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Changes in out-of-pocket payments for contraception by privately insured women during implementation of the federal contraceptive coverage requirement☆,☆☆,★

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Abstract

Background: As part of the Affordable Care Act, a federal requirement for private health plans to cover contraceptive methods, services and counseling, without any out-of-pocket costs to patients, took effect for millions of Americans in January 2013.
Study design: Data for this study come from a subset of the 3207 women aged 18–39 years who responded to two waves of a national longitudinal survey. This analysis focused on the 889 women who were using hormonal contraceptive methods in both the fall 2012 and spring 2013 waves and the 343 women who used the intrauterine device at either wave. Women were asked about the amount they paid out of pocket in an average month for their method of choice.
Results: Between Wave 1 and Wave 2, the proportion of privately insured women paying zero dollars out of pocket for oral contraceptives increased substantially, from 15% to 40%; by contrast, there was no significant change among publicly insured or uninsured women (whose coverage was not affected by the new federal requirement). Similar changes were seen among privately insured women using the vaginal ring.
Conclusions: The initial implementation of the federal contraceptive coverage requirement appears to have had a notable impact on the out-of-pocket costs paid by privately insured women. Additional progress is likely as the requirement phases in to apply to more private plans, but with evidence that not all methods are being treated equally, policymakers should consider stepped-up oversight and enforcement of the provision.
Implications: This study measures the out-of-pocket costs for women with private, public and no insurance prior to the federal contraceptive coverage requirement and after it took effect; in doing so, it highlights areas of progress in eliminating these costs and areas that need further progress.

Keywords: Contraception; Oral contraceptive pills; Insurance; Health care reform; Out-of-pocket costs

1. Introduction

In the realm of reproductive health, one of the most important and most discussed provisions of the Affordable Care Act is a requirement that private health plans include coverage of contraceptive methods, services and counseling for women and that they do so without requiring copayments, deductibles or other forms of out-of-pocket costs for their enrollees [1]. This requirement — part of a broader provision requiring coverage without cost sharing for dozens of recommended preventive care services — was phased in starting in August 2012.

Coverage of a wide range of contraceptive methods was already standard in U.S. private health plans. According to the most recent in-depth study of insurance coverage of contraception, a nationally representative survey of private U.S. health insurers in 2002, almost every reversible and permanent contraceptive method available was covered by 89% or more of typical insurance plans at that time [2]. Moreover, at the time the federal requirement went into effect in 2012, 28 states already had requirements in place

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that private insurance plans cover the full range of prescription contraceptive methods [3].

Where the federal requirement broke new ground, at least for private health plans, was in its prohibition on patient cost sharing. That change brought with it the potential to eliminate cost as a reason for choosing one method of contraception over another, a change that could be particularly important for women considering an intrauterine device (IUD) or implant — methods that are highly effective and cost effective but have substantial upfront costs. Federal law since the early 1970s has similarly prohibited cost sharing for contraceptive methods and services under Medicaid [4].

The new federal contraceptive coverage requirement is not applicable to all health plans and enrollees. First, the requirement is being phased in, affecting new plans as they are created and existing plans when they begin a new plan year; because most plans begin their plan year in January, millions of enrollees gained these coverage protections in January 2013. In addition, existing plans are grandfathered — exempt from the requirement — so long as they make no significant negative changes, such as benefit reductions or cost-sharing increases; 36% of covered workers were enrolled in a grandfathered health plan in 2013 [5].

Second, the federal government has granted an exemption to the requirement for health plans offered by houses of worship and other religious employers [6], and dozens of for-profit and not-for-profit employers have challenged the contraceptive coverage requirement in court, claiming it is a violation of religious rights [7]. With federal appeals courts already having issued conflicting rulings on the subject, the U.S. Supreme Court will address the controversy during its 2014 spring session.

Moreover, it is not yet clear how the requirement is being interpreted and implemented by health plans. The federal government provided some guidance in a set of "frequently asked questions" released in February 2013 [8]. Notably, that guidance clarifies that plans must cover "the full range" of contraceptive methods approved by the Food and Drug Administration when prescribed for a woman, and specifically mentions the IUD and implant as examples. However, the guidance repeated earlier assurances that health plans may use "reasonable medical management techniques"; the specific example given is that plans may use drug formularies that require copayments for some brand-name drugs that have generic equivalents. Plans must have a process to waive such restrictions when a woman's provider determines that it is medically appropriate for her needs to do so. The guidance also reaffirmed that the contraceptive coverage requirement applies only to services obtained from in-network providers, but it clarified that a plan must cover a given service out of network without cost sharing if the plan's network does not have anyone to provide that service.

