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Rounding Out the Contraceptive Coverage Guarantee: Why 'Male' Contraceptive Methods Matter for Everyone

By Adam Sonfield

One of the highest profile pieces of the Affordable Care Act (ACA) is the contraceptive coverage guarantee, which requires most—and eventually almost all—private health plans in the United States to cover the full range of contraceptive methods and services, as prescribed for women, without copayments, deductibles or other out-of-pocket costs. Contraception is one of dozens of preventive health services afforded this protection under the ACA.

In response to growing evidence of problems with how some insurance plans have interpreted and implemented the contraceptive coverage guarantee, the federal government issued new guidance in May providing more clarity about health plans' obligations.[1] Most notably, the guidance lists 18 distinct methods of contraception used by women—as identified by the U.S. Food and Drug Administration (FDA)—that all plans must cover.

Yet, two additional methods identified by the FDA continue to be left out: Under the Obama administration's interpretation of the contraceptive coverage guarantee, private plans are not required to provide cost-sharing-free coverage of methods used by men, which currently means vasectomy and male condoms, but could include others if any of the male methods in development ever end up on the U.S. market. This interpretation interferes with the reproductive health decisions of individuals and couples, which could put women at greater risk of unintended pregnancy and undermine their health. And it benefits no one—not men, not women, not families, not health plans.

HIGHLIGHTS

- *Contraceptive methods used by men—currently, vasectomy and male condoms—provide preventive health benefits for women, by helping them to prevent unplanned pregnancies and space wanted ones.*
- *Vasectomy and condoms were left out of the Affordable Care Act's guarantee of contraceptive coverage without out-of-pocket costs, despite their proven health benefits and long history of inclusion in other public and private programs.*
- *There are multiple potential pathways to rectify this oversight, most notably state-level actions to clarify and expand the ACA's guarantee, and new recommendations from the U.S. Preventive Services Task Force; however, all of those have obstacles.*

The Source of the Problem

The ACA's requirement that private health plans cover a range of preventive services without out-of-pocket costs is tied to four sets of recommended services. Two of those sets of recommendations apply broadly to people regardless of age, sex or other characteristics: those from the U.S. Preventive Services Task Force (USPSTF) and from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Yet, members of Congress recognized that those two sets of recommendations were too limited to serve as the sole basis for private insurance coverage of preventive services. So, they added in two additional sets of recommendations to fill in some of the clear gaps that they and outside experts identified. This is where the problem of excluding contraceptive methods used by men began.

To fully meet the numerous preventive health needs of children, Congress turned to guidelines written by the American Academy of Pediatrics and supported by the Health Resources and Services Administration (HRSA), a branch of the U.S. Department of Health and Human Services. And to fully meet the preventive health needs of women, they added in another set of HRSA-supported guidelines. That latter set of recommendations did not yet exist when the ACA was being drafted; instead, HRSA commissioned a panel of the Institute of Medicine to study the issue and identify the gaps that needed to be filled.

As the authors and proponents of that piece of the ACA hoped and expected, the Institute of Medicine panel's recommendations for women's preventive care included "the full range of Food and Drug Administration–approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity." It did not list out the specific methods. In adopting these recommendations and establishing what is commonly referred to as the federal contraceptive coverage guarantee, HRSA concluded that because the law refers to preventive care "with respect to women," methods used by a man—such as vasectomy and male condoms—could not be included.

Notably missing from the preventive services provision is anything to meet the needs of adult men, beyond the limited recommendations of the USPSTF and the immunizations committee. That was not a decision rooted in some sort of animus against men. Rather, lawmakers' and advocates' focus on women's health issues was in response to their historical neglect. Many services needed primarily or exclusively by women—including maternity care and contraception—had been excluded or covered unfavorably by health plans, and federal and state policymakers had attempted to address those disparities repeatedly over recent decades. The ACA's provision was a culmination of those efforts. By contrast, there are few health care services that are exclusively or primarily needed by men, and few high-profile gaps in coverage for such services.

Why Methods Used by Men Matter

One basic truth for reproductive health advocates when talking about the contraceptive coverage guarantee is that contraceptive methods are not interchangeable. Methods differ dramatically in their effectiveness, both on average and depending on the experience of individual users. Moreover, contraceptive needs and choices are influenced by concerns about and experiences with side effects and drug interactions, how frequently individuals expect to have sex, their perceived risk of STIs, worries about confidentiality and control, and a host of other factors. Women who are not completely satisfied with their choice of a method are particularly likely to use it inconsistently or incorrectly, or to experience gaps in use.[2] For these reasons, people need unfettered access to not just any method of contraception, but to the one most suitable for their individual needs and circumstances at any given time in their reproductive lives.

Vasectomy and male condoms have advantages and disadvantages that crystallize that argument. Only 15 out of every 10,000 couples will experience an unplanned pregnancy in their first year of relying on vasectomy.[3] That places vasectomy among the most effective contraceptive methods available—second only to the contraceptive implant in its theoretical ("perfect use") and everyday ("typical use") failure rates, and slightly superior to the hormonal and copper IUDs and female sterilization. And according to the most recent comparison of methods' cost-effectiveness, vasectomy comes out on top by the third year of use—edging out the hormonal and copper IUDs and the implant, and about four times as cost effective as female sterilization.[4] Vasectomy is also less invasive and carries fewer risks than female sterilization.

