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Family Planning

Patient Education About the Affordable Care Act Contraceptive Coverage Requirement Increases Interest in Using Long-Acting Reversible Contraception

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A B S T R A C T

Background: The Patient Protection and Affordable Care Act (ACA) requires health insurance to cover all Food and Drug Administration-approved contraceptives at no cost to patients, including highly effective long-acting reversible contraception (LARC). Our objective was to determine whether a brief educational intervention about these provisions would increase interest in LARC use.

Methods: This is a cross-sectional survey of women seeking contraceptive care in an urban outpatient obstetrics/gynecology clinic. We collected baseline contraceptive attitudes and knowledge of the ACA's contraceptive coverage provisions before the intervention. Our primary outcome was interest in using a LARC method before and after reading a short description of the ACA's contraceptive coverage provisions.

Results: Surveys were completed by 316 participants. Most participants (52.8%) could not correctly identify any of the contraception coverage stipulations protected under the ACA. We observed a significant increase in LARC interest after the intervention in all participants (37.3% vs. 44.3%; $p = .038$), primarily among participants who did not originally identify any ACA provisions correctly ($n = 167$; 38.3% vs. 48.5%; $p = .030$). This subset also demonstrated a greater adjusted odds ratio of post-intervention LARC interest (odds ratio, 2.889; 95% CI, 1.234–6.723; $p = .014$). Interest in short-acting reversible contraception and contraception overall remained unchanged.

Conclusions: Most women seeking birth control lack comprehensive understanding of the contraceptive coverage protected by the ACA. Incorporating patient education about the ACA's no-cost contraception provision into routine contraceptive counseling may increase interest in LARC use and better enable women to make informed family planning decisions unrestrained by financial considerations.

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Long-acting reversible contraceptives (LARCs), including the copper intrauterine device (IUD), levonorgestrel IUD, and subdermal implant, are the most effective forms of contraception with less than 1% failure annually, yet are used by only 11.6% of American women using contraception (Kavanaugh, Jerman, & Finer, 2015). Upfront device and insertion expenses often exceed $1,000, discouraging uptake by otherwise interested women (Eisenberg, McNicholas, & Peipert, 2013; Gariepy, Simon, Patel, Creinin, & Schwarz, 2011; Pace, Dusetzina, Fendrick, Keating, & Dalton, 2013). Inexpensive short-acting reversible contraceptives (SARCs), including the oral contraceptive pill (OCP), patch, and ring, are more widely used but have typical annual failure rates of 9% (Trussell, 2011). The CHOICE project has shown that when all forms of contraception are offered at no cost alongside comprehensive contraception counseling, up to three-quarters of women select a LARC (McNicholas, Madden, Secura, & Peipert, 2014), and recent research in Colorado supports that increased LARC uptake may reduce unintended pregnancy and abortion rates (Ricketts, Klingler, & Schwalberg, 2014).

The Patient Protection and Affordable Care Act (ACA) defines contraception as an essential preventative health service for women, and requires almost all insurance policies to cover all forms of Food and Drug Administration-approved contraceptives

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at no cost ("The Patient Protection and Affordable Care Act (PPACA)," 2010). Fully implemented, the ACA has the potential to make no-cost, highly effective contraception coverage universally accessible nationwide by eliminating the prohibitive upfront costs previously passed on to patients (Tschann & Soon, 2015). Although exceptions exist for religious institutions and grandfathered plans unchanged since March 2010, out-of-pocket LARC costs have been decreased or eradicated for the vast majority of insured women since the implementation of the contraception coverage guarantee in August 2012 (Bearak, Finer, Jerman, & Kavanaugh, 2015; Finer, Sonfield, & Jones, 2014; Sonfield, Tapales, Jones, & Finer, 2015). Although as of 2015 most privately insured patients now have access to LARCs at no cost (Bearak et al., 2015), many insurers continue to evade the law by failing to cover associated office visits or contraceptives with no generic alternative (National Women's Law Center, 2015; Tschann & Soon, 2015), and public misconceptions about the ACA's coverage of contraception persist nationwide (Chuang et al., 2015; Hamel, Firth, & Brodie, 2014b).

No published study has yet examined whether educating patients about the ACA's contraceptive coverage provisions could itself increase interest in LARC uptake. Given that many women are likely unaware that they may now have access to long-acting, highly effective contraception at no cost, we hypothesized that informing patients about the ACA's expansion of contraceptive coverage would increase interest in LARC use. Our secondary objectives were to assess baseline familiarity with the ACA's contraceptive coverage provisions and determine how women value this information to guide future contraceptive decision making.

