on March 1, 2012, Secretary of HHS Kathleen Sebelius implied that alleged cost-savings due to certain services would facilitate ethical non-participation in those services, stating, "The reduction in the number of pregnancies compensates for the cost of contraception." She was responding to a question from Rep. Tim Murphy (R-Pa.) about who bears the cost of compliance with the contraception-abortifacient-sterilization component of the mandate. Because these practices save money for the insurer, she implied, there is no actual burden on or participation by the employer in the provision of these services by their carrier or third-party administrator. The logical extension of this argument would have even greater force in the case of assisted suicide, denial of care for the terminally ill, or elective abortion – in short, in any case where the government could plausibly allege that the health care service, or denial of service, reduced the expenses borne by an insurer.

Arguments to this effect and policies reflecting it are not fanciful hypotheticals. In 1993 the Guttmacher Institute included elective abortion on a list of reproductive health services that should be mandated for zero-dollar coverage of preventive services in private health care plans.[8] In 2004 Guttmacher updated the study, and a chart accompanying it showed that the percentage of employer-provided group insurance plans covering surgical abortion had risen to more than 85 percent.[9] Guttmacher did not examine self-insured plans, many of which are offered by nonprofit and religious organizations precisely because of their ability to control costs and define coverages in keeping with their missions and

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[6] Thomas Jefferson, "Letter to the Republican Citizens of Washington County, Maryland," March 31, 1809, The Writings of Thomas Jefferson, ed. H. A. Washington, Vol. 8, p. 165 (1871).

[7] "OECD Health Data 2011: How Does the United States Compare" (sic), at http://www.oecd.org/dataoecd/46/2/38980580.pdf (June 20, 2012)

[8] AGI Study of Private-Sector Health Insurance Coverage, CBS Interactive Business Network Resource Library, at http://findarticles.com/p/articles/mi_7355/is_1995_Jan/ai_n32003785/?tag=content;col1 (June 19, 2012).

[9] Adam Sonfield and Rachel Benson Gold, "New Study Documents Major Strides in Drive for Contraceptive Coverage," The Guttmacher Report on Public Policy, June 2004, Volume 7, Number 2; at http://www.guttmacher.org/pubs/tgr/07/2/gr070204.html (June 19, 2012).

moral/religious beliefs. Lobbying for the expansion of the preventive services mandate is likely to remain intense, and advocates for covering elective abortion this way are almost certain to cite the precedent for abortion-inducing drugs established under the ANPRM.

Second, the encouragement of assisted suicide through allocation of public funds for lethal prescriptions but not for certain forms of cancer treatment has been noted with respect to Washington and Oregon's assisted suicide laws. As Marilyn Golden[10] of the Disability Rights and Education Fund wrote in the *New York Times* on April 10, 2012, "Mixing assisted suicide and profit-driven managed health care is a dangerous mistake. A lethal prescription costs about $300, often much cheaper than treatment regimens." Without doubt, the temptation to impose new mandates on health care providers to control costs under the Affordable Care Act will continue to grow, with the result that, under the preventive services mandate or another broad provision of law, a scheme of requiring insurers to include lethal prescriptions could be devised that impacts conscientiously opposed providers and their plans. With the inclusion of services to which they object already established by the ANPRM, religious and other employers can see the deadly writing on the wall.

[10] Marilyn Golden, "Too Many Flaws in the Law," The New York Times, April 10, 2012, at http://www.nytimes.com/roomfordebate/2012/04/10/why-do-americans-balk-at-euthanasia-laws/too-many-flaws-in-assisted-suicide-laws (June 19, 2012).