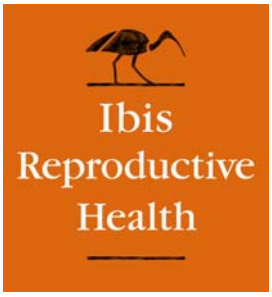

Young adults & the coverage of contraceptive services in the wake of health care reform

Results from an assessment of young adult-targeted health plans in the Commonwealth of Massachusetts

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About Ibis Reproductive Health
Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide. We accomplish our mission by conducting original clinical and social science research, leveraging existing research, producing educational resources, and promoting policies and practices that support sexual and reproductive rights and health.

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REaDY

(Reproductive Empowerment and Decision Making for Young Adults)
An initiative to prevent unplanned pregnancy and promote sexual health

A coalition of Massachusetts health service providers, advocates, and researchers are collaborating on a unique, statewide project to reduce unplanned pregnancy among young adults in the wake of health care reform in the Commonwealth. This multi-pronged initiative is focused on better understanding the individual, community, provider, and structural factors that influence the contraceptive behaviors of young adults aged 18 to 26 and on developing strategies to ensure that this age group has the resources they need to lead healthy sexual and reproductive lives. This includes making decisions about whether and when to become parents. The first year of the initiative involves formative research, the results of which will inform actions undertaken in the second year to improve the health care system and better prepare health service providers to care for young adults. REaDY promises to offer a model for addressing pregnancy prevention and planning for young adults at the state level. Research findings and lessons learned will also inform national health care reform efforts.

REaDY is led by an Executive Committee of multiple organizations and agencies within the Commonwealth. Ibis Reproductive Health is leading the formative research component, and the statewide, multi-agency taskforce is chaired by the Massachusetts Department of Public Health Family Planning Program and coordinated by the Pro-Choice Massachusetts Foundation. Other Executive Committee members include the Massachusetts Family Planning Association, youth development specialist TiElla Grimes, and the Boston Public Health Commission.

Table of contents

Acronyms, abbreviations & key terms

BCBS-MA	Blue Cross Blue Shield of Massachusetts
Chapter 58	Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care*, also referred to as the Health Care Reform Law.
Commonwealth Care	Established through Chapter 58, the Commonwealth Care Health Insurance Program provides subsidized insurance to Massachusetts residents who meet income and other eligibility requirements. The program is administered by the Health Connector.
Commonwealth Choice	Established through Chapter 58, Commonwealth Choice is an unsubsidized offering of six private health plans selected by competitive bidding and available through the Health Connector.
Commonwealth Connector website	A website developed by the Health Connector to provide MA residents with information about health care reform and to help consumers find health insurance (www.mahealthconnector.org).
EC	Emergency contraception
FAQs	Frequently asked questions
FCHP	Fallon Community Health Plan
FDA	Food and Drug Administration
FPL	Federal Poverty Level
HNE	Health New England
HPHC	Harvard Pilgrim Health Care
Health Connector	Commonwealth Health Insurance Connector Authority, an independent state agency responsible for implementing various aspects of health care reform and connecting Massachusetts residents to health care coverage.
HMO	Health Maintenance Organization
IUD/IUS	Intrauterine device/Intrauterine system
LARC	Long acting reversible contraception
MassHealth	A public health insurance program for low- to medium-income residents of Massachusetts. MassHealth combines Medicaid and the State Children's Health Insurance Program into one program.
MCC	Minimum Creditable Coverage
MDPH-FPP	Massachusetts Department of Public Health Family Planning Program
NHP	Neighborhood Health Plan
OCPs	Oral contraceptive pills
QSHIP	Qualified Student Health Insurance Program
REaDY Initiative	Reproductive Empowerment and Decision Making for Young Adults Initiative
Rx	Prescription drug
SHP	Student Health Program
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
Tufts	Tufts Health Plan
YAP	Young Adult Plan

Executive summary

Background

Massachusetts's Health Care Reform Law (Chapter 58) represents a ground-breaking effort to increase access to affordable, high quality health care. Passage of the law in 2006 set in motion a series of reforms that considerably reduced the uninsurance rate, including individual and employer "mandates," expansions of subsidized care, and market reforms. Chapter 58 and subsequent revisions established the Commonwealth Health Insurance Connector Authority (the Health Connector), an independent state agency responsible for implementing various aspects of health care reform, establishing coverage standards, and connecting individuals and small businesses to affordable health insurance plans. The Health Connector also administers two health insurance programs: the subsidized Commonwealth Care program and the unsubsidized Commonwealth Choice program. The Health Connector's website (www.mahealthconnector.org) provides information about health care reform and helps residents find affordable coverage.

