Changes in Contraceptive Use & Service Utilization Before & After the Affordable Care Act

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ABSTRACT

Background: Research has established that the Affordable Care Act (ACA) substantially increased rates of insurance coverage within the first year of implementation, including among women of reproductive age. Since the ACA requires that contraceptive services and counseling be provided without any copay, deductible or out-of-pocket costs, it is possible that more women started accessing SRH care and using contraception after the ACA went into effect.

Objective: We analyzed use of reproductive health care services and contraceptive use patterns before and after the implementation of the ACA.

Methods: We conducted two cross-sectional studies, collecting data from 8,062 women aged 18-39 in Fall 2012 and Spring 2015. We examined utilization of reproductive health services and contraceptive use patterns during both time periods. We used logistic regression to determine whether differences between the two time periods were statistically significant.

Results: The proportion of women who made a visit for women’s health care actually decreased between 2012 and 2015, from 61% to 57%. We observed no significant changes in contraceptive use patterns among women who had sex in the last month. However, we found that use of the pill nearly doubled from 23% to 44% among young women aged 18-24 who had not had sex in the last month. Many of these women cited benefits of the pill unrelated to pregnancy prevention.

Implications: Increased pill use among young women who had not had sex recently may indicate that they previously rationed the pill to periods of sexual activity.

Key words: contraception, health insurance, Affordable Care Act
1. INTRODUCTION

The federal Affordable Care Act (ACA) aims to increase access to healthcare for all individuals in the United States. Research has demonstrated that this happened within the first few years of implementation, including for women of reproductive age. Special provisions of the ACA that apply to women of reproductive age include no copayments for reproductive health visits and prescription contraceptives. These provisions came into effect for some women in August 2012, but began to affect most women in January 2013, as the ACA provisions only affected new or renewed insurance coverage.

Jones & Sonfield’s analysis of the same data analyzed here found that between Fall 2012 and Spring 2015, the percent of women 18-39 without insurance decreased 40%, from 19% to 12%. Moreover, a sizeable literature suggests that making prescription contraceptives available at no cost leads to increases in contraceptive use as well as declines in birth and abortion rates. These include analyses of states’ insurance mandates, changes to health plans, and interventions which educate women about their options and provide their preference at no cost. These findings inform the expectation that similar results will follow the implementation of the ACA.

Prior research shows that, since the implementation of the no-cost preventive coverage requirement, more women have, or at least have the ability to, obtain contraception for lower or no cost. Since more U.S. women have health insurance coverage, and, in turn, access to low or no-cost contraception, and free preventive care visits, it is possible that more women are
making women’s health visits and using prescription contraceptive methods. To answer this question, this study uses cross-sectional data from two national samples of women—one collected before and one collected after the ACA—to explore whether more women contracept or use more effective methods.

2. MATERIAL & METHODS

We conducted two cross-sectional studies, gathering data from a national sample of women aged 18-39 in November-December 2012, and, in a second national sample, in May-June 2015. We relied on GfK to administered the surveys through their KnowledgePanel, a nationally representative sample of individuals recruited to respond to surveys administered online (and provided with a computer if necessary). GfK obtained informed consent from all individuals, and we obtained expedited approval from our Institutional Review Board for both surveys. Surveys were available in both in English or Spanish. Because the original focus of the study was contraceptive use among women at risk of unintended pregnancy, women were screened out of the study if they had never had sex with a man, were currently pregnant, had had a tubal ligation or had a main male sexual partner had a vasectomy. Previous studies describe the survey design in more detail.1,18

In November and December of 2012, 11,365 women were asked to fill out the survey; 6,658 answered the four screener items, for a response rate of 59%. Of these, 4,634 were eligible to participate and completed the full survey. In May-June of 2015, 9,539 women were asked to participate in the study and 5,029 answered the four screener items (53% response rate). Some
3,428 of these women were eligible to participate and completed the survey. Of our combined sample of 8,062 women, we deleted 168 women (2%) due to non-response to individual questions. Our analytic sample includes 7,894 women, 4,524 from Fall 2012 and 3,370 from Spring 2015. All analyses are weighted to adjust for non-response. The weighted samples are substantively similar; a discussion which compares these samples is published elsewhere.¹

We used simple logistic regression to assess whether differences between the two time periods were statistically significant. We present unadjusted statistics for ease of interpretation, but we also performed a sensitivity analysis which adjusts for for age, marital status, births, race, nativity, educational attainment, employment, and income relative to the federal poverty threshold. Results are approximately identical with or without including these controls, so we do not discuss covariates’ impact on the results.

