

Minneapolis Department of Health and Family Support Policy and Research Brief, March 31, 2005

Potential Adverse Consequences and Estimated Economic Costs of Requiring Parental Consent in Order for Minors to Access Reproductive Health Services

Minor's consent law

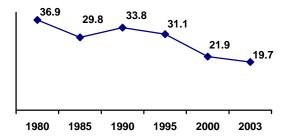
Since 1971, Minnesota law has allowed minors access to confidential health services related to pregnancy, sexually transmitted diseases (Minn.Stat. §144.343 Subd.1). Deliberations to modify the existing law to mandate parental consent should take into account the following points:

- Pregnancies among minors have declined in Minnesota in recent decades.
- Teens report they would stop seeking health care but remain sexually active.
- In Illinois, a county that mandated parental consent saw an immediate increase in teen pregnancies.
- Annual medical costs associated with mandatory parental notification in Texas have been estimated at \$44 million.
- The estimated annual cost associated with requiring parental consent in Minnesota is \$11 million, which includes an additional 1,235 teen pregnancies, 888 births, and 349 abortions among minors.

Pregnancies among minors have steadily declined

In recent decades, pregnancies in Minnesota among girls aged 15-17 years have declined by almost half (47 percent), from a rate of 36.9 pregnancies per 1,000 girls in 1980 to a rate of 19.7 in 2003. Minnesota currently has the nation's fourth lowest pregnancy rate among minors. While it cannot be determined to what extent Minnesota's minor's consent law may have contributed to this desirable decrease in teen pregnancies, it is indisputable that confidential access to health services has **not** led to pregnancies increasing among minors.

of pregnancies in Minnesota per 1000 females aged 15-17 years



¹ Minnesota Department of Health Center for Health Statistics.

Most teens would stop seeking care but remain sexually active, and many would engage in unprotected sex

A Wisconsin study concluded that the majority of minors currently using the services of reproductive health clinics would stop.³ This conclusion was based on a 1999 survey of female clinic visitors under age 18 who were using confidential family planning services. The majority (59 percent) said they would stop using some or all of the available clinic services if parental involvement were mandated. A subset of these girls were also asked about how mandated parental involvement would change their sexual behavior. Only one of 110 sexually active girls said she would stop having sexual intercourse, and she said she would engage in oral sex instead. Almost one-third (29 percent) of the girls said they would have unprotected sexual intercourse, while the remainder said they would rely on condoms and/or have their partner withdraw before ejaculating.

A larger and more recent study reached similar conclusions. In 2003 and 2004, more than 1,500 girls in 33 states who were using reproductive health services were surveyed about their reactions to mandated parental notification. Only 7 percent said they would stop having sex, while 20 percent said they would use no contraception or rely on their partner withdrawing.⁴

McHenry County, Illinois experienced increased teen pregnancies after changing their law

A study of an actual change in minors' access to contraceptives without parental consent presents even more compelling evidence of unanticipated adverse impact. In 1998, McHenry County, Illinois, began to require parental consent before minors could receive contraceptives. The number of births to teens in McHenry County increased by 24 percent in the two years after the law went into effect compared to the previous two years (from 224 to 278 births among girls 18 or younger). During the two-year post enactment period, the number of births declined slightly (1 percent) in three neighboring counties where confidential services remained available to minors.

⁶ Zavodny M, unpublished data provided by author, March 31, 2005...

² Alan Guttmacher Institute. U.S. Teenage Pregnancy Statistics. Available at www.guttmacher.org/pubs/state_pregnancy_trends.pdf.

³ Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA*, 2002;288:710-714.

 ⁴ Jones RK, Purcell A, Singh S, Finer LB. Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception. *JAMA*, 2005;293:340-348.
 ⁵ Zavodny M. Fertility and parental consent for minors to receive

^o Zavodny M. Fertility and parental consent for minors to receive contraceptives. *American Journal of Public Health*, 2004;94:1347-1351.

Economic costs associated with mandated parental notification in Texas have been estimated to total \$44 million annually

The economic costs of impeding minors' access to reproductive health care merit further consideration. A Texas study estimated an annual cost of \$43.6 million associated with enactment of legislation in 2003 that required parental consent for minors to receive contraceptives. The study estimated the costs and health consequences of the loss of confidentiality for female minors on pregnancies, births, abortions and untreated sexually transmitted diseases. The estimates were limited to medical costs associated with female minors using publicly funded reproductive health care in 2001. It should also be noted that Texas's teenage pregnancy rate is the 5th highest in the nation.

Estimated costs in Minnesota are estimated to total \$11 million annually

The Texas cost estimation model was used to calculate cost estimates of modifying the current minor's consent law in Minnesota. Estimates are based on the 8,495 females under the age of 18 years who used publicly funded clinics in 2004. Without access to confidential health services, it is estimated that there would be an additional 1,235 pregnancies, 888 births, and 349 abortions among minors. The costs associated only with medical care for these events would total \$11,364,000. These costs would be offset by an anticipated reduction in the number of clinic visits among young women under age 18 and fewer cases of chlamydia, gonorrhea and pelvic inflammatory disease being treated, resulting in a savings of \$306,000. Subtracting the costs of forgone health care from the projected increased medical costs results in an estimated annual economic cost of \$11,058,000. (The specific projections and calculations are presented in Tables 1 and 2 on the next page).