This article provides the first national-level data about the initial reach and impact of the contraceptive coverage requirement. It takes advantage of information collected from a longitudinal survey of women, comparing women's responses in fall 2012 (before the contraceptive coverage requirement would have taken effect for most women) and spring 2013 (after the requirement would have come into force for millions).

2. Materials and methods

Data for this analysis come from Waves 1 and 2 of the Guttmacher Institute's Continuity and Change in Contraceptive Use study, which is examining women's contraceptive use over an 18-month time period. The study is being administered online to a national sample of women aged 18–39 years. We opted for online administration because it is the most efficient way to collect information from large national samples, as the changing dynamics of home and cell phone use have made phone surveys less representative [9]. Recent work has indicated that Internet surveys of probability-based samples, along with post-stratification weights, can achieve results that are comparable to or in some cases better than telephone surveys [10–12].

We subcontracted with GfK (formerly Knowledge Networks) to administer the survey using their KnowledgePanel, a national household panel recruited using a probability-based methodology. The panel totals approximately 50,000 individual household members older than 13 years and is representative of the U.S. population. GfK uses address-based sampling to recruit panel members; if a household invited to participate in the panel lacks a computer or Internet access, GfK provides them free of charge. GfK estimates that its panel covers 97% of U.S. households. This panel has been used previously in several published papers on sexual behavior and contraception, demonstrating the willingness of the sample members to participate in surveys related to sexual behavior [13–16]. In particular, the distribution of contraceptive users in the KnowledgePanel has been found to be similar to that in the National Survey of Family Growth, an in-home nationally representative survey that is arguably the best source of information about reproductive health behaviors in the United States [17].

In order to focus on women at risk of pregnancy, our baseline survey population was restricted to women aged 18–39 years who had ever had vaginal sex with a man, who were not currently pregnant, who had not had a tubal ligation and whose main sexual partner had not had a vasectomy. (Although women aged 40–44 or 40–49 years are often considered to be within the fecund range, their fecundity is typically lower than that of younger women. In addition, they have lower rates of unintended pregnancy and substantially higher rates of sterilization; the latter group would have been ineligible to participate.)

The baseline (Wave 1) survey instrument contained approximately 60 questions, and the median time for survey completion was 12 min. Over a 3-week period in November and December of 2012, 11,365 women between the ages 18 and 39 years were invited to participate in the survey. Of those,

Table 1
Percent of women who paid US$0 for their method, by method, insurance type and study wave

Only women who used the same method and had the same insurance type at both Wave 1 and Wave 2 (paired data and tests)

Method and insurance type	N	% who paid US$0		Difference	Significance
		Wave 1	Wave 2		
Pill					
Private	624	15	40	+25	***
Public	71	65	79	+14	ns
None	65	28	34	+5	ns
Vaginal ring					
Private	49	23	52	+29	**
Public	9	[a]	[a]	–	–
None	4	[a]	[a]	–	–
Injectable					
Private	37	39	31	−8	ns
Public	20	[a]	[a]	–	–
None	10	[a]	[a]	–	–

Women who used the method at either Wave 1 or Wave 2 (unpaired data and tests)

Method and insurance type	N_{W1}	N_{W2}	% who paid US$0		Difference	Significance
			Wave 1	Wave 2		
IUD						
Private	211	28	47	42	−5	ns
Public	50	8	92	[a]	–	–
None	36	10	72	[a]	–	–

Asterisks indicate statistical significance at *p<.05, **p<.01 and ***p<.001. ns, not significant.
[a] N too small to calculate percentage.

6658 answered the four screening items, yielding a response rate of 59%; 4647 of those were eligible to participate, and 4643 completed the full survey. Wave 2 was fielded over a 3-week time period in May and June of 2013. A total of 3207 women, or 69% of the baseline respondents, completed the Wave 2 survey. Nine respondents were excluded from the final dataset because they were deemed ineligible.

Respondents could choose whether to take the survey in English or Spanish, and participants received US$10 remuneration for each wave completed. GfK obtains informed consent from all individuals prior to including them in its panel; we did not obtain any identifying information from respondents (e.g., name, date of birth). The project was approved by our organization's federally registered institutional review board.

