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Facts Are Important: Correcting the Record on the Administration's Contraceptive Coverage Roll Back Rule

Facts are important, especially when discussing the health of women and the American public. On October 6, the Trump Administration released a regulation – Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act – that threatens women's access to and coverage of contraception. The Administration makes several false statements in this Rule that do not meet a basic standard of scientific evidence. Sound health policy must adhere to the facts.

Contraception is not an abortifacient; contraceptives do not cause abortions or miscarriages.

- FDA-approved contraceptive methods are not abortifacients. Every FDA-approved contraceptive acts before implantation, does not interfere with a pregnancy, and is not effective after a fertilized egg has implanted successfully in the uterus.[i]
- No credible research supports the false statement that birth control causes miscarriages.[ii]

Increased access to contraception is not associated with increased unsafe sexual behavior or increased sexual activity.[iii,iv]

- The percentage of teens who are having sex has declined significantly, by 14% for female and 22% for male teenagers, over the past 25 years.[v]
- More females are using contraception the first time they have sex. Young females who did not use birth control at first sexual intercourse were twice as likely to become teen mothers.[vi]
- Increased access to and use of contraception has contributed to a dramatic decline in rates of adolescent pregnancy.[vii]
- School-based health centers that provide access to contraceptives are proven to increase use of contraceptives by already sexually active students, not to increase onset of sexual activity.[viii,ix]

Physicians and patients, not politicians, should determine the right contraceptive for her health care needs.
As with any medication, certain types of contraception may be contraindicated for patients with certain medical conditions, including high blood pressure, lupus, or a history of breast cancer.[x,xi] For these and many other reasons, access to the full range of FDA-approved contraception, with no cost sharing or other barriers, is critical to women's health.

- The Rule suggests an increased risk of venous thromboembolism (VTE). VTE among oral contraceptive users is very low. In fact, it is much lower than the risk of VTE during pregnancy or in the immediate postpartum period.[xii]
- The Rule suggests contraception increases the risk of breast cancer. In fact, there is no proven increased risk of breast cancer among contraceptive users, particularly those under 40. For women over 40, health care providers must consider both the risks of becoming pregnant at advanced reproductive age, as well as the risks of continuing contraception use until menopause [xiii]

ACOG strongly opposes this political interference in patient and physician health care decisions. Every woman, regardless of her insurer, employer, state of residence, or income, should have affordable, seamless access to the right form of contraception for her, free from interference from her employer or politicians.

[i] Brief for Physicians for Reproductive Health, American College of Obstetricians and Gynecologists et al. as Amici Curiae Supporting Respondents, Sebelius v. Hobby Lobby, 573 U.S. XXX. 2014. (No. 13-354).

[ii] Early pregnancy loss. FAQ No. 90. American College of Obstetricians and Gynecologists. August 2015.

[iii] Kirby D. Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancy. 2009.

[iv] Meyer JL, Gold MA, Haggerty CL. Advance provision of emergency contraception among adolescent and young adult women: a systematic review of literature. J Pediatr Adolesc Gynecol. 2011;24(1):2–9).

[v] Martinez GM and Abma JC. Sexual activity, contraceptive use, and childbearing of teenagers aged 15–19 in the United States, *NCHS Data Brief*, 2015, No. 209, Hyattsville, MD: National Center for Health Statistics. 2015.

[vi] Ibid.

[vii] Lindberg L, Santelli J, Desai S. Understanding the Decline in Adolescent Fertility in the United States, 2007–2012. J Adolesc health. 2016;59(5):577-583. DOI: 10.1016/j.jadohealth.2016.06.024.

[viii] Minguez M, Santelli JS, Gibson E, Orr M, & Samant, S. Reproductive health impact of a school health center. Journal of Adolescent health, 2015;56(3), 338-344.

[ix] Knopf JA, Finnie RKC, Peng Y, et al. Community Preventive Services Task Force. School-based health centers to advance health equity: a Community Guide systematic review. American Journal of Preventive Medicine 2016;51(1):114–26.

[x] Progestin-only hormonal birth control: pill and injection. FAQ No. 86. American College of Obstetricians and Gynecologists. July 2014.

[xi] Combined hormonal birth control: pill, patch, and ring. FAQ No. 185. American College of Obstetricians and Gynecologists. July 2014.

[xii] Risk of venous thromboembolism among users of drospirenone-containing oral contraceptive pills. Committee Opinion No. 540. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:1239–42.

[xiii] Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1.