Insurance Coverage for Long-Acting Reversible Contraception Placed in Office: A Buy and Bill Demonstration Project in Hawai'i

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Abstract

Access to the full range of contraceptive options for all people is critical in allowing individuals to make decisions that are consistent with their reproductive goals and values, which, in turn, enables them to achieve educational, social, and economic goals. In 2010, the Patient Protection and Affordable Care Act mandated that health plans must cover contraceptive supplies and services, including drugs and devices approved by the US Food and Drug Administration without any out-of-pocket costs to patients. This federal mandate was similar to a law passed by the Hawai'i state legislature in 1999. Despite the Affordable Care Act, access barriers continue to prevent people from obtaining their preferred methods upon request. Same day access to long-acting reversible contraceptive (LARC) devices is a particular challenge in many clinical settings due to the high upfront cost of the device for providers. This Insights article describes the context of this issue in Hawai'i and information about a pilot test of a "buy and bill" program for LARC devices in an outpatient obstetrics and gynecology practice in Honolulu, Hawai'i. Ultimately, the majority of LARC devices were paid for fully by insurance, resulting in increased access to same day insertion with limited financial risk for the clinic.

Keywords

long-acting reversible contraception, contraception, access, buy and bill

List of Abbreviations

ACA = Patient Protection and Affordable Care Act
FDA = Federal Drug Administration
IUD = intrauterine device
LARC = long-acting reversible contraception

Introduction

Reproductive justice is defined as the "…complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights," which recognizes women's right to reproduce as a fundamental human right.[1] This definition encompasses people's right to manage their reproductive capacity; access adequate information, resources, services and personal safety measures while pregnant; and parent their child—regardless of race, religion, sexual orientation, economic status, immigration status, citizenship status, disability status, and status as an incarcerated person.[1] The SisterSong Women of Color Reproductive Health Collective, which originally defined reproductive justice, hold that reproductive health options available for people must be safe, affordable, accessible, and supported by governments to facilitate individual life choices.[1] The concept of reproductive justice was developed out of the need for representation of the rights and needs of marginalized communities, including Black, Indigenous people, people of color (BIPOC), trans, and queer people in the women's rights movement.[2]

The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 helped to increase access to affordable, quality care by emphasizing prevention and wellness.[3,4] A provision of the ACA restricts insurance cost-sharing—the amount a person must pay out of pocket in the form of deductible, coinsurance, or copayments—for a range of preventive health services, including contraception.[3,4] Contraception is defined in the ACA by the National Academy of Medicine's Committee on Preventive Services for Women as "the full range of Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity."[4,5]

Nearly all women in the United States (US) who have ever engaged in sexual intercourse have used a contraceptive method during their reproductive lives.[6] Access to the full range of contraceptive services and methods is necessary for women's health and reproductive autonomy.[6] Long-acting reversible contraceptive (LARC) devices, which include intrauterine devices (IUDs) and the contraceptive implant are highly effective at pregnancy prevention because they require little action on the part of the user to maintain efficacy after insertion.[7–10] LARC devices are favorable to many people for a variety of reasons. For instance, the copper IUD contains no hormones. The hormonal IUDs and the progestin implant result in shorter, lighter menstrual periods, or the cessation of menstrual periods (amenorrhea),

which many patients find desirable.[11–13] Furthermore, LARCs have higher continuation rates after 1 year (80%) compared to other reversible methods (49% to 57%), and higher satisfaction rates (78% to 85%) compared to other reversible methods (54% to 44%).[14] While LARCs have higher continuation and satisfaction rates, access issues remain due to the high cost of devices, with the average wholesale price reported to range from $718 - $844 depending on the selected device.[15]

