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Contraception and abortion coverage: What do primary care physicians think?

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Abstract

Background—Insurance coverage for family planning services has been a highly controversial element of the U.S. health care reform debate. Whether primary care providers (PCPs) support public and private health insurance coverage for family planning services is unknown.

Study Design—PCPs in three states were surveyed regarding their opinions on health plan coverage and tax dollar use for contraception and abortion services.

Results—Almost all PCPs supported health plan coverage for contraception (96%) and use of tax dollars to cover contraception for low-income women (94%). A smaller majority supported health plan coverage for abortions (61%) and use of tax dollars to cover abortions for low-income women (63%). In adjusted models, support of health plan coverage for abortions was associated with female gender and internal medicine specialty, and support of using tax dollars for abortions for low-income women was associated with older age and internal medicine specialty.

Conclusion—The majority of PCPs support health insurance coverage of contraception and abortion, as well as tax dollar subsidization of contraception and abortion services for low-income women.

Keywords

contraception; abortion; primary care providers; health care reform

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1. Introduction

The national debate leading up to the 2010 U.S. Patient Protection and Affordable Care Act promoted fresh discussion about controversial health care topics impacting our country's health[1]. One topic that frequently polarizes opinions is funding for family planning services, specifically contraception and abortion. In 2011, the Institute of Medicine (IOM) recommended that eight preventive health services for women be added to services that health plans will cover under the Patient Protection and Affordable Care Act. The recommendation from the report that has received the greatest amount of scrutiny concerns contraception—the IOM committee recommended health plan coverage for the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity [2]. Contraceptive coverage has become standard practice for most private insurance and federally funded insurance programs—28 states currently have regulations requiring private insurers to cover contraceptives. In fact, the Equal Employment Opportunity Commission found an employer who failed to cover prescription contraceptives and devices to be in violation of the Civil Rights Act due to discrimination against women in 2000 [3]. In spite of this, several anti-choice groups have denounced the IOM's recommendation, claiming that certain contraceptives act as abortifacients.

Since 1976, the Hyde Amendment has barred the use of federal funds for abortions; however, the Hyde Amendment specifically applies to federal funds only, and not to those from private insurance companies or state Medicaid programs. When it was recognized that health care reform could potentially include a federal insurance option or a federally organized health insurance exchange, several pro-life Democratic legislators stated they could not support health care reform unless there was a continued commitment to the federal funding ban for abortions. Ultimately, President Obama signed Executive Order 13535 on March 24, 2010, which restricted the use of federal funds for abortion services within health insurance reform.

While much attention about federal abortion funding during the health insurance reform talks focused on the opinions of politicians, the public, and activist organizations, physicians and their professional societies were noticeably silent. This was despite President Obama acknowledging that he needed physicians' support on health care reform and the vast majority of physicians believing that they have a professional obligation to address societal health policy issues [4-5]. Primary care physicians (PCPs) provide routine care for women of reproductive age, and are thus well positioned to understand the impact that such health care policies can have on their patients. PCPs largely support a public health insurance option [6], but it is unknown whether or not they believe that it should include contraceptive and abortion services. The purpose of this study was to assess the opinions of PCPs who care for women of reproductive age regarding health insurance coverage for contraception and abortion.

2. Materials and methods

We distributed an online survey to a convenience sample of 550 PCPs trained in General Internal Medicine or Family Medicine practicing in Western Pennsylvania (n=70), Central Pennsylvania (n=100), Rhode Island (n=180), and Oregon (n=200) in 2009. Physicians were invited to complete the survey shared an institutional or professional affiliation with one of the study investigators, allowing for easy distribution of the survey through existing e-mail list servers. The study sample includes physicians still in residency training. Physicians were offered \$20 for completing the survey. This survey was part of a larger project designed to assess PCPs' experiences using clinical decision support systems, as well as opinions

regarding contraception and abortion. Specific to this analysis, the questionnaire probed whether PCPs think prescription benefits offered by health plans should include coverage for contraception and abortion, and whether state or federal tax dollars should be used to pay for contraception or abortion for poor women. Possible response choices for these items were yes, no, or unsure. The survey also assessed participants' sociodemographic characteristics, including age and gender. Additional items assessed practice characteristics, such as years since medical school graduation, hours per week spent providing direct patient care, and proportion of patients who are women of reproductive age. To assess attitudes toward contraception and abortion, PCPs were asked whether they had religious objections to contraception or abortion, and whether they thought abortion should be illegal.

