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Effects of the Affordable Care Act's contraceptive coverage requirement on the utilization and out-of-pocket costs of prescribed oral contraceptives

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ABSTRACT

Background: The Affordable Care Act (ACA) mandated that private health insurance plans cover prescribed contraceptive services for women, including oral contraceptives (OCs), without charging a patient any cost-sharing beginning in August 2012.
Objective: To evaluate the effects of the ACA's contraceptive coverage requirement on the utilization and out-of-pocket costs of prescribed OCs after two years of implementation.
Methods: A retrospective, cross-sectional study was designed using data from the 2010 to 2014 waves of the Medical Expenditure Panel Survey. The sample consisted of reproductive-aged women who have either private health insurance or Medicaid. Utilization of OCs was evaluated using 1) the proportion of women who purchased any OCs and 2) the mean annual number of cycles prescribed per woman. Out-of-pocket costs for OCs were evaluated using 1) the proportion of women who had any OC purchase with $0 out-of-pocket costs, 2) the mean annual out-of-pocket costs per woman, and 3) the mean out-of-pocket costs per cycle. Descriptive analyses and a difference-in-difference linear regression approach were used.
Main findings: No substantial changes were seen in the utilization of OCs after the ACA requirement became effective. The difference-in-difference regression showed that the proportion of women who had any OC purchase with $0 out-of-pocket costs increased significantly by 54.0 percentage points after the ACA requirement in the private insurance group relative to the Medicaid group. Mean annual out-of-pocket costs in the private insurance group dropped by 37% in the first year and an additional 52% decrease was found in the second year of the policy. Mean out-of-pocket costs per cycle also decreased substantially in the private insurance group by 39% in the first year and an additional decrease of 44% was seen in the second year.
Conclusions: The ACA's contraceptive coverage requirement markedly reduced out-of-pocket costs of prescribed OCs for women with private health insurance.

1. Introduction

Nearly one-half of all pregnancies in the U.S are unintended.[1] These pregnancies are associated with negative health outcomes to the infants and mothers including increased risk of abortion, infant mortality, and maternal depression and anxiety.[2] Unintended pregnancies also bring substantial financial burden to society; annual costs to taxpayers for unintended pregnancy care are estimated at $11.3 billion.[3] In 95% of unintended pregnancies, women did not use any contraceptive methods or used them inconsistently.[4] Ensuring women have good access to contraceptive methods is important to avoid unintended pregnancies. As a result, many efforts have been undertaken by states and the federal government to remove barriers to the use of contraceptive methods.

One of the recent changes made by the Affordable Care Act (ACA) is that it mandated private health insurance plans cover prescribed contraceptive services for women without charging a patient any cost-sharing (e.g., copayment, coinsurance, or deductible) beginning in August 2012.[5,6] All women of reproductive age who are privately insured are eligible to get this expanded benefit unless their plan is a grandfathered plan, sponsored by a religious employer, or the services were offered by an out-of-network

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provider.[6] The prescribed contraceptive services for this provision were defined as the full range of Food and Drug Administration (FDA)-approved contraceptive products, sterilization procedures, and patient education and counseling for all women with reproductive capacity.[7]

Among the FDA-approved contraceptive products, oral contraceptives (OCs) are the most common method used by reproductive-aged women in the United States. According to the National Survey of Family Growth, over 80% of sexually experienced women aged 15–44 have ever used OCs, and about 26% of women currently using contraception are using OCs.[8,9] Despite their popularity, some patients stopped using OCs or couldn't use them consistently because of cost-related concerns or a lack of insurance coverage.[9,10] Also, more than half of the women who were willing to change their contraceptive methods if cost were not an issue were using less effective methods than OCs such as male condom or withdrawal.[11] Thus, reducing financial barriers to the use of OCs is important to promote their use and potentially avoid unintended pregnancies.

