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Mainstreaming Contraceptive Services In Managed Care—Five States' Experiences

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Context: *The ongoing, rapid national transition from a health care financing and delivery system dominated by traditional indemnity insurance to one dominated by managed care has enormous implications for the accessibility of contraceptive services.*

Methods: *In each of five areas with relatively mature managed care environments (all of Colorado, Massachusetts and Michigan, as well as selected counties in California and Florida), all managed care organizations serving commercial or Medicaid enrollees were asked about their coverage of contraceptive services and the procedures for obtaining that care. In addition, all publicly funded family planning agencies in these areas were queried about their involvement with managed care plans, and representative samples of reproductive-age women at risk of unintended pregnancy and enrolled in managed care plans were asked about their plan's coverage and their experiences in obtaining contraceptive services.*

Results: *Fifteen percent of health maintenance organizations and point-of-service plans did not cover all five of the most commonly used medical contraceptive methods, and another 6% covered none of the methods. Only half the plans informed enrollees—and even fewer informed enrollees insured indirectly as dependents—of whether they covered contraceptive services. One in four women in commercial plans were unsure whether their plan covered oral contraceptives, and two in three did not know if their plan covered the other medical methods. Only one in four commercial plans have brought community-based family planning providers into their networks, and more than half of all publicly funded family planning agencies reported having no contracts with managed care organizations. Finally, nearly one in three women in managed care plans reported difficulties in obtaining contraceptive services, with 13% of enrollees in commercial plans waiting at least four weeks for an appointment for contraceptive care.*

Conclusions: *To adequately address the contraceptive needs of their employees, employers must ensure that the health insurance plans they purchase provide adequate coverage of contraceptive methods. For their part, managed care organizations and state Medicaid programs should examine their policies and procedures to ensure that services are easily accessible to women needing contraceptive care.* Family Planning Perspectives, 1998, 30(5):204–211

With most women of reproductive age relying on some form of public or private health insurance, the ongoing changes in health care financing and delivery in the United States have enormous implications for the delivery of contraceptive services. Seventy-four percent of U.S. women aged 15–44 have some form of private, employment-related health insurance coverage.[1] Most of these women are insured through a managed care arrangement. From 1993 to 1995, the market share of managed care organizations skyrocketed, increasing from 51% to 73% of insured, commercial enrollees in the United States.[2]

The managed care marketplace includes several types of health maintenance organizations (HMOs), along with newer systems known as preferred provider organizations (PPOs) and point-of-service (POS) plans.[3] Although the various types of plans differ in important ways, most rely on a system of primary care providers whose job is to coordinate enrollees' overall care. In one way or another, all encourage the use of a designated pool of providers, although a growing number of plans are allowing enrollees to obtain care outside their designated pool of providers, albeit with strong financial disincentives.

As shown in an earlier study conducted by The Alan Guttmacher Institute (AGI), the coverage of contraceptive services varies greatly by type of plan: HMOs, and to a somewhat lesser extent, POS plans, provide much more comprehensive coverage of contraceptive services than do traditional fee-for-service plans. PPOs are closest to traditional plans in their coverage, and often provide only scant coverage of reversible contraceptives. Moreover, traditional patterns of health insurance coverage apply to reproductive health services: Surgical care is favored over nonsurgical procedures, and curative care is favored over preventive services.[4]

In the absence of insurance coverage, using contraceptives is a costly proposition. In 1993, the average total cost of the contraceptive implant (effective for five years) exceeded $700, and the cost of an IUD (effective for 10 years) was about $500. A one-year supply of oral contraceptives and the associated physical examination cost nearly $300. While potentially problematic for anyone, these out-of-pocket costs can be particularly burdensome for marginal-income women and teenagers.[5]

Sixteen percent of U.S. women aged 15–44 are insured through the Medicaid program,[6] which is the single leading source of funding for publicly subsidized family planning services in the United States.[7] At least four in 10 Medicaid recipients are enrolled in managed care

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plans, and the proportion is even higher among low-income families covered by Medicaid, the population most likely to need contraceptive services.[8]

The federal Medicaid statute provides a broad framework within which each state structures and operates its own program; sharp differences exist among different state programs, especially in terms of delivery mechanisms and provider payment. In 1972, Congress mandated that all state Medicaid programs cover family planning services and supplies. Since that time, Congress has singled out family planning for special advantageous treatment in three additional respects. First, states are reimbursed for 90% of the costs of providing family planning services to enrollees, compared to 50–77% for other covered services.

Second, the federal Medicaid statute prohibits the imposition of cost-sharing for family planning services and maternity care provided through the program, even though cost-sharing may be required for other covered benefits. Finally, the statute requires that most Medicaid managed care enrollees be allowed to obtain family planning services from the provider of their choice even if that provider is not affiliated with their managed care plan. Most of the handful of states not bound by this federal requirement also continue to allow enrollees to choose their family planning provider.

