Women's Awareness of Their Contraceptive Benefits Under the Patient Protection and Affordable Care Act

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The Patient Protection and Affordable Care Act mandates that there be no out-of-pocket cost for Food and Drug Administration–approved contraceptive methods. Among 987 privately insured reproductive aged Pennsylvania women, fewer than 5% were aware that their insurance covered tubal sterilization, and only 11% were aware that they had full coverage for an intrauterine device. For the Affordable Care Act contraceptive coverage mandate to affect effective contraception use and reduce unintended pregnancies, public awareness of the expanded benefits is essential. (*Am J Public Health.* 2015;105:S713–S715. doi:10.2105/AJPH.2015.302829)

Half of the pregnancies in the United States are unintended.[1] Cost is a barrier to contraceptive use; in fact, when contraception is provided at no cost, women choose more effective and more expensive methods, such as long-acting reversible contraceptives (LARCs)—which include intrauterine devices (IUDs) and contraceptive implants—and have fewer unintended pregnancies.[2,3] The Patient Protection and Affordable Care Act (ACA; Pub L No. 111–148) eliminates the cost barrier to contraception for most women with private health insurance by mandating coverage without patient cost sharing for Food and Drug Administration–approved contraceptive methods and tubal sterilization.[4] Although this contraceptive coverage requirement went into effect in

TABLE 1—MyNewOptions Participant Characteristics and Current Contraceptive Use (n = 987): Pennsylvania, 2014

Characteristic	No. (%)
Age, y	
18–25	449 (45.5)
26–33	365 (37.0)
34–40	173 (17.5)
Race/ethnicity	
Non-Hispanic White	921 (94.0)
Non-Hispanic Black	18 (1.8)
Hispanic	12 (1.2)
Asian	15 (1.5)
Other	14 (1.4)
Employment	
Employed full time	552 (56.1)
Employed part time	137 (14.0)
Unemployed	27 (2.7)
Homemaker	49 (5.0)
Student	186 (18.9)
Other	33 (3.4)
Marital status	
Married	369 (37.5)
Partnered and cohabiting	166 (16.9)
Partnered and not cohabiting	295 (29.9)
Not partnered	154 (15.6)
Previous pregnancy and intendedness	
Never pregnant	634 (64.3)
Previously pregnant, ≥ 1 unintended pregnancy	171 (17.3)
Previously pregnant, no unintended pregnancies	181 (18.4)
Future pregnancy intention	
Intends pregnancy in 1–2 y	132 (13.4)
Intends pregnancy in 3–4 y	249 (25.3)
Intends pregnancy in ≥ 5 y	224 (22.7)
Does not intend any future pregnancy	153 (15.5)
Not sure	228 (23.1)
Current primary birth control method	
Birth control pills	428 (43.4)
Condoms	186 (18.8)
Withdrawal	77 (7.8)
IUD	74 (7.5)
Vaginal ring	34 (3.4)
Natural family planning	33 (3.3)
Injectable	23 (2.3)
Contraceptive implant	9 (0.9)
Spermicide alone	4 (0.4)
Patch	3 (0.3)
Diaphragm	2 (0.2)
Sponge	1 (0.1)
No method	113 (11.5)

Note. IUD = intrauterine device.

August 2012,[5] whether privately insured women are aware of their newly expanded contraceptive benefits is unknown.

METHODS

Data were from 987 women participating in the MyNewOptions study, an ongoing randomized controlled trial of an intervention to assist women with contraceptive decision making.[6] We recruited the sample in 2014 from Highmark Health members in Pennsylvania who were aged 18 to 40 years.

After we confirmed their eligibility (sexually active, not intending pregnancy in next year, not surgically sterile, and did not have a partner with vasectomy) and consent, participants completed a baseline survey assessing pregnancy and contraceptive history, relationship status, health history, and health behaviors. We assessed awareness of insurance coverage benefits with the following question, "To the best of your knowledge, does your health insurance policy currently cover these birth control methods at no cost to you (no copay or deductible payment)?—tubal sterilization ("tubes tied"), birth control pills, IUD." The response choices for each of the 3 methods were "yes," "no," and "I don't know." Throughout the survey, we defined the IUD as an intrauterine contraception (e.g., ParaGard, Mirena, Skyla). We further asked women currently using contraception if they would switch methods if they did not have to worry about cost.