A study examining the cost-effectiveness of contraception methods, including LARCs, at a publicly funded family planning program in California found LARCs were more cost-effective than oral contraceptives, injectable methods, and barrier methods, with a cost savings of more than $7.00 for every $1.00 spent on services and supplies.[10,16] However, access to LARCs is still lacking in the United States compared to short-acting reversible methods, with the availability of devices ranging from 32% to 56% in office-based facilities to 36% to 60% in Title X clinics.[7] Despite ACA-mandated insurance coverage for these devices, same day access to LARC devices is a challenge in many clinical settings. Nationally, providers cite lack of insertion training, adequate reimbursement, and the high upfront cost of LARCs as barriers to keeping adequate supplies in office.[7] Barriers specific to Hawai‘i are not known. A statewide survey to determine the availability of LARC in Hawai‘i is ongoing (The Expanded Access to Contraception Project, research in progress). Appropriate compensation for contraceptive services allows providers to provide the full range of contraceptive methods, thereby increasing access to preferred methods of contraception, improving quality of care, optimizing health outcomes,[6] and respect reproductive autonomy.

The American College of Obstetricians and Gynecologists has stated that 2-visit IUD insertion protocols are a barrier to contraceptive access, and instead advocates for insertion of an IUD or contraceptive implant at the time of request, as long as the provider is reasonably certain the patient is not pregnant.[17] Studies show that 2-day LARC insertion protocols impede IUD access and often result in a failure to obtain an IUD.[18] A study investigating reasons why people failed to obtain an IUD in a 2-day clinic setting reported additional time needed for the second visit, inability to return to the clinic, and lack of transportation to attend a second visit as principal barriers.[18,19]

Providers can only provide a LARC device on the day of the request if they have IUDs and contraceptive implants available in the clinic for insertion. “Buy and bill” is a practice wherein a health care provider purchases a medical device or medication to stock in the office, provides it to the patient on the same day it is requested by the patient, and subsequently bills the patient’s insurance to obtain reimbursement for the cost of the device or medication. For medical devices like IUDs or medications that need to be administered by a health care provider, like intravenous chemotherapy, buy and bill often results in more timely care because it obviates the need for a pharmacy to fill a prescription and deliver it to the facility, and the patient does not have to return to the health care facility for administration. However, if the insurer does not reimburse the health care provider, the clinic sustains a financial loss or passes the expense along to the patient.

LARC Background and Access in Hawai‘i

The state of Hawai‘i has historically supported access to reproductive health care, evidenced by its policies that expand access to contraception and reproductive health services. Prior to the ACA, Hawai‘i had already instituted an insurance mandate that required all insurance plans in the state, except those with a religious exemption, to cover any FDA-approved prescriptive contraception or device and contraceptive services.[20]

In 2016, the state legislature passed Act 205, requiring insurers to cover up to 12-months of contraception supplies to their beneficiaries with no waiting period.[21] The act also reaffirms comprehensive coverage for all contraceptive devices and services, “…all policies, contracts, plans, or agreements…, that provide contraceptive services or supplies, or prescription drug coverage, shall not exclude any prescription contraceptive supplies or impose any unusual copayment, charge, or waiting requirement for such supplies.”[21] Most recently in 2017, the state legislature passed Act 67, allowing pharmacists with additional training to prescribe and dispense self-administered contraceptives citing evidence from several other states that this is a safe practice that improves access to contraceptives.[22] Hawai‘i was the sixth state, after California, Oregon, Washington, New Mexico, and Maryland to pass such a law.[23]

While Hawai‘i’s policies are necessary for increasing access to all methods of contraception, they are not sufficient to ensure all patients have equal access to all methods, including LARCs. Statewide, ongoing education for former Title X sites is aimed at making providers familiar and comfortable with providing LARCs. The Department of Human Services, MedQuest Division released a memo notifying providers and birthing facilities that the state’s Medicaid would reimburse for LARC devices provided in the inpatient setting separate from bundled global labor and delivery fees. Prior to this memo, birthing facilities risked non-payment for LARC services provided at time of delivery. The clarification now encourages birthing facilities to stock LARC devices and provide them at the time of delivery without risk of financial losses. In addition, the state Department of Health, Office of Planning, Policy and Program Development and the Maternal Child Health Branch – Women’s and Reproductive Health Section has partnered with the Hawai‘i Maternal and Infant Health Collaborative, a public private partnership, to further expand these efforts.

What is not known at this time are the number of LARC providers across the state and the unmet need of patients who desire LARC devices as their preferred contraceptive method.

