Access to contraception after health care reform in Massachusetts: a mixed-methods study investigating benefits and barriers

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Abstract

Background: In 2006, Massachusetts passed sweeping health care reform legislation aimed at improving access to health care for residents. This study investigates how this landmark legislation affected contraceptive access for low-income women.

Study Design: This study included (a) 16 in-depth interviews with family planning providers, (b) 9 focus group discussions with 52 low-income English- and Spanish-speaking women, (c) 10 self-administered surveys of family planning administrators and (d) a systematic review of Web sites for government-subsidized insurance plans.

Results: Findings from all study components were highly consistent. We found that while most low-income women in Massachusetts continue to regularly obtain contraception, challenges such as maintaining insurance coverage, understanding benefits, securing an appointment with a provider and obtaining prescriptions were identified post reform. Findings about contraceptive affordability under reform were mixed.

Conclusion: Though health care reform legislation has benefited many women, barriers remain to ensuring consistent access to contraception for low-income women.

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1. Introduction

In 2006, the Commonwealth of Massachusetts passed health care reform legislation aimed at improving access to affordable, high-quality health care for its residents. This legislation required all residents to obtain health insurance or face a tax penalty. To help ensure that residents could afford insurance under the mandate, a group of publicly subsidized low- or no-cost private insurance programs called Commonwealth Care was created. Five Commonwealth Care plans are currently available to residents with incomes at or below 300% of the federal poverty level (FPL) who are not Medicaid or Medicare eligible and lack employer-sponsored insurance [1].

Massachusetts has also demonstrated a commitment to uninsured residents through support of family planning initiatives. Since 1991, the Commonwealth has supported the Massachusetts Department of Public Health (MDPH) Family Planning Program, which provides services through a robust network of family planning clinics (FPCs). The FPCs are operated by a range of agencies, including Planned Parenthood affiliates and other stand-alone family planning centers, and by hospitals, community health centers and community action agencies [2]. Among a wide variety of services, these safety net providers offer prescription and nonprescription contraceptives on a sliding-scale income-based payment basis [2]. In fiscal year 2009, 12 MDPH-funded family planning agencies oversaw more than 80 FPCs throughout Massachusetts, providing services to over 90,000 clients [3]. Between passage of health care reform in 2006 and 2010, the percent of uninsured Massachusetts residents dropped from 11% [4] to 2%, leaving the Commonwealth with the highest insured rate in the United States [5]. Of those newly insured, 38% were enrolled in a Commonwealth Care plan in 2009 [4]. Given these numbers,
the fact that half of low-income women nationally utilize FPCs for contraceptive services [6] and that the Commonwealth Care plans cover a full range of family planning services (including abortion care), it is likely that some newly insured family planning clients transitioned from accessing contraception from FPCs to obtaining contraception via Commonwealth Care plans.

Clients who undergo this transition in coverage move from being able to access multiple months of contraception directly, and on a sliding scale from FPCs, to accessing contraception through a private insurance model. Under the private insurance model, clients must choose a provider contracted with their plan, which may or may not include FPCs. To obtain reimbursement, providers may not be able to give contraception directly to clients, but instead may provide prescriptions, requiring clients to go to the pharmacy monthly and pay a standardized copay to obtain contraception.

Ibis Reproductive Health and the MDPH Family Planning Program collaborated to investigate the impact of health care reform on low-income women’s access to contraception. In a previous report on this study, we described challenges to contraceptive access for women not eligible for Commonwealth Care plans, particularly undocumented immigrants and minors [7]. This report focuses on women eligible for the publicly subsidized private insurance plans and the impact of health care reform on their access to contraception.

2. Materials and methods

A detailed description of the study procedures has been reported previously [7]. In brief, from August 2008 through March 2009, we undertook a four-part mixed-methods study. First, we conducted a systematic Web site review of the four then-available Commonwealth Care plans. Next, we sent self-administered surveys to the administrators of MDPH Family Planning-funded agencies and conducted in-depth telephone interviews with MDPH Family Planning-funded agency and clinic staff (collectively referred to as family planning providers). Finally, we conducted English- and Spanish-language focus group discussions with women at or below 300% of the FPL.

