MASSACHUSETTS
HEALTH POLICY COMMISSION

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# HPC DATAPOINTS

## Persistent cost-sharing for contraception in Massachusetts, 2017-2020

### INTRODUCTION

Since 2012, the Patient Protection and Affordable Care Act (ACA) contraceptive mandate has sought to make contraception more affordable and accessible for patients. The mandate requires commercial insurers to cover at least one form of contraception in each Federal Drug Administration (FDA)-approved category of contraception without patient cost-sharing, as well as related services. The mandate applies to all plans, including individual, small-group, large-group, and self-insured plans, whether offered by employers or on state marketplaces.[1]

The contraceptive mandate has had numerous benefits for patients. One national survey found that within its first two years, the share of commercially insured women with zero cost-sharing for birth control increased from 15% to 67%, with patients saving an average of $250 in out-of-pocket spending each year. In addition to cost savings, the contraceptive mandate is associated with increased adherence to prescription oral contraceptive use and increased use of highly cost-effective methods such as intra-uterine devices (IUDs) which can have high upfront costs – especially among those enrolled in high-deductible health plans. The mandate has also been associated with a decrease in unintended pregnancies and a narrowing of income disparities in unintended pregnancy rates. The mandate may also improve other positive outcomes associated with expanded access to birth control, such as increased completion of higher education, increased labor force participation, and reduced likelihood of living in poverty.

The contraceptive mandate has had **benefits** for patients, including **cost savings**, increased use of highly **cost-effective contraceptive methods**, and a decrease in **unintended pregnancies**.

Likewise, prior research from the HPC has found compelling evidence of the mandate's benefits for the residents of the Commonwealth. From 2011 to 2014, the share of contraceptive prescriptions with patient cost sharing decreased precipitously, from 98.1% to 6.5%. The share of patients with cost sharing for IUD insertion and devices also fell dramatically over the same time period, from 51.6% to 6.9%.

The federal Health Resources and Services Administration (HRSA) issues guidance on what must be covered under the mandate, and most recently provided updated guidance in 2019, clarified it in 2021, and issued a further round of guidance in 2022 about exactly which services must be covered without cost-sharing.[2] The clarified guidance noted that "contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care," and defined follow-up care to include "management and evaluation as well as changes to, and removal or discontinuation of, the contraceptive." Despite this guidance, confusion has persisted among health care providers, insurers, and patients about which contraceptive methods and services should be covered, and about how providers should bill for certain services.

During this time of significant federal policy change and uncertainty about access to reproductive health care services, it is important to understand the current status of cost sharing for contraception in Massachusetts. It is particularly important because the Commonwealth has made access to and affordability of reproductive health services a priority, with measures such as the 2017 ACCESS Law, the 2020 ROE Act, and Chapter 127 of the Acts of 2022.

This issue of the HPC's DataPoints series provides updated findings on out-of-pocket costs for common contraceptive methods and services in the Commonwealth, exploring prescription oral contraception and encounters for implant and IUD services (including insertion, removal, and the contraceptive device), IUD follow-up care, and contraceptive options counseling. This analysis includes Massachusetts residents aged 14-45 with commercial insurance coverage who are included in the Massachusetts All-Payer Claims Database (APCD) 10.0 for years 2017, 2018, 2019, and 2020.[3]