Community-based family planning agencies are a particularly important source of care for Medicaid recipients and other low-income women. In 1994, an estimated 6.6 million women received contraceptive services through this network of 3,100 agencies and 7,100 clinic sites.[9] Using a sliding fee scale based on income, these agencies offer low-income women without insurance or Medicaid coverage a wide range of contraceptive care.

Recent data show that the transition to managed care has not always been smooth. A recent study of managed care enrollees in the Sacramento, California, area found that one in four households covered by managed care plans had experienced a difficulty related to the plan in the previous year.[10] Medicaid recipients were more likely to have difficulties than were commercial enrollees. The most commonly cited problem was delay or denial of coverage.

In the absence of large-scale quantitative data, anecdotal reports point to the existence of similar problems in the accessibility of contraceptive services in managed care plans.[11] Contraceptive services are highly time-sensitive; an excessive wait for an appointment or the need to obtain prior authorization from a primary care provider may delay or deter a woman from receiving the services she needs to avoid an unintended pregnancy. Some primary care providers may have religious or moral objections to providing these services or even referring women to other providers who offer them. Further, the coordination of care that is such a strength of managed care systems may threaten patient confidentiality, which is critical to the willingness of some women to seek sensitive services.[12]

Our study was designed to provide policymakers, managed care organizations, employers, family planning agencies and the public with information on how well managed care plans meet the needs of women seeking contraceptive care and closely related services, such as screening for sexually transmitted diseases (STDs). To achieve this goal, we surveyed managed care organizations, women enrolled in managed care plans and family planning agencies in five states. We focus on four key questions: How well is the range of medical contraceptive methods covered in managed care plans? Are women adequately informed of their plan's coverage? To what extent are community-based family planning providers being used as a resource by managed care organizations seeking to provide contraceptive services and supplies? Finally, are covered contraceptive services easily accessible to women enrolled in managed care plans?

We look at five selected states (or major geographic areas of states) with more mature managed care environments—those in which at least 20% of the privately insured and 20% of the publicly insured population is enrolled in managed care plans. In addition, the areas were selected to provide geographic diversity and variety in the types of family planning service networks (health departments, Planned Parenthood affiliates and independent agencies, among others) dominating the provision of publicly funded family planning services. The areas selected are the entire states of Colorado, Massachusetts and Michigan, as well as clusters of contiguous counties in Florida (Hernando, Hillsborough, Orange, Osceola, Pasco, Pinellas and Polk) and California (Orange, Sacramento, San Diego and Solano).

By design, therefore, the results of this study do not reflect the accessibility of contraceptive services in managed care plans nationwide. The study areas were chosen in large part because providers and enrollees have had time to adjust to managed care. Moreover, these areas are in states that have made the delivery of family planning services through Medicaid a priority. In addition, two of the five states—California and Colorado—have passed legislation specifically aimed at improving access to gynecologic care for women enrolled in managed care plans. By examining the experiences of providers and enrollees in these mature managed care environments, we are able to identify some important issues that will need to be addressed if managed care plans are to fulfill their promise of making high-quality, cost-effective preventive care readily accessible to enrollees.

Methodology

In each of the five study areas, AGI conducted three surveys: a survey of all managed care organizations serving commercial and Medicaid enrollees, interviews with a sample of women enrolled in commercial and Medicaid managed care plans, and a survey of all publicly funded family planning agencies.

Managed Care Plans

We obtained lists of commercial managed care organizations from the Group Health Association of America[13] and the American Association of Preferred Provider Organizations.[14] Where appropriate, we contacted managed care organizations to confirm that they offered coverage in specific study areas. State Medicaid agencies and the federal Health Care Financing Administration provided lists of plans serving Medicaid enrollees.* We identified a total of 196 organizations, of which 148 served commercial enrollees and 48 served Medicaid enrollees.

In conjunction with a panel of experts, AGI developed a 12-page survey instrument. Questionnaires were developed separately for commercial plans and for Medicaid plans, although they contained almost identical items. In September 1996, we sent surveys to the chief executive officers of the 196 managed care organizations identified as eligible for the study. For most questions, respondents were instructed to provide information concerning the typical plan covering enrollees in the study areas (with typical defined as "that which represents the coverage written for most of the lives covered" by the managed care organization).

*The Medicaid plans surveyed did not include primary care case management plans operating in the study areas because those plans involve direct contracting between the state and providers, with no organizational plan structure.