Young adults, a population that has historically been disproportionately uninsured and faces a high rate of unintended pregnancy, have been proactively incorporated into health care reform efforts. In Massachusetts, there are two types of plans that have been specifically designed to provide young adults with affordable health insurance: the Student Health Program (SHP) and the Young Adult Plans (YAPs). The SHP (formerly called the Qualified Student Health Insurance Program) was enacted in 1988 and mandates that students enrolled at least 75 percent time in institutes of higher learning participate in a qualified student health insurance program or provide proof of comparable coverage. The YAPs developed out of Chapter 58 and are part of the unsubsidized Commonwealth Choice program. The YAPs are available to young adults aged 18 to 26 who are not eligible for a subsidized plan and are not offered an employer health benefit. Enrollment in either a YAP or a SHP plan satisfies the individual mandate. However, in an effort to limit the cost of these plans, both the SHP and the YAPs have been exempted from providing some of the services included in the Minimum Creditable Coverage (MCC) standards required of qualifying health plans in the Commonwealth. These exemptions, particularly the prescription drug benefit exemption, raise concerns about the degree to which young adults' contraceptive and other sexual and reproductive health (SRH) needs are being met.

Study objectives

The main aim of this project was to conduct a rigorous, systematic review of health plans targeting young adults in Massachusetts to determine the plans' coverage of contraceptive services and counseling. To place these findings in context we also reviewed the plan materials for information about a range of other SRH services in order to address the following key questions:

- What contraceptive and other SRH services are available to young adults in Massachusetts through different young adult-targeted plans, as reported in publicly available materials?
- What information about the coverage of contraceptive and other SRH services is publicly available to young adults and how comprehensive and user-friendly is that information?
- Have the design and structure of young adult-targeted plans created new and/or unintended barriers to young adults seeking contraceptive services?
- If systems barriers do exist, how might they be addressed in the wake of health care reform in the Commonwealth?

Methods

From November 2008 through March 2009, our study team conducted a systematic review of publicly available information about 19 health plans targeting young adults in Massachusetts. The sample consisted of all 12 YAPs and the SHPs of seven colleges and universities, purposively selected for their variation in geographic location, size, source of funding, religious affiliation, and two- vs. four-year degree granting status. We obtained information from the Commonwealth Connector website, the websites of the six health insurance carriers that offer YAPs, and college and university websites. We reviewed all available materials to identify:

1. **The types of contraceptive & other SRH services covered**. We assessed publicly available materials for information about the coverage of contraceptive counseling and services, including any reference to specific methods of contraception. We also reviewed materials for information about other SRH services including prenatal, maternity, and postnatal care, abortion care, infertility services, HIV/STI testing and treatment, and services for sexual assault survivors.
2. **The costs associated with various SRH services**. We collected information about the premiums, deductibles, co-payments, and co-insurance associated with each plan and identified the costs associated with different "categories" of SRH services. For contraceptive services, we sought information about the costs associated with contraceptive counseling, non-prescription contraceptives, prescription contraceptives, and contraceptive procedures.
3. **The type & location of the facility providing contraceptive & other SRH services**. We systematically reviewed the plan materials for information about the type(s) of facilities that provide referenced contraceptive and other SRH care, as well as the location of these facilities if external to or separate from the principal facility.
4. **The comprehensiveness & accessibility of information provided by the plans**. In reviewing the materials, we conducted a "global assessment" of the information available to a young adult seeking information about contraceptive and other SRH coverage. This assessment was based on a variety of factors including level of detail, ease of navigation and information retrieval, and complexity of language.

We conducted a content analysis of all collected information based on the presence or absence of information using *a priori* (i.e., pre-determined) categories and codes. Further, we used open analysis techniques to make global assessments of the information's accessibility.

Key findings

The results of this study raise concerns that young adult-targeted health plans may not provide a full range of contraceptive services. Specifically, YAPs that do not offer a prescription drug benefit fail to provide coverage for prescription contraceptive methods. This lack of prescription contraceptive coverage raises important questions about gender (in)equity in health care financing. Publicly available information about the YAPs' coverage of contraceptive and other SRH services is limited, not highlighted, and difficult to find. Although the SHP plans provided more robust information about the coverage of contraceptive and other SRH services, our results suggest that students enrolled at some religiously-affiliated colleges may face barriers to obtaining contraceptive services. Students who are eligible for enrollment in the SHP are barred from enrolling in the Commonwealth Care plans and young adults who are offered an employer health benefit are ineligible for enrollment in the YAPs. These criteria make it difficult for a young adult who is eligible for a plan that excludes contraceptive services to enroll in an affordable alternative. Our findings indicate that young adults may be unaware of the limitations in their plans and may also lack information about where affordable services are offered.