Methods

Study Protocol

We administered an anonymous cross-sectional survey to women aged 18 to 45 years presenting for routine care at the outpatient Obstetrics and Gynecology offices of Thomas Jefferson University, an urban academic center with an estimated payor mix split evenly between public and private insurance. Patients were approached in the waiting room using a standard script to assess eligibility criteria (Figure 1). Patients who were not pregnant, not sterilized, spoke English, and affirmed current use or interest in using contraception were offered a paper survey to complete in the waiting room. The study was designed to have 80% power to detect a 5% change in LARC interest in a sample of 316 participants from an estimated interest in LARC use of 10% to 15% after the intervention, based on an estimated 8.5% rate of LARC usage nationwide at the time (Finer, Jerman, & Kavanaugh, 2012). Patients were enrolled until the target sample of 316 completed surveys was reached. Participants provided verbal consent and completed the survey before receiving contraceptive counseling from their health care provider. This study was declared exempt by the Thomas Jefferson University Institutional Review Board, and was consistent with the Strengthening the Reporting of Observational Studies in Epidemiology guidelines (von Elm et al., 2008).

Survey

This two-step, multiple choice survey consisted of a baseline survey, a brief intervening informational page about the ACA contraceptive coverage guarantee, and a postintervention survey

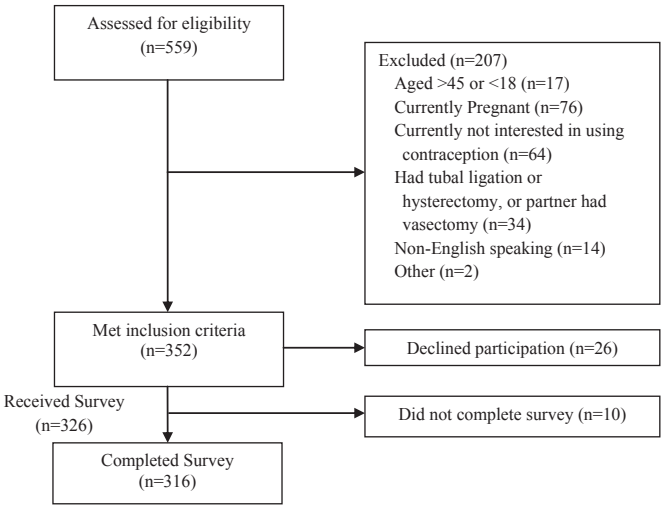

Figure 1. Study design flow chart.

to assess change in contraception interest. Participants were enrolled using a standard script that described the study's purpose as an investigation to determine how people choose different types of contraception, without any specific mention of LARC methods. Both the script and the survey were written at a sixth-grade level. The initial survey assessed demographics, pregnancy history, current contraception use, desired interval to postpone pregnancy, and attitudes toward commonly used SARCs (OCPs, hormonal patch, hormonal ring, depot medroxyprogesterone acetate injection) and LARCs, (subdermal implant, copper IUD, levonorgestrel IUD), identified by both generic and brand names. Participants ranked their interest in using a given method as well as their impression of its effectiveness, safety, and cost on a Likert scale of 1 to 5, from 1 (very interested) to 5 (not at all interested). Participants were also prompted with four statements about the ACA's coverage of contraception, and asked to identify from them any correct statements. The options included two correct statements, one stating that the ACA requires insurance to cover all types of contraception, and another stating that insurance must cover contraception at no cost. The educational intervention consisted of a simply written page stating that the ACA contraceptive requirement "requires that insurers cover all Food and Drug Administration-approved birth control methods, and provide them at no cost to patients, including no copay or deductible charges," followed by caveats about insurer variability and exceptions. After the intervention, participants re-ranked interest in contraceptive use and denoted how they valued this information for future contraceptive decision making. No educational material about the benefits, risks, or cost of specific contraceptives was presented at any point.

Data Analysis

Data were analyzed and described with STATA software version 13 (StataCorp, College Station, TX). The primary outcome variable was participant interest in using a LARC method. This was constructed as a binary variable based on the presence or absence of interest in using a LARC, and captured participants who rated interest on the Likert scale at 1 (very interested) or 2 (somewhat interested) in a given method. Secondary outcome variables included interest in using other contraceptive methods,

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