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Commentary

Making the Most of the Affordable Care Act's Contraceptive Coverage Mandate for Privately-Insured Women

Carol S. Weisman, PhD [a,b], Cynthia H. Chuang, MD, MSc [a,c,*]

[a] Department of Public Health Sciences, Penn State College of Medicine, Hershey, Pennsylvania
[b] Department of Obstetrics and Gynecology, Penn State College of Medicine, Hershey, Pennsylvania
[c] Department of Medicine, Penn State College of Medicine, Hershey, Pennsylvania

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Under the Patient Protection and Affordable Care Act of 2010 (ACA), most women of reproductive age with private health insurance have, or will soon have, first-dollar coverage of contraception and contraceptive counseling. The need for contraceptive coverage is great, because most American families want two children, resulting in the average woman spending three decades of her reproductive life trying to avoid pregnancy (Guttmacher Institute, 2012; Finer & Philbin, 2014). Contraceptive coverage without cost sharing is a sea change in women's health insurance. This policy change has the potential to dramatically shift contraceptive use patterns, to reduce the U.S. unintended pregnancy rate—which stands at approximately half of all pregnancies (Finer & Zolna, 2014)—and to improve the health of women and families. In this commentary, we argue that realizing the potential of this policy change requires more action on the part of public health practitioners, insurers, health care providers, and researchers than is currently evident, and we offer some suggestions for making the most of first-dollar contraceptive coverage.

Trends in Contraception Coverage

The majority of U.S. women ages 18 to 64 have private health insurance—either employer based (57%) or privately purchased (7%; Salganicoff, Ranji, Beamesderfer, & Jurani, 2014)—and the proportion of privately insured will increase with the roll out of the ACA health insurance exchanges. Before the passage of the ACA, most private health insurance plans covered prescription contraception, although the types of contraceptives covered and the level of cost sharing varied widely across states and health plans (Salganicoff & Ranji, 2012; Sonfield, Gold, Frost, & Darroch, 2004). As of 2012, ACA mandated coverage of the full range of Food and Drug Administration-approved contraceptive methods and added the requirement that contraception must be provided without cost sharing (i.e., no copays or deductibles: available: http://www.hrsa.gov/womensguidelines/). The ACA mandate applies to all private health plans—including self-insured employer-based plans—that are not "grandfathered" (i.e., in existence before March 23, 2010, with basically no changes), exempted religiously affiliated employers, or, as recently decided by the U.S. Supreme Court in the Hobby Lobby case, closely held for-profit corporations whose owners object to coverage of contraception for religious reasons.

Evidence is already emerging that the contraceptive coverage mandate is reducing women's out-of-pocket expenditures for contraception. One national survey by the Guttmacher Institute found that the ACA has significantly increased the proportion of privately insured oral contraceptive users and vaginal ring users who pay nothing out-of-pocket for their method; for example, among pill users, the proportion paying nothing out of pocket increased from 15% to 40% between the fall of 2012 and spring of 2013 (Finer, Sonfield, & Jones, 2014). This is noteworthy because oral contraceptives are the most prevalent form of medical contraception used by U.S. women, accounting for about 28% of users (Jones et al. 2012). The 2013 Kaiser Women's Health Survey found that 35% of women using birth control in the past year reported that their insurance fully covered the cost of contraception during their most recent visit, 41% reported partial coverage, 13% reported no coverage, and 8% did not know (Salganicoff et al., 2014).

The proportion of privately insured women obtaining contraception with no out-of-pocket costs is expected to increase. Over time, fewer health plans will fall in the grandfathered category: In 2013, 36% of workers with health insurance were in grandfathered health plans, compared with 48% in 2012 (Claxton, Rae, Panchal, & Damico, 2013). And notwithstanding the recent Supreme Court decision, even women whose employers object to contraceptive coverage on religious grounds

* Correspondence to: Cynthia H. Chuang, MD, MSc, Editorial Board Member, *Women's Health Issues*, Department of Medicine and Public Health Sciences, Penn State College of Medicine, 500 University Drive, HO34, Hershey, PA. Phone: 717-531-8161; fax: 717-531-7726.
E-mail address: cchuang@hmc.psu.edu (C.H. Chuang).

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may have access to first-dollar contraceptive coverage through accommodations providing coverage by the insurance plan (see http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf) or other mechanisms.

