Textbook:
An Introduction to Bioethics: 9780809146239: Medicine & Health Science Books @ Amazon.com
by Thomas A. Shannon, Nicholas J. Kockler, Paulist Press, 2009.

HW 2

Based on what are you read in this article, answer this questions below. (please write more than two pages)

2nd Writing Assignment: ACA sanctions for service cost of Female but not for Male Contraception alternatives	Write a summary of the article: "Putting the Man in Contraceptive Mandate". Discuss why both the individual and society should be concerned about current and future implications of this issue. Address each of the suggestions for change. Your opinion is valued in this summary.	Due Monday October 9th

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ARHP Commentary — Thinking (Re)Productively

Putting the man in contraceptive mandate☆

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Announced on January 20, 2012, and made effective August 1, 2012, the “contraceptive mandate” is an extension of the Patient Protection and Affordable Care Act (ACA) that sanctioned the provision of contraceptives and sterilization services to women at no cost. While the mandate is a landmark for women’s health care, it has not yet directly addressed a role for men. Male involvement is often either absent or a late addition to reproductive policies, as seen with past developments in sexual health such as emergency contraception [1], the human papillomavirus vaccine [2] and expedited partner therapy for sexually transmitted infections [3]. As written currently, the ACA does not direct insurance carriers to reimburse for vasectomy nor prospective male contraceptives or counseling [4].

Sterilization rates in the USA have remained fairly constant over the last 40 years. The National Survey of Family Growth (2006–2010) reported that 27% of women rely on female sterilization for birth control; only 10% rely on their partners’ vasectomies [5,6]. The exclusion of coverage for vasectomy may widen this disparity by comparatively increasing cost barriers and decreasing social expectations for men. In comparison to female sterilization methods, vasectomy has benefits with respect to efficacy, cost and safety [7]; the ACA’s exclusion of vasectomy is neither ethical nor evidence based and warrants re-examination.

Based on the data from the US Collaborative Review of Sterilization, the cumulative probability of failure for female sterilization at 5 years postprocedure was 13.1/1000 procedures (95% confidence interval: 10.8–15.4), compared to vasectomy at 11.3 (2.3, 20.3) [8,9]. Other sources cite higher annual failure rates for tubal ligation, 0.13–0.17%, compared to vasectomy at 0.01–0.04% [10,11].

Female sterilization also carries greater risk of complication than does vasectomy. Abdominal access for tubal ligation carries 20 times the risk of major complications compared to vasectomy, which is performed in the office under local anesthesia ideally with a single <10-mm scrotal incision [12]. Postoperative complications, such as bleeding and infection, are also more common among tubal ligations than vasectomies (1.2% vs. 0.043%) [13]. Costs of these complications each year are also estimated to be US$ 62.52 vs. US$ 0.06 for tubal ligation and vasectomy per procedure, respectively. Pregnancy complications related to sterilization failure are also more common and costly for tubal ligation. A failed vasectomy leads to intrauterine pregnancy that can be terminated for US$ 403 [14] or carried to term and delivered for US$ 9318 [15]. Alternatively, failed tubal ligation carries a 33% risk of ectopic pregnancy, with significant risk of morbidity and mortality [16], costs quoted at US$ 10,613 [17].

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In addition to being more effective and safer than female sterilization methods, vasectomy is less expensive. A 2012 cost index cites the average cost of vasectomy as approximately US $ 708, compared to the average cost of tubal ligation methods at US$ 2912 [18]. Tubal ligations performed in the operating room incur anesthesia fees, leading to procedures costing up to US$ 3449. Even office-based transcervical methods, US$ 1374, are still more expensive than vasectomy [19].

Despite the comparatively low cost of vasectomy, a quarter of insurance carriers do not cover the procedure [20]. Even if insurers paid for 70% of the procedure, the cost to the patient would still be significant (e.g., a 30% patient portion of the US$ 708 vasectomy fee is US$ 212) [18]. Men with insurance may not even see any benefit as they may still be responsible for the full cost of their deductibles, which, at an average of US$ 1097, is already greater than the cost of a vasectomy [21]. Some insurance carriers may independently elect to provide vasectomies without cost sharing; however, a national policy mandating coverage of this highly effective and cost-effective procedure would aid efforts to increase widespread uptake.