We sent self-administered surveys to the administrators of all 12 MDPH-funded family planning agencies through direct mail and email. We developed our sample for the in-depth interviews from the more than 80 FPCs by randomly selecting 10 clinics with the largest client volume and purposively selecting five smaller clinics with a diversity of clinic models and geographic locations. In-depth interviewees were recruited through direct mail, email and phone contact. Focus group participants were recruited from community-based Web sites, flyers at community colleges and FPCs, and community-based organizations serving Spanish-speaking women, including shelters, food pantries and English-language classes.

As we aimed to understand health care reform’s impact on contraceptive access for low-income women from multiple perspectives, domains of inquiry varied by data source. In the systematic review of Commonwealth Care plans, reviewers evaluated the user-friendliness of the Web sites and collected information on eligibility requirements, enrollment procedures, family planning benefits, providers who accepted the plans and costs associated with them. Surveys completed by family planning administrators focused on knowledge of and opinions about health care reform, and perceptions of how health care reform affected service provision and client’s access to services. Topics included in the in-depth interviews were similar to those in the survey, but focused on the impact of health care reform on direct service, as opposed to administration. During the interviews, we also probed about issues that were identified in the self-administered surveys. Focus groups with women centered on participants’ knowledge of and opinions about health care reform, health insurance history and experiences with using and obtaining contraceptives before and after health care reform.

Multiple data analysis strategies were used. For the systematic Web site review, four independent reviewers noted the presence or absence of specific information using predetermined categories and codes, and input all data into one standardized data collection sheet. Discrepancies in the data collected were resolved where possible by two other investigators. Microsoft Excel was used to calculate frequencies and summary statistics of close-ended and quantitative questions for the Web site review and agency self-administered survey. Qualitative data from in-depth interviews and focus group discussions were transcribed verbatim, translated (where necessary) into English and analyzed thematically using a combination of inductive and deductive codes in ATLAS.ti version 5.5.

All study materials and procedures were approved by Northeastern University’s Institutional Review Board.

3. Results

3.1. Respondent characteristics

Ten of 12 self-administered surveys (83%) were returned by administrators at MDPH-funded family planning agencies. Survey participants reported considerable experience working in health care and at their specific agencies (Table 1).

We conducted 16 in-depth interviews with participants representing 15 different clinics; two participants represented one clinic.1 Five in-depth interviewees worked in managerial roles, and six worked in direct service as clinicians or family planning counselors. Additionally, administrators at five agencies completed interviews even

1 Two participants reported on one clinic as the initial participant we interviewed felt a colleague could better answer some interview questions.
though they had previously filled out surveys because clinic staff identified them as the individual with the most knowledge about how health care reform impacted service delivery. Similar to survey participants, the interviewees reported considerable experience working in health care and in their agency or clinic (Table 2).

Nine focus groups with 52 low-income women were conducted. Four English-language focus groups were conducted with 23 women in three cities chosen because of their geographic locations in the Western, Central and Eastern parts of Massachusetts. Five Spanish-language focus groups were also conducted with 29 women in three cities across the Commonwealth (Table 3).

3.2. Benefits of accessing contraception under reform

Most focus group participants and family planning providers reported that, overall, health care reform has had a positive impact on women’s access to contraception in the Commonwealth. Access to insurance has increased, subsequently increasing access to a variety of affordable health services and prescriptions, including contraception.

The majority (81%) of family planning providers reported in the in-depth interviews that most of their clients saw a general increase in access to health services and prescriptions. As one administrator said, “Patients that are able to — that wouldn’t have accessed [health care] before based on lack of insurance coverage are more likely now to seek out services — now that they have coverage.” Other family planning providers said, post reform, their clients were more likely not only to seek care when ill or in need of urgent care, but also to consistently pursue follow-up and nonurgent care. Family planning providers speculated this was due to newly insured clients feeling more “proud,” “autonomous” and in charge of their own health care.

Focus group participants also said health reform improved access to health care services and prescriptions. Many of the women in the focus groups had never had insurance before and frequently described their new ability to obtain insurance, and therefore health services, as a “lifesaver” for which they were “grateful.” One woman said, “It [reform] is very important … that’s why I’m not leaving Massachusetts, because here we have all the help we need” [Boston, Spanish]. Specific to contraception, most women reported that they had “wicked easy” access to their preferred method after health care reform.