Table 1. Percentage of managed care plans that cover specified contraceptive services and supplies and that offer STD or HIV testing, by type of plan, five selected states or areas of states

Services, supplies and testing	Commercial			Medicaid
	Total (N=54)	PPO (N=7)	HMO/POS (N=47)	(N=27)
Coverage of reversible medical methods†				
All five	72	29	79	100
Some but not all	22	57	15	0
None	6	14	6	0
Contraceptive drugs and devices				
Oral contraceptives	91	83	92	96
Injectable	81	33	87	96
Diaphragm	76	33	81	100
Implant	74	33	79	100
IUD	73	33	78	100
Emergency contraception	60	50	61	77
Sterilization				
Tubal ligation	93	100	92	100
Vasectomy	93	100	92	100
Contraceptive services				
Prescription of oral contraceptives	91	83	92	100
Contraceptive counseling visit	87	50	92	100
Diaphragm fitting	83	33	89	100
IUD insertion	81	33	97	100
IUD removal	83	33	89	100
Natural family planning instruction	81	67	83	100
Contraceptive injection	79	33	85	100
Implant insertion	77	33	83	100
Implant removal	77	33	83	100
Prescription of emergency contraception	60	50	62	80
STD/HIV testing‡				
STD testing	100	100	100	100
HIV testing	100	100	100	100

†Oral contraceptives, diaphragm, IUD, implant and injectable. ‡For asymptomatic, high-risk individuals. *Note:* Ns on specific items for HMO/POS plans and Medicaid plans vary from 42 to 47 and from 26 to 27, respectively, because of differential nonresponse.

We conducted extensive follow-up to increase the initial response rate, including a follow-up mailing and a series of telephone calls to plans that did not reply. Of the 196 managed care organizations originally identified as writing coverage in the study areas, 34 responded that they do not write coverage in the study areas or that their organization consists of a network of service providers that does not have defined benefit packages or procedures. Of the 162 that remained, 81 (54 commercial and 27 Medicaid) completed usable questionnaires, for an overall response rate of 50%.

Of the 54 commercial managed care organizations that responded, 42 reported that their typical plan is an HMO, five a POS plan and seven a PPO. For this study, we looked at the 54 plans as a group, except when examining coverage of individual contraceptive services, where PPOs behave differently; in those cases, we separated PPOs from HMO and POS plans. Because of the relatively small number of Medicaid plans (27), we analyzed the three types of plans as a group, and our findings must be interpreted with caution.

Women in Plans

The sample for this survey consisted of 1,006 women enrolled in managed care plans. Women aged 18–44 who were living in the study areas were considered eligible to participate in the survey if they were covered by a managed health care plan and were in need of contraceptive services.* They were classified as being in a managed care plan if the name of their health insurance or health plan was on the list of such plans compiled by AGI. If a woman did not know the name of her managed care plan or if her plan's name was not on the list, she was considered as being in managed care if her medical plan had assigned or would assign her a doctor or if her plan required her to choose a doctor from an approved list of plan doctors and, if she was not on Medicaid, to pay extra if her doctor was not on the approved list.

As part of the study design, we set quotas of 200 completed interviews for each of the five study areas, and required half of the respondents in each area to be enrolled in Medicaid managed care plans (100 per state, 500 total) and the other half to be enrolled in private managed health care plans (100 per state, 500 total). We did not set quotas at the county level.

After the questionnaire was developed and pretested with 25 interviews distributed across the sample strata, it was translated into culturally appropriate Spanish suitable for respondents in multiple U.S. locations. The final questionnaire was programmed into a computer-assisted telephone interview system for administration.

The women interviewed were drawn from 10 random subsamples. We used two subsamples for each state—a "low-income" subsample and a "higher income" subsample. Although most Medicaid managed care enrollees came from the low-income subsample, we interviewed all eligible Medicaid and private managed care enrollees, regardless of the subsample from which they were drawn.

The low-income subsample was a random-digit-dial sample of telephone exchanges with low average household incomes, specifically those ranked in the 10th percentile or lower of listed telephone numbers. The higher income subsample was a random-digit-dial sample from all other telephone exchanges in the geographic area. Every exchange in each study state or county was assigned to one of these two subsamples.

For each home reached by random digit dialing, female interviewers from Survey Methods Group administered a series of screening questions, either in English or in Spanish, to determine whether the household contained an eligible respondent. The interviewers made one initial phone call to each number and up to five follow-up calls.

A total of 109,583 telephone numbers were dialed to find and interview eligible respondents. Of the estimated 6,338 women at these numbers who were eligible for the study, we contacted and identified 1,204, and successfully interviewed 1,006 (84%). The interviews, which averaged 19 minutes, were conducted between September 1996 and March 1997; 150 were conducted in Spanish.

The data have been weighted to take into account the different sampling ratios in low-income and higher income areas, as well as differing eligibility and response rates. The total figures for respondents are weighted so that each study area is represented equally, but the data for each area reflect the proportion of eligible women in that state or state area who are in Medicaid or private managed care plans.

Data showing women in commercial plans and women in Medicaid plans have been separately weighted so that each area is equally represented. Thus, the distributions of the total sample may be somewhat different from the Medicaid and private distributions because fewer than half of the eligible women in each state are, in fact, in Medicaid plans. Neither the total

*A woman was considered in need of contraceptive services if she was not pregnant, trying to get pregnant or wanting to get pregnant; if she had had sexual intercourse with a man at least once in the past 12 months; and if neither she nor her partner was contraceptively sterile or infertile.

nor subgroup figures are necessarily representative of all women in managed care plans in the study areas or in the United States as a whole.

