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Medicaid Expansion, Safety Net Clinics, and Opportunities to Improve Contraceptive Care

Michelle H. Moniz, MD; Nora Becker, MD; Vanessa K. Dalton, MD

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In the US, low-income women face disproportionate barriers to contraceptive care and a higher risk of unintended pregnancy.[1] Access barriers are particularly salient for long-acting reversible contraceptives (LARCs) (ie, intrauterine devices and the contraceptive implant) because these methods are expensive and require a visit to a practitioner for insertion and removal. Enhancing access is crucial because these methods are preferred by many women and are highly effective at preventing pregnancy; they are as effective as sterilization and 10 times more effective than contraceptive pills. Before implementation of the Patient Protection and Affordable Care Act (ACA), cohort studies demonstrated that providing no-cost contraception was associated with improved use rates, including LARC use.[2,3] Accordingly, the ACA introduced national policies to reduce costs for contraception (eg, the contraceptive coverage mandate) and improve insurance coverage overall (eg, Medicaid expansion, the creation of state health insurance marketplaces). Data suggest that ACA implementation has been associated with reduced uninsurance rates, reduced out-of-pocket spending on contraception, and improved contraceptive use among women.[4]

To date, most studies of the association of ACA implementation with contraceptive use patterns have focused on Section 2713, the regulation that prohibits cost-sharing for contraceptive services in commercial health plans. Darney and colleagues[5] examined different features of the ACA, including Medicaid expansion. By using ADVANCE (Accelerating Data Value Across a National Community Health Center Network), they estimated the association of Medicaid expansion with contraceptive provision patterns in a large group of community health centers caring for a medically underserved population. Darney et al[5] found that the adjusted overall proportion of women receiving contraceptives in community health centers was stable in Medicaid expansion states but increasing in nonexpansion states from 2013 (before the ACA) to 2016 (after the ACA). Conversely, the increase in adjusted proportion of women receiving LARC methods was greater in expansion states than in nonexpansion states after ACA implementation. At all time points, receipt of contraception overall and for LARC methods in particular was higher in expansion compared with nonexpansion states.

Darney et al[5] concluded that Medicaid expansion made it easier for women receiving care at community health centers to initiate LARC use. Their results in nonexpansion states suggest that other ACA provisions may also have enhanced contraceptive access in community health centers. These findings raise questions about the mechanisms of the observed trends. ACA implementation was associated with marked insurance coverage changes in expansion and nonexpansion states, with many women newly acquiring insurance, switching between insurance types, and accessing new practitioners. Community health center patient populations likely underwent substantial compositional changes after ACA implementation. Darney et al[5] observed that after ACA implementation, a lower proportion of community health center patients were uninsured and a greater proportion had new patient visits in both expansion and nonexpansion states. After ACA implementation, newly insured patients with unmet contraceptive needs may have contributed to the observed increases in overall contraceptive use and LARC use. In addition, commercially insured, lower-income patients previously using non-LARC methods may have switched to LARC methods after out-of-pocket costs were eliminated. This method switching could explain why overall contraceptive provision was stable while LARC provision increases in expansion states. ACA

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implementation may also have affected community health centers' capacity to provide affordable contraceptive options to uninsured women by lowering sliding fee scales, for instance. With an increasing proportion of patients having insurance and first-dollar coverage for contraception, community health centers may have been better able to offset the costs of contraception for uninsured patients—more effectively removing financial barriers to contraceptive use. Overall, the findings of Darney et al[5] suggest that increased insurance coverage after ACA implementation was associated with changes in overall contraceptive use and the mix of contraceptive methods that individuals choose. Future evaluations may address still unanswered questions about exactly which of the ACA's provisions affected these choices and through what mechanisms.

Darney et al[5] also present interesting findings on trends in contraceptive use by community health center Title X status. The Title X Family Planning Program distributes federal grants to clinics providing comprehensive contraceptive services to lower-income individuals. Title X clinics have historically been required to offer onsite access to a range of effective contraceptive methods, including LARC. Darney et al[5] observed that the proportion of total contraceptive users was higher in Title X clinics compared with non–Title X clinics at all time points before and after ACA implementation. In addition, within expansion and nonexpansion states, LARC provision was higher at Title X clinics than non–Title X clinics across the study period.

These findings underscore the importance of Title X and what is at stake with recent policy changes affecting the program. In 2019, a new rule went into effect banning Title X clinics from performing or referring patients for abortion care. The new rule also removed the requirement that Title X grantees offer a range of medically effective contraceptive options. In response, some former Title X grantees have left the program, including Planned Parenthood affiliates. Planned Parenthood clinics formerly served over 40% of all Title X patients.[6] With a shift in Title X clinics from those focused on reproductive health to those focused more generally on primary care, women may lose access to evidence-based services, including the full range of available contraceptive methods. Title X clinics have also been demonstrably effective in offering a high-quality patient experience of care. The most common reason women cite for choosing a Title X clinic specializing in reproductive health services is feeling that staff treated them respectfully.[7]

Ultimately, the goal of contraceptive care is to ensure that all individuals can decide whether and when to have children. Individuals' ability to access contraception profoundly affects their careers, their finances, and their economic stability.[8] Policies that expand insurance coverage and improve benefit design are vital for improving contraceptive access. Such policies may also have downstream effects on the quality of frontline contraceptive care, including the patient experience of care and access to all contraceptive methods. As the policy landscape governing contraceptive health care evolves, it will be crucial to continue evaluating the effects of these large-scale policy changes on the lives of women and their families.

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Corresponding Author: Michelle H. Moniz, MD, Department of Obstetrics and Gynecology, University of Michigan, 2800 Plymouth Rd, Bldg 10, Rm G016, Ann Arbor, MI 48109-5276 (mmoniz@med.umich.edu).

Author Affiliations: Department of Obstetrics and Gynecology, University of Michigan, Ann Arbor (Moniz, Dalton); Program on Women's Healthcare Effectiveness Research, University of Michigan, Ann Arbor (Moniz, Dalton); Department of Medicine, Brigham and Women's Hospital, Boston, Massachusetts (Becker).

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