3. Results

We begin by assessing the percentage of women making visits for sexual and reproductive health services in the past six months (Table 1). Overall, the percent of women accessing women’s health care within the past six months declined from 61% in Fall 2012 to 57% in Spring 2015. We found similarly small but significant declines in the percent of women making a visit for a gynecological exam or pap smear, or making a visit for some other type of women’s health care. We found no change in the percent of women making a contraceptive visit, which remained constant at 34% in both surveys.
We next examined contraceptive use patterns during the two time periods (Table 2). We found no significant changes among women who had sex in the past month (hereafter, “sexually active” women). In both surveys, we found that 59% used a prescription method, 36% used a non-prescription method, and 5% used no method. We found a small and non-significant increase in the percent of women who used contraception every time they had sex, from 83% to 86%. The right panel of Table 2 presents results for women who had not had sex in the last month (hereafter, “sexually inactive” women). During both time periods, a substantial minority of sexually inactive women reported using a prescription contraceptive method in the last month, and, moreover, this increased significantly, from 36% to 45%, between the two surveys. In particular there was a substantial and significant increase in pill use among this group, from 23% in 2012 to 30% in 2015.

We explored whether changes in contraceptive use before and after the ACA differed by demographics including age, educational attainment, poverty status, race, marital status, fertility and whether or not a woman was an immigrant. Among sexually active women not trying to become pregnant, we found no evidence of increased contraceptive use in any subgroup. Among sexually inactive women, we found that the increased use of the pill was driven by young women. Among sexually inactive young women 18-24 years old, use of the pill nearly doubled, from 23% to 44% (Table 3). We found trivial and non-significant changes of –1 to 2 percentage points in other age groups.

The substantial increase in pill use among sexually inactive young women may reflect age differences in the reasons women use the pill. Substantially more sexually inactive women
reported using the pill to reduce menstrual pain, regulate their periods, or prevent acne, 81% in contrast to 60% of sexually active women (Table 4). It is worth noting that 79% of sexually inactive women reported using the pill to prevent pregnancy. Even among sexually active women, many reported using the pill for reasons other than pregnancy prevention. Among these, younger women were much more likely than older women to report using the pill for non-contraceptive reasons. Whereas 72% of sexually active women aged 18-24 reported using the pill to reduce menstrual pain, regulate their periods, or prevent acne, many fewer – 55%, 49%, and 51%, respectively – of women aged 25-29, 30-34, and 35-39 reported using the pill for its non-contraceptive benefits.

Among women without health insurance and not trying to become pregnant in 2015, 44%, 44%, and 48%, respectively, agreed that insurance would help them afford and use birth control, choose a better method, and to use contraception consistently. The remainder disagreed or were unsure; of these, 82% indicated that they consistently contracepted in the past month.

4. Discussion

We expected the Affordable Care Act to increase women’s access to health care. However, we found a decline in women’s health visits and no change in contraceptive use among sexually active women. We suspect the decline in women’s health visits may reflect changing guidelines as to how frequently women should undergo these procedures.\(^{19}\) As to the lack of change in contraceptive use among sexually active women, we suspect that women face diverse barriers to contraceptive use. Simply having insurance may not necessarily translate to better access to care.
Waiting at the doctor’s office and, every month, at a pharmacy, may present barriers for
disadvantaged women with limited resources and flexibility. Women may also access
contraception through alternative means, such as Title X clinics, or they may be happy with non-
prescription methods like condoms and withdrawal; this may relate to why 23% of women
without health insurance disagreed that having it would improve their access to or use of
contraception (Table 5). Moreover, for newly insured individuals, contraception may not have
been the first item on their list of priorities. Finally, it is worth noting that a number of factors
impact women’s contraceptive use aside from cost, including concerns about side effects,
partners’ preferences, and ambivalence about becoming pregnant.20–22