RESULTS

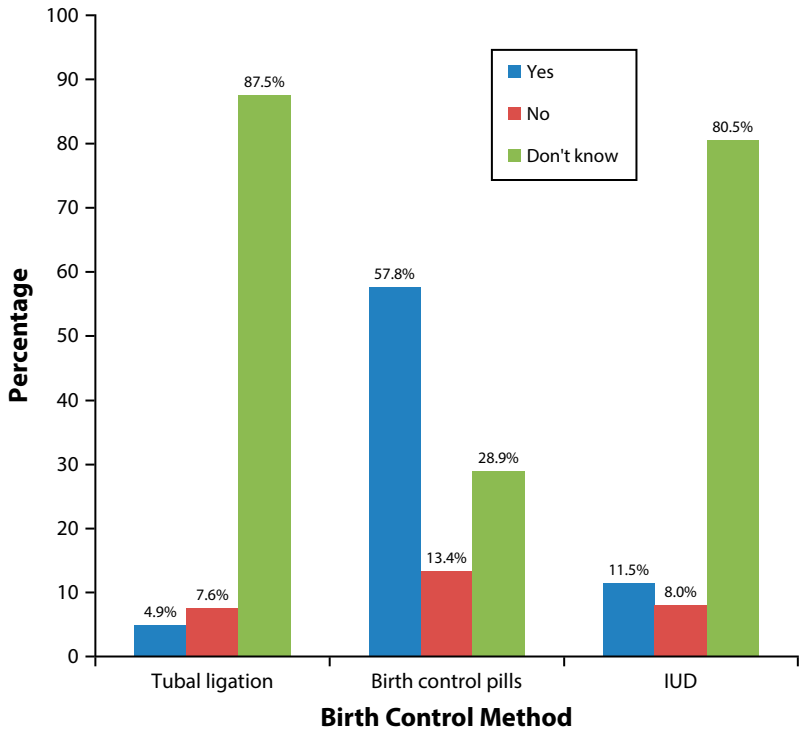
Characteristics of the study sample are shown in Table 1. MyNewOptions participants were largely White and employed, as expected for a privately insured sample in Pennsylvania. More than one third were not intending a pregnancy for at least 5 years or ever, nearly 40.0% were intending pregnancy between 1 and 5 years, and nearly one quarter were unsure. Despite the large proportion of women who were not intending a pregnancy soon, fewer than 9.0% were currently using an LARC; 7.5% of women were using an IUD and 0.9% of women were using the contraceptive implant.

Figure 1 shows that most women (57.7%) were aware that they had full coverage for birth control pills, the most prevalent contraceptive method currently used in our study sample. However, fewer than 5.0% and 12.0% of women were aware that they had first-dollar coverage for tubal sterilization and the IUD, respectively. Awareness of sterilization and IUD coverage did not differ by age, but younger women were more likely to be aware of birth control pill coverage than were older women (data not shown). Nearly 1 in 5 women reported they would change methods if they did not have to worry about cost, of whom 30.0% would switch to an IUD and 9.0% would switch to the contraceptive implant (data not shown).

DISCUSSION

Privately insured women are largely unaware of their contraceptive benefits under the ACA, and a substantial proportion would switch methods if there were no cost barrier. It is unclear whether the high proportion of women reporting "I don't know" about coverage reflects a lack of method awareness or a lack of knowledge about coverage, which is a study limitation.

Before the ACA, studies suggested that full contraceptive coverage could increase use of LARCs and reduce unintended pregnancies and abortions. In 2002, the Kaiser Foundation Health Plan in California sent quarterly outreach publications to inform enrollees of their policy change to include 100% coverage of injectables and LARCs, resulting in a significant increase in the use of these methods.[7] In the CHOICE project, women in the St. Louis, Missouri, region received dedicated counseling promoting LARCs and were provided no-cost contraception, resulting in a high uptake of LARCs and a reduction in unintended pregnancy.[3] These demonstrations suggest that the ACA mandate may not lead to more effective contraceptive method use without efforts to



Note. IUD = intrauterine device. The sample size was n = 987.

FIGURE 1—Awareness of contraceptive coverage based on the question, "To the best of your knowledge, does your health insurance policy currently cover these birth control methods at no cost to you (no copay or deductible payment)?": Pennsylvania, 2014.

inform both women and health care providers of the coverage mandate and to provide accurate information about method options. Furthermore, it is not clear whether insurers are complying with the mandate[8] or if there is an adequate workforce to provide LARCs.[9] Although system-level barriers to female sterilization under Medicaid regulations are well recognized, low awareness of coverage for sterilization may prove to be a barrier even among privately insured women.[10]

For the ACA contraceptive coverage mandate to affect the use of effective contraception, raising women's awareness of the expanded benefit is an essential first step. Private insurers, health care providers, and policymakers must do a better job of communicating the benefit, or this could be a missed opportunity to reduce unintended pregnancies and abortions among US women. ■

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This brief was accepted July 4, 2015.

Contributors

C. H. Chuang was the principal investigator for the MyNewOptions study; she conceptualized the study and wrote the article. J. L. Mitchell, D. L. Velott, R. S. Legro, E. B. Lehman, L. Confer, and C. S. Weisman contributed to data interpretation and to writing the article. E. B. Lehman analyzed the data.

Acknowledgments

This work was supported by the Patient-Centered Outcomes Research Institute (PCORI; award CD-1304-6117).

The authors would like to acknowledge Chris Sciamanna, MD, MPH, and Vernon Chinchilli, PhD, for their contributions to study design; Erica Francis as the MyNewOptions patient representative; and Suzanne Stoner and Vanessa Adjei for assisting with participant recruitment. We also thank Highmark Health for its assistance with participant recruitment.

Note. All statements in this brief, including its findings and conclusions, are solely those of the authors and do not necessarily represent the views of Highmark Health or PCORI, its board of governors, or its methodology committee.

Human Participant Protection

This study was approved by the Penn State College of Medicine institutional review board.

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