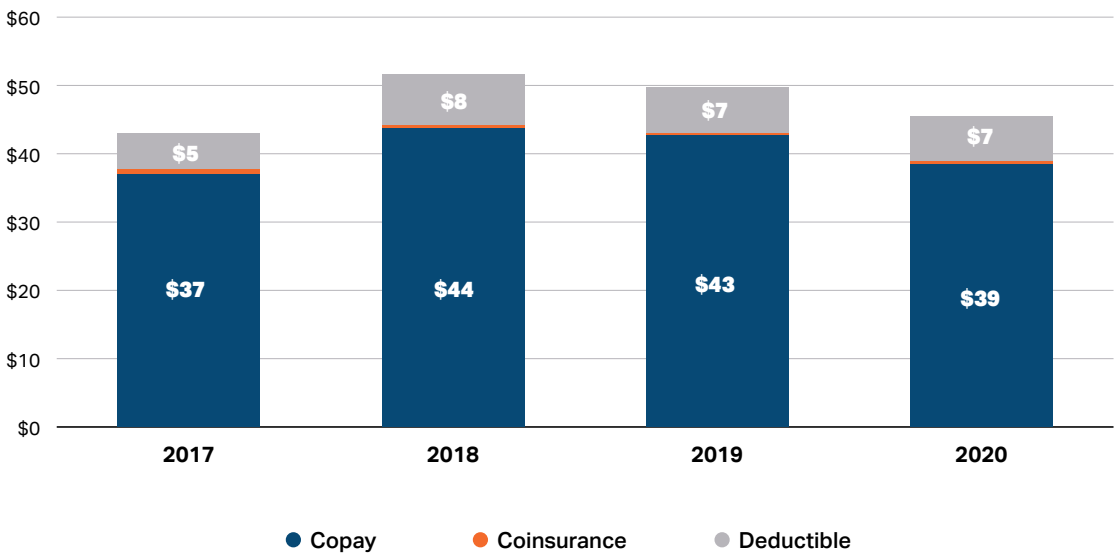
## COST-SHARING FOR ORAL CONTRACEPTION

From 2017-2020, **under 2%** of oral contraceptive prescriptions had **cost-sharing**.

Over 55,000 commercially insured individuals had oral contraceptive prescriptions during 2019. Patient cost-sharing for oral contraceptive prescriptions in Massachusetts is relatively rare: under 2% of oral contraceptive prescriptions had cost-sharing during the study period. From 2018-2020, over 80% of this subset of prescriptions with cost-sharing were branded drugs. It is possible that cost-sharing for this relatively small number of branded prescriptions may be appropriate under the contraceptive mandate: payers are required to cover in full at least one form of contraception per FDA-approved category, but may impose cost-sharing on additional forms, and doing so for branded drugs with a generic equivalent is common. Where cost-sharing is applied, patients may use an exceptions process, required under federal law, or the payers' appeals procedures to challenge the application of cost-sharing on the form of contraception that the patient requires.[4]

For the 2% of oral contraceptive prescriptions that continue to come with cost-sharing, patients consistently pay $40-$50 for a one-month supply, with most of the cost coming from copays.

**Mean copay, coinsurance, and deductible spending per one-month supply of oral contraceptives with cost-sharing, 2017-2020**




## COST-SHARING FOR CONTRACEPTIVE IMPLANTS, IUDS, IUD FOLLOW-UP CARE, AND OPTIONS COUNSELING

The share of commercially insured Massachusetts residents **paying out-of-pocket costs** for birth control services received in visits with health care providers fell from **16% in 2017 to 12% in 2020**.

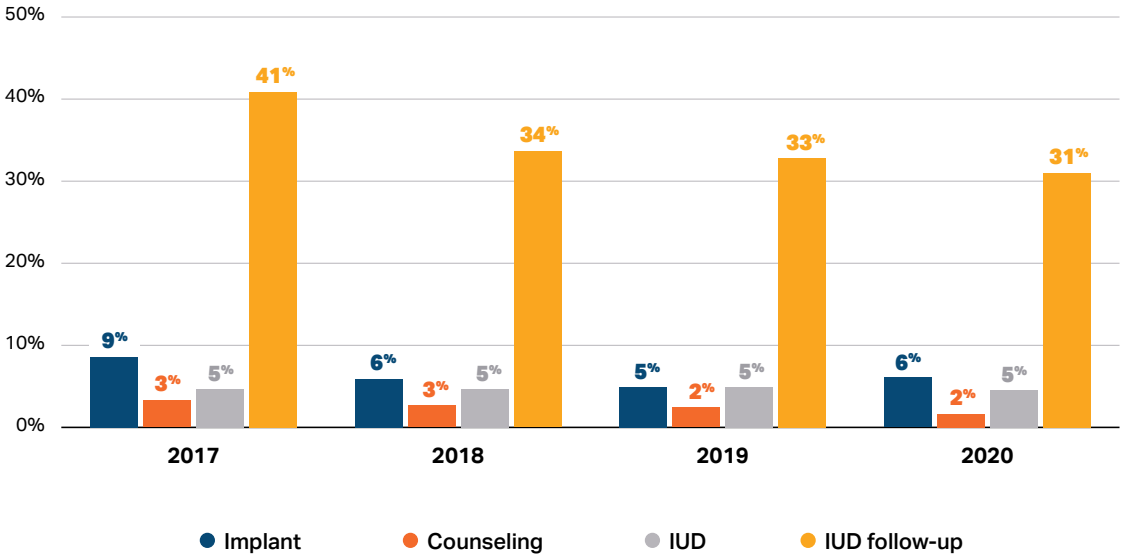
Approximately 20,000 individuals had claims for birth control services received in encounters with health care providers in 2019, including implant insertion and removal, IUD insertion and removal, IUD follow-up care, and contraceptive options counseling. The share of commercially insured Massachusetts residents who pay out-of-pocket costs for birth control services received in such encounters has decreased over time, falling from 16% in 2017 to 12% in 2020.

