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Contraceptive Coverage and the Affordable Care Act

Mary Tschann, MPH* and Reni Soon, MD, MPH

Department of Obstetrics, Gynecology, and Women's Health, University of Hawaii John A. Burns School of Medicine, 1319 Punahou Street, Suite 824, Honolulu, HI 96826, USA

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INTRODUCTION

The Affordable Care Act, Preventative Health Care, and Contraception

The ACA was signed into law by President Obama on March 23, 2010, with the primary goals of expanding access to insurance coverage and reducing health care spending. A major underpinning of the legislation was shifting the focus of both health care and insurance providers away from reactive medical care toward preventive care.

Public health advocates have long recognized that the most successful health care systems are those that focus on primary prevention of disease, rather than on treatment of acute illnesses. Specifically, an analysis in the United States of preventive health care services, such as tobacco cessation screening and immunizations, showed that these programs saved 2 million life-years at minimal cost.¹ Such studies serve as the foundation for the ACA's goal of pivoting the US health care system toward prevention of disease and promotion of overall health and well-being.

To actualize this goal, the ACA stipulated that insurers may not apply cost sharing (co-pays, co-insurance, or deductibles) to a panel of preventive services. These services include high blood pressure and cholesterol screening, testing for sexually transmitted infections, alcohol misuse and abuse screening and counseling, and a variety of cancer screenings and immunizations. The ACA preventive services coverage mandate also included specific preventive care for women.

When the ACA was signed in 2010, the value of covering preventive health care services was well recognized. Many private sector insurance payors were already covering preventive services: all 50 states required plans to cover mammography screening, and 29 states required plans to cover cervical cancer screening.²

After the signing of the ACA, the Department of Health and Human Services (HHS) tasked the Institute of Medicine (IOM) with determining which services should be included as

*Corresponding author. mtschann@hawaii.edu.

preventive health care services under the ACA. The IOM convened the Committee on Preventive Services for Women, which comprised experts from diverse fields in medicine, public health, and health policy. In 2011, this committee released its recommendations on which services should be covered by the ACA.² This list included “the full range of Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.” The HHS adopted these recommendations, and implementation of this provision began in August 2012.

Although some question the need for including contraception as a component of general preventive services for women, the public health benefits of preventing unintended pregnancy are pronounced and well established. Every year in the United States, 600 to 700 women die because of complications associated with pregnancy,³ and the maternal mortality ratio (MMR) in the United States continues to increase.³ In a recent examination of US pregnancy-related mortality, the MMR was 16.0 per 100,000 live births for the period 2006–2010.³ Another analysis of global maternal mortality found that the US MMR in 2013 was 18.5 per 100,000 live births, which is comparable to the ratio in countries with fewer health care resources, including Turkey, Russia, Iran, and Romania.⁴ Reducing unintended pregnancy is an important element of addressing the unacceptably high MMR in the United States.

In addition, there are well-established negative health and socioeconomic outcomes associated with unplanned births. Unplanned pregnancies are associated with delayed initiation of prenatal care and a decreased likelihood of breast-feeding.⁵ Short spacing between pregnancies increases the risk of negative birth outcomes, namely, preterm birth and low-birth-weight babies.^{6,7} Moreover, the ability to plan pregnancies allows women the time and finances to invest in their own education and careers and participate more fully in the workforce, benefitting not only themselves and their families but also the society as a whole.^{8,9}

Unintended pregnancies may risk the health and well-being of women and their families, and the financial implications of unintended pregnancy are also substantial. Including only the medical costs of an unplanned pregnancy and 1 year of life of the child, the Brookings Institute, a nonpartisan public policy group, estimated that the cost to taxpayers of publicly funded unintended pregnancies and the infants born of those pregnancies averaged \$11 billion annually.¹⁰

Although the contraceptive coverage mandate has proved to be a highly divisive issue, it is not a provision unique to the ACA. By the time the ACA was signed, government-funded insurance had already been covering contraception for decades. More than half of states had laws requiring that insurance plans cover contraceptive methods even before ACA implementation.¹¹ In 2002, the most recent year before the ACA with data available, more than 89% of insurance plans covered contraception,¹¹ and in a 2010 survey of employers, FDA-approved contraceptives were reported to be covered by 85% of large employers and 62% of small employers.¹²

