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Ongoing Implementation Challenges to the Patient Protection and Affordable Care Act's Contraceptive Mandate

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Perhaps among the most notable achievements of the Patient Protection and Affordable Care Act (ACA) is the requirement that private health insurance plans cover contraceptive counseling, services, and Food and Drug Administration (FDA)-approved methods without cost sharing. Since 2013, decreased out-of-pocket medical expenditures for contraceptives have benefited millions of insured women in the U.S.^{1,2} Highly effective long-acting reversible methods (LARCs), including intrauterine devices (IUDs) and implants, have now become more readily accessible options for many more with the ACA's elimination of high up-front insertion procedure and device costs. In tandem, increased coverage (greater prescription supply, reduced co-pays) of oral contraceptive pills and other refillable forms as a result of the ACA has removed important financial barriers to more commonly used methods. Ultimately, the hope is that the contraceptive mandate will increase access to effective contraception, thereby supporting planned pregnancies and improving outcomes for women, their families, and society.

Unfortunately, ongoing multilevel challenges to the ACA's implementation continue to preclude many women from receiving their full reproductive healthcare benefits.^{1,3} These challenges may not be widely understood among women or even health professionals and have received little mainstream attention in lieu of other timely, important, and highly sensitive policy debates around Zika virus, religious exemption, congressional fights to end Planned Parenthood funding, and legislation restricting access to abortion.^{4,5} Meanwhile,

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though, the general public and healthcare work force is still grappling with the meaning of “contraceptive mandate” and nature of services that comprise preventive family planning care. Additionally, the political and ideological “blurring” of contraception and abortion, which may not reflect women’s views of and priorities for reproductive health policy, has distracted and disserved women by precluding much needed education on the ACA and perpetuating unfavorable views of it.^{6–8} New results from the Pew Research Center indicate that 54% of Americans disapprove of the ACA.⁹ Thus, increasing awareness of several key woman-, healthcare systems-, and policy-level issues with the ACA and contraception appears warranted. The following paragraphs summarize these multilevel issues and offer recommendations for how women, health systems players, and health policymakers may fully leverage the ACA’s contraceptive mandate (or expand upon it) to improve the status of women’s reproductive health and health care in the U.S.

1. Women should be empowered to drive the demand for comprehensive, quality, patient-centered reproductive health services by being armed with accurate information

With critical gaps in knowledge of the ACA, insurance plan details, coverage changes, and how to access services, the contraceptive mandate cannot have a broad impact on women’s health outcomes. In 2013, the authors conducted a study to investigate early understanding of the ACA among 1,078 reproductive-aged women across the U.S. It was found that 65% of women reported not knowing about their contraceptive coverage under the ACA.¹⁰ In 2015, Chuang and colleagues¹¹ found that only 11% of their privately insured, reproductive-aged Pennsylvanian sample reported awareness that their insurance covered full IUD costs. Moreover, research over the last decade has documented women’s lack of basic understanding of contraceptive methods, how they work, and how they can be effectively used, especially LARCs.¹² Targeted public health and media campaigns focused on the ACA and its reproductive health provisions are urgently needed. Clinicians can play a critical role in educating women about their contraceptive options, with cultural sensitivity and without coercion, and in informing them of how to best advocate for their full family planning insurance benefits. Insurance providers should offer clearer mechanisms and accessible resources to support women in better understanding and utilizing specific family planning benefits covered under their plans—when desired and needed by women. For instance, effective models of health education, promotion, and workplace wellness programs, such as those for smoking cessation, chronic disease management, or perinatal health, could be thoughtfully adapted to family planning care, but such approaches would need to be patient-centered, flexible, and easily tailored to individual women’s fertility goals and contraceptive preference.¹³

2. Healthcare systems players, including providers, administrators, and insurers, need education, training, and oversight on best practices to ensure compliance with the contraceptive mandate

Many providers and administrators are unclear about specific details and rules of the ACA and its implications for their practice.^{1,3} In addition to covering the costs of contraceptive devices/methods themselves, the law also states that clinical services required to provide contraceptive methods (e.g., counseling, insertion of drugs/devices, follow-up care) must be provided without cost sharing. However, there has been confusion regarding appropriate billing for services, especially LARCs and sterilization, including in the context of immediate postpartum care. Nuanced issues around billing for non-contraceptive method indications, cost sharing for office visits that include non-contraceptive care, device/drug stocking, bundling of family planning and obstetric services at the time of delivery, and reimbursement are difficult to manage, track, and explain to patients. As standardized implementation processes are needed, some professional organizations have offered guidance on coding, billing, and managing supply issues. Even then, many providers lack the knowledge and skills necessary to provide the full range of ACA-mandated contraceptive methods and services. Enhanced clinical training and LARC mentoring efforts, such as those already underway by the American College of Obstetricians and Gynecologists, the Family Planning National Training Centers, industry manufacturers, private and non-profit companies, and even states themselves, can help remedy these important service delivery gaps. Some such current state-level efforts are strategically addressing specific barriers related to immediate postpartum LARC delivery. Other innovative approaches have included those like in South Carolina, where outpatient LARC specialty pharmacies have been established for overnight delivery of a device billed directly to Medicaid.