Table 1. Insurance Reimbursement Per Long-Acting Reversible Contraceptive Device			
	Hormonal Intrauterine Device (n=27) n (%)	**Contraceptive Implant (n=10) n (%)**	**Total (N=37) n (%)**
Full Reimbursement	20 (74%)	8 (80%)	28 (76%)
Partial Reimbursement	6 (22%)	0 (0%)	6 (16%)
No Reimbursement	1 (4%)	2 (20%)	3 (8%)

Table 2. Insertion Fee Payment Per Long-Acting Reversible Contraceptive Device			
	Hormonal Intrauterine Device (n=27) n (%)	**Contraceptive Implant (n=10) n (%)**	**Total (N=37) n (%)**
Full Payment	0 (0%)	0 (0%)	0 (0%)
Partial Payment	27 (100%)	10 (100%)	37 (100%)
No Payment	0 (0%)	0 (0%)	0 (0%)

This pilot project gives us insight into what providing same-day access to LARCs could look like for providers. This pilot project can serve as a successful demonstration of the financial implications of providing same-day LARC services.

Pilot Study

Providing same day access to LARCs in Hawai‘i is a way to give people access to the full range of contraceptive options. To assess the feasibility of a buy and bill LARC practice in Hawai‘i, the Women’s Health Research Center conducted a pilot study evaluating a buy and bill LARC program in an obstetrics and gynecology outpatient practice at the Queen Emma Clinics (QEC) in Honolulu. The QEC are located at The Queens Medical Center, a non-profit, acute care health facility accredited by the Joint Commission on Accreditation of Healthcare Organizations. Healthcare services are provided by residents and attending physicians who are also faculty of the University of Hawai‘i John A. Burns School of Medicine. The QEC serves a diverse population on O‘ahu, including the insured, underinsured, and uninsured.

Between March 2016 and November 2016, Liletta (a hormonal IUD manufactured by Allergan) and Nexplanon (a contraceptive implant manufactured by Merck) were made available for insertion to patients with any form of health insurance on the same day as the patient requested the device at an outpatient practice site in Honolulu, Hawai‘i. Although a copper IUD is also FDA approved contraception, the levonorgestrel IUD was more frequently requested by patients in the obstetrics and gynecology outpatient practice at the Queen Emma Clinics. Additionally, other hormonal IUDs are FDA approved for contraception, but the 52-mg levonorgestrel IUD is the most commonly used IUD in the United States.

For all patients who opted for same-day insertion of a LARC, the patient’s insurance was billed for the cost of the device. Billing outcomes for the cost of the devices were categorized in 3 ways: (1) full reimbursement (reimbursement in an amount that covers the cost of the device), (2) partial reimbursement (reimbursement not in an amount that covers the cost of the device), and (3) no reimbursement. In addition, health care providers can also be paid a procedural fee by insurers, and these were also tracked. Any denied claims were appealed. Insurance companies billed in this pilot project included 5 major carriers in Hawai‘i, including Hawai‘i Medical Service Association (HMSA) health maintenance organizations and preferred provider organization plans, Quest plan administrators (UnitedHealthcare, AlohaCare, HMSA, and ‘Ohana), University Health Alliance, Hawai‘i Medical Assurance Association, and Hawai‘i – Mainland Administrators.

During this pilot project, patients were not billed for devices or insertion fees that were not reimbursed. Insurance reimbursement was tracked until November 2017, approximately 1 year from the last insertion. A reason for unreimbursed devices were attempted to be obtained from insurance companies via telephone. Of note, there are other costs to the clinic associated with placing IUDs or implants using a buy and bill framework, including the cost of personnel to order and track devices, office space to store devices, local anesthetic, equipment and instruments used at the time of insertion, and personnel to order and inventory devices and seek reimbursement. Calculating these costs was not attempted given that these costs will vary widely between clinics.

