

Original research article

The relationship between long-acting reversible contraception and insurance coverage: a retrospective analysis

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Abstract

Objective: The objective was to determine if there is a relationship between patients' financial responsibility (out-of-pocket expenses) and placement of long-acting, reversible contraceptive (LARC) methods among girls and women living in Appalachia who expressed interest in LARC device placement.

Study design: A retrospective chart analysis of patients prescribed an intrauterine device (IUD) or an etonogestrel implant between December 2011 and July 2013 in an Appalachian private practice was performed. Of the 571 identified patients aged 13 to 50, the majority were Caucasian (98.7%) and using Medicaid (53.2%). Outcomes measured the patients' decision regarding whether to use LARC after being informed of out-of-pocket expenses.

Results: There was a dramatic increase in the proportion of patients who had LARC methods placed if expense was under \$200 ($p < .001$). Placement rate for privately insured patients was 86.6% for those who paid less than \$200 compared to 27.8% for those who paid \$200 or more. Medicaid patients, for whom the device was free, had a 78.0% placement rate. For every additional \$100 patients had to pay out of pocket, the odds of deciding to use the prescribed LARC method decreased.

Conclusions: LARC methods are utilized significantly more often when out-of-pocket cost is low. Cost appears to be a significant barrier to device placement for the group of privately insured Appalachian patients with out-of-pocket expenses over \$200. Despite the improvements in coverage for many women provided under the Affordable Care Act, cost may remain a barrier for privately insured women who are required to pay some or all of the cost of LARC methods.

Implications: Unintended pregnancy rates in the United States remain high, especially in Appalachia. One contributing factor is reliance on user-dependent methods which have significantly high typical use failure rates. Placement of LARC methods for more patients could decrease unintended pregnancy, but device costs may be one barrier to utilization, even for those with private insurance.

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1. Introduction

Identification and reduction of barriers to effective contraceptive use are essential to the reproductive health of women in the United States and other countries. Despite implementation of the Affordable Care Act (ACA) which requires new insurance plans to provide FDA-approved contraceptives and services without cost, out-of-pocket cost for contraceptives may be a barrier for many privately insured and uninsured women. Privately insured women may have insurance plans in

compliance with the ACA's requirement that contraceptives be covered without cost sharing or may be enrolled in plans which are exempt from complying, either because the plan is grandfathered or because it meets another exemption. Unfortunately, some health plans simply violate the ACA requirements and illegally impose costs or restrictions on patients who are entitled to no-cost contraceptive care [1]. Although the number of workers in grandfathered plans has fallen from 56% in 2011 to 26% in 2014, the number of women still enrolled in these plans is significant [2]. Out-of-pocket costs are of particular concern for long-acting, reversible contraceptive (LARC) methods, which are significantly more effective than shorter-acting contraceptives but are more expensive to initiate due to the high cost of the devices and insertion fees.

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User-independent methods, such as LARC methods, are more effective at preventing pregnancy than shorter-acting user-dependent methods. Higher failure rates have been demonstrated with typical use of short-acting methods due to inconsistent or incorrect use, and this is of particular concern in adolescent patients [3]. In 2009, the American Congress of Obstetricians and Gynecologists (ACOG) stated that “LARC methods should be offered as first-line contraceptive methods and encouraged as options for most women” and recommended barriers including high upfront costs be addressed [4]. While there is momentum to increase utilization of LARC methods, cost may be a significant barrier.

An increase in utilization of LARC methods can be expected if barriers to use were reduced or eliminated. The Contraceptive CHOICE Project clearly demonstrated that removal of both financial and knowledge barriers to use of LARC methods resulted in the choice of a LARC method by 75% of adolescents and women enrolled in that study [5]. A study of women enrolled in the Kaiser Foundation Health Plan in California demonstrated that use of all forms of contraception increased when that health plan changed its benefits to offer 100% universal coverage for the most effective forms of contraception, with the largest increase in utilization seen with IUDs [6]. Even those who do not face financial or knowledge barriers may face other barriers such as transportation, fears about medical intervention and consequences of using a LARC device (e.g., fear of needles, pain, irregular periods), or concern about confidentiality [7,8].

Patients may be deterred from using LARC methods if they are responsible for some or all of the high initial expenses associated with purchase and placement of the devices. One small study showed that out-of-pocket costs of more than \$50 was a significant deterrent to urban women with private insurance seeking placement of an IUD [9]. While Ohio Medicaid covers LARC methods at 100%, private insurance coverage varies from 0% to 100%, depending on the plan’s benefits. Based on previous studies, we hypothesized that women requesting LARC methods would be less likely to follow through for placement if they were required to pay some or all of the cost.

2. Materials and methods

2.1. Participants

We performed this retrospective chart analysis at Athens Medical Associates Obstetrics and Gynecology, where six providers saw an average of 27,000 gynecologic visits a year. Data were extracted from the electronic medical record (EMR) for all patients prescribed either an implant (etonogestrel subdermal implant) or an IUD (levonorgestrel-releasing IUD or copper IUD) between December 2011 and July 2013. A report was generated of all for whom an implant or IUD was

prescribed. The patients were covered by Medicaid or private insurance, and a small number were uninsured. The Institutional Review Board at Ohio University Heritage College of Osteopathic Medicine approved this study.

During an office visit, the provider educated the patient about her contraceptive options, and if she expressed interest in a LARC, the provider then “prescribed” the device electronically. Patients included those who were sure they wanted a device as well as some who were considering it along with other options. A precertification specialist then investigated coverage and out-of-pocket expense, recorded this information in the EMR, reported back to the patient and documented this process in the EMR. The patient either proceeded or did not proceed with placement of the device based on cost information or other factors, such as choosing another method after more consideration.

Data points included the following demographic variables: age, educational achievement (less than high school, high school, college, postcollege), race (African American, Asian, White, Other), ethnicity (Hispanic, non-Hispanic), relationship status (no steady partner, steady partner, married), gravidity and live births. Other variables included contraceptive method being used at time of prescriptive visit (IUD, implant, pill/injection, condoms, no method), LARC method prescribed (IUD, implant), patient’s decision to use prescribed LARC method (yes, no), parity (nulliparous, parous), coverage status (no insurance, private insurance or Medicaid) and total out-of-pocket cost for the device and insertion (if insured total out-of-pocket cost equaled the deductible plus co-payment, if uninsured or did not have Medicaid, then total out-of-pocket cost equaled the total cost of the device and insertion to be paid by the patient coded in the following intervals — \$0, \$1 to \$99, \$100 to \$199, \$200 to \$299, etc.). Unfortunately, data on personal income were not available; therefore, we considered utilization of Medicaid to be the next best surrogate measure for income status.

2.2. Data analysis

We assessed basic demographic variables using descriptive statistics. We performed a series of bivariate logistic regression analyses with the decision to use the prescribed LARC method as the dichotomous outcome variable and patient age, education, relationship status, birth control method at prescriptive visit, parity and total out-of-pocket expenses for LARC as independent variables. Independent variables with a significant bivariate relationship with the decision to use the prescribed LARC were then forced into a trimmed model with the decision to use LARC as the dichotomous dependent variable. As previous research has found patient age, education, parity and relationship status to be related to use of LARC methods [10–14], we included these variables as independent variables in the analysis. Since patients already using LARC at the prescriptive visit may be more likely to continue its use, we included this

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