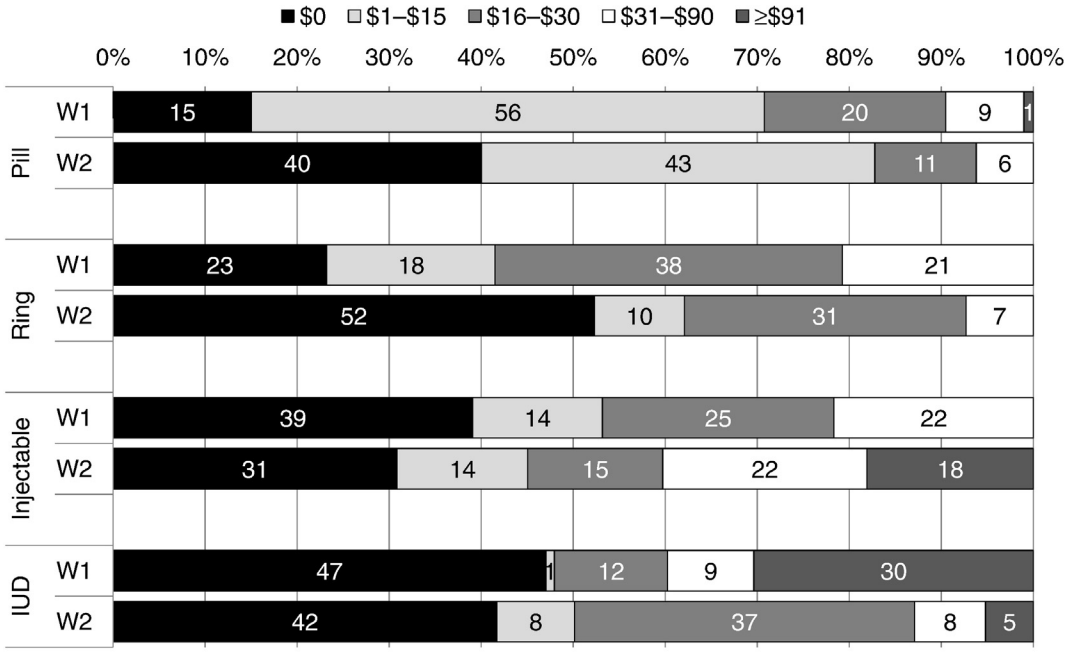
In this analysis, we focused on questions about out-of-pocket payments for contraception among women who used hormonal methods or the IUD in the last 30 days. All of these women, by definition, were not actively seeking to become pregnant. The specific questions were:

1. "In an average month, approximately how much do you, yourself, pay for a one-month supply of the [pill/patch/ring]?"
2. "How much do you, yourself, have to pay each time you get your Depo-Provera shot?"
3. "How much did you, yourself, have to pay when you got your [IUD/implant]?"

Women were also asked about their health insurance coverage at each wave and were given the choices of private insurance, Medicaid or other government-sponsored health insurance (asked using state-specific program names; we denote this group as "public"), some other type of health insurance or no health insurance. The number of women who indicated "some other type" was only 1% of respondents, so we omitted this group. The focus of the paper is on privately insured women. We also looked at women with public insurance and uninsured women as comparison groups because we would not have expected coverage for women in those groups to be affected by the new policy.

We examined the percentage of women who reported paying nothing, as well as the distribution of women by amount paid. We chose categories for the latter based on heaping in the data.

Women who reported that they used the pill, patch, vaginal ring or injectable during the last 30 days were asked the above questions at each wave. Thus, for each of these methods, we performed paired t tests of the differences between waves for women who used the method at both waves and had the same insurance coverage at both waves (n=889). IUD users, on the other hand, were only asked about cost the first time they reported use of the method because it was expected that they would only pay when first obtaining the method. Thus, we performed unpaired t tests comparing those who obtained the IUD before their Wave 1 survey to the group of (different) women who obtained it



Figures for pill, ring and injectable are based on paired data; figures for IUD are based on unpaired data.

Fig. 1. Amount paid out of pocket, women who were privately insured at both waves, by method and study wave.

anytime between Wave 1 and Wave 2 (n=343). Comparisons were omitted if at least one wave had fewer than 25 respondents. The number of users of the patch and implant were too small to conduct these analyses, so those methods were excluded from this analysis. Analyses were conducted using Stata 13, and all used post-stratification sampling weights provided by GfK.

3. Results

Among women who reported using the pill at both waves and having private health insurance at both waves, the proportion who did not pay anything increased substantially and significantly, from 15% to 40%, between Waves 1 and 2 (Table 1). A similar increase was seen for vaginal ring users with private insurance, from 23% to 52%. There was no significant change among privately insured injectable users or IUD users.

As expected, the proportion of publicly insured and uninsured pill users who paid US$0 did not change significantly between the two waves; for Wave 2, 79% of publicly insured women and 34% of uninsured women paid US$0. There were too few publicly insured or uninsured users of the ring or the injectable to report findings. For the IUD, only the Wave 1 samples were large enough: 92% of publicly insured IUD users and 72% of uninsured IUD users paid US$0 out of pocket in Wave 1.