Male condoms are another important contraceptive option. In typical use, they are considerably less effective than most other forms of modern contraception. Among couples relying on condoms, 18% experience an unplanned pregnancy in their first year, in large part because of inconsistent use; if used consistently and correctly, that rate drops to only 2%.[3] Male condoms have several well-known disadvantages—particularly,

many men and women dislike using them and feel they interfere with sexual enjoyment. Yet, male condoms have two key advantages over most other methods. First, they provide effective protection against the transmission of HIV and many other STIs. Second, they are convenient: available without a prescription or a medical appointment and in a wide array of drug stores and other retail locations. Because of that mix of pros and cons, many health care providers recommend male condoms as one part of a "dual use" regimen—that is, paired with a prescription method that provides more reliable pregnancy protection.

Both methods are widely used in the United States, with 15% of female contraceptive users relying on male condoms and 8% relying on their partner's vasectomy as their primary method of contraception (see chart).[5] Together, that amounts to about nine million U.S. women relying on these methods. By contrast, 26% of contraceptive users rely on the pill, 25% on female sterilization and 10% on the hormonal or copper IUD. Male condom use is particularly common among teens and young adults, who are at highest risk of STIs.[6]

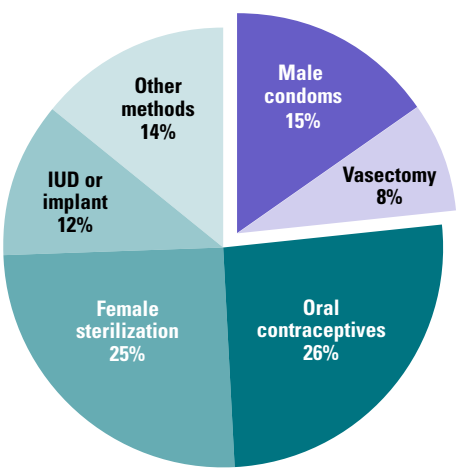
The exclusion of methods used by men from the contraceptive coverage guarantee has real-world public health implications. Contraception enables people to prevent unplanned pregnancies, and to plan and space those they do want. Prevention and planning, in turn, decreases pregnancy-related illness, injury and death; reduces the chances of premature and low-birth-weight deliveries; and is linked to improved prenatal care and breastfeeding.[7] Those positive health consequences still accrue to women and their children, regardless of whether it is the women or their male partners who technically use the method. For that reason alone, HRSA could have legitimately labeled vasectomy and male condoms as preventive services for women.

Instead, as currently interpreted, the ACA's contraceptive coverage guarantee fails to fully eliminate financial barriers to the contraceptive choices of individuals and couples. Specifically, it creates a financial incentive for couples to choose female over male sterilization, by eliminating cost-sharing for the former but not the latter. Female sterilization is already three times as popular as vasectomy in the United States, and this financial incentive might exacerbate the gap. Because female sterilization is more invasive than vasectomy and has higher (although still very low) health risks, the incentive is a disservice to women. And because vasectomy is considerably more cost-effective than female sterilization, the incentive is not good for health plans either.

Excluding methods used by men from the contraceptive coverage guarantee also sends a message reinforcing the all-too-common cultural attitude that contraception is solely a woman's responsibility. Many women do favor contraceptive methods that they can control and possibly even conceal from their partners, and some experience attempts by partners to interfere with their contraceptive use.[8] Yet, many women also express a desire for their partner to be more involved in pregnancy planning and prevention. And there is indirect evidence suggesting that better communication between partners and better partner involvement in contraceptive decision making could result in more consistent and effective contraceptive use.

A BIG SLICE OF THE PIE

Roughly one-quarter of female contraceptive users rely on methods used by their partners—male condoms or vasectomy—as their most effective means of preventing an unplanned pregnancy.



Source: Centers for Disease Control and Prevention.

An Out-of-Step Policy

Treating contraceptives differently based on whether they are used by women or men is at odds with numerous other long-standing policies and practices. In private insurance before the ACA, for example, plans covered vasectomy and tubal ligation at virtually the same rates, according to a pair of Guttmacher Institute studies from 1993 and 2002.[9]

Medicaid, too, has treated male and female methods the same: All are considered family planning services, and family planning services must be exempt from cost-sharing under every state's program. Almost all state Medicaid programs cover both male and female sterilization, and most cover male condoms—for both women and men.[10] Generally, the client needs a prescription for the condom to be covered by Medicaid, although a few states have mechanisms in place to reimburse pharmacists for over-the-counter purchases.[11]

Further precedents for equal coverage of male and female contraceptive services come from the family planning–specific Medicaid expansions that are in place in about half the states.[12] Most of these expansions cover men as well as women. And that principle of equity has been endorsed by the Centers for Medicare and Medicaid Services (CMS): In implementing a provision of the ACA that gave states the option to initiate a Medicaid family planning expansion (without having to obtain a "waiver" from federal law, as had been the case before the ACA), CMS has made it clear that states are required to include men in these expansion programs.

