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Policy matters

Barriers to Contraceptive Access after Health Care Reform: Experiences of Young Adults in Massachusetts

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A B S T R A C T

Objective: To explore how Massachusetts' 2006 health insurance reforms affected access to sexual and reproductive health (SRH) services for young adults.
Study Design: We conducted 11 focus group discussions across Massachusetts with 89 women and men aged 18 to 26 in 2009.
Results: Most young adults' primary interaction with the health system was for contraceptive and other SRH services, although they knew little about these services. Overall, health insurance literacy was low. Parents were primary decision makers in health insurance choices or assisted their adult children in choosing a plan. Ten percent of our sample was uninsured at the time of the discussion; a lack of knowledge about provisions in Chapter 58 rather than calculated risk analysis characterized periods of uninsurance. The dynamics of being transitionally uninsured, moving between health plans, and moving from a location defined by insurance companies as the coverage area limited consistent access to contraception. Notably, staying on parents' insurance through extended dependency, a provision unique to the post-reform context, had implications for confidentiality and access.
Conclusions: Young adults' access to and utilization of contraceptive services in the post-reform period were challenged by unanticipated barriers related to information and privacy. The experience in Massachusetts offers instructive lessons for the implementation of national health care reform. Young adult-targeted efforts should address the challenges of health service utilization unique to this population.

Introduction

Massachusetts's 2006 health care reform, *An Act Promoting Access to Affordable, Quality, Accountable Health Care*, known as Chapter 58, benefitted young adults through general reforms (such as the expansion of MassHealth [Medicaid], and the creation of subsidized Commonwealth Care), as well as through several young adult-targeted initiatives (Dembner, 2007; Long, 2008; Pratt, 2007).[1] One year after Chapter 58 was implemented, nearly 100,000 young adults were enrolled in a young

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[1] These initiatives include Young Adult Plans specifically designed to provide young adults not eligible for a subsidized plan or employer health benefit with affordable health insurance; the Student Health Program, in which students enrolled at least 75% time in institutes of higher learning and without coverage are mandated to participate; extension of dependency statutes such that young adults became eligible to remain on a parental health plan through age 25 or for up to 2 years after the loss of dependent status under 26 U.S.C. 106, whichever occurs first. Dependency statutes were further reformed under national reform in 2010, by expanding dependent coverage for all adult children up to age 26 (Center for Consumer Information & Insurance Oversight, 2010).

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adult-targeted health plan (Commonwealth Health Insurance Connector Authority, 2009; Rukavina, Pryor, D'Amato, & Beberman, 2007; The Commonwealth of Massachusetts, 2008).

Widely recognized as a model for the 2010 *Patient Protection and Affordable Care Act* (ACA), Chapter 58 undoubtedly increased young adults' access to insurance. Yet some aspects of Chapter 58, particularly the very popular extended eligibility to be enrolled on a parent's health insurance as a dependent, raise concerns about the degree to which young adults' contraceptive and other sexual and reproductive health (SRH) needs are being met. This paper explores barriers to contraceptive access reported by young adults, which reflect circumstances unique to the post-Chapter 58 context and ongoing concerns that take on new importance in the context of national health care reform. The ACA has targeted and enrolled young adults with mechanisms based on those of Chapter 58 (Landler & Shear, 2014; WhiteHouse.gov, n.d.). We conclude with several recommendations that may ameliorate these unique challenges created or intensified by enrollment in parental insurance through extended dependency.

Materials and Methods

From August through November 2009, we conducted 11 focus group discussions (FGDs) in six Massachusetts counties. Eight included students and nonstudents, and three targeted currently enrolled female students. We held nine FGDs with women (eight in English and one in Spanish) and two with men (one in English and one in Spanish). In total, 89 young adults participated in 90-minute, semistructured discussions on health insurance, contraception, health care reform, and possibilities for improving service delivery. FGD size ranged from 3 to 17 participants; each participant received $50.

We employed a multimodal recruitment strategy, advertising online, in print, through flyers, and by snowball sampling. Potential participants completed a 10-minute phone interview to verify eligibility; 86 young adults (response rate, 97%) also completed a 35-item exit survey. We audio-recorded and took notes at all FGDs. Spanish-language FGDs were transcribed verbatim, then translated into English. We conducted a content analysis of all FGDs using both a priori (predetermined) categories and inductive analysis developed from post-discussion memos and discussions among members of the study team. All transcripts were systematically coded by the lead author incorporating nonverbal cues (such as head nodding) and using the constant comparison technique (Glaser & Strouss, 1967). This study received approval from the Allendale Investigational Review Board (Old Lyme, CT).

