

GYNECOLOGY

The impact of cost sharing on women's use of annual examinations and effective contraception



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BACKGROUND: We sought to describe the relationship between the elimination of out-of-pocket costs and women's use of preventive care office visits and long-acting reversible contraception after accounting for baseline levels of cost sharing.

OBJECTIVES: The objective of this analysis was to describe the relationship between the elimination of out-of-pocket costs and utilization of preventive care visits and long-acting reversible contraception insertion while taking baseline cost sharing levels under consideration.

STUDY DESIGN: In 2017, we used administrative health plan data to examine changes in out-of-pocket costs and service utilization among 2,172,065 women enrolled in 15,118 employer-based health plans between 2008 and 2015. We used generalized estimating equations to examine utilization patterns.

RESULTS: Women in this sample generally had low costs at baseline (\$24 and \$29 for preventive care visits and long-acting reversible contraception insertion, respectively). The elimination of baseline out-of-pocket costs were related to changes in the utilization of both services but more consistently for contraceptive device placement. Women whose low/moderate out-of-pocket costs were eliminated were more likely to use

a preventive care office visit than women with persistent low/moderate costs (odds ratio, 1.05; 95% confidence interval, 1.04–1.05), but women with high out-of-pocket costs had lower utilization rates, even after their costs were eliminated. In contrast, the odds of having a contraceptive device placed was higher among all groups of women when out-of-pocket costs were zero, as compared with women with low/moderate costs. For instance, when compared with women with low/moderate costs, women were less likely to have a contraceptive device inserted (odds ratio, 0.92; 95% confidence interval, 0.86–0.97) when they had high costs but more likely after their costs were eliminated (odds ratio, 1.15; 95% confidence interval, 1.09–1.20).

CONCLUSION: Out-of-pocket costs were low prior to the Affordable Care Act. Eliminating costs was associated with increases in preventive service use among those with high levels of cost, but effect sizes were low, suggesting that cost is only 1 barrier. Failing to recognize that cost sharing was already low could cause us to falsely conclude that the elimination of cost sharing was ineffective.

Key words: contraception, cost sharing, health care reform, women's health

In 2017, the Trump administration rolled back restrictions on patient cost sharing for contraception-related services established by the Affordable Care Act (ACA) in 2012. In contrast to language included in the administration's ruling and based on evidence generated by decades of clinical and epidemiological studies,¹ there is widespread acceptance that contraception use effectively prevents pregnancy and is a high-value service for reproductive-aged women. As policymakers continue to consider revising aspects of the ACA, including other limits on patient cost sharing, it is crucial to understand the

performance of innovative aspects of this policy.

Individuals may disagree about how to reform our health care system, but there is considerably more consensus that too much health care spending is on services that do not advance health. Value-based insurance design (V-BID), a strategy to encourage health care consumers to use high-value medical services, has bipartisan support. Under V-BID principles, consumers' out-of-pocket costs (OOPCs) are reduced or eliminated for services with strong evidence supporting their ability to improve clinical outcomes and/or increase health system efficiency.² V-BID was incorporated into Section 2713 of the ACA and requires non-grandfathered health insurance plans to cover a range of services, including contraception, without patient OOPCs.³

Removing OOPCs has the potential to increase women's use of recommended

services, including preventive care and contraception services. There is particularly strong evidence that the utilization of the most effective methods of contraception—long-acting reversible contraception (LARC)—is inversely associated with OOPCs.⁴⁻⁷ Increasing the use of LARC for women, which includes intrauterine devices and implants, is a key strategy in the efforts to decrease the United States' high unintended pregnancy rate.⁸

Studies demonstrate that women's OOPCs for some preventive services, including contraception, declined substantially following the ACA,⁹⁻¹⁴ but it is not clear whether these declines have led to increased utilization.^{11,12,15} Perhaps these studies were conducted too early to observe the full impact of cost-sharing elimination on utilization. Alternatively, studies to date have not accounted for variation in baseline OOPCs and were conducted among women with rather low baseline out-of-pocket

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AJOG at a Glance

Why was this study conducted?

This study clarifies whether cost sharing level is a barrier to use of 2 recommended preventive care services: preventive care office visits and insertion of long-acting reversible contraception. In contrast to previous studies, we considered levels of baseline cost sharing because we expected that women may be more responsive to the elimination of higher baseline levels of out-of-pocket cost than lower baseline levels.