Similarly, methods used by men and family planning services provided to men are core components of the Title X family planning program. Male condoms are routinely provided at no cost or at a steep discount to both female and male clients. And recommendations for providing quality family planning care—released in 2014 by the Centers for Disease Control and Prevention and the Office of Population Affairs—include guidance on vasectomy and male condoms alongside other contraceptive methods, as well as detailed guidelines about how to serve both female and male clients.[13]

Potential Solutions

At least in theory, there are multiple routes to making the ACA's contraceptive coverage guarantee encompass contraceptive methods used by men and to put it in line with these precedents, the evidence and common sense. These options, however, are by no means equal in their potential impact or their feasibility.

Congress. One potential source of a fix is Congress, which could enact legislation that explicitly includes the full range of contraceptive methods—male or female—under the preventive services provision. However, given the current conservative leadership and majorities in both chambers of Congress that oppose the ACA itself, attempts to undermine contraceptive coverage are more likely than attempts to bolster it. A second option might be to add a fifth category of preventive services—an expanded group of preventive services for men—into the ACA's provision. But that would require health advocates to identify a convincing range of prominent gaps in the current preventive services list for men (aside from vasectomy and male condoms) and rally political support around that list—an unlikely prospect.

The administration. Another potential fix could come from the Obama administration. It could adopt a different interpretation of the ACA provision and define methods used by men as preventive care for women. That would require the administration to amend its current public stance—not something it would do lightly. Congressional supporters of contraceptive coverage could try to prompt such a change through communications with the administration.

Health plans. Health plans themselves could be the source of a solution—at least in part. It serves no purpose for plans to favor female over male sterilization, given that vasectomy is the less expensive and less invasive option for a couple. From that perspective, it seems surprising that health plans—which have the authority to go beyond the basic requirements of the ACA—have not yet acted on their own to level that playing field. In fact, some plans have taken a similar step by eliminating cost-sharing for men's preventive care visits, to put that benefit in line with the ACA's

requirement to cover well-woman visits without cost-sharing. Reproductive health advocates may be able to convince health plans to act on vasectomy through behind-the-scenes education, by influencing negotiations between plans and large employers and unions, or by exerting public pressure. A similar effort around male condoms would be more difficult, as they are not typically covered at all by private insurance, and health plans may fear that they will end up simply paying for condoms that people would otherwise pay for out of pocket, rather than actually helping to increase condom use.

The states. State legislatures and insurance regulators are another potential avenue for a piecemeal approach to the problem. For example, in 2014, California legislators and advocates—led by the California Family Health Council and the National Health Law Program—pushed for a law to clarify and bolster the ACA's contraceptive coverage guarantee. That law was enacted, but only after stripping out a requirement that plans cover without cost-sharing methods used by men.[14] The sticking point in California was an obscure provision of the ACA that requires states to cover the costs of any new mandates for plans subject to the essential health benefits (EHB) standards, which apply to small group and individual market plans. Lawmakers feared that extending the contraceptive coverage guarantee to methods used by men would count as a new mandate and trigger those costs.

This problem is not insurmountable. For instance, states could avoid the new costs by expanding the contraceptive coverage guarantee only to plans exempt from the EHB standards, such as those purchased by large employers;[15] however, that would dilute the impact of the state's action. And even without that limitation, states are unable to regulate health plans offered by employers that self-insure (i.e., take on the financial risks themselves)—and that amounts to about six in 10 covered workers.[16] Despite these limitations, if enough states were to impose requirements affecting a substantial number of health plans, it could have ripple effects across the entire insurance industry—something that was true of the first state contraceptive coverage laws enacted in the late 1990s and early 2000s.[17]

U.S. Preventive Services Task Force. Perhaps the most promising approach to achieving equitable coverage of all contraceptive methods is through the USPSTF. Under the ACA, any positive recommendation from that body is automatically incorporated into the preventive services requirement, after a one-year grace period. And there is precedent for the task force correcting a disparity of this sort: The Institute of Medicine panel recommended routine HIV screening for women, going beyond what the USPSTF at the time was recommending (HIV screening for individuals at high risk). That resulted in better protections for women's HIV screening than for men's, which was corrected when the USPSTF revised its own recommendations in 2013.

There is ample evidence to support a recommendation for contraceptive use to prevent unintended pregnancy and improve pregnancy spacing. The USPSTF could address that issue on its own; in fact, it did have a recommendation for contraceptive counseling in the 1990s, but allowed it to lapse under the George W. Bush administration. Alternatively, members of the public can nominate a topic for the task force to review.

As it happens, a recommendation on contraception from the task force would also provide further public support for contraception as preventive care, and would insulate the contraceptive coverage guarantee from politics under future administrations. But regardless of the approaches that advocates and policymakers take to bolstering contraceptive coverage, it is time that vasectomy, male condoms and any future methods used by men stop being treated as second class methods just because they are used by men. ■

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