Women in the focus groups also said a primary benefit of reform was the affordability of the Commonwealth Care plans; most reported paying $0–$2 copays for prescription contraceptives. A small number of women noted that they began taking contraception for the first time after reform because they “could afford it;” most women reported previously using a method supplied on a sliding scale from FPCs. Only a minority of focus group participants, most of whom took multiple prescription medications, reported that

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**Table 1**

Demographic and agency characteristics of self-administered survey respondents

| Survey respondent sample, number (%) | 10 (100) |
| Role at family planning clinic, number (%) | 10 (100) |
| Age in years, mean (range; standard deviation) | 46 (26–62; 12) |
| Education, number (%) | 4 (40) |
| Clinical training | 6 (60) |
| Years in health care, mean (range; standard deviation) | 25 (5–38; 10) |
| Years in agency, mean (range; standard deviation) | 17 (2–37; 11) |
| Number of clients seen per day, mean (range; standard deviation) | 10 (1–53; 15) |

**Table 2**

Demographic and practice characteristics of in-depth interview respondents

| Interview sample, number (%) | 16 (100) |
| Role at family planning clinic, number (%) | 5 (31) |
| Age in years, mean (range; standard deviation) | 47 (28–65; 15) |
| Education, number (%) | 1 (6) |
| Clinical training | 8 (50) |
| Years in health care, mean (range; standard deviation) | 17 (2–38; 15) |
| Years in agency, mean (range; standard deviation) | 9 (1–37; 15) |

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* Respondents could select more than one choice.
* Some clinics might have been counted by more than one agency, resulting in the double counting of some clinics.
* As of July 2009, a new plan (CeltiCare) became part of the Commonwealth Care network [8]. This plan is not discussed as it was not available at the time of our research.
the costs associated with prescription contraception were burdensome. However, a number of women expressed concerns about the affordability of nonprescription methods such as condoms and spermicides.

### 3.3. Barriers accessing contraception under reform

While most participants felt reform increased women’s access to contraception in Massachusetts, some described barriers to access including maintaining enrollment, securing appointments, understanding insurance coverage, managing prescriptions and high costs.

Family planning providers reported that clients had difficulty maintaining enrollment in insurance plans and that many reported frequently being dropped from the plans due to inadvertently not complying with eligibility procedures. Family planning providers indicated that during common life transitions, such as graduating from school, moving, getting married or changing or losing jobs, clients face particular challenges in maintaining enrollment in the Commonwealth Care plans.

Similarly, focus group participants voiced the challenges of maintaining enrollment in the plans. Many women said they were not sure why they were dropped from the plans and that it was a time-intensive, paperwork-heavy process to re-enroll in Commonwealth Care. In a Worcester focus group, one woman described spending 6 months trying to re-enroll in a plan, but being thwarted because of gaps in communication between her and the plan: “I guess they sent the forms [but] I never received [them] to verify my income. And so I didn’t send it back and they cut me off…” I need health insurance and so I had to reapply” [English]. Many participants expressed considerable frustration at the time and energy involved in needing to re-enroll in the plans multiple times.

Once enrolled in Commonwealth Care, family planning providers reported that their clients have trouble determining which health care providers accept the Commonwealth Care plans and then making appointments with those providers. Family planning providers indicated that their clients consistently report trouble accessing contraception from their primary care physicians (PCPs) due to long wait times for appointments, a lack of PCPs who accept plans in their area and general discomfort seeking contraception from a PCP. Further, many providers reported that the Commonwealth Care plans do not inform clients that family planning providers may be covered by their plan.

Challenges scheduling appointments with PCPs to obtain contraception, particularly for intrauterine device insertions, were also reported by women in the focus groups. Participants reported wait times from 1 week to 6 months for appointments, with an average wait of 15 days. Some participants also reported long wait times for follow-up appointments with PCPs to address adverse reactions to their contraception. Focus group participants speculated that the long wait times were due to the influx of new patients after reform. Women living in rural areas reported barriers to making appointments with PCPs due to the limited number of health care providers in their area accepting one of the Commonwealth Care plans.

