Original Report

Insurance Plan Adherence to Mandate for Long-Acting Reversible Contraceptives in a Large Pediatric Hospital Network

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A B S T R A C T

Study Objective: Long-acting reversible contraceptives (LARCs) are the most effective form of pregnancy prevention for sexually active adolescents, yet usage rates are low. The Affordable Care Act (ACA) mandated insurers cover LARCs without cost-sharing. Compliance with this policy is not well documented. This study assessed LARC coverage by insurers in a large pediatric health system.
Design, Setting, Participants, and Interventions: Between June and August 2016, LARC coverage was assessed through content reviews of insurance Web sites, formularies, and summaries of benefits for all Pennsylvania Medicaid plans and the top 20 commercial insurers for a large pediatric health system.
Main Outcome Measures: The primary outcome was adherence to the ACA mandate for LARC coverage without cost-sharing.
Results: Among the 37 plans (17 public, 20 private), 21 (56.8%) were adherent and 16 (43.2%) were nonadherent. Among nonadherent plans, 3 plans covered LARC services but required cost-sharing, whereas 13 did not cover LARC services at all. There was not a statistically significant difference in LARC coverage between public and private plans.
Conclusion: Despite the landmark ACA mandate, insurance coverage of LARCs in pediatric hospitals is low for young women among private and public insurers. Insurer failure to adhere to the ACA among pediatric patients represents a barrier to LARC access for those at high risk of unintended pregnancy.
Key Words: Contraceptives, Adolescent health, Insurance coverage, Long-acting reversible contraceptives

Introduction

Unintended pregnancy remains a pervasive public health problem in the United States with adolescents experiencing disproportionately higher rates.[1] Long-acting, reversible contraceptive (LARC) devices (eg, intrauterine systems and subdermal implants) work for 3-10 years depending on the device, are highly effective at preventing pregnancy, and require no user action to be effective after placement. These methods are 20 times more effective for preventing pregnancy than the short-acting methods that are more commonly used among adolescents (pills, patch, and vaginal ring).[2] Despite their high effectiveness, LARC utilization rates among adolescents in the United States remain low; 4% are current users compared with 12% of adult women.[3–5] Increasing LARC use among adolescents, therefore, has the potential to prevent unintended pregnancies.

Passage of the Patient Protection and Affordable Care Act (ACA) in 2012 broadened contraceptive access for all women by requiring that insurance companies cover 18 categories of US Food and Drug Administration (FDA)-approved contraceptive methods, including LARCs, without cost-sharing.[6] Although this was a laudable policy change under the Obama administration, adherence with the mandate as it relates to LARC coverage varies across insurers and states.[7] There are no data regarding how insurers covering pediatric populations are complying with the ACA mandate regarding LARC coverage. Variability in implementation of the ACA contraceptive mandate could create inconsistencies in LARC utilization resulting in differential effects on unintended pregnancy rates among adolescents. Pediatric health systems might not have clinicians who provide LARC services, thus insurance plans might not universally include these services in their institutional contracts. Further, the current presidential administration's attempts to roll back contraceptive choices could further limit access, if these policies are enacted. As a result, it is an important moment to take stock of the current landscape.

We sought to determine insurance adherence with the ACA contraceptive mandate for LARC coverage in a large pediatric health system. Understanding insurance company practices and consumer-facing plan information available to adolescents and parental caregivers about LARC coverage can inform strategies for ensuring more

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universal coverage. We sought to determine the proportion of insurers' whose plan Web sites indicate compliance with the ACA contraceptive mandate for LARC coverage without a copay and to characterize types of nonadherence.

Materials and Methods

This study was conducted at the Children's Hospital of Philadelphia, a large pediatric health system with a regional network of primary care and subspecialty clinics covering 3 states. The 37 insurance plans most used by Children's Hospital of Philadelphia patients (20 commercial; 17 Medicaid) were identified using billing records. None qualified for an exemption allowing them to avoid covering LARC services. Between June and August of 2016, we performed a content review of insurance plan's online contraceptive benefits (formulary and Summary of Benefits and Coverage).

Two coders independently reviewed each plan's online documents. Plans were considered compliant with the contraceptive mandate if the plan documents indicated that LARC services were covered without cost-sharing. Plans were considered noncompliant if LARC services were not covered, required cost-sharing for LARC services, or coverage benefits were unclear but other contraceptives were clearly covered. Descriptive statistics (frequencies, means, medians) were calculated to describe the proportion of insurance plans that were compliant. We used *t* tests to compare adherence rates and reasons for nonadherence between commercial and Medicaid plans.