Medicaid Expansion and Family Planning

Another component of the ACA was the loosening of eligibility requirements for Medicaid family planning services. For approximately the last 20 years, states have had the option of increasing the income threshold or establishing other criteria by which individuals could access low- or no-cost family planning services through the Medicaid waiver program. The waiver program was a mechanism for creating demonstration projects that both expand services and provide a real-world analysis of a project's feasibility and impact on beneficiaries. States receive funding to support the projects, but funding is contingent on periodic reapplication and approval by the Centers for Medicaid and Medicare Services.¹³ These projects have been immensely effective at reducing unintended pregnancies,¹⁴ increasing uptake of highly effective contraceptive methods,¹⁵ and improving pregnancy spacing,¹⁶ while also being highly cost-effective.¹⁷ These programs have been shown to produce cost savings of up to \$159 million annually.¹⁸

As the ACA was being developed, the success of expanded family planning waiver programs was apparent, and many of these had moved beyond being demonstration projects to become integral parts of a state's family planning services. In light of this success, legislators created a mechanism in the ACA by which these programs could be permanently integrated into state's Medicaid plans. States that choose to make their expanded access to family planning permanent may now do so through a State Plan Amendment (SPA). SPAs are implemented state by state, and therefore their eligibility requirements vary, but all are tied to consumer income, with eligibility ranging from approximately 140% to 300% of Federal Poverty Level (FPL).¹⁹

The ACA provided funds for the expansion of Medicaid in general to all individuals making up to 138% of the FPL. Before the ACA, each state dictated coverage eligibility for its own Medicaid program. However, as discussed later, the Supreme Court determined that the federal government could not require states to expand their Medicaid programs, which effectively made this intended expansion optional for states. If all states participated in the expansion, an additional 17 million low-income individuals who otherwise would not have qualified for Medicaid would have coverage.²⁰ Because Medicaid provides for full coverage of family planning services, increasing access to Medicaid also expands access to contraception.

Contraceptive Coverage Mandate Goal: Reducing Barriers to Effective Prevention

Although coverage of contraception was already standard practice in most private health insurance plans and government-funded insurance, the ACA was ground-breaking in that it stipulated that this coverage could not include any co-payments, deductibles, or other cost sharing by patients; this is significant in light of recent evidence showing that co-payments are a barrier to accessing contraception, particularly the most effective methods of contraception, which typically have substantial up-front costs.²¹

Several studies have shown that with counseling and removal of logistical and financial obstacles, such as prohibitive cost sharing, most women will choose the most effective methods of contraception.^{22,23} In a prospective study in St Louis, more than 9000 women

were provided with contraceptive counseling and the method of their choice at no cost.^{23,24} About 75% of the women chose an intrauterine device (IUD) or an implant, which is markedly higher than the national IUD and implant use rate of 7.2%,²⁵ and subsequent analyses have shown a decrease in the unintended pregnancies, abortions, and teen births in this population.^{24,26}

Trussel and colleagues²⁷ created an economic model to estimate the potential savings if more women in the United States switched to highly effective methods of contraception, such as IUDs and implants. They found that if just 10% of women aged 20 to 29 years switched from oral contraception to an implant or IUD, the cost savings would be approximately \$288 million each year.

The current landscape of contraceptive coverage in the United States after the enactment of the contraceptive mandate and the delays and inconsistencies related to its implementation to date are described in the following.