Cost-sharing is most common for encounters for IUD follow-up care, which may include verifying that the IUD has been placed properly. Of all encounters for contraceptive services that had cost-sharing, over 60% involved IUD follow-up care each year. As of 2020, 31% of IUD follow-up encounters had cost-sharing, compared to under 10% of encounters for other types of contraceptive services.[5] Given that 2021 HRSA guidance on the contraceptive mandate clarified that follow-up care should

be covered without cost-sharing, it is possible that this trend reflects a lack of clarity about the status of follow-up services under the mandate.

Patients **paid cost-sharing** in nearly **one-third of IUD follow-up visits** as of 2020.

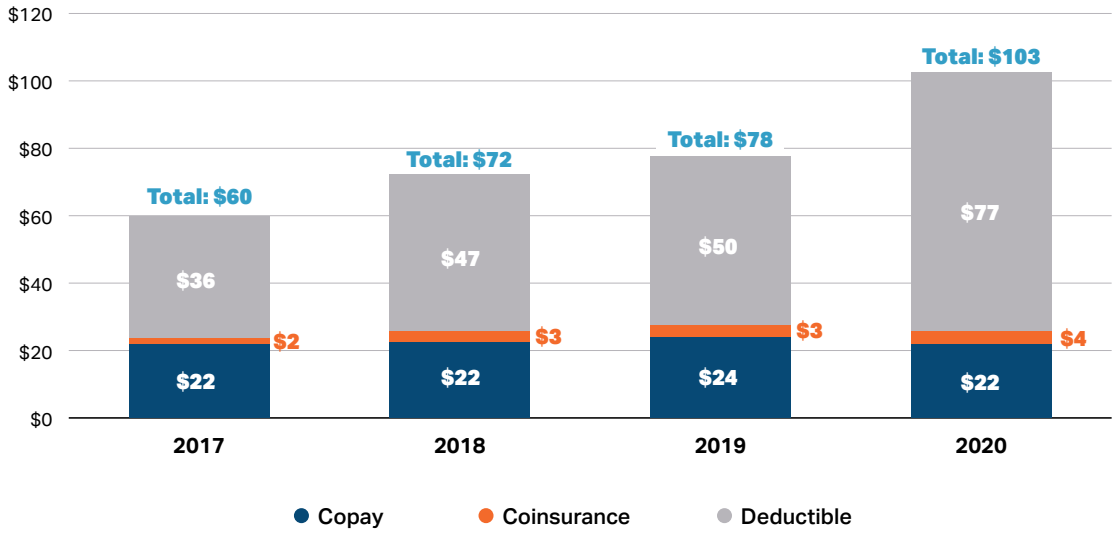
**Share of encounters for IUD, implant, counseling, and follow-up services with out-of-pocket costs, 2017-2020**




While a decreasing share of individuals pay out-of-pocket costs for contraceptive encounters, among those who do pay cost-sharing, the average cost-sharing amount per person has grown over time, rising from $60 in 2017 to $103 in 2020. This increase is primarily due to rising spending on deductibles, which made up 60% of mean per-person cost-sharing amounts for contraceptive encounters in 2017 and 75% in 2020, while copay and coinsurance amounts were largely unchanged.

