

Original research article

Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update ☆,☆☆

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Received 4 September 2014; revised 10 September 2014; accepted 10 September 2014

Abstract

Background: The Affordable Care Act requires most private health plans to cover contraceptive methods, services and counseling, without any out-of-pocket costs to patients; that requirement took effect for millions of Americans in January 2013.

Study design: Data for this study come from a subset of the 1842 women aged 18–39 years who responded to all four waves of a national longitudinal survey. This analysis focuses on the 892 women who had private health insurance and who used a prescription contraceptive method during any of the four study periods. Women were asked about the amount they paid out of pocket in an average month for their method of choice.

Results: Between fall 2012 and spring 2014, the proportion of privately insured women paying zero dollars out of pocket for oral contraceptives increased substantially, from 15% to 67%. Similar changes occurred among privately insured women using injectable contraception, the vaginal ring and the intrauterine device.

Conclusions: The 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, and that impact has increased over time.

Implications: This study measures the out-of-pocket costs for women with private 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.

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

1. Introduction

One high-profile provision of the Affordable Care Act is a requirement that private health plans cover contraceptive methods, services and counseling for women, without any copayments, deductibles or other patient out-of-pocket costs [1]. This federal contraceptive coverage guarantee — part of a broader provision requiring coverage without cost sharing

for dozens of recommended preventive care services — was phased in starting in August 2012 and began affecting health plans widely in January 2013.

Even before that requirement took effect, coverage of a wide range of contraceptive methods was standard in U.S. private health plans [2]. 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 low-income women and women considering methods with substantial upfront costs.

This report provides new, national-level data about the reach and impact of the contraceptive coverage requirement. It utilizes information collected from a longitudinal survey of women, comparing women's responses in fall 2012, before the contraceptive coverage requirement would

☆ Conflicts of interest: The authors have no conflicts of interest to report.

☆☆ Funding: The Continuity and Change in Contraceptive Use Study, on which this analysis was based, was supported by the JPB Foundation. Additional support was provided by the Guttmacher Center for Population Research Innovation and Dissemination under National Institutes of Health grant 5 R24 HD074034.

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have taken effect for most women, with their responses to three subsequent rounds of the survey (at 6-month intervals) that were fielded after the requirement was implemented for millions.

An earlier analysis, using just the first two waves of this survey (fall 2012 and spring 2013), was published in December 2013 and found substantial increases in the proportions of privately insured women paying zero dollars out of pocket for oral contraceptives and the vaginal ring over just the first few months of the federal guarantee [3]. An April 2014 report from the IMS Institute for Healthcare Informatics found similar trends and estimated that women saved nearly half a billion dollars in out-of-pocket costs for contraception in 2013 in the wake of the guarantee [4]. Our report provides more up-to-date information to bolster this body of knowledge.

2. Materials and Methods

Data for this analysis come from all four waves of the Guttmacher Institute's Continuity and Change in Contraceptive Use Study, which surveyed women about their contraceptive use repeatedly over an 18-month time period. This analysis is based on the methodology used for the Guttmacher Institute's first analysis described above [3]. More details on the methodology can be found in that article, but we provide a brief description below.

The survey was administered online to a national sample of women aged 18–39 years. It was administered by the market research firm GfK using their KnowledgePanel, a national household panel recruited using a probability-based methodology.

The survey was conducted over 3-week periods in fall 2012, spring 2013, fall 2013 and spring 2014. Of the 4634 women who participated in the baseline study, 3207 participated at Wave 2, 2398 participated at Wave 3 and 1842 participated at Wave 4, resulting in between-survey response rates of 69%, 75% and 77%, respectively. The sample for the current analysis was limited to women who participated in all four waves of the study or 40% of the baseline sample. The sample used for this analysis was further limited to women who had private health insurance *and* used a prescription contraceptive method during any of the four study periods (892 women).