Key Findings

Service use increased after costs were eliminated, especially for contraception device insertion among women with the highest levels of baseline costs.

What does this add to what is known?

Findings suggest that even among commercially insured women, there was cost-related unmet demand for these services, and the elimination of cost sharing appears to reduce this barrier.

costs.^{12,14} It is not clear that eliminating a small (eg, \$20) payment will result in meaningful changes in utilization for most women. Furthermore, it is possible that women are more price sensitive for some health services than others.

Answers to these questions are key to informing value-based insurance designs. Furthermore, this information would help distinguish between 2 possible reasons that studies to date have not consistently observed increased utilization of some services following the ACA including the following: (1) that elimination of cost sharing is not an effective approach and (2) that OOPCs were already low.

Accordingly, our objective was to describe the relationship between the elimination of OOPCs and utilization of preventive services while taking baseline cost sharing levels under consideration. Our analysis examines the relationship between cost sharing and utilization for 2 services relevant to reproductive-aged women that the ACA requires to be covered without OOPCs: preventive care office visits (POV) and insertion of LARC devices.^{16,17}

We expected that health plans would fall mainly into the following 4 categories: (1) plans with high OOPCs that fell to zero; (2) plans with low OOPCs that fell to zero; (3) plans that always had OOPCs; and (4) plans that never had OOPCs. We hypothesized that women enrolled in plans with high OOPCs at

baseline would increase the use of services to a greater degree than women with low or no OOPCs at baseline, following cost-sharing elimination.

Materials and Methods

We used deidentified data from the Clinformatics Data Mart Database (OptumInsight, Eden Prairie, MN) to examine the relationship between changes in OOPCs and service utilization among commercially insured women between 2008 and 2015. Our data source includes patient copayment, deductible, and coinsurance amounts along with standardized costs and demographic characteristics such as patient age, race, and whether a patient had an income below 400% of the 2015 federal poverty level. This study was deemed exempt by our institutional review board.

Our analytic sample was drawn from a population of 6,047,781 females aged 15–45 years who were enrolled in an employer-based health plan. We restricted our sample to women with continuous enrollment in a single employer-based health plan for at least 1 year between 2008 and 2015. Women with evidence of having undergone a hysterectomy were included in our analysis until the month prior to their surgery date. To estimate the level of OOPCs for a specific service, a woman's health plan needed to be utilized for our target services during 2008–2009

(preperiod) and 2014–2015 (post-period); therefore, health plans (and their members) that were not utilized at least once in both time periods were excluded from the analysis for that service.

We identified service utilization—our outcome of interest—and service date for a given patient using *International Classification of Diseases* diagnosis or procedure codes (revisions 9 and 10) and/or current procedural terminology (CPT4/HCCPCS) procedure codes. Total OOPC was calculated by summing patient copayments, coinsurance, and deductible payments for each service. All payments and cost estimates were adjusted to 2015 dollars using the Medical Consumer Price Index. Service utilization was calculated as the proportion of women in the analytic sample with at least 1 claim for that service for each year.

We had the following 2 key predictors of interest related to patient OOPCs: (1) the elimination of OOPCs and (2) the level of baseline OOPCs. To construct these measures to include in our patient-specific model, we conducted a plan-specific analysis to calculate the mean and median OOPCs for each service for each plan in each year. Based on observed levels of OOPCs over time, plans were defined as treatment plans if the following were present: (1) they had non-zero median OOPCs at baseline, and (2) OOPCs declined to zero by the end of 2015.

Treatment plans were further divided into high- and low/moderate-cost plans based on median baseline OOPCs for the service of interest. This process was repeated for each service outcome and resulted in 4 groups of plans specific to each service: (1) plans with high baseline OOPCs in 2008 or 2009 that dropped to zero OOPCs (high-cost treatment plans); (2) plans with low to moderate OOPCs in 2008 or 2009 that dropped to zero (low/moderate-cost treatment plans); (3) plans that always had OOPCs (always-OOPC plans); and (4) plans that never had OOPCs (never-OOPC plans).

For POV, we defined high-cost treatment plans as those with median OOPCs for preventive care visits at or greater than \$100. For LARC insertion, we

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