Recommendations

- **Create information resources to help young adults understand & navigate coverage in the YAPs.** Information about young adult-targeted health plans, in general, is often difficult to navigate and contraceptive coverage is often unstated or unclear. It is critical that information about coverage in the YAPs be transparent, accessible, and youth-friendly.
- **Address the "gaps" in the YAPs by ensuring contraceptive coverage.** Keeping the cost of YAPs low by exempting plans from providing a prescription drug benefit has important implications for young adults' access to contraceptive services and raises concerns about gender (in)equity in health care financing. Possibilities for addressing these gaps include 1) requiring that all YAPs meet the prescription drug benefit component of the MCC standards; 2) revising the MCC standards such that young adult-targeted plans must include coverage of a "young adult formulary" (which would include prescription contraceptives) in order to meet the individual mandate; or 3) extending subsidized coverage of family planning services through the Massachusetts Department of Public Health Family Planning Program (MDPH-FPP) to young adults who are effectively underinsured for the purpose of preventing pregnancy.
- **Develop mechanisms for providing contraceptive services to underinsured young adults.** If a young adult is enrolled in a YAP with no prescription drug benefit, a SHP plan that does not provide contraceptive services, or a religiously-affiliated health plan through their employer, for example, she may satisfy the individual mandate but be underinsured with respect to contraceptive care. Meeting these young adults' contraceptive needs is imperative. Possibilities for consideration include extending eligibility for subsidized services through the MDPH-FPP and easing eligibility requirements for Commonwealth Care plans.
- **Require health plans to disclose limitations & exclusions, including restrictions on contraceptive coverage.** As of June 1, 2009, the SHP plans are required to provide information regarding benefits and covered services, including all limitations and exclusions. This effort is commendable and serves as a model for ensuring transparent communication about the services, including contraceptive counseling and care, that are (and are not) covered. It is imperative that all young adults, not just students, be made aware of any contraceptive exclusions in qualified health plans. We recommend that disclosure requirements be extended such that all plans, including those that are religiously-affiliated, are required to disclose any departures from the MCC standards as well as any other limitations or exclusions. Complete, accurate, and accessible information should be provided to both current and potential enrollees. The Commonwealth Connector website should also provide information about any exclusions pertaining to the Commonwealth Care and Commonwealth Choice plans (including the YAPs) as well as information about affordable alternatives.
- **Collect more robust data on young adults & health care reform.** The Health Connector should collect more data on young adults in the context of health care reform, including their enrollment patterns, health services utilization, and uninsurance rates, as well as demographic information about those enrolled in a YAP or other young adult-targeted plan.
- **Learn from the experiences & perspectives of clinicians & young adults.** Although our study reveals important information from the systems perspective, it is critical that we learn from and listen to both clinicians and young adults. Over the next few months, the REaDY Initiative will be conducting research with clinicians who provide care to young adults, as well as with young adults who are enrolled in different types of health plans. We expect to have preliminary findings from both studies available in the fall of 2009.

Setting the context

An overview of health care reform in the Commonwealth

Massachusetts has long been committed to ensuring access to health care for all of its residents [1]. Yet, in the mid-2000s, approximately 500,000 Massachusetts residents were uninsured. Moreover, the rising costs of health care and concerns about access, quality, and disparities prompted renewed multi-stakeholder efforts to promote health care reform [2]. In April 2006, the Massachusetts Legislature demonstrated a bold commitment to improving access to health services in the Commonwealth through the passage of the landmark health care reform act, Chapter 58 of the Acts of 2006 [3]. Entitled *An Act Promoting Access to Affordable, Quality, Accountable Health Care,* Chapter 58 aims "to more effectively cover currently uninsured low-income populations and make quality health coverage more affordable for *all* residents"[3]. The bill set in motion a series of initiatives geared towards providing (near) universal access to health care across the Commonwealth [3,4].

Chapter 58 set forth a mandate requiring Massachusetts residents to obtain health insurance coverage or risk financial penalties. As of July 1, 2007, individuals 18 years of age or older must be enrolled in a health plan that meets or exceeds the minimum coverage standards established by the Commonwealth [4]. Individuals are exempt from purchasing health insurance if they have religious objections, are ineligible for a subsidized plan but cannot afford to purchase unsubsidized private health insurance, or are faced with "special circumstances or hardships"[1,5]. Failure to enroll in a qualifying plan results in state income tax penalties, which can reach up to 50 percent of what an individual would pay for enrollment in an "affordable" qualified health plan and are lowest for young adults 18 to 26 years of age and individuals living below 300 percent of the Federal Poverty Level (FPL) [1,4,6,7].

