THE IMPACT OF THE ACA'S PREVENTIVE COVERAGE MANDATE ON SPENDING AND UTILIZATION OF CONTRACEPTION IN MASSACHUSETTS

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INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 (ACA) established requirements for health plans to cover certain preventative services with no patient cost sharing. The Health Resources and Services Administration (HRSA) interpreted preventive services so as to include contraceptive devices and services. With the possibility of Congressional repeal of some of the ACA's provisions or a substantial broadening of exceptions to these provisions for employers or insurers by the Trump Administration, states may play a larger role in determining coverage requirements for these services for their populations. The Massachusetts Health Policy Commission (HPC) investigated the impact of these ACA provisions on spending and utilization of contraception in the Commonwealth.

OBJECTIVES

The HPC sought to quantify the impact of the ACA's preventive services requirements on outcomes in Massachusetts in the years following the ACA's passage, including:

- Total spending and out-of-pocket spending on all prescription drugs
- Total spending and out-of-pocket spending on contraceptive drugs and intrauterine devices (IUDs)
- Utilization of contraceptive drugs and IUDs

STUDY DESIGN

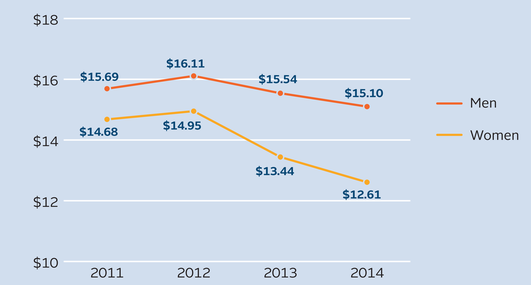
We used the Massachusetts All Payer Claims Database (APCD) to calculate average spending and cost sharing for prescription drugs and medical procedures from 2011 to 2014. We analyzed insurance claims for members of the three largest commercial payers in the Commonwealth: Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan.

Spending includes total payer and patient contributions. Cost sharing or out-of-pocket spending is defined as the sum of any patient copayment, coinsurance and deductible spending. Averages are calculated across members in the pharmacy and medical claims who used their respective coverage at least once in the calendar year.

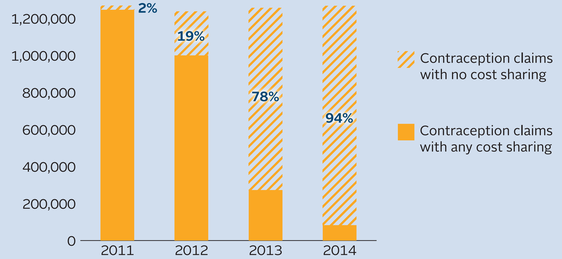
To identify prescription contraception claims, we compiled national drug codes (NDCs) from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) tables and from the Oregon Health Authority's (OHA) Coordinated Care Organization supporting documents.[1] In the medical claims, we identified intrauterine devices (IUDs) using the CPT code 58300 (IUD insertion) and J-codes J7297, J7298, J7300, J7301, and J7302. We used data on median household income by zip code from the American Community Survey to group individuals in the database into income quintiles by their zip code of residence. We defined IUD users as women who had at least one insertion or device claim within the year. We identified women with no cost sharing as those who had no cost sharing on all IUD-related claims within the year.

RESULTS

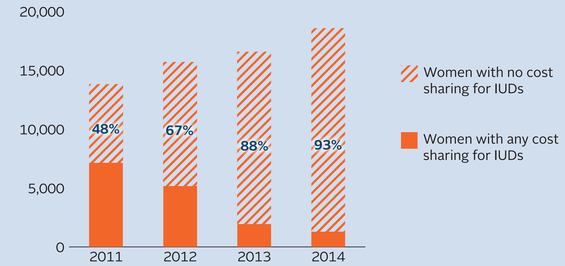
Average out-of-pocket spending per prescription claim, by gender, 2011 – 2014



Number of prescription contraception claims, by cost sharing, 2011 – 2014



Women with any IUD insertion or device claims, by annual cost sharing, 2011 – 2014



TRENDS IN PHARMACY SPENDING AND CLAIMS WITH NO COST SHARING

Across all prescription drugs, although average spending per prescription claim increased from $81 to $97 between 2011 and 2014, average out-of-pocket spending per claim decreased about 13%, from $16 to less than $14 over this period. This drop in out-of-pocket spending was due in large part to an increase in the proportion of claims with no cost sharing, from 0.8% to 8.7% of pharmacy claims between 2011 and 2014.