Contraceptive Choices

It is too soon to tell whether the ACA contraceptive coverage mandate is impacting contraceptive use patterns among privately insured women, but we would expect to see important changes. First-dollar contraceptive coverage not only makes contraception affordable for more women, but also increases contraceptive options by making the most expensive—and most effective—methods more accessible. Long-acting reversible contraceptives (LARCs), including intrauterine devices (IUDs) and implants, are more effective at preventing pregnancy than the more commonly used oral contraceptives, but LARCs have higher upfront costs owing to the charge for the product and the need for a dedicated visit and procedure to obtain the method. Proponents of LARCs are hopeful that coverage of contraception without cost sharing will increase utilization of LARCs relative to other methods. There is some evidence that this could happen.

Research has shown that contraceptive choices are sensitive to costs to the woman. Pre-ACA studies of privately insured women found that lower cost sharing was associated with greater adoption of IUDs, controlling for other factors (Gariepy, Simon, Patel, Creinin, & Schwarz, 2011; Pace, Dusetzina, Fendrick, Keating, & Dalton, 2013). When the Kaiser Foundation Health Plan in California provided full coverage without copays for LARCs and for emergency contraception, use of these methods increased substantially over a 5-year period (Postlethwaite, Trussell, Zoolakis, Shabear, & Petitti, 2007). The ongoing Contraceptive CHOICE Project promotes LARC use by providing women in the St. Louis region with their chosen contraceptive at no cost for 3 years, with information about LARCs, and with structured one-on-one contraceptive counseling (Secura, Allsworth, Madden, Mullerman, & Peipert, 2010). In that project, 75% of participants chose a LARC, with early results showing significantly fewer teen births and abortions compared with national levels (Peipert, Madden, Allsworth, & Secura, 2012).

Such a high proportion of women choosing LARCs requires some comment. In addition to providing information and counseling encouraging adoption of LARCs, the CHOICE Project established a network of private providers who were trained and available to provide the contraceptive chosen by the participant. In the typical health plan in which a woman sees a primary care provider who may not be trained in the provision of LARCs, the choice of an IUD or implant is likely to require a referral. The vast majority (84%) of privately insured women of reproductive age obtain reproductive health care in a private doctor's office or managed care plan (Salganicoff et al., 2014). Most primary care physicians do not provide IUDs and have training and knowledge gaps related to their use (Harper et al., 2012; Rubin, Fletcher, Stein, Segall-Gutierrez, & Gold, 2011). And even though about 96% of obstetrician–gynecologists provide IUDs, training gaps remain and same-day insertion is not generally available (Luchowski et al., 2014). Thus, the CHOICE Project findings may overestimate adoption of LARCs for the general population of privately insured women, at least in the short term. Over time, increased demand for LARCs may lead to an increase in the proportion of clinicians trained to provide them.

The efficacy of LARCs compared with other reversible contraceptive methods is undeniable, but whether that makes them the right contraceptive methods for most women is a different matter. Factors other than efficacy and cost are important to women when they choose a contraceptive; these factors include side effects, convenience, comfort level with using hormones or devices, and partner influences. Although discontinuation rates of LARCs are relatively low compared with other reversible methods, they are not insignificant at 25% to 50% after 24 months (O'Neil-Callahan, Peipert, Zhao, Madden, & Secura, 2013). A recent commentary points out pitfalls in assuming that LARCs will solve the unintended pregnancy problem, in emphasizing LARCs over other methods, and in the potential of targeting poor women of color for LARCs (Higgins, 2014).

Need for a Woman-Centered Approach

In contrast with promoting the use of LARCs, a more woman-centered approach would view the contraceptive coverage mandate as an opportunity to help women make the contraceptive choices that are right for them. In this framework, the objectives include increasing women's awareness of first-dollar contraceptive coverage, providing information on the range of contraceptive options available and their relative benefits and risks, and helping women to make optimal contraceptive decisions in the context of their reproductive life stage, health status, and personal preferences. Rather than advocating use of specific methods, a woman-centered approach would provide the tools for the woman to make an informed decision, access her chosen method in a timely manner, and change her method as her life circumstances or health status change.

Many women are unaware of their new covered benefits under the ACA. In late 2013, only 57% of women ages 18 to 64 were aware that the ACA requires most private health insurance plans to cover the full cost of preventive services (Salganicoff et al., 2014). In another national survey, 65% of women ages 18 to 55 did not know if their coverage for contraception would change as a result of the ACA (Hall, Fendrick, Zochowski, & Dalton, 2014). Many women may be confused about the contraceptive coverage mandate and which health plans are affected. To date, there have been few efforts to develop and test tools to inform women of their coverage benefits and to assist them with contraceptive decision making in the context of having first-dollar coverage.