Over 9-month pilot period, a total of 37 devices were inserted, including 27 hormonal IUDs and 10 contraceptive implants. Each hormonal IUD cost the clinic $593.75, and each contraceptive implant cost $462.91. For IUDs, 26 of 27 (96%) were either fully or partially reimbursed, and 1 (4%) device was not reimbursed. The insurance plan that did not reimburse for the IUD cited that the device was not covered under the patient’s plan. On average, insurance reimbursement per hormonal IUD

was $609.95 (range, $312.00–$703.00), and insertion fee reimbursement averaged $72.49 (range, $36.76–$137.00). The one insurer that did not reimburse for the cost of the hormonal IUD did pay the insertion fee.

For implants, 8 of 10 (80%) were fully reimbursed for the cost of the device, and 2 (20%) devices were not reimbursed. Reimbursement for a contraceptive implant device averaged $628.29 (range, $493.00–$704.00), and insertion fee payments averaged $108.00 (range, $82.00–$187.00). The insurance plans that did not reimburse for the 2 implants cited that the devices were not covered under those patients' plans. The 2 insurers that did not provide reimbursement for the contraceptive implant paid for the insertion fees. Insertion fee payments for both IUDs and implants averaged $72.49 (range, $36.76–$137.00) with a total amount of $2964 paid for all insertion fees. All devices were inserted successfully, with 1 hormonal IUD subsequently being expulsed following insertion.

Conclusion

In the pilot study, over 90% of LARC devices purchased using a buy and bill model at an obstetrics and gynecology outpatient practice were paid sufficiently for the clinic to recover its costs and sustain the program. Although reimbursement amounts varied by carrier, plans appear to be paying for devices as mandated by the ACA and doing so without requiring prior authorization or imposing patient cost-sharing. Bulk purchasing options can further reduce upfront costs for providers. It is noted that only hormonal IUDs and contraceptive implants were inserted in this project. It is possible that reimbursement would differ for other devices. This pilot program was an encouraging first step in confirming that improved same day access to these highly effective methods is financially feasible and sustainable in a general obstetrics and gynecology practice.

The availability of LARCs in health care facilities and physician offices is necessary to ensure same day insertion when requested by a patient and is considered a best practice.[24] In light of barriers to accessing care from specialized providers, such as obstetricians and gynecologists, across areas of Hawai‘i, it is important that these providers along with family medicine providers are able to stock these devices in their offices to ensure people seeking a contraceptive method in their community are able to access on the day they request it. Utilization of a buy and bill program, which has been used in other areas of health care such as outpatient chemotherapy,[25] has shown to be an effective way to allow for continuous stocking of LARCs in facilities and physician offices. In 2016, Rankin et al. demonstrated the utilization implementation science methods, including the Consolidated Framework for Implementation Research, to guide and evaluate institutional policies supporting inpatient postpartum LARC across 13 states.[26] The authors found that facilities' readiness to adopt strategies to increase resource availability, such as a buy and bill program, increase access to inpatient postpartum LARCs.[26] As demonstrated with this pilot study, buy and bill is a feasible and effective process to continuously stock LARCs in office, which could increase same day access upon patient request, as observed by the project staff.

As demonstrated, a buy and bill program is a sustainable option to stock and increase access to LARCs in Hawai‘i. However, this finding may have limited generalizability to other health care facilities or physician offices in the United States depending on individual state Medicaid and private insurer policies. In Hawai‘i, a buy and bill program was found to be a practical approach to address LARC stocking and contraceptive access, with minimal financial risk to the facilities and physician offices. To the authors' knowledge, this is the first study to look at increasing access to LARCs utilizing a buy and bill program in Hawai‘i.

While the findings can reassure providers in Hawai‘i who are interested in using a buy and bill model to expand access to LARC devices, some insurance plans are not required to cover the costs of LARCs under the ACA thus limiting access to contraception for patients under these plans. Further advocacy with these plan administrators could encourage the consideration of cost-effectiveness of full-spectrum contraceptive coverage.

If reproductive justice is to be acheieved by supporting people in making life decisions that are best for them, the systemic barriers that prevent people from accessing their preferred methods of contraception and constrain their reproductive life planning must be continually examined. This will require a shift of medical care toward prioritization of preventive care, as was intended by the ACA.[4]

Conflict of Interest

None of the authors identify a conflict of interest.

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