STATUS OF THE CONTRACEPTIVE COVERAGE MANDATE IMPLEMENTATION: PROGRESS AND DELAYS

No-Cost Contraceptive Coverage Expansion

As the contraceptive coverage mandate went into effect in August 2012, there is as yet no extensive evidence regarding its impact. However, recent Guttmacher analysis found that since the implementation of the contraceptive coverage mandate, out-of-pocket costs for contraception for privately insured women have been substantially reduced. The proportion of privately insured women paying out of pocket for oral contraception decreased from 85% in the fall of 2012 to 33% in spring of 2014.²⁸ Among women who reported using IUDs, the proportion who paid nothing for their method increased from 45% in the fall of 2012 to 62% in the spring of 2014. The estimated cost savings in 2013 related to the contraceptive mandate was more than \$483 million in out-of-pocket costs, an average of \$269 per woman.²⁹

Medicaid Expansion and Expanded Contraceptive Access

As of July 2015, 29 states and the District of Columbia have adopted Medicaid expansion under the ACA.³⁰ Since the beginning of 2014, 8 million additional women have obtained insurance through expanded Medicaid coverage.³¹ Because the ACA was written with the expectation that all states would have expanded coverage through Medicaid, in states that have declined to expand coverage there exists a large gap in coverage options for individuals whose income is more than the threshold for their state's Medicaid but less than the minimum required to qualify for federal health insurance premiums. In states that have not chosen to expand their Medicaid coverage, 4 million people are in the coverage gap, and 49% of these individuals are women.³²

A total of 29 states have expanded access to family planning through Medicaid waiver or SPAs. The authors found no published analysis of the increased enrollment or corresponding increase in contraceptive uptake associated with these programs since the signing of the

ACA, but an analysis in 2011 predicted that the states without an SPA could serve up to 100,000 women each and save between \$2.3 million and \$17.4 million dollars per year if they were to establish a program.³³

Limitations and Inconsistencies with Mandate Compliance

Grandfathered plans—To promote a smooth implementation, the ACA provided for tiered adoption of certain components of the legislation by some insurance plans. This accommodation, known as grandfathering, allows plans that were already in existence at the time the ACA was signed into law to continue to apply cost sharing to preventive services. Plans maintain their grandfathered status as long as they impose no increases in patient cost sharing through premiums, deductibles, or co-pays.³⁴ These plans are quickly disappearing; employees covered by a grandfathered plan dropped from 48% in 2012 to 26% in 2014.³⁵ Employers are also reducing the number of grandfathered plans offered to employees, with 54% offering at least 1 grandfathered plan to employees in 2013, down from 72% in 2011.³⁵

Inconsistencies in compliance—Inconsistencies in interpretation and compliance with the contraceptive mandate have been confirmed by recent research. A report by Sonfield³⁶ found that some plans are not providing full coverage for the entire range of contraceptive methods available, particularly for coverage of IUD and injectable contraceptives. This same study found that some plans are declining to provide coverage for the contraceptive patch and ring because they have the same hormonal ingredients used in oral contraceptives,³⁶ even though the FDA classifies these as distinct methods because of their different modes of delivery.³⁷ Similarly, a recent review of coverage for emergency contraception (EC) among the largest insurers in the state of Hawaii revealed that the predominance of plans were still applying cost sharing for the 3 types of FDA-approved EC—levonorgestrel, ulipristal acetate, and the copper IUD (de Silva KL, unpublished data, 2015).

A Kaiser Foundation report reinforced these findings. Through an analysis of 20 insurance carriers in 5 states, California, Georgia, Michigan, New Jersey, and Texas, significant variability was seen for coverage of 12 prescribed contraceptive methods. Only 12 of the 20 insurers reported covering the contraceptive ring with no cost sharing, whereas only 10 of the 20 insurers cover all FDA-approved IUDs without limitations or cost sharing, and 1 carrier in the study does not cover the Paragard IUD, the only nonhormonal IUD, at all.³⁸

In response to these inconsistencies, HHS published new guidance for insurers and consumers in May 2015.³⁹ These guidelines, outlined in Table 1, specifically delineate the methods of contraception that must be covered without cost sharing. The guidelines confirm that plans must offer at least 1 method with no cost sharing within each of the categories (currently 18) of contraception identified by the FDA and that coverage cannot be restricted based on the plan offering other methods that are “medically appropriate” for a patient.