Results

Sample Characteristics

Seventy-seven women and 12 men participated in FGDs (Table 1). The average age was 22.5 years (range, 18–26) and the majority of participants self-identified as White (62%) and heterosexual (84%). Eighty-four percent had at least one sexual partner in the past year. More than one half of participants (52%) were enrolled as either part-time or full-time students. At the time of the FGD, 10% of participants were uninsured. More than one half of participants (53%) were enrolled in a private insurance plan, including 29% as dependents on parental plans. Twenty-one percent were enrolled in a subsidized plan. Fifteen percent reported receiving all or some of their insurance through a student health program. Six percent knew that they were insured but were not able to specify the type of insurance. Women, Latino/as, and Blacks were intentionally oversampled to ensure diversity of experiences and, along with American Indians, are overrepresented in our sample relative to the population of Massachusetts and of the United States more generally (U.S. Census Bureau, 2014).

Key Themes

Participants discussed their use of contraceptive and other SRH services in the context of their gender, sexual orientation, sexual activity, relationship status, pregnancy desires, and prior SRH experiences. Herein, we identify the specific unintended barriers also described by young adults after health care reform in Massachusetts.

Poor Knowledge of Contraception and SRH Services

> I didn't even know you could get an implant.…They [providers] might, you know, let you know what new options are coming out.
> - Arielle, 20, Boston[2]

SRH services, in particular contraceptive services, comprised young women's primary interaction with the health system. As Bianca explained, "I wasn't going to the doctors a lot, I really use my doctor to get my birth control, so, for me [insurance] was a big cost." Of the women, 68 (88%) had used prescription contraceptives in the past year, and two thirds of them reported that their prescription drug use was limited to contraceptives, usually oral contraceptive pills (OCPs).[3] Consistent with other research (Culwell & Feinglass, 2007; Frost & Darroch, 2008; Frost, Singh, & Finer, 2007a; Frost, Singh, & Finer, 2007b; Nearns, 2009; Raine, Minnis, & Padian, 2003; Ranji, Wyn, & Salganicoff, 2007), we found that insurance coverage affected young adults'—especially women's—access to contraceptive services and utilization of specific contraceptive methods. The cost associated with contraceptive methods was repeatedly identified as a factor influencing method choice in. Juliet explained that she would not fill her prescription for OCPs until her insurance was activated: "[W]ith the whole mess with insurance, I just decided to wait it out…cause I wanted just not to pay the full amount."

Despite the importance of SRH services, we found young adults' knowledge about contraceptive options generally poor (see also Craig, Dehlendorf, Borrero, Harper, & Rocca, 2014), and every FGD included at least one person (and often many) reporting feeling that providers rarely gave them information about the full spectrum of contraceptive methods. Women reported being especially uninformed about long-acting reversible contraceptives, including both implants and intrauterine devices, although women enrolled in MassHealth and women who sought their care at Title X clinics or Planned Parenthood were more likely to report being offered a variety of contraceptive methods.

Although men spoke about feeling responsible for using condoms and getting tested for sexually transmitted infections,

[2] We use pseudonyms throughout this paper to protect participants' confidentiality.

[3] We did not collect detailed information on individual prescription drug use. Participants may have not volunteered this level of detail in focus discussion groups or they may have underreported medications for mental health conditions in group settings.

Table 1
Demographic Characteristics of Focus Group Participants (n = 86)

Demographic Characteristic	n	%
Language of focus group discussion*		
English	79	89
Spanish	10	11
Gender*		
Men	12	13
Women	77	87
Race*		
American Indian, Alaska Native, Native Hawaiian, Other Pacific Islander	5	6
Asian/Asian-American	4	4
Black/American-American	14	16
White	55	62
Other	9	10
Don't know/no response	2	2
Ethnicity*		
Hispanic or Latino/a	19	21
Not Hispanic or Latino/a	70	79
Sexual orientation		
Bisexual	8	9
Gay/lesbian	2	2
Heterosexual	72	84
Unsure/other/no response	7	5
Marital status		
Never married	68	79
Cohabitating	10	12
Married/domestic partner	5	6
Divorced/other	3	3
Sexual activity		
Sexual partner within the last year	72	84
Household income (U.S.$)		
≤25,000	30	35
25,001–50,000	19	22
50,001–75,000	4	5
75,001–100,000	3	3
>100,000	6	7
Unknown/no response	24	28
Student status		
Full-time student	38	44
Part-time student	7	8
Not a student	41	48
Education completed		
Some high school	5	6
High school diploma/GED	16	19
Associate's/some college	37	43
Bachelor's degree	21	24
Some graduate school/graduate degree	7	8
Health insurance at time of discussion†		
Uninsured	9	10
Subsidized plan		
MassHealth or MassHealth and Medicare	14	16
Commonwealth Care	5	6
Other subsidized plan	2	2
Private plan		
Parental plan	25	29
Employer plan	16	19
Commonwealth Choice plan	3	3
Partner's plan	2	2
Plan through College or University (Student Health Program)	13	15
Unsure of Insurance type	5	6

* n = 89 for these items. Three participants left the focus group discussions without completing the exit survey, but all completed an intake survey that allowed us to determine race/ethnicity, gender, and language preference. See Methods for details.

