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Policy matters

# Barriers to Contraceptive Access after Health Care Reform: Experiences of Young Adults in Massachusetts

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A B S T R A C T

*Objective:* To explore how Massachusetts' 2006 health insurance reforms affected access to sexual and reproductive health (SRH) services for young adults.
*Study Design:* We conducted 11 focus group discussions across Massachusetts with 89 women and men aged 18 to 26 in 2009.
*Results:* Most young adults' primary interaction with the health system was for contraceptive and other SRH services, although they knew little about these services. Overall, health insurance literacy was low. Parents were primary decision makers in health insurance choices or assisted their adult children in choosing a plan. Ten percent of our sample was uninsured at the time of the discussion; a lack of knowledge about provisions in Chapter 58 rather than calculated risk analysis characterized periods of uninsurance. The dynamics of being transitionally uninsured, moving between health plans, and moving from a location defined by insurance companies as the coverage area limited consistent access to contraception. Notably, staying on parents' insurance through extended dependency, a provision unique to the post-reform context, had implications for confidentiality and access.
*Conclusions:* Young adults' access to and utilization of contraceptive services in the post-reform period were challenged by unanticipated barriers related to information and privacy. The experience in Massachusetts offers instructive lessons for the implementation of national health care reform. Young adult-targeted efforts should address the challenges of health service utilization unique to this population.


## Introduction

Massachusetts's 2006 health care reform, *An Act Promoting Access to Affordable, Quality, Accountable Health Care*, known as Chapter 58, benefitted young adults through general reforms (such as the expansion of MassHealth [Medicaid], and the creation of subsidized Commonwealth Care), as well as through several young adult-targeted initiatives (Dembner, 2007; Long, 2008; Pratt, 2007).[1] One year after Chapter 58 was implemented, nearly 100,000 young adults were enrolled in a young

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[1] These initiatives include Young Adult Plans specifically designed to provide young adults not eligible for a subsidized plan or employer health benefit with affordable health insurance; the Student Health Program, in which students enrolled at least 75% time in institutes of higher learning and without coverage are mandated to participate; extension of dependency statutes such that young adults became eligible to remain on a parental health plan through age 25 or for up to 2 years after the loss of dependent status under 26 U.S.C. 106, whichever occurs first. Dependency statutes were further reformed under national reform in 2010, by expanding dependent coverage for all adult children up to age 26 (Center for Consumer Information & Insurance Oversight, 2010).

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adult-targeted health plan (Commonwealth Health Insurance Connector Authority, 2009; Rukavina, Pryor, D'Amato, & Beberman, 2007; The Commonwealth of Massachusetts, 2008).

Widely recognized as a model for the 2010 *Patient Protection and Affordable Care Act* (ACA), Chapter 58 undoubtedly increased young adults' access to insurance. Yet some aspects of Chapter 58, particularly the very popular extended eligibility to be enrolled on a parent's health insurance as a dependent, raise concerns about the degree to which young adults' contraceptive and other sexual and reproductive health (SRH) needs are being met. This paper explores barriers to contraceptive access reported by young adults, which reflect circumstances unique to the post-Chapter 58 context and ongoing concerns that take on new importance in the context of national health care reform. The ACA has targeted and enrolled young adults with mechanisms based on those of Chapter 58 (Landler & Shear, 2014; WhiteHouse.gov, n.d.). We conclude with several recommendations that may ameliorate these unique challenges created or intensified by enrollment in parental insurance through extended dependency.

## Materials and Methods

From August through November 2009, we conducted 11 focus group discussions (FGDs) in six Massachusetts counties. Eight included students and nonstudents, and three targeted currently enrolled female students. We held nine FGDs with women (eight in English and one in Spanish) and two with men (one in English and one in Spanish). In total, 89 young adults participated in 90-minute, semistructured discussions on health insurance, contraception, health care reform, and possibilities for improving service delivery. FGD size ranged from 3 to 17 participants; each participant received $50.