In order to further the implementation of the "individual mandate," the Commonwealth launched a series of efforts to both establish and expand access to a greater range of affordable health plans [4,8]. Chapter 58 expanded MassHealth, which combines Medicaid and the State Children's Health Insurance Program, by increasing children's enrollment eligibility from 200 to 300 percent of the FPL, restoring optional benefits for adults that had previously been eliminated (e.g., dental and eyewear coverage), raising enrollment caps, and exempting adults with incomes below 100 percent of the FPL, as well as those with incomes greater than 100 percent of the FPL but at or below 150 percent of the FPL who are enrolled in a Type 2A plan and live in certain areas of the Commonwealth, from paying premiums [1,7,5]. These reform measures were coupled with additional efforts to establish both subsidized and non-subsidized affordable insurance plans for residents in Massachusetts.

The Massachusetts Health Care Reform Law (Chapter 58 and subsequent revisions) established the Commonwealth Health Insurance Connector Authority (the Health Connector), an independent state agency responsible for implementing various aspects of health care reform, establishing coverage standards, and connecting individuals, as well as small businesses with 50 or fewer employees, to affordable health insurance plans [4]. The Health Connector oversees and administers two portable health insurance programs: the Commonwealth Care Health Insurance Program (Commonwealth Care) and Commonwealth Choice [5].

Commonwealth Care is a subsidized program available to Massachusetts residents who earn less than 300 percent of the FPL ($32,496 for an individual in 2009), are not eligible for enrollment in

another health insurance program, including MassHealth or Medicare, and are either not working or work for an employer that does not provide a health benefit [5]. As of June 2009, Commonwealth Care included three Plan Types (Plan Types 1, 2, and 3), which carry no deductibles and were provided by four health insurance carriers: Boston Medical Center HealthNet Plan, Fallon Community Health Plan (FCHP), Neighborhood Health Plan (NHP), and Network Health. The three Plan Types confer different levels of benefits and have different premiums and co-payments, graduated by income level [5]. As of July 1, 2009, a fifth plan option, CeltiCare Health Plan, became available to low-income residents in the Boston, Northern, Central, and Southern regions of Massachusetts [5,9].[1]

The second program administered by the Health Connector is Commonwealth Choice, an unsubsidized program that offers private health plans from six health insurance carriers that meet the Health Connector's quality and affordability standards. Each carrier provides different levels of benefits and cost-sharing options (entitled Bronze, Silver, and Gold) to individuals, families, and small businesses with 50 or fewer employees. Bronze plans are characterized by low monthly premiums ($212.41 to $293.71), but most covered services require deductibles and co-payments. Silver plans have higher monthly premiums ($281.58 to $414.51), but offer some services without any deductible and require moderate co-payments. Finally, Gold plans have the highest monthly premiums of all three options ($370.13 to $529.60), but services have low co-payments and do not require any deductible prior to receiving coverage [5].

Chapter 58 also enacted a number of market reforms to increase access to health insurance. The most notable was the merger of individual and small group health insurance markets on July 1, 2007 which considerably decreased the cost of premiums for individuals purchasing non-group plans [8]. The new legislation also enforces a business mandate that requires employers to participate in the reform process. Businesses with eleven or more full-time employees must make a "fair and reasonable premium" contribution to their employees' health insurance costs and provide them with a cafeteria plan (Section 125 plan), either under their own health plan or through the Health Connector. Employers who do not make adequate contributions to their employees' health care coverage will be required to pay a "fair share," the lower of $295 per employee per year or the fair share contribution determined annually (in addition to the cost of services provided in the Uncompensated Care Pool) [10]. As of June 2009, there were no requirements for small businesses and employers with ten or fewer full-time employees [7].

Secondary to the development of these new programs, individuals in the Commonwealth can meet the individual mandate through enrollment in a number of different programs and plan types, including MassHealth, Medicare, and the health plans offered through the Commonwealth Care or Commonwealth Choice programs. Enrollment in qualified plans offered through employers and institutions of higher education, as well as direct purchase of qualified plans from insurance carriers, also satisfy the mandate. In the fifteen months after the mandate went into effect, nearly 440,000 Massachusetts residents became newly insured [11]. Fifty-seven percent of newly-insured residents