A recent initiative in Massachusetts targeting young women ages 18 to 26 is noteworthy. Massachusetts introduced health care reform including coverage for contraception in 2006. In that state, research suggested that some groups of women, including younger women, could "fall through the cracks" of health care reform if services such as contraception were not readily accessible given increased demands for care (Dennis et al., 2012). To help young women, the Reproductive Empowerment and Decision-Making for Young Adults (REaDY) Initiative prepared a website tool, My Little Black Book for Sexual Health: A Guide for Getting the Health Insurance You Need to Prevent Pregnancy Until You are Ready (www.littleblackbookhealth.org), available in English and Spanish. The objective was to assist young women to access health insurance, providers, contraception, and other reproductive health services, and to provide informational resources that are understandable and tailored to their needs. During development of the materials, literacy demands assessment and usability testing identified areas, such as reading level and site navigation issues, requiring modification. The impact of

this tool on women's contraceptive choices has not been reported.

A women-centered initiative targeted at women ages 18 to 44 is underway at the Pennsylvania State University College of Medicine in partnership with Highmark Blue Shield. This project is testing a web-based intervention, *MyNewOptions*, designed for privately insured women who have first-dollar contraceptive coverage. The intervention consists of three components: 1) Information about the ACA contraceptive coverage mandate and contraceptive options, including effectiveness, side effects, and safety issues for specific contraceptives, 2) a reproductive life plan (adapted from the CDC's reproductive life planning tool: http://www.cdc.gov/preconception/reproductiveplan.html) to help clarify goals and self-assess contraceptive needs, and 3) decision aids to help women with "if–then" action planning aimed at improving contraceptive adherence for the chosen method. The intervention components were designed with the help of a patient advisory group, which also informed the project's recruitment strategies in conjunction with the Penn State Clinical and Translational Sciences Institute's Community Advisory Board. In a randomized, controlled trial, this ongoing project is testing the impact of the intervention on method choice and adherence over a 2-year follow-up period.

What Is Needed?

The ACA has changed the landscape for access to contraception for U.S. women. The requirement that private health plans provide contraception without cost sharing has the potential to increase overall use of medical contraception, increase use of LARCs, improve continuous use of contraception by eliminating gaps that occur when health insurance coverage changes, improve birth spacing, reduce the U.S. unintended pregnancy rate, and improve the health of women and families (Institute of Medicine, 2011). However, although first-dollar coverage of contraception removes a major barrier to contraception, additional access and informational barriers remain. To fully realize the potential of the contraceptive coverage mandate, we argue that it is crucial to raise awareness of coverage among women and to provide contraceptive information, decision tools, and system supports to enable women to access contraception and improve outcomes. Specifically, we need:

- Clear **communications to the public** about the ACA contraceptive coverage mandate, including explanations of which types of health plans are included and which are exempt.
- Clear **communications to private health plan enrollees** about their plan's contraceptive coverage. Health plan administrators should also ensure that patient liaisons are aware of the contraceptive coverage benefit, can respond to questions from consumers about which methods or products are covered by the plan, and can help women to navigate the plan to access contraception in a timely manner.
- Design, assessment, and dissemination of **woman-centered information and decision tools** to help women make optimal contraceptive choices in the context of their own circumstances and preferences. Evidence-based tools are needed to assist women with initial contraceptive choices and with ongoing contraceptive decisions to improve continuity of use and to support method changes when needed.
- **Training of primary care providers** in effective contraceptive counseling methods and in the relative benefits and risks of the full range of Food and Drug Administration-approved contraceptive methods, including LARCs. Because demand for contraceptive services from primary care providers is likely to increase, provider training is essential for ensuring privately insured women's access to contraception from the primary care provider or through a timely referral.
- **Seamless referral arrangements** are needed so that women seeking contraceptive methods not available through their primary care providers can access those methods efficiently within the health plan's in-network providers or affiliated family planning clinics and, optimally, can receive same-day insertion of LARCs. Without seamless referrals, women may be at increased risk of delays or gaps in contraceptive use—and of unintended pregnancy—even though they have first-dollar coverage for contraception.

The combined efforts of policymakers, insurers, health care providers, and public health and health services researchers are needed to make the most of the contraception coverage mandate in a new era for women's health care.

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Author Descriptions

Carol S. Weisman, PhD, is Distinguished Professor of Public Health Sciences and Obstetrics and Gynecology. She is a sociologist and health services researcher with a special interest in women's primary and preventive care.

Cynthia H. Chuang, MD, MSc, is Associate Professor of Medicine and Public Health Sciences at the Penn State College of Medicine. Her research focuses on reproductive health care for women with chronic medical conditions.