Under the new guidance, plans are still allowed to use “reasonable medical management techniques” to regulate costs. Commonly used management techniques include tiered drug formularies that allow cost sharing for brand-name pharmaceuticals when a generic is available or the collection of co-pays and deductibles if services are received outside of the preferred provider network.³⁹ However, the new guidelines clarify the boundaries of these

techniques and reinforce that plans must also have an “easily accessible, transparent, and sufficiently expedient exceptions process” for methods deemed to be medically necessary by the provider. There is no generic equivalent for many contraceptive methods approved by the FDA, including the contraceptive ring, ulipristal acetate EC, implant, and IUDs, so this specific medical management technique should not be applied to these methods.

Legal Challenges to the Affordable Care Act

In both its development and implementation, the ACA has been steeped in debate and disagreement. Although Congress has made efforts to repeal or eliminate certain provisions of the law, the political tug-of-war regarding the ACA has been primarily focused in the courts. Within minutes of the law being signed by President Obama, the first lawsuit challenging the law’s constitutionality was filed.⁴⁰

At present, 150 cases have been filed regarding the ACA.⁴¹ These cases may be grouped into 2 broad categories: cases aimed to repeal the ACA in its entirety and cases focused specifically on eliminating or refining the contraceptive coverage mandate. The authors briefly review seminal cases regarding the ACA as a whole and then focus on legal challenges aimed specifically at the contraceptive coverage mandate.

Overall Challenges to Affordable Care Act Implementation

In *National Federation of Independent Businesses v Sebelius*, decided in 2012, the Supreme Court upheld the constitutionality of the individual insurance coverage mandate component of the ACA, thereby validating the central tenet of the legislation. In the same decision, however, the Supreme Court limited the scope of the ACA substantially by ruling that the Medicaid expansion provisions of the ACA, which required that states expand Medicaid to cover nonelderly, nondisabled adults with income less than 138% of the FPL, were coercive.⁴² This case confirmed the fundamental constitutionality of the ACA, and it also allowed states to choose whether or not to participate in the Medicaid expansion. As of July 2015, nineteen states have refused the expansion.

A second series of cases (consolidated as *King v Burwell*) was decided by the Supreme Court in June 2015.⁴³ The plaintiffs in this case were disputing the federal government’s right to grant health insurance premium subsidies to individuals who have purchased their health insurance from the federal, rather than a state-run, health insurance exchange. This challenge is derived from a single line of text in the law that describes those eligible for the subsidies as individuals who purchase their insurance through state-run exchanges. The Court decided against the plaintiffs, determining that when read in context, the statutory language was clearly intended to treat the federal and state-run exchanges equally under the law, meaning that taxpayers who purchase their insurance through either type of exchange are eligible for subsidies. Had the Court sided with the plaintiffs, consumers in 36 states would have lost their access to health insurance subsidies, which the Court determined would destabilize the individual insurance market in those states and cause the very kind of market volatility that the ACA was designed to prevent.

Contraceptive Coverage Mandate Legal Challenges

By far the largest proportion of legal challenges to the ACA has focused on the contraceptive coverage mandate embedded in the preventive services provision. To date, 101 cases have been filed challenging the mandate.⁴¹ These challenges cite both an infringement of the religious freedom guarantees of the First Amendment and of the Religious Freedom Restoration Act of 1993 (RFRA). RFRA states that the “government shall not substantially burden a person’s exercise of religion.” The corporations and organizations filing suit claim that the requirement to provide contraceptive coverage in their health plans is a violation of their rights under RFRA.

HHS has responded to these concerns through clarifications and changes to the law (Table 2 for a list of these accommodations). As of 2012, religious institutions that are primarily houses of worship are fully exempted from the requirement to provide contraceptive coverage in their insurance plans. To qualify for exemption, an organization must meet specific criteria under the federal tax code. The predominance of institutions that meet these criteria is churches, synagogues, or other houses of worship.⁴⁴

These narrow inclusion criteria were purposeful.⁴⁵ It is intended to limit the exemption for this requirement only to those organizations whose primary goal is the inculcation of specific religious values and who are most likely to employ individuals who share the same religious values as the organization; this is in contrast to other religiously affiliated organizations, such as hospitals and universities, that often employ or educate large numbers of individuals of a variety of religious backgrounds. HHS argues that employees and students in these organizations should not have their access to the full breadth of preventive health services guaranteed by the ACA limited because of the views of their employer or institution.