[1] On March 12, 2009 the Health Connector awarded a Commonwealth Care contract to a newly formed company now named CeltiCare. CeltiCare was originally conceptualized as a joint venture between a subsidiary of Centene Corp. and Caritas Christi Health Care, a Catholic hospital system founded by the Archdiocese of Boston (with 51 percent and 49 percent ownership, respectively). On June 26, 2009, Caritas announced its withdrawal from the joint venture citing the conflict between the ethical directives that govern provision of health care at Catholic institutions and the Commonwealth's requirement that Commonwealth Care insurers cover abortion services. The Centene subsidiary, Celtic Group, now owns 100 percent of CeltiCare [12].

enrolled in MassHealth or Commonwealth Care programs. The remaining 43 percent (i.e., 187,000 residents) enrolled in private commercial insurance, either through a Commonwealth Choice offering (approximately 19,000 residents), an employer plan, or direct purchase [5]. By the end of 2008, 97.4 percent of Massachusetts residents were enrolled in a health plan, and Massachusetts boasts the lowest percentage of uninsured individuals in the country [5]. Although uninsurance rates are highest among Latinos (7.2 percent), low-income residents (5.0 percent), and non-elderly (3.7 percent) populations, increases in coverage have been most significant among communities of color, low-income adults, and young adults [11,13].

Minimum Creditable Coverage standards

One of the major objectives of the Health Care Reform Law was to ensure that residents are enrolled in health insurance plans that are not only affordable but also provide coverage for a number of key health services [4]. Thus, in order to satisfy the individual mandate and avoid tax penalties, Massachusetts residents must enroll in a health plan that meets or exceeds coverage standards set by the Health Connector under 956 CMR 5.00 [15]. As of January 1, 2009, these Minimum Creditable Coverage (MCC) standards include [5]:

1. Prescription drug coverage;
2. Three visits for preventive care prior to charging a deductible;
3. Caps on deductibles and out-of-pocket spending for individuals ($2000, $5000) and families ($4000, $10,000);
4. No caps on benefits on a single sickness, during a single year, or on payment toward a single hospital day or stay; and
5. A broad range of medical benefits.

For 2009, "a broad range of medical benefits" has been defined as including coverage of preventive and primary care, mental health and substance abuse services, emergency and ambulatory care, and hospitalization. This range of benefits will expand to include additional services, including diagnostic imaging, screening, and chemotherapy, in 2010.

Several types of health plans that do not meet the standards provided in 956 CMR 5.00 have been deemed "qualified" by the Health Connector and thus enrollment in one of these plans also satisfies the individual mandate [16]. All Commonwealth Choice and Commonwealth Care plans, by definition, meet the MCC standards. Plans offered by the US Veterans Administration, AmeriCorps, Medicare Part A or B, the Student Health Program, and "any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs" have also been deemed by the Health Connector to provide MCC for the purposes of meeting the individual mandate [16].[2]

[2] As we detail later in this report, the Qualified Student Health Insurance Program (QSHIP) was established in 1988 and requires that students enrolled in institutes of higher education either enroll in a student health plan or provide proof of comparable coverage and that all colleges and universities provide a student health insurance plan. On June 1, 2009 the Massachusetts Division of Health Care and Finance Policy renamed the program, and it is now entitled the Student Health Program (SHP). Throughout this report, we use both SHP and QSHIP to refer to this program, depending on the temporal reference.

Other mandated benefits

The MCC standards establish broad requirements and allow consumers to meet the Chapter 58 individual mandate. However, a number of laws in the Commonwealth that predate Chapter 58 established mandated benefits [14]. Mandated benefits regulate state-licensed group health insurance plans such that specific health care benefits and services are included in their coverage options [15]. Just prior to the passage of Chapter 58, Massachusetts mandated that health insurance companies in the Commonwealth include coverage of 26 specific benefits, ranging from diabetes-related services to newborn screening [15]. Pursuant to Massachusetts General Laws c. 175 § 47, health insurance carriers in the Commonwealth are required to provide coverage for infertility treatment (including in vitro fertilization), prenatal, childbirth and postpartum care, and cytological screening (Pap smears) [14,15,17]. Health insurance plans must also provide contraceptive services, in parity with outpatient services and the prescription drug coverage in the plan. Known popularly as the "contraceptive equity law," insurance plans purchased by churches or "qualified church-controlled" organizations are exempt from providing this coverage [17]. Thus, in addition to requiring health plans to meet MCC standards, health insurance carriers in the Commonwealth must also provide mandated benefits, including a number of sexual and reproductive health (SRH) services.

Massachusetts General Laws c. 176A § 8W

Outpatient contraceptive services shall mean consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration [FDA].