In this analysis, we focused on survey questions about out-of-pocket payments for contraception among women who used hormonal methods in the last 30 days or obtained an intrauterine device (IUD) between surveys. We examined the percentage of women who reported paying nothing, as well as the mean and median amounts that women paid for the pill; the number of women paying for methods other than the pill was too small for an analysis of means and medians.

Women who reported that they used the pill, injectable or vaginal ring during the last 30 days were asked how much they paid for the method out of pocket each month. We

assessed change over time in cross-tabulations using Rao-Scott-corrected χ^2 tests in order to include as many women as possible in all analyses while also taking into account the clustering of data within individuals. Our focus is change over time, and χ^2 statistics allow us to assess differences across all waves at once rather than whether specific waves are statistically different from each other. Our analysis is based on a total of 1916 observations of pill use, 107 observations of injectable use and 151 observations of ring use as reported by 892 women; some women contributed up to four observations per method, while others only contributed one.

IUD users were only asked about cost the first time they reported use of the method. Because we captured relatively few new IUD users covered by private health insurance in waves two through four ($n=45$), we used t tests to assess for differences between the proportions who paid nothing for the method at Wave 1 compared to the users at Waves 2, 3 and 4 grouped together. Our analysis is based on 165 IUD users. We did not ask about type of IUD — copper vs. hormonal — and both are grouped together.

The number of users of the patch and implant were too small to be reliable; thus, those methods were excluded from this analysis. Analyses were performed using Stata 13. All findings presented were statistically significant at the $p<.05$ level.

3. Results

Among women who reported using the pill and having private health insurance, the proportion who did not pay anything out of pocket increased from 15% to 67% between Waves 1 and 4 (Fig. 1). The most substantial increase occurred between Wave 1 and Wave 2 (from 15% to 44%¹), but there was a continuing upward trend over the 18-month time period.

We conducted a sensitivity analysis that examined changes in out-of-pocket costs when the sample was restricted to women who were privately insured *and* using the pill during *all four waves* ($n=308$, obs=1227). The proportions paying US\$0 were virtually the same, 15%, 45%, 57% and 69% ($p<.001$), respectively (data not shown). In addition, we also examined these changes when the sample was restricted to women who were privately insured and using the pill at both Waves 1 and 4 ($n=350$). The proportions paying US\$0 were 16% and 69%, and a paired t test indicated that the difference was significant at $p<.001$

¹ The previously published article in *Contraception* reported that 40% of pill users paid nothing out of pocket during Wave 2. The difference is because the prior study restricted analyses to women who were privately insured and using the pill at both points in time, while the current study incorporated women who may have experienced changes in insurance coverage or method use. Moreover, respondents included in the earlier analyses who failed to participate in subsequent waves are excluded from the current study.