Family Planning Agencies

Using a list of publicly funded family planning agencies compiled by AGI and last updated in 1994,[15] we identified 265 family planning agencies as operating in the study areas. Family planning agencies, defined as organizations with operating responsibility for one or more clinics that provide publicly funded family planning services, include hospitals, health departments, Planned Parenthood affiliates, community health centers and independent agencies.

The 18-page questionnaire for this survey, which was developed by AGI staff and pretested at several family planning agencies, was mailed to the director of family planning at each agency in November 1996. We sent three more mailings to agencies that did not reply, and then followed up by telephone.

Of the 265 agencies originally identified, 16 responded that they had not actually provided family planning services during the period in question or had served fewer than 10 family planning clients. Of the remaining 249 agencies, 155 returned usable questionnaires (a response rate of 62%). The response rate varied somewhat by state from a low of 53% in Massachusetts to a high of 70% in Michigan. Response rates varied even more by type of agency, with Planned Parenthood affiliates replying at the highest rate (93%) and hospitals at the lowest (43%).

Because response rates differed by state and type of agency and because of different numbers of eligible agencies in each state, we constructed weights that adjusted for nonresponse and equalized the weight of responses from each state. For example, we assumed that nonrespondent agencies of each type in each state were similar to agencies of the same type and state that did respond, and we constructed a weight accordingly. Then, to obtain a total response that combines information from all five states, we adjusted the weight so that the responses of agencies in each state accounted for one-fifth of the total response.

Agencies that provide family planning services can be distinguished from one another not only by type, but also by the extent to which their services focus on the provision of contraceptive care. In this article, we compare the one-third of agencies in which at least half of the client caseload is made up of contraceptive clients with the two-thirds of agencies in which contraceptive clients account for less than half of the caseload. Agencies that primarily serve contraceptive clients are more likely to be health departments, Planned Parenthood affiliates or independent agencies such as Family Planning Councils. For example, all the Planned Parenthood agencies, and at least four of 10 health departments and independent agencies, reported that at least 50% of their patients are contraceptive clients. Hospitals and community health centers generally responded that fewer than half of their patients are contraceptive clients.

Findings

Plan Coverage

Nearly all of the managed care plans surveyed provide coverage of some contraceptive methods. Seventy-nine percent of the commercial HMO and POS plans offer enrollees a choice of the five reversible medical contraceptive methods (oral contraceptives, the diaphragm, the IUD, the implant and the injectable) approved by the U.S. Food and Drug Administration (FDA). The remaining 21% include 15% that cover some but not all of the five methods and 6% that cover none (Table 1). Oral contraceptives, the leading reversible contraceptive method in the United States, are covered by 92% of HMO and POS plans. Coverage is much less extensive among PPOs: Only two of the seven responding plans cover all five methods.

In some cases, plans provide only partial coverage of methods. For instance, 97% of HMO and POS plans in the five states cover IUD insertion, but only 78% cover the device itself and only 89% cover removal.

All 27 Medicaid plans cover the entire range of contraceptive services, with the exception of the prescription of emergency contraception, for which 80% of plans reported coverage. Two Medicaid plans (7%) reported requiring that women pay part of the cost of contraceptive services (data not shown).

All plans, whether they serve commercial enrollees or Medicaid enrollees, cover testing of asymptomatic, high-risk individuals for the most common STDs (chlamydia, genital herpes, gonorrhea, human papillomavirus and syphilis) as well as HIV infection (Table 1), although their definitions of "high-risk"* tend to differ. Fewer plans, however, indicated that they not only *cover* testing but actually have a policy of *offering* such testing to enrollees considered at high risk. Approximately six in 10 commercial plans and seven in 10 Medicaid plans reported a policy of offering testing to asymptomatic, high-risk enrollees (data not shown).

Information Provided

Only one-half of commercial plans and one-third of Medicaid plans in the study regions reported that they routinely provide enrollees with a written list of the specific contraceptive methods covered by the plan (Table 2). Just 10% of commercial plans and 15% of Medicaid plans said that they routinely provide information on the conditions under which testing for HIV or other STDs is provided, even though all plans cover the testing itself.

Other related information is also provided infrequently. Very few commercial or Medicaid plans reported that they routinely notify enrollees that, for religious or personal reasons, some participating providers may not provide or refer for all covered contraceptive services. Thirteen percent of commercial plans and 39% of Medicaid plans provide enrollees with other written information relating to reproductive health services, generally either pamphlets on specific contraceptive methods or information on how to obtain family planning services.