A good deal of research suggests that making prescription contraceptives available at no cost
leads to increases in contraceptive use as well as declines in birth and abortion rates.3–10
However, analyses of interventions that target select, motivated populations may not generalize
to a national sample of women. One study analyzed state mandates, but used a limited sample of
states which became less and less representative over time; moreover, the women affected by the
ACA may systematically differ from the women already affected by state mandates.3,23

Although we found no improvement to contraception among sexually active women, we found
that use of the pill nearly doubled among young sexually inactive women, with small and non-
significant or no change among other age groups. These findings are compatible with prior
research which indicates that women use the pill for reasons other than pregnancy prevention,
especially while young.22–24 Our findings may suggest that some women rationed the pill, so that,
before the ACA, when they faced copayments or lacked insurance, they only purchased
prescription contraceptives when they had sex. If women who previously rationed the pill now use it year round, this additional practice may lead them to use the pill more perfectly during periods of sexual activity. Potentially, women may be taking the pill outside of sexual activity as a precaution, in case they have sex. If use of the pill regardless of sexual activity leads to more consistent use, this may contribute to a further decline in unintended pregnancy rates in the United States.

Alternatively, this may not affect whether women use the pill consistently, but reflect use of the pill for other health benefits. Many women report that they use the pill to reduce menstrual cramps and help with acne, and a non-trivial proportion do not even list pregnancy prevention. This may suggest that the ACA reduces disparities in access to the secondary benefits of the pill. Dysmenorrhea, for example, affects up to 90% of women, many of whom report that this impacts their ability to function at work or in school.\footnote{22–24} If the ACA helps women who had previously rationed the pill take it year round regardless of their sexual activity, this may reduce socioeconomic and gender inequality in the domains of health, education and work.

4.1 Limitations

A limitation of our approach is that we cannot be sure what proportion of change over time to attribute to the ACA. Increased use of the pill among young women who had not had sex last month may constitute the continuation of a trend which preceded the ACA. Unfortunately, our data do not allow us to assess earlier years. However, our finding of no change in contraceptive use among women who had sex in the last month suggests either that the ACA has yet to
improve contraceptive use, or that the ACA mitigated another phenomenon that counterbalances the ACA, reducing contraceptive use by exactly the opposite amount, resulting in equilibrium; we find this less plausible.

Sensitivity analyses show that results are similar before and after adjusting for demographics. However, a potential limitation of our analysis is that a comparison of two cross-sections may not reflect change over time if the samples differ along unobserved characteristics correlated with the outcomes of interest. Our cross-sections are comparable after weighing, but the unweighted samples substantively differ. This may lead to the concern that the weights may not account for unobserved differences between the samples. To address this, we performed a sensitivity analysis in which we analyzed a four-wave panel. The women from the first cross-section, interviewed in Fall 2012, were re-interviewed three times, in Spring 2013, Autumn 2013, and Spring 2014. Of the original sample of 4,634 women, 3,207 responded in Spring 2013 (69% of the original sample), 2,398 (52%) responded in Autumn 2013, and 1,842 (40%) responded in Spring 2014. Due to this panel’s high attrition, as well as to conserve space and simplify exposition, we do not present an analysis that includes those samples. However, supplementary analyses in which we analyzed changes over this panel confirmed our findings.

A final concern may be that the ACA could have increased contraceptive use among women not captured in our small sample. This suggests the importance of reproducing this analysis with the National Survey of Family Growth, when post-ACA data become available.
4.2 Conclusion

An extensive literature discusses barriers that inhibit women’s access to sexual and reproductive healthcare in the United States. Motivated by questions of reproductive justice and socioeconomic disparities in unintended pregnancies and births, this literature often emphasizes financial barriers that prevent women from obtaining and consistently using their preferred method of contraception. Expectations that the ACA would increase contraceptive use have been informed by analyses of non-representative samples; for example, interventions that educated women about their options and provided their preferred method at no cost, and changes that occurred within a convenience sample of states.\textsuperscript{2-9} Our results suggest that these findings may not generalize to a broader population or that improvements to contraceptive use will take longer than anticipated to emerge. This should motivate future research on barriers to women’s consistent use of effective contraception.