Trends in cost sharing differed by gender. The percentage of claims with no cost sharing increased from 0.9% in 2011 to 13.4% in 2014 for women, compared to an increase from 0.6% to 2.4% for men. Overall, average out-of-pocket spending per claim for women declined 14.2%, compared to 3.8% for men.

The greater decline in out-of-pocket spending for women was almost entirely due to decreasing cost sharing for contraception prescriptions. In 2011, less than 1% of all pharmacy claims (n = 106,000) had no patient cost sharing. Of those claims, 22% were for prescription contraception. By 2014, over 13% of claims had no cost sharing (n = 1,487,000), and 80% of those claims were for contraceptive methods. Ninety four percent of prescription contraception claims we identified were oral contraceptives. Other methods included hormonal rings and patches.

Overall, the percentage of contraception claims with no cost sharing rose from 2% to 93%, leading to a decrease in average out-of-pocket spending per oral contraception claim from $16.00 in 2011 to $1.73 in 2014.

As a specific sub-focus, we investigated trends in use and spending on intrauterine devices (IUDs), a form of long acting reversible contraception that is known to be cost-effective but can have a higher up-front cost than oral contraception. The percentage of women with no cost sharing on IUD insertion and device claims in the year increased from 48% to 93% between 2011 and 2014, leading to a decrease in average out-of-pocket spending (including both the insertion and cost of the device) from $28.11 to $5.27 over that time. Most women were therefore shielded from the full cost of the procedure, which averaged $957.09 in 2014 for the insertion and device.

UPTAKE OF CONTRACEPTION

Between 2011 and 2014, the total number of prescription contraception claims we identified remained relatively constant each year at roughly 1.2 million. However, the number of women with IUD claims between 2011 and 2014 rose 34%, from about 13,800 to 18,500.

While all income quintiles had substantial increases in IUD insertions, higher income regions generally had larger increases in IUD insertions. However, cost sharing fell across all income quintiles at similar rates. Comparing differences by age, 18 to 24 year olds saw larger increases in IUD insertions than 25 to 34 year olds or 35 to 44 year olds (83% versus 29% and 18%, respectively). Average cost sharing fell similarly for all age groups.

CONCLUSIONS

Women in Massachusetts with commercial insurance experienced a large decrease in out-of-pocket costs in the years following implementation of the ACA. The legislation has been successful in reducing the out-of-pocket cost of contraception for women in Massachusetts, for both prescription contraception and IUDs.

While use of prescription contraception remained relatively constant from 2011 to 2014, use of IUDs increased 34% over this time, suggesting increased use of more effective methods of contraception.

POLICY IMPLICATIONS

Access to affordable contraception is essential for women's continued participation in education and employment.[2] In addition to expanding access to coverage, the ACA reduced the out-of-pocket burden of contraception for commercially insured women across all reproductive ages and a range of income levels in the Commonwealth. While average cost sharing for IUDs was already relatively low in Massachusetts in 2011, the high price for the device and associated professional fees likely resulted in many women facing a high cost burden for this procedure before full implementation of the ACA requirements. IUDs are a cost saving form of contraception compared to prescription contraception, in part due to the devices' higher rate of effectiveness.[3] Therefore, the increase in use of IUDs may represent an efficient use of healthcare resources. The increased affordability of IUDs may have served as a driver of increased use over this time period, among other factors. As more recent data on birth rates and abortion rates become available, it will be important to monitor trends in these measures following periods of more affordable access to contraception. As changes in national health care legislation remain uncertain, these findings can provide context for discussions about maintaining preventive and contraceptive coverage at the state level.

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