After concerns were expressed by these religiously affiliated organizations, HHS issued revised rules that provided for an accommodation, but not an exemption, for these plans.⁴⁶ This accommodation allowed these institutions to notify their insurance carrier of their objection to providing contraception, at which point the insurance carrier assumes responsibility for providing this coverage to the individual directly. The nonprofit itself therefore is not required to pay for, facilitate, or participate in any of the transactions associated with the employee obtaining contraception. Despite these accommodations, challenges to the mandate continue.

Challenges brought by nonprofit organizations—At present, 46 nonprofit institutions have filed suit over the contraceptive mandate.⁴¹ Some religiously affiliated institutions have argued that the act of completing the self-certification form violates their moral values as it facilitates employees obtaining contraception. Circuit courts have disagreed about the merits of this claim (*Michigan v Burwell* and *Roman Catholic Archbishop v Sebelius*), but in an unsigned decision in 2014, the Supreme Court supported Wheaton College’s argument that completing the form was a violation of its religious values⁴⁷ and granted an injunction. In its decision, the Supreme Court agreed with the institution that it should not have to complete a form to certify that it has moral objections to providing contraception, and instead the institution could simply inform the HHS in writing

that they qualified for an exemption. HHS would then bear the responsibility for arranging third party coverage for these methods via the institution's insurance carrier. In a strongly worded rebuttal, dissenting justices noted that this decision will create additional confusion and new layers of bureaucracy in an already complicated system. HHS recently released new guidelines for nonprofits (see Table 2) in response to this ruling.

Challenges brought by for-profit institutions—A slightly larger number of challenges (49 at present⁴²) to the contraceptive coverage mandate are from for-profit organizations. For-profit organizations were not included in the religious accommodations in the ACA as, historically, corporations were not considered capable of practicing religion. In these suits, for-profit employers have argued that covering some or all contraceptive methods violates their religious beliefs and contend that they should not be required to provide their employees with health care plans that offer such coverage.

In June 2014, the Supreme Court issued their decision in the primary case for this issue, *Burwell v Hobby Lobby*. In a 5-to-4 decision, the Court decided that closely held corporations, defined as those with a limited number of shareholders, can assert protections under RFRA. The Court majority stated that the owners' belief that their religious freedom was being burdened was sufficient cause to warrant an accommodation by the government. Because HHS had created accommodations for nonprofit organizations, the Court reasoned that the same accommodations could be extended to closely held corporations that expressed a religious objection to providing contraceptive coverage.

However, as mentioned previously, the Supreme Court issued an injunction on the implementation of this accommodation for Wheaton College a few days after the Hobby Lobby decision. At present, the administration is accepting public comment on and finalizing new rules in response to these regulations that would allow closely held for-profit companies to register their objection to the contraceptive coverage mandate. At question are definitions of closely held corporations and the mechanism by which for-profit organizations should be required to certify their objection to the contraceptive mandate.⁴⁴ In the meantime, women in these insurance plans are in limbo when it comes to coverage for some contraceptive methods.

Table 2 shows the current list of coverage exemptions and accommodations for employer-sponsored health insurance. This list will continue to evolve as new rules are introduced.

Discussion

Pending legal challenges to the ACA and the contraceptive mandate indicate that additional developments in contraceptive coverage are likely. Despite this, already there are benefits from the mandate in the number of privately insured women who are obtaining their methods without cost sharing. As discussed earlier, eliminating cost as a barrier to highly effective methods of contraception is associated with increased uptake of those methods, which in turn has been shown to contribute to reductions in unintended pregnancy and abortion rates.²³

Despite the ongoing legal wrangling about the appropriateness of including contraception as a preventative health benefit, evidence shows that coverage for contraception is popular among consumers. A recent study found that 69% of respondents to a nationally representative survey expressed support for requiring employers to provide insurance coverage for contraception.⁴⁸ Another study of religiously affiliated women found universally high levels of support for requiring insurers to cover contraception.⁴⁹

A most troubling result of the evolving nature of the contraceptive coverage mandate is the increased difficulty faced by patients and their providers in accessing insurance benefits. A large-scale national study demonstrated the challenges researchers faced in obtaining accurate information from insurance companies about contraceptive benefits.³⁸ Patients, particularly those who are young or nonnative English speakers, are likely to face even greater hurdles in trying to understand what their benefits are and whether they are being unfairly denied access to a method.