Information disseminated by commer-

Table 2. Percentage of managed care plans that routinely provide information on coverage of contraceptive and STD services, by information provided and recipient, according to type of plan

Information and recipient	Commercial		Medicaid	
	N	%	N	%
Information provided				
Specific methods covered	49	49	26	35
Conditions for coverage of STD/HIV testing	48	10	26	15
Notification that some participating providers may not provide or refer for all covered services because of religious or personal reasons	48	4	26	4
Other reproductive health information	39	13	26	39
Direct recipients				
Spouse dependents	25	48	12	58
Other dependents ≥18	19	47	13	62
Other dependents <18	23	30	13	46

*Plans are most likely to classify individuals as being at high risk if they are sexually active, have multiple partners or have nonmonogamous partners; they are less likely to automatically include teenagers or individuals who are unmarried in the definition.

Table 3. Among women in managed care plans, percentage reporting lack of knowledge about contraceptive coverage and percentage citing particular sources of coverage information, all by type of plan (N=1,006)

Measure	Total	Commercial	Medicaid
Method coverage unknown			
Oral contraceptives	24	25	17***
Injectable	60	64	43***
IUD/insertion	66	67	60*
Implant/insertion	66	70	51***
Emergency contraceptive pills	70	72	58***
No written information on coverage	69	70	69
Major source of information on coverage			
Plan materials	19	22	4***
Doctor/nurse/staff	59	57	65**
Family/friends	2	1	7***
Other	9	10	5**
None	23	22	29**

*p<.05. **p<.01. ***p<.001. *Note:* Differences between enrollees of commercial plans and Medicaid plans were tested using a one-tailed z test. †Ns for commercial plans (472–503) and Medicaid plans (480–503) vary because of differential nonresponse on specific items.

cial plans is often provided only to the employee and not directly to family members who are insured as dependents on the employee's policy. About half of commercial plans provide information directly either to spouses or to other dependents aged 18 or older; about one-third provide information directly to dependents younger than 18. In the remaining plans, the written information is provided indirectly through the dependent's parents or spouse. Similarly, six in 10 of the Medicaid plans provide information directly to spouses or other dependents aged 18 or older; fewer than half provide information directly to dependents younger than 18. Logistic regression showed that women enrolled in managed care plans through their parents were less likely than those with their own coverage to have received any written information on plans' contraceptive coverage (odds ratio=0.21).

Information Obtained

Our telephone survey found that many women are unaware of their plan's policies. Although more than 90% of commercial plans in the areas studied cover oral contraceptives, 25% of women enrolled in the commercial plans said they did not know if this method is covered by their plan (Table 3). More than half the women did not know whether their plans cover hormonal injectables or implants, the IUD or emergency contraceptive pills.

Among Medicaid enrollees, 17% did not know about their plan's coverage of oral contraceptives, and 43–60% indicated they were unaware of whether their plans cover other methods. (Differences by type of plan in enrollees' knowledge of contraceptive coverage may reflect both differences in coverage of contraceptive methods and differences in the extent to which plans inform women of that coverage.) Approximately 70% of enrollees in the Medicaid and commercial plans reported having received no written information from their plan about its coverage of contraceptive services.

Enrollees in both commercial and Medicaid plans overwhelmingly identified medical providers as their main sources of information about plan coverage of contraceptive services (57% and 65%, respectively). Plan materials or brochures were much less likely to be cited as the woman's primary information source. More than one in five enrollees said they had gotten no information from either official or unofficial sources about their plan's coverage, with that proportion significantly higher among Medicaid enrollees (29%) than among commercial enrollees (22%).

Family Planning Agencies

Whether a community-based family planning provider is a participating provider in a managed care plan's network largely determines the provider's accessibility to plan enrollees. If the plans studied are typical, women enrolled in managed care plans almost always obtain contraceptive services from providers affiliated with their plan. Only 10% of enrolled women who had made a contraceptive visit had chosen an out-of-plan provider.

About three in four women (74%) who had made a visit for contraceptive services had chosen their provider from a plan list or used a provider directly affiliated with the plan. Another 16% had been assigned a provider by their plan—13% of women in commercial plans and 25% of those in Medicaid plans who had made a visit while in their plan. Only 12% of women—11% of those in commercial plans and 16% of those in Medicaid plans—reported having received family planning care from a clinic (data not shown).

Managed care plans serving commercial enrollees did not report extensive contracting with community-based family planning providers. Just over one-quarter reported having entered into contractual relationships with community-based family planning providers for the provision of contraceptive services, and 16% reported having contracted with such agencies to provide STD testing. Plans serving Medicaid enrollees were more likely than those serving commercial enrollees to report contracts with community-based family planning providers. Among these plans, 52% reported contracts to provide contraceptive services and supplies, and 46% reported contracts for STD testing (data not shown).

Although only a minority of managed care plans reported contracting with community-based family planning providers, almost half of all publicly funded family planning agencies reported having at least one contract with a managed care plan (Table 4). Among all family planning agencies, 46% reported that they had entered into at least one contractual relationship with a managed care plan—38% as part of overall primary care and 8% solely for the provision of contraceptive services and supplies.