Determining what contraceptive methods are covered under the plans is another challenge for the newly insured. In the systematic review of the Commonwealth Care plan Web sites, locating specific methods to determine if the plans covered them was challenging as there is no specific location on the Web sites to search for contraception categorically; searching the Web site using generic terms such as “the pill” or “birth control” netted no information for any of the
insurance plans. Clients must enter a specific brand name of the medicine to locate a method. A clinic counselor reported that lack of clarity about method coverage under the new plans is common among clients. She stated, “It’s just this big circle of confusion for people and people just don’t know ... what is covered or not.” In addition, the majority of focus group participants reported being unsure about which contraceptive methods were covered under their health insurance plans and described determining which methods are covered as a “guessing game.”

Family planning providers and focus group participants both reported that, after reform, some women found obtaining contraception with a prescription challenging. Family planning providers reported that clients were unsure how to navigate the prescription system and faced challenges interacting with pharmacists. Focus group participants reported that they were sometimes inappropriately denied or overcharged for prescriptions. Participants were confused about why this happened, but speculated that there was misunderstanding about their insurance status or prescription benefits. Some women were also frustrated that their plan only covered a 1-month supply of pills, as they found it difficult to pick up prescriptions on a monthly basis. Distance to a pharmacy was also noted as a barrier to accessing prescription contraception, particularly for women living in rural areas.

Finally, contrary to reports from most focus group participants, family planning providers reported that copays for prescriptions and clinic visits were burdensome for their clients, who were used to accessing contraception on a sliding scale. As one clinic counselor reported, even small copays are barriers for their clients: “They’re trying to pay the rent, they’re trying to go to school, they’re trying to work, and keep their kids in daycare ... Sometimes paying $1 or $2 can be difficult.”

3.4. Role of family planning providers

Family planning providers reported that they frequently provide contraception on a sliding-fee scale for clients who have experienced barriers accessing it elsewhere, regardless of the woman’s insurance status or her ability to pay. Findings from the focus groups confirmed the reports from family planning providers. Many women said they relied on family planning providers to help them access contraception whenever they did not have insurance, could not afford their preferred method or faced other challenges to contraceptive access. Family planning providers also played a critical role helping clients navigate the insurance paperwork. Of note, most focus group participants reported that they had reliable and affordable access to prescription and nonprescription methods before reform in Massachusetts due to the robust family planning system in place. It appears that, after reform, the family planning providers continue to play a role in ensuring access to contraception.

3.5. Access to abortion services under reform

Though we focused on the impact of reform on contraceptive access, some participants also spontaneously discussed the impact of reform on abortion services.

Most family planning providers indicated that health care reform has not changed their clients’ access to abortion services, though some said that they now spend more time helping clients determine which abortion providers accept their insurance. In addition, a small number of providers who provide abortions indicated that wait times for abortions have increased due to the influx of the newly insured. One provider also said that wait times have increased due to abortion providers struggling to confirm prior to appointments that the Commonwealth Care plans provide coverage for terminations.

Women in the focus groups did not describe specific experiences using their insurance to pay for abortions services, but some women described personal experiences with failed, imperfectly used or inaccessible contraception and the resulting abortions.

4. Discussion

Health care reform in the Commonwealth was designed to dramatically expand access to affordable health insurance for Massachusetts residents. Indeed, reform has reduced the already low rate of uninsured in the Commonwealth; in 2010, Massachusetts had the lowest rate of uninsured residents in the nation [5], and 97% of women were insured [9].

The apparent success in reducing the proportion of people who are uninsured raises a new question: Does access to health insurance produce gains in access to health care? This study suggests that while obtaining insurance can lead to marked improvements in access to care, reform also presents unique challenges for some women accessing contraceptive benefits for the first time through a private insurance model.

Primary among the challenges identified are difficulties maintaining insurance coverage with Commonwealth Care that lead to women frequently being temporarily uninsured. This finding is supported by other research that has documented coverage gaps among Commonwealth Care-eligible residents whose coverage is terminated due to complex recertification requirements [9].

Given that these gaps in insurance coverage can last for months [10] and that oral contraception is currently the most commonly used contraceptive [11], women who are required to obtain monthly refills for oral contraception are put at increased risk for contraceptive discontinuation and, subsequently, unintended pregnancy [12,13].

