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HPC DATAPOINTS

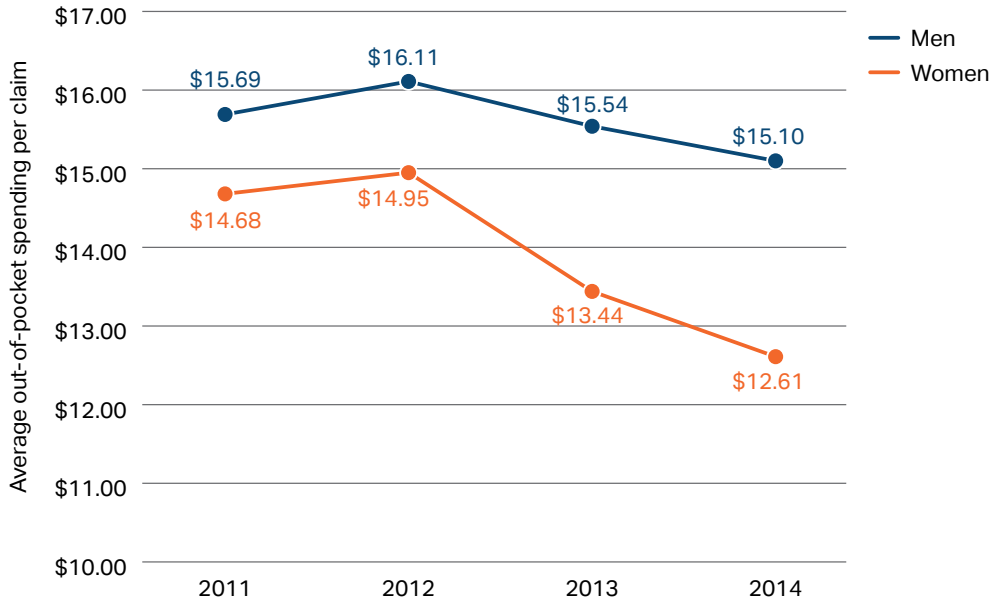
The ACA's preventative coverage mandate: Impact on spending and utilization of contraception in Massachusetts

The Patient Protection and Affordable Care Act of 2010 (ACA) established requirements for health plans to cover certain preventive services with no patient cost sharing. The preventive services guidelines adopted by Health Resources and Services Administration (HRSA) include the full range of contraceptive devices and services. With the possibility of Congressional repeal or revision of the ACA and the opportunity for the Trump Administration to make substantial regulatory changes, it is important to study the impact of coverage and cost sharing requirements on state health care spending and patient out-of-pocket costs.

In the 2016 Cost Trends Report, the Health Policy Commission (HPC) reported on an increase in prescription drug claims with no cost sharing in the years following the ACA's implementation across the three largest commercial payers in the Commonwealth. The HPC has now expanded this analysis to better understand the nature of these claims, including the extent to which they comprised claims for contraception services, which represent high-value care.

Between 2011 and 2014, across all prescription drugs, claims with no cost sharing grew from 0.8% to 8.7% of pharmacy claims. Claims with no cost sharing increased more for women (from 0.9% of claims in 2011 to 13.4% in 2014) than for men (0.6% to 2.4% of claims). Average out-of-pocket spending per claim for women declined 14.2%, compared to 3.8% for men.

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



NOTE: Data include privately insured individuals covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan who use the prescription drug benefit at least once in the calendar year.

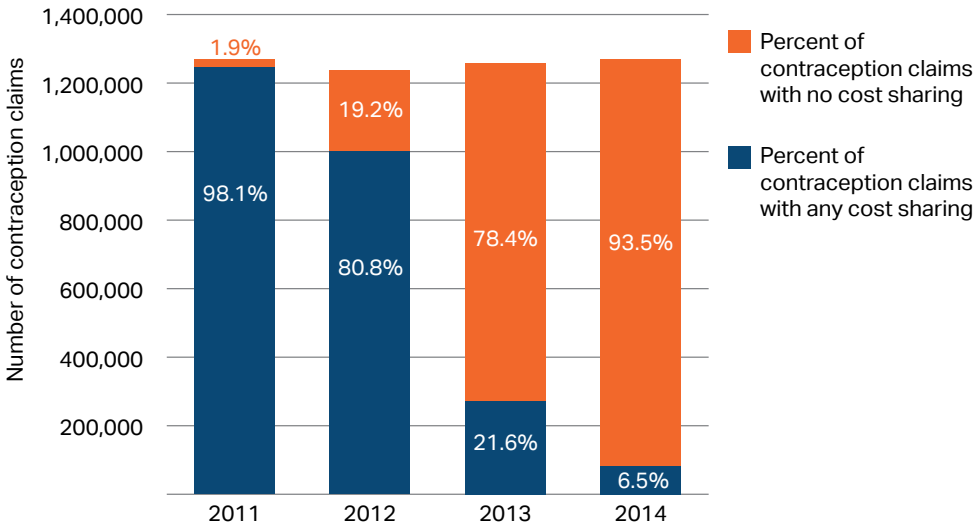
SOURCE: HPC analysis of Massachusetts All Payer Claims Database, 2011 – 2014

For women, the decline in out-of-pocket prescription spending was almost entirely due to a significant decrease in cost sharing for contraception. In 2011, less than 1% of all pharmacy claims had no patient cost sharing. Of those claims, 22% were for prescription contraception. By 2014, over 13% of claims had no cost sharing, and 80% of those claims were for contraceptive methods. Ninety four percent of prescription contraception claims the HPC identified were oral contraceptives. Other methods included hormonal rings and patches.