† Because some respondents listed more than one type of insurance (usually SHP in combination with another insurance), percentages total more than 100.

they universally confessed to little knowledge of contraceptive methods other than condoms and OCPs and rarely received information from their providers about female-oriented methods. As Manuel explained: "Being a man, I was only told 'condom'… and now that I am with a partner, she knows a lot about her options, but I do not, so we cannot have that conversation."

Information Barriers to Insurance

> I'm a student also and I have to get insurance through my school. And I have insurance through Mass—like, here, and I guess I'm just like kind of ignorant about it. I don't even understand why I have both or what would cover which.…I guess I don't even know so like I have two insurances.
> -Arianna, 20, Boston

Most FGD participants understood Chapter 58 only as an individual mandate. A recurring theme in discussions was their lack of adequate knowledge to make informed decisions about health insurance. The recurrent statement that they had "no choice" in selecting a plan because of socioeconomic, employer, or educational institution constraints produced many nodding heads, leaving young adults with little incentive to learn about health insurance. Difficulty navigating the online materials of both the Health Connector[4] and some private insurers was also mentioned at every FGD; in particular, respondents reported difficulty comparing plans and assessing overall out-of-pocket expenses. Among those who were healthy and expected to have few office visits, most were willing to pay higher copayments in favor of lower premiums when choosing their own plan.

Parents were frequently involved in insurance-related decisions. Nearly one third of all insured participants (and more than one half of those enrolled in a private insurance plan) were enrolled as a dependent in a parental plan. In almost all of these cases, young adults described the plan as chosen by their parents with the entire family's needs in mind, but without their participation in decision making. Young adults also sought help from parents, and particularly mothers, when choosing their own health insurance plans, often turning the entire project over to them. Faced with choosing new insurance for the first time, Stephanie described her interaction with her mother: "I…was kind of like, 'I can't deal with this right now, it's overwhelming. Like, whatever you say, I'll do.'" These young adults reported having little input on the decision, but assumed it was made in their best interests. No participant described having a conversation with parents about insurance in relation to their contraceptive and other SRH needs and how these may evolve over time.

Women generally assumed that their OCPs would be "covered" by any health plan, but they rarely could predict the cost of the copayments for that specific medication based on the "tier" chart presented in print and online materials. Women commonly reported being unsure about which prescriptions fell under which tier and found it difficult to find information about the brand they used. In contrast with OCPs, women did not generally speak about long-acting reversible contraceptives in discussing their decision making about insurance coverage.

Lack of Confidentiality

> I think the reason that I haven't had, you know, oral contraception or that before was kind of because I didn't want my

[4] The Health Connector is the website for the Massachusetts insurance exchange.

> mom to find out that I had to like purchase this.… I didn't want it to show up on my mom's bill for insurance or whatnot.
> -Adeline, 19, Cambridge

Although young adults universally appreciated being able to stay on their parents' health plans longer as a result of dependency reforms, their access to contraception and SRH services was mediated by the loss of privacy that the extension of dependency brought. A parent is almost always the primary subscriber for health insurance for the mechanism of extended dependency, and explanations of benefits used by dependents are therefore sent to parents. Consistent with other young adults who sought to avoid disclosure, Aidan said he would rather use condoms than alert his or his girlfriends' parents about their sexual activity: "Another big thing is being on a parent's health plan—that [prescription contraception] has to go through them." University and college students also reported confusion about how their on-campus services and external coverage (either through the school or through enrollment in a parental plan) fit together and what information their parents could receive or access. In contrast, participants who received services at Planned Parenthood and other Title X family planning clinics praised them for their cost effectiveness and respect for confidentiality; many reported turning to these clinics when they lacked coverage or were unable to use their insurance for contraceptive services.

Transition Barriers

> [B]ecause once I'm done with school, when I'm done for the summer, then what do I do about health care?
> -Amanda, 23, Worcester

Ten percent of participants reported being uninsured at the time of the FGD. Uninsured periods and other changes in insurance status were often related to broader life transitions characteristic of young adulthood, such as graduation from college or other changes in student status, probationary periods with new employers or changes in employment status, moving residence, and birthdays. Graduation loomed large in FGD conversations about loss of health insurance. Nearly all participants who reported going without health insurance would have preferred being insured, but could not find affordable or suitable insurance; Aubrey regretfully described the policy offered by her unpaid summer internship as "way more than I could afford" and was uninsured for this period and for the first 3 months' probation at her new job. Like Amanda, who enrolled in a graduate program specifically to stay on her father's insurance, few young adults in our study were aware of mechanisms that had been enacted under health care reform to help young adults to weather transitional periods.