We employed a multimodal recruitment strategy, advertising online, in print, through flyers, and by snowball sampling. Potential participants completed a 10-minute phone interview to verify eligibility; 86 young adults (response rate, 97%) also completed a 35-item exit survey. We audio-recorded and took notes at all FGDs. Spanish-language FGDs were transcribed verbatim, then translated into English. We conducted a content analysis of all FGDs using both a priori (predetermined) categories and inductive analysis developed from post-discussion memos and discussions among members of the study team. All transcripts were systematically coded by the lead author incorporating nonverbal cues (such as head nodding) and using the constant comparison technique (Glaser & Strouss, 1967). This study received approval from the Allendale Investigational Review Board (Old Lyme, CT).

## Results

### *Sample Characteristics*

Seventy-seven women and 12 men participated in FGDs (Table 1). The average age was 22.5 years (range, 18–26) and the majority of participants self-identified as White (62%) and heterosexual (84%). Eighty-four percent had at least one sexual partner in the past year. More than one half of participants (52%) were enrolled as either part-time or full-time students. At the time of the FGD, 10% of participants were uninsured. More than one half of participants (53%) were enrolled in a private insurance plan, including 29% as dependents on parental plans. Twenty-one percent were enrolled in a subsidized plan. Fifteen percent reported receiving all or some of their insurance through a student health program. Six percent knew that they were insured but were not able to specify the type of insurance. Women, Latino/as, and Blacks were intentionally oversampled to ensure diversity of experiences and, along with American Indians, are overrepresented in our sample relative to the population of Massachusetts and of the United States more generally (U.S. Census Bureau, 2014).

### *Key Themes*

Participants discussed their use of contraceptive and other SRH services in the context of their gender, sexual orientation, sexual activity, relationship status, pregnancy desires, and prior SRH experiences. Herein, we identify the specific unintended barriers also described by young adults after health care reform in Massachusetts.

### *Poor Knowledge of Contraception and SRH Services*

> I didn't even know you could get an implant.…They [providers] might, you know, let you know what new options are coming out.
> - Arielle, 20, Boston[2]

SRH services, in particular contraceptive services, comprised young women's primary interaction with the health system. As Bianca explained, "I wasn't going to the doctors a lot, I really use my doctor to get my birth control, so, for me [insurance] was a big cost." Of the women, 68 (88%) had used prescription contraceptives in the past year, and two thirds of them reported that their prescription drug use was limited to contraceptives, usually oral contraceptive pills (OCPs).[3] Consistent with other research (Culwell & Feinglass, 2007; Frost & Darroch, 2008; Frost, Singh, & Finer, 2007a; Frost, Singh, & Finer, 2007b; Nearns, 2009; Raine, Minnis, & Padian, 2003; Ranji, Wyn, & Salganicoff, 2007), we found that insurance coverage affected young adults'—especially women's—access to contraceptive services and utilization of specific contraceptive methods. The cost associated with contraceptive methods was repeatedly identified as a factor influencing method choice in. Juliet explained that she would not fill her prescription for OCPs until her insurance was activated: "[W]ith the whole mess with insurance, I just decided to wait it out…cause I wanted just not to pay the full amount."

Despite the importance of SRH services, we found young adults' knowledge about contraceptive options generally poor (see also Craig, Dehlendorf, Borrero, Harper, & Rocca, 2014), and every FGD included at least one person (and often many) reporting feeling that providers rarely gave them information about the full spectrum of contraceptive methods. Women reported being especially uninformed about long-acting reversible contraceptives, including both implants and intrauterine devices, although women enrolled in MassHealth and women who sought their care at Title X clinics or Planned Parenthood were more likely to report being offered a variety of contraceptive methods.

Although men spoke about feeling responsible for using condoms and getting tested for sexually transmitted infections,

[2] We use pseudonyms throughout this paper to protect participants' confidentiality.

[3] We did not collect detailed information on individual prescription drug use. Participants may have not volunteered this level of detail in focus discussion groups or they may have underreported medications for mental health conditions in group settings.