Results

Of the 37 plans, 21 (56.8%) were adherent and 16 (43.2%) were nonadherent for LARC coverage with no copay. Among noncompliant plans, 3 reportedly covered LARC services but required cost-sharing, whereas 13 did not cover LARC services at all. A larger proportion of Medicaid plans covered LARC services without cost-sharing compared with commercial plans, but this difference was not statistically significant (65% vs 60% respectively, $P = .39$).

Overall, 94.4% of plan Web sites indicated failure to adhere to the ACA mandate regarding contraceptive coverage for failure to cover all 18 contraceptive categories. On average, commercial insurers covered 9.1 (50%) of the 18 (SD, 3.2) contraceptive categories whereas public plans covered 8.2 (45.5%) of the 18 categories (SD, 3.6). Nine (24%) plans specified coverage for 0-6 of the 18 FDA-approved contraceptive categories, 20 (54%) specified coverage for 7-12 categories, and 8 (22%) specified coverage for 13-18 categories. Only 1 plan specified coverage for all 18 categories of contraception; however, this plan required a copay for LARC services and was therefore coded as nonadherent with the ACA contraceptive mandate. Review of materials for each of the 37 plans required an average of 45 minutes per review.

Discussion

More than 4 years after the passage of the ACA, almost half of insurance plans at a large pediatric health system were nonadherent with the ACA mandate to cover LARC services without cost-sharing, with no statistically significant differences between public or private plans. These coverage barriers might represent 1 modifiable reason for low LARC utilization rates among adolescents, a population at high risk for unintended pregnancies. The data suggest a need to increase awareness among insurers about the need to amend their plan benefits to be consistent with the ACA guidelines. This is an opportunity to highlight the potential cost-savings plans might realize by doing so—savings realized by averting unplanned teen pregnancies.

Previous research has underscored the importance of developing health care delivery systems, education modules, and policies aimed at engaging adolescents and young adults, who are often characterized as a difficult to reach population with low rates of health care utilization.[8] Most research on LARC accessibility following the ACA contraceptive mandate has focused on adult women, which also pointed to implementation challenges but overall improvement in cost-sharing for LARC users.[9,10] Our study shows the importance of examining the differential effect on adolescents compared with older adults. In doing so, we found that most insurance plans, regardless of whether public or private, failed to adhere to the ACA mandate to cover all 18 FDA-approved contraceptive methods, and nearly half failed to adhere specifically for LARC coverage.

Increased uptake of highly effective contraception among adolescents is an important and necessary step for decreasing their high rates of unintended pregnancy. Insurance coverage and cost-sharing are important barriers to adolescent access to LARCs and when cost barriers are removed, LARC utilization rates increase.[11] This is important, especially in light of the current presidential administration's efforts to limit contraceptive options.

There are several key limitations of this study. The data were drawn exclusively from publicly available, Web-based information and written policies and might not actually reflect final coverage decisions. The findings represent those from 1 hospital system and includes only a portion of the insurers, which might limit generalizability of our findings. However, the data represent those of a large, urban pediatric health system that provides care to almost 30,000 inpatients, and 1.3 million outpatients annually, including patients from around the country and internationally. Insurance coverage in this setting is likely one of the broadest in the nation. Despite these limitations, this is one of the first studies to show high levels of nonadherence by insurance companies to the ACA contraceptive mandate for LARC coverage without co-pay.

Future research could strengthen our understanding of the effect of insurance coverage on LARC access among young women. Studies that include a larger sample of pediatric hospitals across multiple states would advance our knowledge of patterns of adherence to the ACA mandate for

LARC coverage for young women. Where appropriate, insurance plans should revise their policies regarding coverage for LARC services and cost-sharing requirements to be consistent with the ACA mandate. Moreover, insurers should make information regarding coverage for LARC services more easily accessible to adolescents and parents who might be searching the internet to determine their coverage benefits. The average time for reviewing a single plan was 45 minutes for our reviewers, which points to the lack of readability and accessibility of insurance companies' online materials.

The ACA provided important access to contraception by reducing out of pocket costs. Our findings indicate that insurance coverage might remain an important access barrier for adolescents, even in the post-ACA era.

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