Prescription contraception

Overall, the percentage of prescription contraception claims with any patient cost sharing decreased significantly from 98% to 6.5%, leading to a decrease in average out-of-pocket spending per contraception claim from $16.00 in 2011 to $1.73 in 2014. This represents an 89% reduction in average cost sharing during this period. The total number of prescription contraception claims was relatively constant across the four years.

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



NOTE: Prescription contraceptive methods identified in the claims using 917 contraception National Drug Codes (NDCs). Data include privately insured individuals covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan who use the prescription drug benefit at least once in the calendar year.

SOURCE: HPC analysis of Massachusetts All Payer Claims Database, 2011 – 2014

Intrauterine Devices (IUDs)

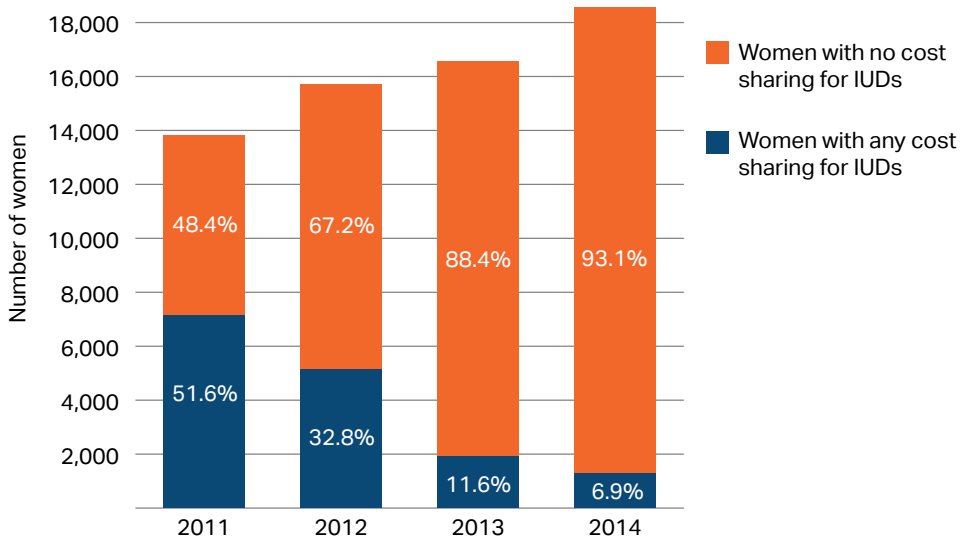
The HPC also examined use and cost sharing for intrauterine devices (IUDs) over this period. IUDs are a form of long-acting, reversible contraception (LARC) that have been shown to be cost saving compared to other forms of contraception, including the pill and other hormonal methods.[1] While IUDs have higher upfront costs than the pill (which include the cost of the device itself and the insertion procedure), over a five-year time horizon, total costs of the monthly pill exceed the total costs of an IUD.[2] Cost savings are compounded by the device's higher rate of effectiveness at preventing pregnancies.[2, 3, i] The upfront costs of getting an IUD, however, can serve as a deterrent to use, particularly for younger women.[4, 5]

The percentage of women with any patient cost sharing on IUD insertion and devices decreased significantly from 52% to 7%, leading to a decrease in average out-of-pocket spending (including

i In fact, a study from the U.S. Department of Health and Human Services concluded that comprehensive coverage of LARCs (such as IUDs) actually reduced net total spending on health care. The direct cost of comprehensive LARC coverage resulted in insurance premium increases of less than 1%, but that cost was offset by avoiding spending on unwanted pregnancies and childbirth. (Bertko et al. The cost of covering contraceptives through health insurance. 2012 Feb. Washington, DC: Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human services.)

both the insertion and cost of the device) from $28.11 to $5.27. This represents an 81% reduction in average cost sharing during this period. Most women were therefore shielded from the full cost of the procedure, which averaged $957.09 in 2014 for the insertion and device. The HPC's findings on prescription contraception and LARCs are consistent with national trends.[6,7]