While not a mandated benefit, the coverage of abortion care in the Commonwealth merits specific mention. The Hyde Amendment, first passed by the US Congress in 1976, prohibits the use of federal Medicaid funding for abortion services except for women whose pregnancies are life endangering or are due to rape or incest. However, states are permitted to use their own funds to cover abortion care in a broader range of circumstances. In Massachusetts, women eligible for public assistance for general health services have long been able to obtain public funds to pay for a "medically necessary abortion," defined in the Commonwealth as an abortion that is "necessary in light of all factors affecting the woman's health" [18,19,20].[3] The creation of the Commonwealth Care program extended coverage of abortion care to enrollees in these subsidized plans, subject to a $50 co-payment for those in Plan Type 2 and a $100 co-payment for those in Plan Type 3. Abortion care is provided free of charge for Commonwealth Care participants enrolled in Plan Type 1 [21]. However, abortion care is not a mandated benefit within the Commonwealth and health insurance carriers are not required to provide payment or referrals for abortion care unless the procedure is necessary to preserve the woman's life [22]. Individuals and facilities may refuse to provide abortion care (or sterilization procedures) after objecting in writing on moral or religious grounds. Notification of patients and provision of referrals are not required.

[3] In Moe vs. Secretary of Administration and Finance, 382 Mass. 629, 417 N.E.2d 387 (1981), the Massachusetts Supreme Judicial Court ruled that, based on the state constitution, restrictions on the funding of abortions under the Medicaid program, which limited such funding to cases in which the procedure was necessary to prevent a woman's death, to the exclusion of other lawful, medically necessary abortions, are unconstitutional and that low-income women have the right to Medicaid funding for all "medically necessary" abortions.

Establishment of the Commonwealth Connector website

The Massachusetts Legislature recognized that full implementation of the Health Care Reform Law would require significant public education and support. As stated in Chapter 58,

> The council shall establish and maintain a consumer health information website.[4] The website shall contain information comparing the cost and quality of health care services and may also contain general information related to health care as the council determines to be appropriate. The website shall be designed to assist consumers in making informed decisions regarding the medical care and informed choices between health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website and make available written documentation available upon request and as necessary [23].

In the first phase of implementation of the Health Care Reform Law, the Health Connector launched the Commonwealth Connector website (www.mahealthconnector.org) to help Massachusetts residents find health insurance that meets both their needs and the state's MCC requirements. The website provides information about health care reform in general, as well as all Commonwealth Care and Commonwealth Choice plans (including eligibility requirements) [5]. Massachusetts residents can enroll in plans directly from the Commonwealth Connector website. In 2008, the Commonwealth established the Health Care Reform Outreach and Education Unit in order to coordinate all marketing, outreach, and educational activities related to health care reform, including providing assistance and support to consumers, employers, and businesses [3].

Young adults & health care reform

Young adults, health insurance & unplanned pregnancy

Historically, young adults in the US have been disproportionately uninsured compared to other age cohorts [24]. Although they composed only 10 percent of the total US population in 2000, young adults aged 18 to 24 represented 19 percent of all uninsured individuals [25]. Moreover, 27 percent of 18 to 24 year olds were uninsured for the entire year compared to 16 percent of those aged 25 to 64 [25]. This trend has continued over the last decade and data from the 2007 National Health Interview Survey showed that 18 to 24 year olds represented the greatest proportion (27.5 percent) of uninsured individuals below the age of 65 [26]. A number of studies have shown that young men are at particularly high risk of being uninsured and that young adults who are not offered health insurance coverage at work, have low educational attainment, are not enrolled in school, and/or report lower income levels are more likely to be uninsured than their respective counterparts [27,28]. National studies have also consistently demonstrated significant racial and ethnic disparities in rates of uninsurance and shown that American Indian, Alaska Native, Latino, and African-American/black young adults are less likely to have insurance than white young adults [27,29].

Consistent with national studies, prior to the implementation of Chapter 58, young adults in the Commonwealth were disproportionately uninsured and the nearly 75,000 uninsured 19 to 24 year olds in the Commonwealth represented the largest segment of the uninsured in Massachusetts [30].

[4] The original legislation called for the creation of a "council" to oversee many aspects of the implementation of health care reform. At the time the legislation was passed, the name and exact structure of this entity had not been determined. The Commonwealth Health Insurance Connector Authority fulfills the role of the generically titled "council."

A study published in 2004 found that 15 percent of Massachusetts young adults in this age group were uninsured, with 20 percent of young men and 10 percent of young women lacking health insurance [25]. Students and young adults with higher incomes were more likely to be insured when compared to peers not enrolled in school and those who reported lower incomes, respectively [25]. Also consistent with national findings, the researchers identified significant racial and ethnic disparities in insurance coverage among young adult men in the Commonwealth [25].