Descriptive statistics were used to describe the study population. Frequencies regarding physician characteristics, attitudes toward contraception and abortion, and physician beliefs about health plan coverage and tax dollar use for contraception and abortion are presented. Using multivariable logistic regression, we created two models to predict the likelihood of PCPs supporting 1) health plan coverage for abortion services, and 2) state or federal tax dollar use for abortion services for poor women. We tested the independent effect of gender, age (younger than 30 years, 30 to 39 years, 40 to 49 years, or 50 years and older), specialty (internal medicine vs. family medicine), being a resident, and practice location (Western Pennsylvania, Central Pennsylvania, Rhode Island, Oregon, or missing) in the models. We did not include the variable indicating years since medical school graduation in the regression due to collinearity with the age variable. Similarly, we did not include hours per week providing direct patient care or proportion of patients who are women of reproductive age due to collinearity with being a resident. We did not model the likelihood of supporting health plan coverage or tax dollar use for contraception for poor women due to the small numbers of PCPs that did not support these policies. All analyses were performed using SAS 9.1 (Cary, NC). This study was approved by the Institutional Review Boards of the University of Pittsburgh, the Penn State College of Medicine, Oregon Health Sciences University, and Memorial Hospital of Rhode Island.

3. Results

Of 550 PCPs invited to participate in the study, 192 completed the online survey, producing a response rate of 35%. We excluded surveys where the main outcome variables were missing, resulting in a final sample of 174. Slightly more than half of the PCPs were women, most were trained in internal medicine (87%), and approximately one-third were residents (Table 1). Male PCPs were more likely to be older and less likely to be residents. Women PCPs were providing fewer hours of direct outpatient care per week but had a greater proportion of patients who were women of reproductive age. Nine percent of the respondents reported a personal religious objection to contraceptive use, 25% reported a religious objection to abortion, and 13% believed abortion should be illegal. These personal beliefs toward contraception and abortion did not differ by gender.

Almost all of responding PCPs believed prescription benefits offered by health plans should cover contraception (96%) and that state or federal tax dollars should be used to pay for contraception for poor women (94%)(Table 2). These beliefs did not differ by gender. A smaller majority of PCPs responded that health care plans should cover abortion services (61%) and supported use of state or federal tax dollars to cover abortion services for poor women (63%). Female PCPs were significantly more likely than male PCPs to endorse health plan coverage for abortion services (69% vs. 49%, $p<0.01$). Female PCPs were also more likely than male PCPs to endorse use of tax dollars to pay for abortion services for poor women, which was of borderline significance (69% vs. 55%, $p=0.05$).

In multivariable analysis (Table 3), we tested whether PCP characteristics were independently associated with supporting health plan coverage or tax dollar coverage for abortion services for low-income women. Women PCPs were significantly more likely than male PCPs (adjusted OR 2.11, 95% CI 1.05 – 4.21) and internists were significantly more likely than family physicians (adjusted OR 6.43, 95% CI 1.34-30.92) to support health plan coverage for abortion. Characteristics that predicted PCP support of tax dollars for abortion services for low-income women were older age group (PCPs 50 years and older vs. younger than 30 years—adjusted OR 6.92, 95% CI 1.46-32.81) and internal medicine specialty (compared with family physicians—adjusted OR 12.72, 95% CI 2.44-66.29). PCPs from central Pennsylvania were less likely to support health plan coverage for abortion and tax dollar coverage for abortions in low-income women compared with PCPs from other locations.

4. Discussion

Insurance coverage of contraceptive and abortion services directly impacts U.S. women's access to reproductive health services. Unfortunately, physician opinions about coverage for such services were noticeably absent during the recent health care debates, perhaps because the organizations representing physicians feared alienating some constituents by taking a stance on such a nationally divisive issue. In this study, we found that the majority of PCPs support health insurance coverage for both contraception and abortion. Furthermore, PCPs widely endorsed tax dollar coverage for contraception for poor women, and the majority supported tax dollar coverage for abortion for poor women. In spite of the controversy that ensued after the recent IOM recommendation that health plan coverage include contraception under the Patient Protection and Affordable Care Act, our findings suggest that PCPs would overwhelmingly support this recommendation.

Several of the PCP characteristics we tested were independently associated with whether or not physicians supported health plan coverage or tax dollar use for abortion services in low-income women. Specifically, women PCPs were twice as likely as men to support health plan coverage for abortion. PCPs who were 50 years and older were more likely than PCPs younger than 30 years to support tax dollar coverage for abortion in low-income women, which is consistent with other studies [7], and may reflect support for abortion access among physicians who practiced prior to legalization of abortion. Interestingly, we found that family physicians were less likely than internists to support either health plan coverage or tax dollar use for abortion services in low-income women. This was an unexpected finding, and we are unaware of prior literature that demonstrates differing attitudes toward abortion among these primary care specialties. It is possible that the family physicians were more likely than internists in our sample to be in rural community-based practices, which could account for the differences in attitudes, rather than actual specialty. Finally, we found that our outcomes were predicted by practice location, with the least amount of support for abortion coverage in Central Pennsylvania. This suggests that attitudes toward payment for abortions differs geographically, which likely reflects geographical variation in attitudes toward abortion in the general population [8].

These findings illustrate the views of PCPs on coverage for reproductive health services, which to our knowledge has not previously been investigated. While our study included PCPs from four geographically diverse locations in the U.S., the majority of PCPs were from university-affiliated practices and thus may not represent the opinions of PCPs in community practices. While our 35% response rate was typical for physician surveys of this type [9-10], we cannot be certain that the participating physicians are representative of their peers. The email invitation to potential participants described this as a research study examining outpatient clinical reminder systems, which was the purpose of the parent study.