Even the least costly, most commonly performed and effective method of female sterilization, postpartum partial salpingectomy, can only be performed within 48 h of delivery. Furthermore, only half of women desiring the procedure ultimately receive it [22,23]. Considered an elective procedure, postpartum tubal ligations are subject to routine delays on labor and delivery, as well as the religious affiliations at approximately 12% of hospitals that prohibit provision [24]. Regret may also be more common in the postpartum rather than interval setting [25], especially for low-income, minority women who may feel pressured to accept their only perceived opportunity for a Medicaid-funded sterilization [26]. As patients may not seek sterilization outside the postpartum context or receive less effective procedures at a later date, the availability of no-cost vasectomy is especially important [27].

Though health care providers should prioritize the care of women, the lack of male involvement in reproductive health care contributes to the excessive burdens of reproduction and contraception that these women experience. Without guaranteed reimbursement for the care of male patients, reproductive health clinics will lack the financial incentive to broaden care to include male-specific services and outreach. The marginalization of men in family planning clinics has the untoward effect of deterring men who, despite their need for help, consider these environments too embarrassing or exclusive to use [28]. Some states already attribute rising rates of gonorrhea and chlamydia to the inability of low-resource clinics to reach men [29]. Low rates of male attendance at reproductive health clinics may mislead funding sources into believing that men are not interested in these resources, when in fact more funding is needed to improve the visibility of vasectomy, train more providers and correct widespread misconceptions that prevent its uptake [30]. As novel male contraceptives are currently under study, their subsidy and support from the government and pharmaceutical manufacturers depends on perceived demand as well, which may decrease due to the ACA's emphasis on the sufficiency of reproductive care for women alone [31].

The US government has recognized the importance of family planning by approving the contraceptive mandate; however, its exclusion of vasectomy and provisions for prospective male contraceptives reflect the nation's current view of family planning as a "woman's issue." An amendment to the contraceptive mandate would help to establish family planning as a "human issue," for which the involvement of men will increase safety and overall savings, as well as ethically balance the weight of the reproductive burden.

1. Call to action

The Health Resources and Services Administration of the US Department of Health and Human Services (DHHS) recognizes the unique health needs of women and extended their health care coverage under the ACA to include several preventive services, including the provision of contraceptive counseling, contraceptive methods and sterilization. However, the current federal interpretation of this legislation excludes family planning services for men despite the fact that women benefit from male reproductive awareness and use of contraceptives.

There are still multiple avenues for change:

1. The DHHS can directly amend the ACA's contraceptive mandate to specifically include cost-free coverage of male contraceptives, sterilization and counseling.
2. The US Preventive Services Task Force can formally evaluate the benefits of providing not only counseling but also contraceptive and sterilization services to both men and women. Should these services receive at least a Grade B recommendation, all new insurance plans would be required to cover contraception and sterilization.
3. States have the ability to extend coverage to men when composing the Essential Health Benefits expected to be covered by all insurance providers and respective state Medicaid plans in 2014.
4. In 2016, the federal government will revisit how Essential Health Benefits are defined and at that point can explicitly include male and female reproductive care among the categories of essential health services.

The National Health Law Program, a public interest law firm serving underserved and underinsured Americans, has already begun asking the DHHS to extend critical reproductive services to men. Their efforts will be bolstered by the written contribution of physicians and health care providers to state and federal representatives. Government representatives may otherwise be unaware of the efficacy, safety and cost savings of vasectomy compared to tubal ligation, as well as the patient experiences of health care inequality that provide the emotional impact needed to invoke change. Petitions can further help representatives understand the demand for gender

equality in reproductive decision making. Awareness campaigns and social media need to be used to inform more people about the significant benefits of male contraception and sterilization, as well as their underuse compared to female methods. Support of more research on male methods, their safety and their impact on reproductive health outcomes will better inform clinical practice recommendations that will impact future amendments to the ACA.

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