The health insurance status of a young adult has a considerable impact on both health outcomes and behaviors and young adults who lack health insurance face a range of barriers to accessing health care [31]. Although young adults are typically categorized as a "healthy" population (particularly in comparison to other age cohorts), this group has age-specific health needs and priorities. A number of health concerns and conditions are most likely to first present in young adulthood, often subsequent to routine screening and care [25,32,33]. Further, the "life phase" of young adulthood has shifted markedly in recent decades and aggregate patterns of education, employment, relationships, and childbearing have significant implications for sexual behaviors and reproductive health [33,34].

Priority health issues for young adults

- **Injuries & accidents**
- **Overweight, obesity & physical activity**
- **Chronic conditions**
  - **Diabetes**
  - **Asthma**
  - **Arthritis (women)**
- **Mental health & suicide prevention**
- **Substance use, dependence, & abuse**
- **Sexual & reproductive health**
  - **Contraceptive services & counseling**
  - **Pelvic exams & pap smears**
  - **Prenatal, maternity & postnatal care**
  - **Abortion care**
  - **STI/HIV screening & treatment**
  - **Sexual assault services**

A number of SRH issues, and in particular contraceptive counseling and service provision, are critical in the lives of young adults [32,33,34]. Young adult women are at especially high risk for unintended pregnancy. Women in their 20s account for more than half (54 percent) of all unintended pregnancies in the US, and in 2001 there were more than 1.4 million unintended pregnancies among 18 to 24 year olds [35]. Promoting access to and consistent and correct use of effective methods of contraception is critical for both reducing unintended pregnancy among this age cohort and fostering women's reproductive autonomy. Yet, a recent study demonstrated that while 61 percent of all sexually active, unmarried young women aged 15 to 24 had received a prescription for or method of contraception in the past year, only 35 percent reported having received counseling about contraception [36].

Moreover, previous research has provided important insight into why women do not (consistently) use contraception, including a number of individual, interpersonal, and structural factors, and has repeatedly highlighted the need for providing women with comprehensive, affordable family planning services [37,38,39,40]. A 2006 survey in Massachusetts found that nearly half (46 percent) of women aged 18 to 24 reported having had an unintended pregnancy and that adults with an annual household income of less than $25,000 were more likely to report having had an unplanned pregnancy than those with an annual household income of $75,000 or more (50 percent versus 8 percent, respectively) [41]. Further, a growing body of evidence has established an association between insurance status and (effective) contraceptive use. Oral contraceptive pills (OCPs), which require a prescription, are the leading form of contraception among women under the age of 35 [42].

Several studies have shown that women who lack health insurance are more likely to forgo, delay, and/or reduce the dose of a prescription drug, including prescription contraceptives, compared to those with health insurance [43,44]. Analyses have also revealed that women with health insurance are more likely to report using prescription contraceptives and that uninsured women are more likely to report using less effective non-prescription contraceptive methods or no contraception at all [44]. Finally, a study published in 2009 found that young women enrolled in both private insurance plans and Medicaid were more likely to use prescription contraception than uninsured women but that women enrolled in other types of government health plans (including Medicare and military plans) used prescription contraceptives at the same rate as women without insurance [45]. Thus, the insurance status of young adults has a significant impact on the access to and use of contraception, and reduced access to effective methods of contraception in turn increases the risk of unplanned, unintended, and/or unwanted pregnancy.

The health insurance status of young adults is multi-faceted. Young adulthood marks a period of life transition that often impacts the availability of health insurance. Young adults "age out" of parental coverage and college and university students often lose health insurance upon graduation or change in student status. In addition, young adults are more likely to have low wage and entry-level positions that do not offer health benefits, and many within this age cohort lack the financial resources required to independently purchase health insurance [31]. In Massachusetts, the cost of health insurance for young adults has historically been relatively high as a result of previous insurance reforms which mandated a narrow range of rate differences based on age [46].

Health care reform efforts in the Commonwealth identified young adults, and specifically young men, as an important target group [30,47,48]. Certainly, enrolling young adults in affordable insurance plans yields significant benefits through the promotion of healthy behaviors, the provision of preventative and primary care, and the offer of protection against preventable diseases and medical debt associated with uninsurance [49]. The young adult age cohort is, on average, healthier than other cohorts, and the inclusion of young adults in insurance plans also has the benefit of "lessening the impact of adverse selection" [46]. Thus, the Health Care Reform Law included a number of efforts to expand health coverage to young adults in the Commonwealth.