Since potential participants were not aware that the survey included items on contraceptive and abortion services, they should not have been subject to selection bias due to the topic of the current analysis.

By issuing Executive Order 13535, President Obama upheld the Hyde Amendment continuing the ban on federal funds for abortion in the context of health insurance reform. More recent budget talks have also proposed further limits on the use of federal money for family planning for poor women, both domestically and internationally [11]. Many fear that health insurance companies will be unlikely to provide separate abortion coverage policies for their federally-supported options and their private insurance options, such that eventually private insurance will no longer routinely cover abortion services. How health insurance reform will affect utilization and payment for abortions services in the coming years has yet to be seen. Similarly, it is yet to be seen how contraceptive use by U.S. women will be affected when mandated health plan coverage for contraception takes effect after January 1, 2013 under the Patient Protection and Affordable Care Act. Given the high rate of unplanned pregnancy and abortion in the U.S., physicians bear witness daily to the consequences for individual women and families of restricted access to family planning services, but their voice has been missing from the current debate. Policy makers should heed PCP endorsement of insurance coverage and public funding for contraception and abortion services.

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Table 1

Primary care physician characteristics, N=174

	Total	Men N=73 (42%)	Women N=101 (58%)	p-value^I
Age category—n (%)				0.01
Younger than 30 years	40 (23)	12 (16)	28 (28)	
30 to 39 years	62 (36)	23 (32)	39 (39)	
40 to 49 years	33 (19)	13 (18)	20 (20)	
50 years and older	39 (22)	25 (34)	14 (14)	
Specialty—n (%)				0.08
Internal Medicine	152 (87)	60 (82)	92 (91)	
Family Practice	22 (13)	13 (18)	9 (9)	
Practice location—n (%)				0.21
Western Pennsylvania	57 (33)	27 (37)	30 (30)	
Central Pennsylvania	19 (11)	9 (12)	10 (10)	
Rhode Island	9 (5)	5 (7)	4 (4)	
Oregon	36 (21)	9 (12)	27 (27)	
Missing	53 (30)	23 (32)	30 (30)	
Resident—n (%)	61 (35)	16 (22)	45 (45)	<0.01
Years since graduation— median (IQR)	10 (2-20)	16 (4-25)	6 (2-15)	<0.01
Hours of direct outpatient care/week—median (IQR)	10 (5-24)	16 (5-28)	9 (5-20)	0.05
% of patients who are women of reproductive age—median (IQR)	25 (10-40)	20 (10-28)	30 (20-50)	<0.01
Has religious objection to contraceptive use—n (%)	16 (9)	8 (11)	8 (8)	0.49
Has religious objection to abortion—n (%)	43 (25)	21 (29)	22 (22)	0.29
Believes abortion should be illegal—n (%)	22 (13)	12 (16)	10 (10)	0.20

IQR=Interquartile range.

^I Chi-square or Wilcoxon rank sum tests comparing men vs. women.

Table 2

Primary care physicians' responses regarding reproductive health services coverage, N=174

	Total	Men N=73	Women N=101	p-value^I
Health plans should cover contraceptive services—n (%)	167 (96)	69 (95)	98 (97)	0.41
Tax dollars should cover contraceptive services for poor women—n (%)	163 (94)	68 (93)	95 (94)	0.81
Health plans should cover abortion services—n (%)	106 (61)	36 (49)	70 (69)	<0.01
Tax dollars should cover abortion services for poor women—n (%)	110 (63)	40 (55)	70 (69)	0.05

^IChi-square tests comparing men vs. women.

Table 3

Multivariable analysis predicting physicians who support health plan coverage for abortion services and tax dollar coverage for abortion services for low-income women, n=174.

	Supports health plan coverage for abortion services Adjusted OR (95% CI)	Supports use of tax dollars for abortion services for low-income women Adjusted OR (95% CI)
Female	2.11 (1.05-4.21)	1.93 (0.94-3.94)
Age Category		
Younger than 30 years	Reference	Reference
30 to 39 years	1.68 (0.54-5.18)	3.07 (0.98-9.67)
40 to 49 years	0.98 (0.23-4.19)	1.68 (0.39-7.27)
50 years and older	2.42 (0.55-10.62)	6.92 (1.46-32.81)
Specialty		
Internal medicine	6.43 (1.34-30.92)	12.72 (2.44-66.29)
Family practice	Reference	Reference
Practice Location		
Western Pennsylvania	Reference	Reference
Central Pennsylvania	0.28 (0.09-0.89)	0.20 (0.06-0.66)
Rhode Island	4.30 (0.65-28.49)	4.71 (0.69-32.40)
Oregon	1.87 (0.64-5.49)	1.16 (0.41-3.28)
Missing	0.96 (0.39-2.34)	0.92 (0.36-2.36)
Resident		
Yes	1.60 (0.52-4.96)	1.80 (0.56-5.75)
No	Reference	Reference