Spending on deductibles **made up 60%** of **average cost-sharing payment amounts** per person for contraceptive encounters in 2017, and **75% in 2020.**

**Mean per-person contraceptive encounter copay, coinsurance, deductible, and total cost sharing amounts among those with any out-of-pocket costs for contraceptive encounters, 2017-2020**




Although IUD follow-up care is the most common source of cost-sharing, it is not the most expensive for patients. Among encounters involving cost-sharing, average per-encounter out-of-pocket costs for IUD services – including insertion, removal, and the IUD device – rose from $90 in 2017 to $157 in 2020. By contrast, average out-of-pocket costs for follow-up care rose from $42 to $61.[6]

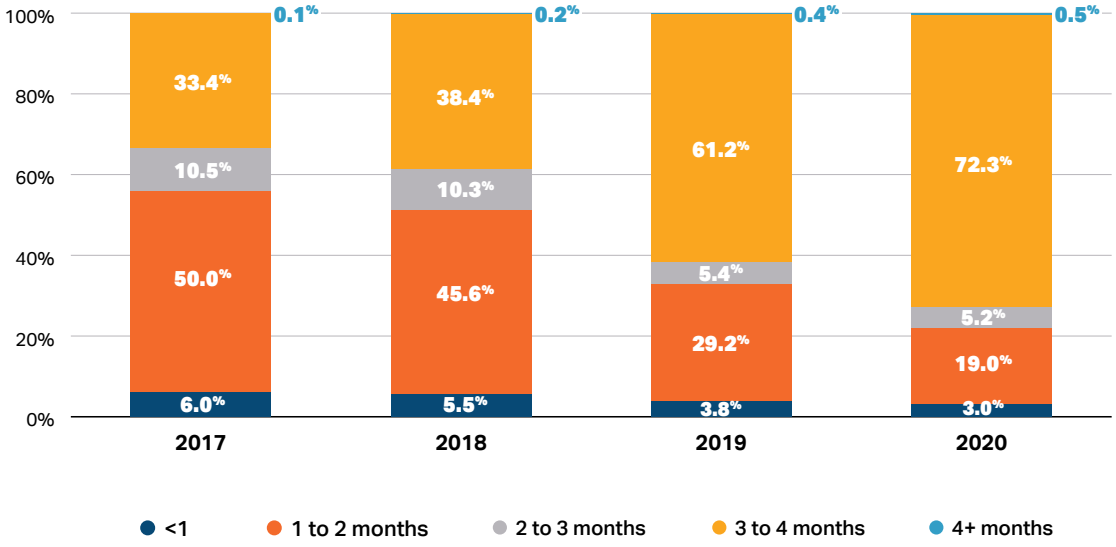
## EXPLORING THE ACCESS LAW

One area in which the Commonwealth has recently prioritized access to reproductive health services is in the 2017 ACCESS Law, which permits patients to be prescribed a 12-month supply of birth control at a time, without being subject to cost-sharing.[7] This includes oral contraceptives, transdermal contraceptives (i.e., patches), intra-vaginal contraceptives, and injectables. Research from other states has found that patients who receive a 12-month supply of oral contraception have 30% lower odds of unplanned pregnancy compared to those receiving a 3-month supply.

The HPC investigated whether patients have been filling prescriptions for larger supplies of birth control pills following the passage of the law. While the share of oral contraceptive prescriptions filled for 3-4 months' supply has steadily increased over time – representing nearly three-quarters of oral contraceptive prescriptions as of 2020 – there appears to have been little uptake of 12-month supplies following the 2017 ACCESS law, possibly in part due to lack of familiarity with it among patients, providers, and pharmacists.[8] In 2022, the Commonwealth released resources for the public to support improved understanding of benefits available under the ACCESS law.

A **decreasing share** of Massachusetts residents **pay out-of-pocket costs** for contraception, but those who do face **cost-sharing** are **paying more over time.**

**Share of oral contraceptive prescriptions each year by number of months' supply, 2017-2020**




## CONCLUSION

A decreasing share of Massachusetts residents pay out-of-pocket costs for contraception, but those who do face cost-sharing are paying more over time. While cost-sharing amounts for oral contraceptive prescriptions did not substantially change from 2017-2020, cost-sharing amounts for contraceptive services received in encounters with health care providers have risen due to increased spending on deductibles. Cost-sharing is most likely to occur for IUD follow-up services, with patients paying cost-sharing in nearly one-third of IUD follow-up visits as of 2020.