Other economic costs not quantified

The annual cost estimate of \$11 million associated with modifying the current minor's consent law is an underestimate of the economic costs associated with forgone health care and increased teen pregnancies.

This estimate excludes substantial costs which could not be quantified for the economic model employed, such as:

- Costs to private payers, since the model was based solely on services received through government funded programs.
- Sexually transmitted disease testing and treatment costs for males.
- Costs associated with possible increases in HIV/AIDS associated with lack of access to health counseling.
- Neonatal intensive care costs for preterm infants.
- Long-term health care costs due to infertility caused by untreated infections.
- Long-terms costs associated with teen pregnancies, which include the family's dependence on government assistance and high rates of juvenile delinquency among children. Data from Hennepin County indicated that families that began with a teen birth accounted for more than half of all families on long-term welfare, 70 percent of families with delinquent children under 10 years of age, and 76 percent of all families that ranked among the costliest in terms of social services.

Conclusions

Both the experience of other jurisdictions and current scientific research indicate that restricting confidential access to reproductive health services for minors triggers broad and long-term negative social and economic consequences. Changes to current law intended to limit minors' access to reproductive health services would jeopardize their health and well-being. The City of Minneapolis supports the current Minor's Consent law

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⁸ Alan Guttmacher Institute Contraception Counts: Texas. Available at: www.guttmacher.org/pubs/state_data/states/texas.html. Accessed March 28, 2005.

⁷ Franzini L, Marks E, Cromwell PF, et al. Projected economic costs due to health consequences of teenagers' loss of confidentiality in obtaining reproductive health care services in Texas. *Archives of Pediatrics and Adolescent Medicine*. 2004:158:1140-1146.

⁹ Families that Began with a Teen Birth, Hennepin County Fact Sheet. Center for Health Policy and Community Services Integration, 2002.

Table 1. Projected Costs due to Requiring Parental Notification in Minnesota: Scenario in 8,495 Clients Younger than 18 Years Served by Publicly Funded Clinics in Minnesota

Consequences	Additional No.	Additional Costs, \$
Pregnancies	1,235	ουσισ, ψ
Births	888	11,194,000
Abortions	349	170,000
Total Costs for Pregnancies		11,364,000
Untreated chlamydia	322	
Untreated gonorrhea	88	
PID	73	
Total Costs for STI ^a		-59,000
Reduction in Client Visits	-3,993	-247,000
Total Projected Costs		11,058,000

^a Savings resulting from reduced screening and treatment plus PID costs

Table 2: Assumptions used to Compute Projected Costs due to Requiring Parental Notification in Minnesota

Element	Source/Formula	Number
Number of MN girls <18 receiving publicly funded	MNI Dead of House of Commission	0.405
reproductive health care (2004)	MN Dept of Human Services	8,495
Percent of adolescent girls who would stop using services	Reddy et al 2002 ²	47%
Cost of Visit	MN Dept of Human Services	61.80
Pregnancies averted per client	Franzini et al 2004 ⁵	0.3094
Births averted per client	MN Dept of Health	0.2224
Abortions averted per client Cost of Birth (includes prenatal care and first year infant	MN Dept of Health	0.0873
care)	MN Dept of Human Services	12,606
Cost of Abortion	Franzini et al 2004 ⁵	487
Per 100 Girls		
Additional Pregnancies	Pregnancies averted x reduction	14.54
Additional Births	Births averted x reduction	10.4528
Additional Abortions	Abortions x reduction	4.1031
Cost of additional births, \$	Additional births x cost of birth	131,768
Cost of additional abortions, \$	Additional abortions x cost of abortions	1998
Cost of additional pregnancies, \$ Prevalence of chlamydia among females attending	Cost of births + cost of abortion	133,766
reproductive clinics	MN Dept of Health	10.0%
PID resulting from untreated chlamydia Prevalence of gonorrhea among females attending	Franzini et al 2004 ⁵	20%
reproductive clinics	MN Dept of Health	2.6%
PID resulting from untreated gonorrhea	Franzini et al 2004 ⁵	10%
Cost of screening	MN Dept of Human Services	49.04
Return for treatment	Franzini et al 2004 ⁵	85%
Cost of treatment for chlamydia (Zithromax 1g)	Allscripts	32.68
Treatment effectiveness for chlamydia	Franzini et al 2004 ⁵	95%
Cost of treatment for gonorrhea (Ciprofloxin 500 mg)	Allscripts	8.10
Treatment effectiveness for gonorrhea	Franzini et al 2004 ⁵	99.80%
Cost of return visit for treatment	MN Dept of Human Services	20.60
PID cost	Franzini et al 2004 ⁵	2,150
Per 100 Girls		
Additional untreated chlamydia	Reduction x prevalence x return x effectiveness	3.80
Additional untreated gonorrhea	Reduction x prevalence x return x effectiveness	1.04
Additional PID	Additional untreated cases x PID from untreated cases	0.86
Savings in screening	Reduction x cost of screening	2,304.88
Savings in treatment	Reduction x prevalence x return x trt cost	243
Additional cost of PID	Additional PID x PID cost	1,855
Net cost of untreated STI	Additional PID cost - screen and trt cost	-693