Initial evaluations of the ACA's contraceptive coverage requirement showed that it reduced the cost burden of using OCs.[12–16] By analyzing a large commercial claims database, Law et al. found that mean out-of-pocket costs per OC claim decreased by 66.7% and mean total annual out-of-pocket costs of OCs per woman decreased by 69.8% from 2011 to 2013.[12] During the same period, the proportion of women with $0 annual spending for OCs increased substantially from 7.3% to 69.3%.[12] Sonfield et al. conducted a national online survey of privately insured women, and found a 54.8% decrease in the mean out-of-pocket costs per claim from Fall 2012 to Spring 2014.[13] The proportion of women who didn't pay any cost-sharing for OCs increased remarkably from 15% in Fall 2012 to 67% in Spring 2014.[13] Similar trends were also found by the IMS Institute for Healthcare Informatics; 14% and 56% of commercially insured women did not pay out-of-pocket costs for OCs in 2012 and 2013, respectively.[14] In previous studies, however, no comparisons have been made with women who have another type of insurance, and nationally representative claims data have not been used. Moreover, only descriptive analyses of the short-term effects of the policy at one-year post-implementation have been conducted; no studies have controlled for other possible factors that might have influenced utilization and out-of-pocket costs for prescribed OCs over a longer time period.

The purpose of this study was to evaluate the longer-term effects of the ACA's contraceptive coverage requirement on the utilization and out-of-pocket costs of prescribed OCs among privately insured women. This study estimated the effects two years after the ACA requirement to assess the sustainability of the policy's effect, and compared women with private insurance that were the target of the ACA requirement to women insured by Medicaid that were unaffected by the policy. Medicaid enrollees were selected as the control group, because the ACA's contraceptive coverage requirement only affected private health insurance plans and did not affect Medicaid enrollees. Prior to enactment of this policy, prescribed OCs were covered by most states' Medicaid programs without cost-sharing to enrollees,[17] such that they had better baseline access to prescribed OCs than women with private health insurance.[18] Since most Medicaid programs had similar out-of-pocket costs as what was specified in the ACA requirement, the Medicaid group was used as a benchmark for full implementation of the policy.

2. Methods

2.1. Data

This study uses data from the Medical Expenditure Panel Survey (MEPS), which provides nationally representative estimates for the U.S. civilian non-institutionalized population. Sponsored by the Agency for Healthcare Research and Quality, the MEPS surveys a subsample of households participating in the previous year's National Health Interview Survey. A single household respondent reports all data for the members in their household. The survey has a panel design such that there are 5 rounds of interviews for each panel, covering 2 full calendar years. This study used the full-year consolidated data files and the prescribed medicines files of the MEPS Household Component. The full-year consolidated data file contains person-level data on demographic and socioeconomic characteristics, health insurance coverage, and health status.[19] The prescribed medicines event file includes detailed information on the utilization and expenditures of prescribed medicines. During each round of the survey, respondents were asked about the name of any prescribed medication purchased by household members. The MEPS then contacted pharmacy providers who filled these medications with respondent approval, and requested detailed information such as date filled, national drug code, medication name, strength and quantity, payments made by insurance, and out-of-pocket payments by the user or other household members.[19,20]

2.2. Sample

The ACA's contraceptive coverage requirement became effective on August 1, 2012, and private insurance companies were required to be compliant at the beginning of the new plan year, which commonly began on January 1, 2013.[12,15] Therefore, the MEPS data for calendar years 2010–2012 were used as the pre-ACA period and 2013–2014 were used for the post-ACA period. The sample of this study consisted of women of reproductive age, 15–44 years old. The treatment group was composed of women with private health insurance, and the control group was women enrolled in Medicaid. Health insurance status was determined using a series of indicator variables that indicated the type of insurance the individual was covered by in each month. In this study, a woman was defined as insured if she reported having health insurance for at least 6 months of the year. Women who had health insurance for less than 6 months or had both private insurance and Medicaid during a calendar year were excluded from the sample of this study.

2.3. Outcome variables

Two main outcomes were assessed in the treatment and control groups from 2010 to 2014: the utilization of OCs and associated out-of-pocket costs. Utilization was determined using two outcome measures: 1) the proportion of women who purchased any OCs and 2) the mean annual number of cycles prescribed per woman among those that purchased any OCs. Out-of-pocket costs for OCs were evaluated using three outcome measures: 1) the proportion of women who had any OC purchase with $0 out-of-pocket costs, 2) the mean annual out-of-pocket costs per woman, and 3) the mean out-of-pocket costs per cycle. The sample used to evaluate the second outcome measure of the utilization (i.e., mean annual number of cycles prescribed per woman) and the three outcome measures for out-of-pocket costs was limited to women who had purchased any OCs during a year.

Each record in the prescribed medicines event file of MEPS is an event of purchase (i.e., new or refill prescription), and each event has a different number of tablets dispensed (i.e., quantity) and associated out-of-pocket costs paid for that quantity. Therefore, each OC purchase was normalized to a 28-day-supply to account for the variability in the number of packages dispensed across

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