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

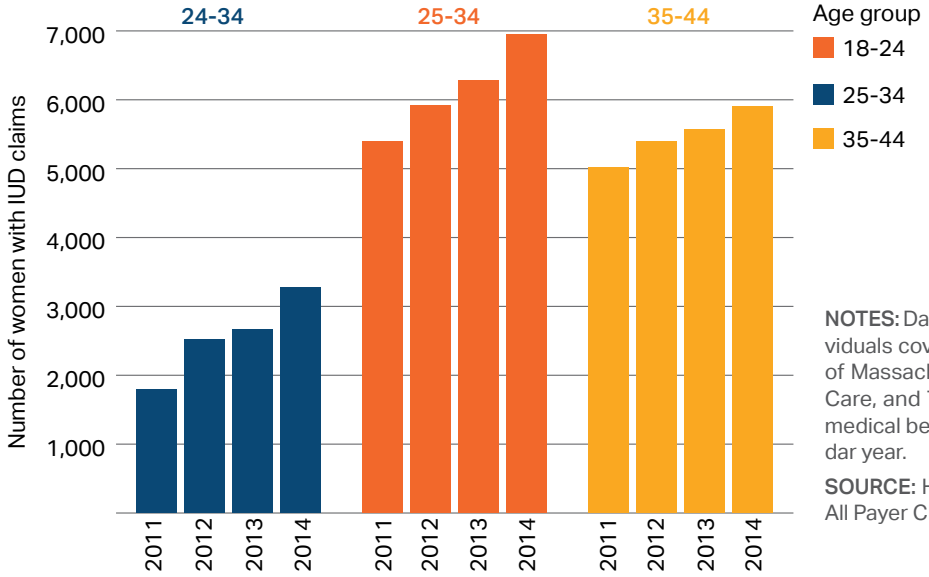


NOTE: The HPC defined new IUD users as women who had at least one insertion or device claim within the year. Women with no cost sharing are defined as those who had no cost sharing on all IUD-related claims within the year. Data include privately insured individuals covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan who used the medical benefit at least once in the calendar year.

SOURCE: HPC analysis of Massachusetts All Payer Claims Database, 2011 – 2014

Whereas the number of prescription contraception claims remained relatively constant each year, the number of women with IUD claims between 2011 and 2014 rose 34%, from 13,800 to 18,500. The increase was substantially larger among younger women (an 83% increase over this time period among those aged 18 to 24), who may be relatively more sensitive to cost-sharing.[5]

Women with any IUD insertion or device claims, by age group, 2011 – 2014



NOTES: Data include privately insured individuals covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan who use the medical benefit at least once in the calendar year.

SOURCE: HPC analysis of Massachusetts All Payer Claims Database, 2011 – 2014

The Massachusetts Health Policy Commission, an independent state agency, strives to advance a more transparent, accountable, and innovative health care system through its independent policy leadership and investment programs.

HPC DataPoints is a series of online briefs that spotlight new research and data findings relevant to the HPC's mission to drive down the cost of health care. It showcases brief overviews and interactive graphics on relevant health policy topics. The analysis underlying these briefs is conducted by staff on the HPC's Research and Cost Trends team. To view all HPC DataPoints, visit our website.

The increased affordability of IUDs may have served as a driver of increased use in Massachusetts and the U.S. over this time period, although other factors such as increased clinical familiarity and acceptance of this method for women pre-childbirth could have also played a role.[8] Given that IUDs are a cost-effective form of contraception compared to other methods, the increase in IUD uptake likely represents an efficient use of healthcare resources.

Some studies have found that eliminating cost sharing for contraception resulted in lower rates of abortion and teen birth rates, such as in Missouri's Contraceptive CHOICE Program.[9] As more recent data on birth rates and abortion rates in Massachusetts become available, it will be important to monitor trends in these health outcomes 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 high-value contraceptive coverage at the state level.

Endnotes

1 Sonnenberg et al. Costs and net health effects of contraceptive methods. Contraception. 2004; 69: 447-459.

2 Trussell et al. Cost effectiveness of contraceptives in the United States. Contraception. 2009; 79:5-14.

3 Trussell et al. The economic value of contraception: A comparison of 15 methods. American Journal of Public Health. 1995; 85:494-503.

4 Kavanaugh et al. Long-acting reversible contraception for adolescents and young adults: Patient and provider perspectives. Journal of Pediatric and Adolescent Gynecology. 2013 April; 26(2):86-96.

5 Eisenberg et al. Cost as a barrier to long-acting reversible contraceptive (LARC) use in adolescents. Journal of Adolescent Health. 2013; 52:S59-S63.

6 Cox et al. Examining high prescription drug spending for people with employer sponsored health insurance. The Henry J. Kaiser Family Foundation; 2016 Oct 27. Available from: http://www.healthsystemtracker.org/insight/examining-high-prescription-drug-spending-for-people-with-employer-sponsored-health-insurance

7 Sonfield et al. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update. Contraception. 2015; 91:44-48.

8 Ott et al. Contraception for Adolescents. Pediatrics. 2014 Oct; 134(4):e1257-e1281.

9 Peipert et al. Preventing unintended pregnancies by providing no-cost contraception. Obstetrics and Gynecology. 2012 Dec; 120(6):1291-1297.