This 46% included 5% with only commercial managed care contracts, 18% with only Medicaid managed care contracts and 23% with both commercial and Medicaid

Table 4. Percentage distribution of family planning agencies, by type of managed care contract, according to contraceptive client caseload and type of agency

Caseload and type of agency	N	Primary care	Contraceptive services	None	Total
All	**155**	**38**	**8**	**54**	**100**
Hospital	27	41	8	51	100
Health department	57	14	5	81	100
Planned Parenthood	14	20	20	60	100
Community health center	31	62	0	38	100
Independent agency	26	41	15	44	100
"General" (< 50% contraceptive clients)	**89**	**46**	**2**	**52**	**100**
Hospital	20	45	0	55	100
Health department	25	24	0	76	100
Planned Parenthood	0	0	0	0	100
Community health center	31	62	0	38	100
Independent agency	13	42	11	47	100
"Dedicated" (≥ 50% contraceptive clients)	**66**	**23**	**20**	**57**	**100**
Hospital	7	33	33	33	100
Health department	32	0	13	88	100
Planned Parenthood	14	20	20	60	100
Community health center	0	0	0	0	100
Independent agency	13	44	19	37	100

contracts (not shown). Thus, agencies were significantly more likely to have contracts to serve Medicaid enrollees than contracts to serve commercial enrollees (41% vs. 28%).

Of all contraceptive services–only contracts, 25% were to hospitals, 17% each to heath departments and Planned Parenthood affiliates and 42% to independent agencies. No community health center reported a contract solely for the provision of contraceptive services. Of the managed care contracts specifically for contraceptive services, 15% were to agencies at which contraceptive clients make up less than half the caseload (referred to here as "general" agencies) and 85% were to agencies at which contraceptive clients make up at least half the caseload ("dedicated" agencies).

Although the "dedicated" family planning agencies are no less likely than the "general" agencies to have at least some official affiliation with a managed care plan, the types of contracts they reported differ greatly. In all, 48% of "general" agencies have managed care contracts, including 46% that reported contracting for contraceptive services as part of general primary care and 2% that reported contracts specifically for contraceptive services (Table 4). The "dedicated" agencies reporting managed care contracts were about evenly divided between those that reported primary care contracts including contraceptive services (23%) and those that reported contracts specifically for contraceptive services (20%).

Among the "dedicated" family planning agencies, 33% of hospitals, 20% of Planned Parenthood affiliates, 19% of independent agencies and 13% of health departments reported having contracts solely for contraceptive services. Only independent agencies were more likely to have primary care contracts than to have contraceptive care contracts.

Direct Access to Services

To what extent are covered services easily accessible to enrollees? We examined plan requirements for enrollees to either obtain care from their primary care provider or seek that provider's approval to obtain care from a different provider.*

Most commercial plans require use of a gatekeeper to coordinate care; only 20% do not do so. Thirty-two percent of plans allow women to designate an obstetrician-gynecologist as their primary care provider, while 84% allow women to select, in addition to their primary care provider, a provider of gynecologic services from whom they can receive at least some services without having to obtain a referral. Twenty-eight percent of plans afford women both options, leaving only 9% that make no accommodations at all for direct access.

All Medicaid plans require the enrollee to designate (or be assigned in the absence of an enrollee designation) a primary care provider. One-third of Medicaid plans make no provisions for direct access to gynecologic services in addition to the services available from a woman's primary caregiver.

Table 5. Percentage distribution of commercial plans, by whether enrollees can obtain contraceptive services without a gatekeeper referral, according to type of service

Service	No referral required	Referral required	Service not covered	Total
Contraceptive injection	52	27	21	100
Diaphragm	56	27	17	100
IUD insertion	54	27	19	100
IUD removal	56	27	17	100
Natural family planning instruction	56	27	17	100
Implant insertion	52	27	21	100
Implant removal	52	27	21	100
Prescription for oral contraceptives	67	23	9	100
Prescription for emergency contraception	42	25	33	100
Tubal ligation	60	33	7	100
Contraceptive counseling only	62	25	13	100
STD testing	71	29	0	100

Notes: Some plans included here allow a woman to select an obstetrician-gynecologist as her primary care provider or do not require a woman to have a primary care provider. †Ns vary from 51 to 53 because of differential nonresponse on specific items.

In both commercial and Medicaid plans, allowing women to select a separate provider of gynecologic care is the most common approach taken to ease access to those services; however, nearly two-thirds of commercial plans that allow women to obtain such care without referral limit that access. Of commercial plans that use the separate-provider model, 51% limit the number of visits, generally to one per year. In addition, 64% of commercial plans using the separate-provider model allow direct access only for specific services, most often routine preventive care.

When we consider both coverage of individual contraceptive methods and direct access to contraceptive services (including plans in which the primary care provider may be an obstetrician-gynecologist and plans that do not require a primary care provider), approximately half of commercial plans allow at least some direct access to contraceptive services (Table 5). The remaining commercial plans either do not cover the specific service or cover the care but do not provide direct access to contraceptive services other than those obtained from the woman's primary care provider. (Differences between methods probably result from differences in coverage; plans are unlikely to provide direct access to some covered methods but not to others.)