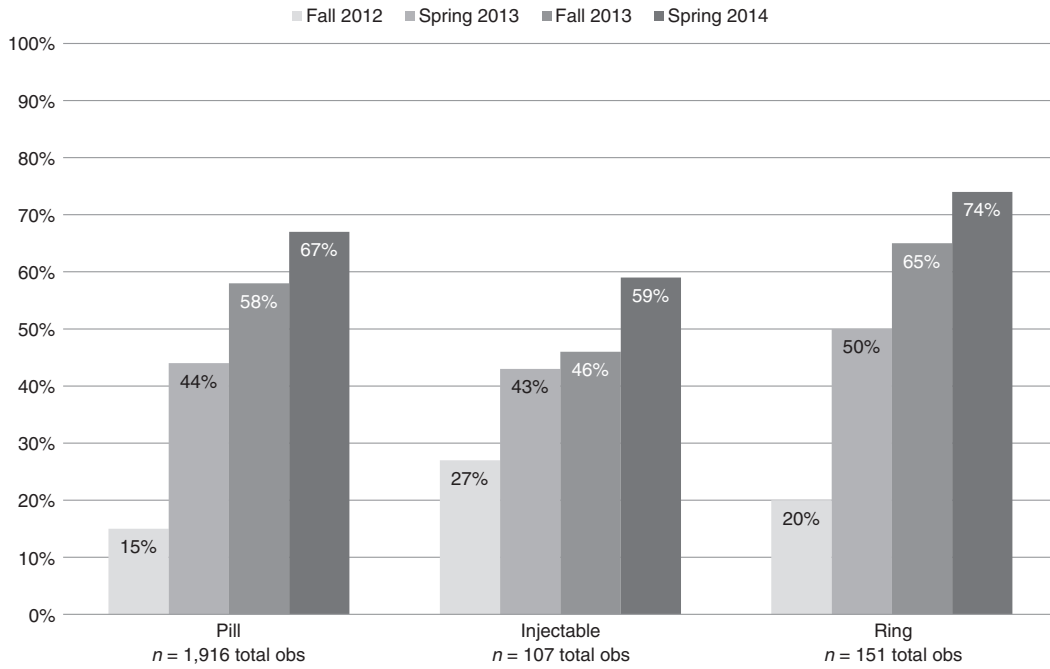


Fig. 1. Percent of privately insured women who paid US\$0 out of pocket for their method.

(data not shown). Both analyses confirmed the patterns found in analyses using all available observations.

Similar increases in the proportion paying zero dollars out of pocket were observed for injectable contraception users and vaginal ring users with private insurance. For injectable users, the proportion increased from 27% to 59% between

Wave 1 and Wave 4. For ring users, it increased from 20% to 74% over the same time period.

Among IUD users with private health insurance at Wave 1, 45% indicated that they paid nothing for the method. This increased to 62% among new users in all three subsequent waves combined (data not shown).

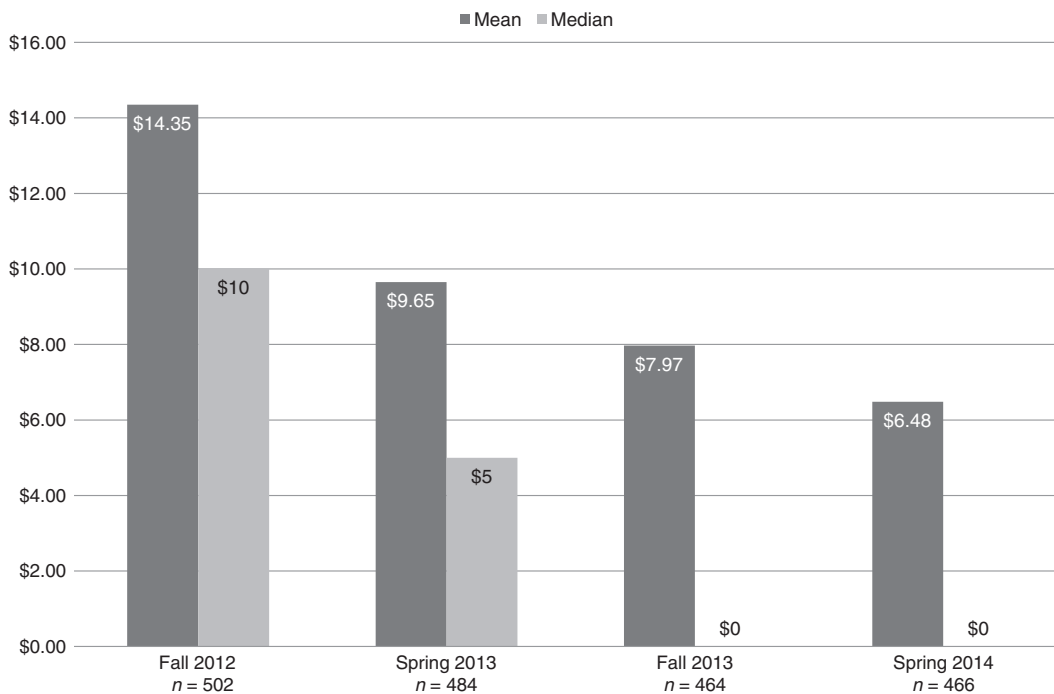


Fig. 2. Mean and median out-of-pocket costs for privately insured women using the pill.