Even in cases where cost-sharing is appropriate under the ACA, such as for certain branded medications, it may represent an access barrier for patients who expect to receive contraceptive services and medications free of charge. Cost-sharing for contraception may particularly limit access for patients with lower incomes, who are less able to absorb unexpected costs. Affordability is a well-documented barrier to using the most effective contraceptive methods, and patients need to know that their birth control method of choice will be covered as anticipated.

The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs.

**HPC DataPoints** is a series of online briefs that spotlight new research and data findings relevant to the HPC's mission to drive down the cost of health care. It showcases brief overviews and interactive graphics on relevant health policy topics. The analysis underlying these briefs is conducted by HPC staff. To view all HPC DataPoints, visit our website.

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The HPC's findings are also consistent with larger trends impacting health insurance affordability in the Commonwealth. Specifically, rising cost-sharing payments due to increased deductible spending may reflect growing enrollment in high-deductible health plans. Increased enrollment in high-deductible health plans, in turn, may be driven by the increasing unaffordability of health insurance premiums, which leads individuals to enroll in plans that balance lower premiums with higher cost-sharing responsibilities, and leads employers to offer less generous coverage in an effort to control the cost of providing health insurance to their employees.

Accessible, affordable contraception is especially important in the current uncertain policy environment around reproductive health. Providers and payers should ensure that they are following the latest guidance under state and federal mandates, and should ensure that their patients have up-to-date information about their rights and options, so that contraceptive services and medications are covered as intended.

## Endnotes

1 The mandate excludes "grandfathered" plans that were in existence prior to March 23, 2010 and have not substantially changed in terms of benefits, cost-sharing, employer contributions, or other features of coverage since then. It also permits religious exemptions for several types of organizations. This includes exempt religious organizations (e.g., churches) who may opt out of providing this coverage and whose employees will pay cost-sharing for contraception if they do so. There is also an exemption for religiously-affiliated nonprofits (e.g., universities, hospitals) who may opt out of providing this coverage, and whose employees' health plans must make separate payments for employees' contraceptive coverage, which should then be covered without cost-sharing if in-network. Additionally, the 2014 U.S. Supreme Court decision in Burwell v. Hobby Lobby Stores, Inc. found that the contraceptive mandate could not be enforced against "closely held" for-profit organizations with religious objections. Health plans offered by these employers can make separate payments for employees' contraceptive coverage, similar to religiously-affiliated nonprofits. See https://www.healthcare.gov/coverage/birth-control-benefits/ and https://journalofethics.ama-assn.org/article/religious-exemptions-insurance-coverage-and-patient-clinician-relationship/2014-11

2 Data for this study was available only through 2020 and does not capture any changes that may have resulted from the updated guidance.

3 Massachusetts residents ages 14-45 with 12 months of commercial insurance enrollment with Blue Cross Blue Shield, Harvard Pilgrim Health Care, AllWays, Tufts, or Anthem and utilization of contraceptive counseling, implant, IUD, or IUD follow-up services, or with prescription oral contraceptive claims were included in this analysis. Current Procedural Terminology (CPT) codes and ICD-10 diagnosis codes were used to identify contraceptive counseling (99401-99404; Z30.09), implant (11981-11983, 11976, J7306, J7307), IUD (58300, 58301, J7296-J7298, J7300-J7302, S4989), and IUD follow-up services (Z30.431), which were measured using encounters collapsing contraceptive services provided to the same individual on the same day. IUD and implant services include insertion, removal, and the contraceptive device. Oral contraceptive prescriptions were identified using generic and brand names. Professional claims site of service and HCCI codes were used to retain only ambulatory care settings. Anthem omitted from prescription analysis due to pharmacy carveouts. Analysis includes 64,000-85,000 individuals each year.

4 45 C.F.R § 156.122(c) details the federal exceptions process. 45 C.F.R § 147.136 details the appeal procedures under federal law, and 958 CMR 3.000 details the state requirements for patient appeals.

5 Multi-service encounters are counted more than once – i.e., an encounter including both contraceptive options counseling and IUD insertion is included as part of both the counseling and IUD statistics.

6 Cost-sharing amounts are for single-service encounters.

7 More information available at https://www.mass.gov/doc/massachusetts-access-law-common-questions-and-answers-qa/download

8 All categories mutually exclusive: 1 to 2 months includes ≥1 and <2 months, 2 to 3 months includes ≥2 and <3 months, 3 to 4 months includes ≥3 and <4 months.