Some plans that require enrollees to designate a primary care provider make provisions for enrollees to obtain certain services without involving that provider. Twenty-one percent of commercial plans and 36% of Medicaid plans that generally require a referral for contraceptive services nonetheless allow the enrollee to obtain that referral on a confidential basis directly from the plan. Seven in 10 commercial plans and nine in 10 Medicaid plans that allow direct access to at least some contraceptive services indicated that they would honor a request that the woman's primary care provider not be notified of services obtained through direct access to another caregiver (data not shown).

Problems in Access to Care

About one in three managed care enrollees (33% of commercial enrollees and 28% of Medicaid enrollees) reported encountering difficulties in obtaining contraceptive services through their plan (Table 6, page 210). Women aged 18–19 were more likely than older women to report having had access problems (not shown).

One of the most common access problems is waiting time for contraceptive services. Thirteen percent of commercial enrollees and 7% of Medicaid enrollees reported waiting at least four weeks. Another frequently reported problem involves choice of providers: Eight percent of commercial enrollees and 13% of Medicaid enrollees said they were not allowed to choose their own provider, even though the choice of a provider was important to them.

Because copayments may impede low-income women from seeking care, the federal Medicaid statute prohibits the imposition of cost-sharing requirements for family planning services. Nonetheless, 9% of Medicaid enrollees reported that they

*Almost all enrollees said it is important to them to be able to choose the doctor or clinic from whom they receive birth control services, and 38% would prefer to go to a different provider than the one they see for their general medical care.

Table 6. Percentage of women in managed care plans who reported access or service problems regarding contraceptive care, by type of plan

Problem	Total	Commercial	Medicaid
Had any problem	32	33	28
Waited at least four weeks for appointment	12	13	7***
Was not allowed to choose birth control provider	9	8	13**
On Medicaid, but paid some/all of cost for last pills	na	na	9
Believed plan paid none of method's costs	7	8	2***
Had difficulties obtaining/continuing method because of plan	5	6	2**
Tried, but made no visit because of access issue	3	3	1*
Planned no visit because of access issue	2	2	0**
Was dissatisfied with way staff explained/answered questions	2	2	5**
Had difficulties with referral/ authorization for last visit	2	2	0*
Discontinued method while in plan partly because of cost	1	1	3**
Was dissatisfied with privacy of care during last visit	2	1	6***
Was concerned about billing confidentiality	0	0	na

*Different from commercial at p<.05. **Different from commercial at p<.01. ***Different from commercial at p<.001. *Note:* na=not applicable, because question not asked.

had paid some or all of the cost for their last package of oral contraceptives. A sizable number of women—8% of commercial enrollees and 2% of Medicaid enrollees—reported that they would have been interested in obtaining a contraceptive method but were concerned about cost and believed that their plan did not cover the method's costs (The data do not indicate whether this is an information problem or a coverage issue.)

The women also reported other types of problems and concerns. Six percent of Medicaid enrollees said they had not been satisfied with the privacy of care during their last contraceptive visit; this concern was echoed by 1% of commercial enrollees. In addition, 5% of Medicaid enrollees and 2% of commercial enrollees were dissatisfied with the way staff had explained issues or answered questions during a previous visit. Six percent of commercial enrollees and 2% of Medicaid enrollees had had difficulties in obtaining or continuing contraceptive use because of cost, coverage or another aspect of the plan's procedures.

Although only 15% of women who made a contraceptive visit reported needing a referral to go to their provider of contraceptive services, 22% of those women (25% of those in commercial plans and 6% of those in Medicaid plans) said that the need for a referral caused difficulties for them (data not shown).

Discussion

Four major concerns emerge from our examination of contraceptive coverage under managed health care. More than one in four plans in our study do not cover all five FDA-approved reversible medical methods, and a few cover none at all. Coverage of the full range of contraceptive methods is crucial if the method a woman chooses is to be the one most appropriate for her and the one she is most likely to use successfully. Clearly, full coverage of methods is a prerequisite to service availability, and it is primarily the responsibility of employers, as purchasers of group plans for their employees, to recognize the importance of this care and ensure that all reversible contraceptives are covered. This added coverage would cost employers only about $17.00 per employee per year, an average increase of less than 1% in health insurance premiums.[16]

Coverage, however crucial it may be, is only the first step. Although enrollees need to be adequately informed of the services covered under their plan, only half of the commercial plans and one-third of the Medicaid plans studied provide enrollees with a list of covered methods. Even fewer routinely inform enrollees of the conditions under which testing for HIV and other STDs is covered or provide a warning that some providers may object to providing contraceptive care.