Among privately insured women using the pill, the Wave 1 mean out-of-pocket payment was US\$14.35 and the median was US\$10; by Wave 4, this had declined to US\$6.48 and US\$0, respectively (Fig. 2).

3.1. Limitations

This study is subject to some limitations. Although our response rates were comparable to those of other studies using online administration, only 40% of the baseline sample participated in all four waves of the study, which compromises the representativeness of the data. The findings might be further biased if our respondents differed from the national population in ways that correlate with contraceptive use. Nonetheless, the data are still useful because they serve as one of the only sources of information about trends in contraceptive copays among the same group of women over time.

Despite the abovementioned concerns, it is reassuring that the findings here are similar to prior published research: The mean (US\$14.35) and median (US\$10) out-of-pocket payments for the pill in Wave 1 of our study are almost identical with the mean (US\$15.13) and median (US\$10) out-of-pocket payments from another nationally representative study carried out before the new federal policy took effect [5].

Some 45% of baseline IUD users reported that they had paid US\$0 for the method, a higher proportion than reported paying US\$0 for the pill, the ring or the injectable at Wave 1. Prior to the contraceptive coverage guarantee, many women had to pay several hundred dollars out of pocket for the IUD. One potential interpretation of the pattern in our data is that many women unable to obtain the method at no cost were unable to afford it at all. That is, prior to coverage guarantee, women may have opted to pay a relatively modest copayment each month for the pill rather than come up with several hundred dollars to cover out-of-pocket costs for the IUD.

4. Discussion

The findings of this study suggest that the federal contraceptive coverage guarantee has had a substantial impact in eliminating out-of-pocket costs among privately insured women using some methods of contraception — including oral contraceptives, the most popular reversible method in the United States. Between fall 2012 and spring 2014, the proportion of pill users paying zero dollars out of pocket increased from 15% to 67%, with similar trends for injectable, ring and IUD users.

Further progress may still be expected as more private health plans become subject to the requirement. Notably, 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. That status is designed to be temporary to allow for a smoother transition to new federal rules, and the number of people enrolled in grandfathered plans has been declining

rapidly, from 48% of covered workers in 2012 to 36% in 2013 and 26% in 2014 [6].

However, the proportion of women paying zero dollars will never reach 100%, for several reasons:

- Federal guidance allows insurers to charge copayments in limited situations, such as when a woman chooses a brand-name drug with a generic equivalent or when a woman receives services from an out-of-network provider [7].
- Federal regulations exempt some employer-sponsored health plans sponsored by houses of worship from the contraceptive coverage requirement on religious grounds, [8] and the U.S. Supreme Court's June 2014 decision in *Burwell v. Hobby Lobby* has extended that to certain closely held for-profit employers.

In addition, several other problems may result in women paying out of pocket for contraceptive methods despite the federal guarantee:

- There is evidence that some private health plans are not adequately complying with what the law clearly requires — coverage of “the full range” of contraceptive methods approved by the Food and Drug Administration when prescribed for a woman — and are instead denying coverage, requiring cost sharing or otherwise restricting access to specific methods [9].
- Other religiously affiliated nonprofits have been offered an accommodation under which they are supposed to be absolved from involvement in covering contraception, but their employees and family members must still receive that coverage through the insurance company [8]. However, there are serious questions, and a complete dearth of information, about whether and how plans are complying.

Despite these gaps in the reach of the federal guarantee, 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 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 [10–12]. By guaranteeing that women have coverage for a wide range of contraceptive choices without cost sharing, the federal requirement may help them overcome financial barriers to choosing a contraceptive method they will be able to use consistently and effectively, thus increasing their likelihood of avoiding unplanned pregnancies.

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