This snapshot of current enrollment only partially reveals the myriad experiences and complicated histories many participants have had with health insurance. Nearly 20% had enrolled in their current health plan within the year before the discussion (after the implementation of Chapter 58); 14% had been on their current plan for 6 months or less. It was not uncommon for participants to describe having had three or more insurance types (including being uninsured) in the post-Chapter 58 period.

Finally, geographic constraints on some plans resulted in difficulties accessing in-network physicians and prescription services for routine care among young adults who lived or went to school in a location other than where their insured parent(s) lived. Four women reported discontinuing OCPs when they encountered difficulties securing a regular supply as a result of the mismatch between the defined coverage area and their school; both men and women mentioned this issue in relation to broader health needs.

Discussion

Among the most popular components of the ACA are provisions affecting young adults: Nearly 40% of Americans agree that young adults will be better off under the ACA (Kaiser Family Foundation, 2012) and 70% approve of the dependency extension (Kopicki, 2013). Young adults, a population that has historically been disproportionately uninsured in the United States (Boonstra, 2009; Callahan, Woods, Austin & Harris, 2004; Park, Mulye, Adams, Brindis, & Irwin, 2006), have been incorporated into health care reform efforts in Massachusetts by extending the "dependency" of young adults and offering subsidized and low-cost coverage. Many participants benefited from components of the initiatives. However, we also identified barriers that are likely to pose challenges to connecting young adults with SRH services at both the state and national levels.

Although the extension of dependency resulted in many young adults being able to retain insurance and weather transitions, the impact of billing procedures and service statements on young adults' privacy may undermine young adults' ability to access SRH care. Adult children enrolled as dependents on parental plans and students enrolled in college/university plans reported concerns about confidentiality if their parents were to receive statements or bills with information about health services utilization. Similarly, access to care was sometimes hindered when young adults left their parents' defined coverage area for school or other travel. Although young women disproportionately bore the responsibility for obtaining and arranging payment for prescription contraception, heterosexual and bisexual men often experienced these barriers via their partners. Both men and women expressed concern about confidentiality, information barriers, and the effect of transition barriers on their insurance status.

We found that young adults' health plan enrollment is often determined by parental decision makers. Many participants reported that their parent(s) was/were not fully aware of their priorities and needs with respect to contraception and other SRH services. We also identified a lack of awareness about the components of Chapter 58. Although most young adults indicated that they knew about the individual mandate, they did not know about reforms designed to make this mandate affordable, including the creation of subsidized and young adult-targeted plans, extended eligibility for MassHealth, and changes in dependency statutes. We found that some young adults made life decisions (including enrolling in additional schooling) or were uninsured for a period of time because of misinformation, usually regarding their eligibility to remain on parental health plans. Among the young adults who participated in this study, a lack of knowledge about provisions in Chapter 58, rather than calculated risk analysis characterized periods of uninsurance and the dynamics of being transitionally uninsured and/or moving between health plans, limited consistent access to contraception (Kaiser Family Foundation, 2013; Sered & Proulx, 2011).

Implications for Policy and/or Practice

Like other recently published studies on the Massachusetts experience with health care reform (Dennis et al., 2012;

Fitzgerald, Cohen, Hyams, Sullivan, & Johnson, 2014; Janiak, Rhodes, & Foster, 2013), this research provides lessons that can be directly applied to the national implementation of the ACA. First, default systems of disclosure must protect young adults' confidentiality to ensure they can obtain needed services with dignity and privacy. Second, creating resources that target both young adults and their parents (or caregivers) would help parents to understand better the insurance needs of their young adult children and either advise them or navigate health plans on their behalf. Third, improving awareness among young adults about the insurance options targeting this population is essential. Although broad educational efforts are essential, we identify college and university students anticipating graduation as one important and easily addressed group. Educational resources for soon-to-be graduates should clearly explain available health insurance options. These guides should also be designed to improve health insurance literacy, which is necessary for individuals to realize the promise of health care reform.

Conclusions

Because the ACA is modeled on Massachusetts, young adults in the Commonwealth and across the United States are likely to encounter the unanticipated barriers in the wake of reform. Because rates of uninsurance were lower in Massachusetts than in other states before Chapter 58 was enacted (Long, 2008) and Massachusetts residents are more likely to hold college and advanced degrees (U.S. Census Bureau, 2011), we believe that the barriers we identified are likely to be the "best case scenario" compared with states in which the population is less likely to be insured and less well-educated. Rather than being "young invincibles," many young adults may need assistance determining how to comply with, and take advantage of the provisions of, the ACA. Enrolling in parental insurance through extended dependency poses unique challenges to young adults' privacy and ability to access contraception and other SRH care. Efforts to help young adults and their parents navigate the new health care insurance landscape seem to be warranted.

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