Reports that women are sometimes unable to access contraception due to long wait times for appointments with PCPs may seem surprising given that only 7% of residents in the Commonwealth live in an area with a documented
shortage of PCPs [14] and that most of the focus group participants lived in well-served areas. However, previous researchers have also identified challenges to securing appointments with PCPs and filling prescriptions. For example, Long et al. [9] found that, from 2008 to 2009, one in five women in Massachusetts experienced difficulty scheduling appointments with PCPs due to provider shortages and that almost 8% of low-income nonelderly women in the Commonwealth could not access prescriptions due to challenges scheduling appointments. Further, a 2009 study found that the average wait time for a PCP in Massachusetts was 54 days and that only 38% of PCPs in Massachusetts accept Commonwealth Care [15]. Our findings, supported by previous research, suggest that low-income women in the Commonwealth in need of new or refilled contraceptive prescriptions may be at risk for lapses in contraceptive use due to a shortage of providers accepting their insurance and long wait times to see a PCP.

Many women faced barriers obtaining prescription contraceptive methods, even with the prescription in hand, due to difficulties navigating an unfamiliar prescription process. Accustomed to obtaining contraceptive supplies on-site, and often in bulk, during their medical appointment, many FPC clients faced challenges obtaining and continually refilling prescription contraceptive methods monthly at a pharmacy.

Conflicting findings about the cost of prescriptions reveal, in part, a limitation of our sample. Commonwealth Care plans have a graduated copay system, meaning that women with higher incomes have larger copays. Most of the women in our focus groups had incomes at or under 100% of the FPL and, therefore, paid $0–$2 copays, which most women found affordable. Reports from family planning providers about high copays likely reflect the fact that they serve clients with a range of incomes, some of whom may purchase multiple prescriptions (not just contraception) every month and pay up to $50 for each prescription under Commonwealth Care plans.

Our results suggest that family planning providers aimed to mitigate challenges to contraceptive access by either directly providing prescription and nonprescription methods to low-income women or helping women understand how to obtain contraception under Commonwealth Care. Other analyses have also identified the critical role of safety net providers in helping the newly insured navigate their insurance, while also providing affordable services to those who are ineligible for subsidized plans or who are temporarily uninsured [11,16,17].

4.1. Limitations

This study was designed to provide preliminary data on the impact of health care reform on contraceptive access in Massachusetts; it is limited in size and not designed to provide generalizable data. The experiences of frontline clinic staff in FPCs are underrepresented as five of our in-depth interviews and all surveys were completed by administrators. Focus group participants were disproportionately located in or near the greater Boston area, only included English- or Spanish-speaking women and were primarily at or under 100% of the FPL. Additionally, the majority of focus group participants reported that they were current or former FPC clients, meaning the experiences of women who have not obtained contraception through FPCs are underrepresented. Though results must be interpreted in light of the above limitations, findings from the plan Web site review, providers and women were similar and consistent with other research, which bolsters confidence in these results.

5. Conclusions

As national health care reform is modeled on the Massachusetts approach, many of the challenges described here are likely to arise as national implementation efforts move ahead. While national reform holds the promise of greatly reducing the number of uninsured, as documented in Massachusetts, proactive efforts to ensure consistent access to contraception during national rollout are imperative. This study highlights the importance of integrating current safety net systems and health care providers into national health care reform efforts to meet the needs of women who have trouble negotiating the health care system or accessing health care benefits.

Our findings suggesting that contraceptive and abortion access may be delayed or prevented due to an influx of insured women seeking care need further investigation. As more women enroll in subsidized insurance plans under national reform, it is critical to rigorously track and address any emerging barriers to reproductive health care. It is also imperative to monitor and evaluate the impact of health reform on reproductive health outcomes. Finally, future qualitative studies should seek to untangle the meaning of “access” to different populations. Though both family planning providers and focus group participants used the term frequently, they may have been describing a range of ideas including affordability or availability of contraception. Finally, additional longitudinal studies are required to track whether increased insurance coverage leads to increased access to reproductive health care services and products, and improved health outcomes over time.

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