Equally disturbing, when managed care organizations do provide this type of information, they often give it only to the enrollee and do not also send it directly to an enrollee's spouse or dependent children, even if they are the people for whom it may be most relevant. Given the sensitive nature of contraceptive and STD services, information provided through a spouse or parent may not always be received by the people most in need of it: Women enrolled through their parents were less likely than those enrolled on their own to report having ever received written information about their plan's contraceptive coverage.

The lack of a concerted effort on the part of plans to inform enrollees efficiently about their contraceptive options may be related to enrollees' apparent low level of knowledge about their plan's coverage. While most enrollees in commercial plans knew whether their plan covered oral contraceptives, a majority did not know whether their plan covered other methods, including hormonal injectables; fewer Medicaid enrollees were uncertain about coverage of injectables, but many did not know their plan's policies about hormonal implants or the IUD. In addition, few enrollees reported that plan materials were their major source of information about plan coverage of contraception, and most indicated that they had received no materials from the plan regarding contraceptive services and supplies.

Managed care organizations seeking to promote access to contraception may want to give serious consideration to including community-based family planning providers in their provider networks. These agencies have a long history of successfully providing high-quality, low-cost contraceptive services to hard-to-serve populations such as low-income women and teenagers. Further, negotiating agreements with community-based providers may offer important leverage to managed care organizations seeking to demonstrate to state Medicaid programs that they have the capacity to serve this population. Clearly, managed care plans are not using this important resource to their full advantage.

Finally, managed care organizations should determine whether their own policies and procedures impede enrollees' access to timely contraceptive care. Recognizing that women view reproductive health care as central to their overall health care, many managed care organizations have taken at least some steps to facilitate access to reproductive health services. For example, some plans give women the option of designating an obstetrician-gynecologist as their primary care provider. (Several states, including California, require plans to offer women this option.) Because obstetrician-gynecologists are more likely than other types of primary care providers to provide a full range of reproductive health care services, allowing a woman to designate one as her primary care provider is an important way to ease access to these services.

Some plans provide women with direct access, without having to obtain a referral from a gatekeeper, to a separate provider of gynecologic care. (Again, several states, such as Colorado, require this option.) Several plans give women both options, while some provide neither.

Although most plans provide some direct access, few make this benefit open-

ended. Most limit direct access to routine gynecologic care, either by covering only an annual well-woman visit on a direct-access basis, or by limiting the care to one or two visits a year.

While direct-access provisions may help women obtain routine gynecologic care on a predictable annual timetable, their usefulness in easing access to contraceptive services is more limited. Some plans, however, have addressed these issues by developing referral procedures that protect the privacy of a woman who has received care from a provider other than her primary care provider.

Echoing complaints now being widely raised about managed care in general, one-third of the women in our study reported a problem in obtaining contraceptive services. Women aged 18–19, a group for whom the consequences of not being able to receive timely care may be particularly acute, were more likely to report access difficulties than were older women.

Although many problems were reported by very small percentages of women, more than one managed care enrollee in 10 reported having to wait at least four weeks for an appointment for contraceptive services. (In contrast, a new client seeking contraceptive services from a community-based family planning agency waits an average of 10 days from the time she schedules the exam until the day of her appointment.[17]) Delays in contraceptive care can cause difficulties for the plan as well as for a woman and her family.

The women surveyed also felt strongly that they would prefer to choose their own provider of care. One in 10 were instead assigned a provider for birth control services, and these women viewed their lack of choice as problematic.

The assessment of Medicaid managed care plans is mixed. On some issues—the range of methods covered and the accessibility of services from outside the plan's network—Medicaid plans are superior to their commercial counterparts. Yet, both coverage of contraception and out-of-plan access are required by federal law, highlighting the importance of the legal protections afforded by this program. On other issues, such as the information provided to enrollees or the accessibility of care within a plan, Medicaid plans were similar to, or worse than, commercial plans.

Finally, despite the federal Medicaid statute's unambiguous prohibition of cost-sharing for family planning services, almost one in 10 women enrolled in Medicaid plans reported out-of-pocket costs for contraception, and some plans serving Medicaid enrollees reported charging women fees for contraceptive services. Such reports merit careful examination by the plans and the state Medicaid programs that contract with managed care plans to serve program enrollees.

Not all these problems in access to contraceptive services in the United States are specific to managed care. In many respects, such as the basic issue of coverage of the range of FDA-approved reversible medical contraceptives, managed care systems are superior to traditional fee-for-service coverage. Nonetheless, our findings clearly indicate some steps that both purchasers and plans can, and should, take to improve the coverage and availability of contraceptive services.

It is important to remember that our findings may not represent current conditions in the nation as a whole. The study areas selected stand out in three key respects: the depth of their experience with managed care, their organized and sophisticated family planning provider networks, and the special emphasis their state Medicaid programs have placed on ensuring that family planning services are accessible to enrollees. As a result, the experiences of these study areas should be taken as harbingers of the types of problems and issues other areas are likely to encounter as managed care becomes more dominant.

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