Moreover, insurers and regulators also have misunderstanding of the mandate and non-compliant practices that capitalize on the vagueness in ACA language regarding allowance of “reasonable cost-containment strategies.”^{1,3} In 2015, the National Women’s Law Center reported on health plan violations of contraceptive coverage: not providing coverage for all FDA-approved methods or imposing out-of-pocket costs, limiting coverage to generic methods only, and failing to cover counseling and follow-up costs.¹⁴ Formal efforts to monitor payers’ compliance with the law and evaluate their reproductive healthcare coverage performance will ensure that the ACA’s contraceptive benefits reach women. When non-compliance issues occur, efforts to disseminate such information to state and federal regulators and the public can facilitate awareness and swift resolutions for women.

3. Health policymakers must address important gaps within the law itself to guarantee full coverage for the full range of contraceptive methods and services for all women, and healthcare professionals and women must advocate for them to do so

Foremost, although the ACA has already made great strides in insuring American women, the law applies only to private plans and leaves behind those at greatest risk for unintended

pregnancy—uninsured women and women with pre-existing Medicaid plans—who are disproportionately younger, poor, and of racial/ethnic minority status. In national surveys of 8,000 U.S. women in 2012 and 2015, the Guttmacher Institute found that though the overall proportion of uninsured women declined dramatically, Latina women and low-income women residing in states without Medicaid expansion programs have not experienced declines at the same rates or magnitude.¹⁵ There is substantial state-level variation in Medicaid contraceptive coverage by eligibility and specific program. State-level variation in coverage also means that some states do not have access to the full menu of contraceptive method options. The magnitude and implications of this heterogeneous landscape are not yet clear but warrant research. Given that traditional Medicaid may not cover all method categories, state policies that better align all plans with ACA rules are strategies that can ensure women under Medicaid enjoy the same benefits as those covered by private health plans under the ACA. Medicaid expansion programs now enacted in several states offer a promising, successful example to reach socially disadvantaged women. Medicaid reimbursement for immediate postpartum LARC placement is another example, and a recent American Congress of Obstetricians and Gynecologists bulletin reported that as of late April 2016, a total of 19 states had posted guidance on this policy.¹⁶ Proactive policies that protect and expand funding for safety net providers, including publicly funded family planning clinics, will help support reproductive healthcare access for the remaining uninsured women.

Moreover, the ACA currently requires private insurance plans cover at least one method from each of the 18 FDA-approved categories (e.g., IUDs, pills, rings) without cost sharing. However, the law does not require that all methods within categories are covered (e.g., all hormone-containing IUDs or pill types). Thus, many insured women do not have access to their preferred or usual methods, which is important given that preference and satisfaction are known predictors of correct, consistent, and continued method use. Healthcare professionals and women can play a critical role in advocating for legislative action to expand the ACA's mandate and assure access to a broader range of FDA-approved methods, especially women's preferred contraception. Other patient-centered strategies may include coverage of male methods and over-the-counter FDA-approved contraceptives without prescription requirements. Certainly, high up-front costs and increased insurance premiums are a likely consequence of mandating coverage for all methods and are thus real concerns. On the other hand, contraceptive coverage without cost sharing could result in greater uptake, continued use of highly effective methods, subsequent decreases in premiums, and overall cost savings for insurers, health systems, and society.¹⁷ Research is needed to evaluate the benefits and costs of the mandate on insurance premiums and other cost-effectiveness indicators. Regardless, all key stakeholders should have an active voice regarding which potential expanded benefits to prioritize.

In sum, improved access to contraceptive methods through the ACA's mandate alone is unlikely to dramatically reduce or eliminate the high rates of unintended pregnancy experienced among women in the U.S.¹⁸ However, at a minimum, the health policy reflects an important shift toward "high-value" services that are cost effective from multiple perspectives and aligned with patient-centered and reproductive justice-informed models of care—that is, care in which costs do not prevent women or subgroups of women from achieving their fertility goals. By increasing awareness of ongoing implementation

challenges and refocusing the conversation so the public is armed with clear, accurate, timely information about the ACA, contraception, and what remains to be done, greater benefits of this landmark policy for women's health in the U.S. can be realized.

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