Acknowledgments

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REFERENCES


Table 1. Estimated percent of women making visits for sexual and reproductive health services

<table>
<thead>
<tr>
<th>Made visit for women's healthcare in the past six months</th>
<th>Fall 2012</th>
<th>Spring 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Women's Health Visit</td>
<td>61</td>
<td>57*</td>
</tr>
<tr>
<td>Gyn or Pap Visit</td>
<td>50</td>
<td>44***</td>
</tr>
<tr>
<td>Contraceptive Visit</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Other Women's Health Visit</td>
<td>27</td>
<td>23*</td>
</tr>
<tr>
<td>Observations</td>
<td>4411</td>
<td>3291</td>
</tr>
</tbody>
</table>

*** p < .001   ** p < .01   * p < .05   ^ p < .1

Results are from logistic regressions with no control variables.
Significance tests compare Spring 2015 to Fall 2012 (reference).
Table 2. Contraceptive use patterns among women aged 18-39 in 2012 and 2015, by whether or not they had sex in the last month.

<table>
<thead>
<tr>
<th>Prescription Method</th>
<th>Had Sex Last Month</th>
<th>Had Not Had Sex Last Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 2012</td>
<td>Spring 2015</td>
</tr>
<tr>
<td>LARC</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Pill</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Depo</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Patch or Ring</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Any Prescription Method</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Non-Prescription Method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Other Barrier Method</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No Method</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Consistently contracepted (for the past month)</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>Observations</td>
<td>3213</td>
<td>2346</td>
</tr>
</tbody>
</table>

*** p < .001  ** p < .01  * p < .05  ^ p < .1
Results are from logistic regressions with no control variables.
Excludes women who were trying to get pregnant.
Significance tests compare Spring 2015 to Fall 2012 (reference).
Table 3. Percent of women using the pill, by age and sexual activity in the last month

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Had Sex Last Month</th>
<th>Had Not Had Sex Last Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fall 2012</td>
<td>Spring 2015</td>
</tr>
<tr>
<td>18-24</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>25-29</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>30-34</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>35-39</td>
<td>26</td>
<td>27</td>
</tr>
</tbody>
</table>

*** p < .001  ** p < .01  * p < .05  ^ p < .1

Results are from logistic regressions with no control variables.
Excludes women who were trying to get pregnant.
Table 4. Percent of women who cite reasons for using the pill, by age group and whether they had sex last month

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>79</td>
<td>18</td>
<td>24</td>
<td>25</td>
<td>29</td>
<td>30</td>
<td>34</td>
<td>35</td>
<td>39</td>
<td>96</td>
<td>94</td>
</tr>
<tr>
<td>Yes</td>
<td>95</td>
<td>83</td>
<td>81</td>
<td>74</td>
<td>73</td>
<td>96</td>
<td>96</td>
<td>94</td>
<td>95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Pregnancy Reasons</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce menstrual pain or cramps</td>
<td>52</td>
<td>18</td>
<td>24</td>
<td>25</td>
<td>29</td>
<td>30</td>
<td>34</td>
<td>35</td>
<td>39</td>
<td>48</td>
<td>44</td>
</tr>
<tr>
<td>Help with acne</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Any of these three</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
<td>81</td>
</tr>
<tr>
<td>Observations</td>
<td>782</td>
<td>250</td>
<td>250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** p < .001    ** p < .01    * p < .05    ^ p < .1

Results are from logistic regressions with no control variables.

+Significance tests compare Yes to No (reference).
++Significance tests compare 25-29, 30-34 and 35-39 to 18-24 (reference).
Table 5. Respondents' Attitudes About Contraceptive Coverage, 2015

<table>
<thead>
<tr>
<th>If I had insurance, I could ...</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>... afford and use birth control</td>
<td>23</td>
<td>32</td>
<td>44*</td>
</tr>
<tr>
<td>... choose a better method</td>
<td>23</td>
<td>33^</td>
<td>44***</td>
</tr>
<tr>
<td>... consistently contracept</td>
<td>24</td>
<td>28</td>
<td>48***</td>
</tr>
</tbody>
</table>

*** p < .001    ** p < .01    * p < .05    ^ p < .1

Results are from logistic regressions with no control variables.
Significance tests compare Unsure and Agree to Disagree (reference).
Excludes women who were trying to get pregnant.