The challenges faced by patients are substantial enough that the National Women's Law Center (NWLC) has established a resource center to assist patients in navigating, understanding, and advocating for coverage of their birth control method. The NWLC has a Web site dedicated to assisting patients with this process (coverher.org) and has created a step-by-step guide for patients. NWLC reported that women from every state have contacted the center to obtain assistance in navigating a health care plan that was inappropriately denying coverage. The new guidance issued by HHS is a sign that plans may soon be using a standardized and more transparent process in interpreting the requirements and providing benefits.

Although it is difficult to yet tell the full impact of the ACA on contraceptive access, unintended pregnancy, unintended birth, and abortion, one has only to look at the benefits seen in public family planning programs to see the potential for substantial public health improvements in these areas. Publicly funded family planning has proved to be a huge cost-saving mechanism for states and a major resource in averting unintended pregnancy and abortion.³³ Lowering the persistently high unintended pregnancy rate will be transformative for women, families, and our communities. Expanded access to highly effective contraception through both public and private insurance is crucial to this effort.

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KEY POINTS

- The Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010, with the primary goals of expanding access to insurance coverage and reducing health care spending.
- A major underpinning of the legislation was shifting the focus of both health care and insurance providers away from reactive medical care toward preventive care, and to meet this goal, the ACA required health insurers to provide preventive health care, including the full range of contraceptives, to patients without cost sharing.
- This article describes both the current landscape of contraceptive coverage in the United States after the implementation of the contraceptive mandate and the delays and inconsistencies related to its implementation to date.

Table 1

Contraceptive methods for women currently identified by the FDA

Method	Coverage Required	FDA-Approved Methods ^a
Contraceptive implant	X	Nexplanon/Implanon
Progestin IUD	X	Mirena/Skyla/Liletta
Copper IUD	X	Paragard
Injectable contraception	X	Generics available
Progestin-only oral contraceptive	X	Generics available
Combined hormonal oral contraceptive	X	Generics available
Extended use oral contraceptive	X	Generics available
Contraceptive patch	X	Xulane ^b generic available
Contraceptive ring	X	NuvaRing
Emergency contraception (levonorgestrel)	X	NextChoice generic available
Emergency contraception (ulipristal acetate)	X	Ella
Diaphragm	X	Milex Omniflex
Cervical cap	X	FemCap
Contraceptive sponge	X	Today sponge ^c
Female condom	X	Multiple types ^c
Spermicide	X	Multiple types ^c
Sterilization, tubal ligation	X	N/A
Sterilization, implant	X	Essure

^aPlans must cover at least 1 method in each category; may be generic.

^bOthroEvra being discontinued by manufacturer; Xulane generic introduced in April 2014.

^cOver-the-counter products covered with valid prescription.

Data from Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury. FAQs about Affordable Care Act implementation (part XXVI), May 11, 2015. Available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf. Accessed July 16, 2015.

Table 2

Current exemptions and accommodations for the Affordable Care Act

Category	Applies To	Description	Effective Since
Grandfathered plans	Plans that insured at least 1 person as of March 23, 2010, and have not made any changes to benefits since that time (including any increases in cost/cost sharing)	Plans do not have to adhere to no-cost sharing preventive services regulations	2010
Full exemption from coverage	Houses of worship (eg, churches, synagogues)	Fully exempt from providing coverage for contraceptives	2012
Accommodation: nonprofit	Nonprofit institutions that have a religious objection to providing some or all contraceptives	Institutions can self-certify (via completion of a form sent to insurer or a letter sent to HHS) their religious objection. Coverage for contraception managed and paid for entirely by insurer	2013: Self-certification form 2014: Option to submit letter directly to HHS
Accommodation: closely held corporations	Closely held corporations	Closely held corporations can use the same accommodations that are available to nonprofit organizations	Pending: provisional rules introduced in 2014; awaiting final rules with definition for closely held and instructions for self-certifying