Fig. 1 is limited to privately insured users and shows the proportion of users who paid various amounts for each method. Among pill users and ring users, the increase in women paying US$0 appears to have been drawn roughly evenly from the higher cost-sharing categories; a χ^2 test of the remaining categories across waves was not significant. There was a significant decline in the proportion of IUD users who paid US$91 or more, from 30% to 5%. The increase in the proportion of injectable users who paid US$91 or more, from 0% to 18%, was not significant.

Among women who were privately insured pill users at both waves, the Wave 1 mean out-of-pocket payment was US$15.18 and the median was US$10; the Wave 2 mean was US$9.57 and the median was US$5 (not shown).

3.1. Limitations

Our study is subject to some limitations. The number of respondents using methods other than the pill and injectable was low, and in the case of the patch and the implant, it was too low to analyze here. We hope that our two additional planned rounds of data collection will increase some of these sample sizes sufficiently to enable analysis and to detect subtler or more gradual changes in out-of-pocket payments.

Only 59% of women who were asked to participate in the Wave 1 survey did so, and 31% of those did not complete the Wave 2 survey. While our response rates were comparable to those of other studies using online administration [10,14–16], the sample might be biased if our respondents differed from the national population in ways that correlate with contraceptive use. Despite these concerns, it is reassuring that the findings here are extremely similar to prior published research: The

mean (US$15.18) and median (US$10) out-of-pocket payment for the pill in Wave 1 of our study are almost identical to the mean (US$15.13) and median (US$10) out-of-pocket payment from another nationally representative study [18] carried out before the new federal policy took effect.

4. Discussion

The findings of this study indicate that the federal contraceptive coverage requirement is already having a substantial impact in eliminating out-of-pocket costs among privately insured women for at least some methods of contraception — including oral contraceptives, the most popular reversible method in the United States. Between fall 2012 and spring 2013, the proportion of pill users paying US$0 out of pocket increased from 15% to 40%, and the proportion for ring users increased from 23% to 52%. That this progress has happened so rapidly — in just the first several months that the requirement has been in wide effect — is particularly noteworthy.

Further progress can be expected as more private health plans become subject to the requirement. Notably, the grandfathered status that is exempting some health plans is designed to be a temporary measure to allow for a smoother transition to new federal rules. The number of people enrolled in grandfathered plans has been declining rapidly, from 48% of covered workers in 2012 to 36% in 2013 [5]. Even if all plans do eventually lose grandfathered status, the proportion of women paying US$0 will never reach 100%; for example, some women will choose a brand-name drug with a generic equivalent, in which case their insurer could legally charge a copayment.

The study does, however, also provide some evidence — the lack of apparent improvement in cost sharing for the injectable and the IUD — that private health plans may not be treating every method of contraception identically. This is in line with anecdotal evidence, as reported in the media, that some plans were placing certain methods on a non-$0 tier of their formularies or taking other steps that appear contrary to a simple reading of the federal requirement to cover "the full range" of methods [19]. Future research, including analyses from additional rounds of this longitudinal study, could assess continuing progress and problems and may be helpful to inform policymakers' decision making about oversight and enforcement of the provision.

This analysis also found potential troubling violations of federal Medicaid law. For Wave 2, about one fifth of women with public insurance reported paying some amount out of pocket for the pill. The vast majority of those women are likely enrolled in Medicaid and should be entirely exempt from cost sharing for family planning services and supplies under a law that has been in force for four decades. That potential problem echoes findings from several earlier studies in which substantial numbers of women enrolled in Medicaid plans reported out-of-pocket costs for contraception [18,20]. Some of the publicly insured women in our study who paid out of pocket for contraception may be enrolled in another public program that does not have Medicaid's cost-sharing protections, such as subsidized coverage designed for individuals above the income cutoffs for Medicaid. Nevertheless, this finding suggests a need for federal and state policymakers to reexamine how the cost-sharing protections for contraception under Medicaid are being applied by state agencies and Medicaid managed care plans.

Substantial proportions of uninsured women reported paying nothing out of pocket for the pill and the IUD. These findings likely reflect the subsidized care provided by publicly supported health centers, such as health departments, Planned Parenthood clinics and community health centers, to low-income clients.

The findings of this study bode well for the health and well-being of women, couples and families. Government bodies and private sector experts have long recognized contraceptive services as a vital and effective component of preventive and public health care, and an extensive body of research shows that contraceptive use helps women avoid unintended pregnancy and improve birth spacing, resulting in substantial health, social and economic benefits [21–23]. The new federal requirement, in giving women coverage without cost sharing of a wide range of contraceptive choices, may help them overcome financial barriers to choosing a contraceptive method they will be able to use consistently and effectively.

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