Young adult-targeted health plans

A number of the components of health care reform increased the availability of affordable health insurance for young adults in Massachusetts, including the creation of the Commonwealth Care program and the implementation of the employer mandate. Further, Chapter 58 ushered reform of the dependency statutes such that young adults are now eligible to remain on a parental health plan through age 25 or for up to two years after leaving full-time school, whichever occurs first [5]. This change in "dependency" marked an important mechanism for young adults to retain health insurance during a life phase characterized by considerable transition. These reforms significantly reduced the uninsurance rate of young adults and the majority of young adults in the Commonwealth are now enrolled in a subsidized plan or an employer plan (either as an employee or as the dependent of an employee). In addition to these mechanisms for increasing enrollment in plans that offer coverage for all age cohorts, health care reform also included efforts to create plans specifically designed to meet the financial and health care needs of young adults.

Young adult-targeted health plans are tailored plans that extend affordable care to individuals within the young adult age cohort. Although young-adult targeted plans in the US have historically centered

on college and university students, in recent years there has been a growth of both commercial and public plans focused on young adults [50]. Young adult-targeted health plans have been part of the health system in the Commonwealth for nearly two decades. Indeed, the Dukakis Universal Health Care Law of 1988 included a "student mandate," which continues to be in effect (even though most of the provisions of Chapter 23 of the Acts of 1988 were subsequently repealed) and represents the first time that an individual mandate was enacted in Massachusetts. In 1988, the Commonwealth implemented the Qualified Student Health Insurance Program (QSHIP), which requires that all students enrolled (at least 75 percent time) in an institution of higher learning participate in the institution's health plan or provide proof of comparable coverage. The QSHIP also requires that all colleges and universities provide a student health insurance plan [51]. Insurance plans provided by the QSHIP are required to provide "reasonably comprehensive coverage" that includes preventive, primary and ambulatory care, emergency care, surgical services, hospitalization benefits, and mental health services but are not required to provide a prescription drug benefit.

Institutions of higher learning can choose to provide some or all of their student health benefits through on-campus student health services, covered by a student health fee. However, if the program is unable to provide all required benefits on-campus, the institution must offer additional coverage through an external health insurance carrier, which requires a premium (per year or semester). Thus, student health insurance programs may consist of one component (with all services provided through either on-campus health services or an external carrier) or two components (with services provided by a combination of on-campus health services and an external carrier). Students are automatically enrolled in an institution's student health insurance program but institutions may waive enrollment if the student provides documentation of comparable coverage from another source (as detailed below). However, institutions may require that students enroll in the on-campus health service and the student health fee (sometimes bundled with other institutional fees) may be mandatory. Thus waivers, if granted, often only apply to external health insurance coverage.[5]

Although the QSHIP predates Chapter 58, all QSHIP plans have been deemed by the Health Connector to provide MCC for the purposes of satisfying the individual mandate and student health insurance plans cover a significant proportion of young adults in the Commonwealth. On June 1, 2009, the QSHIP was renamed the Student Health Program (SHP). Students who are eligible for the SHP are ineligible for enrollment in any of the Commonwealth Care plans, regardless of income.

The QSHIP (now SHP) has long been a mainstay of young adult health care within the Commonwealth, but the program only extends coverage to students (enrolled at least 75 percent time). Building from the model provided by the QSHIP, the Health Care Reform Law included additional efforts to expand health coverage to the non-student population of young adults. To that end, the Health Connector established the Young Adult Plans (YAPs). The Commonwealth Choice program now offers 12 YAPs specifically designed for 18 to 26 year olds.[6] Young adults meeting the age requirement who are offered a health benefit from an employer are ineligible for a YAP [50]. Young adults who are eligible for MassHealth, Commonwealth Care plans, or federally administered programs can enroll directly in those plans and meet the individual mandate, and thus the YAPs

[5] For example, an undergraduate student at Tufts University who is enrolled as a dependent on a parental plan may be eligible to waive enrollment in the student health insurance offered by Aetna Student Health. However, all students are required to pay the health fee for Tufts University Health Service.

[6] Originally, YAPs were restricted to young adults aged 19 to 26. The eligibility was extended to age 18 to 26 by Chapter 205 § 40 of the Acts of 2007, *An Act Further Regulating Health Care Access*, signed into law on November 29, 2007.

have been designed for young adults who make more than 300 percent of the FPL ($32,496 for an individual in 2009) and are otherwise ineligible for subsidized programs [5]. Students eligible for insurance through the SHP can enroll in any Commonwealth Choice plan (including the YAPs). A school may deem enrollment in a YAP and/or MassHealth as providing comparable coverage for the purposes of the waiver. Thus, students at some institutions may be able to waive participation in the SHP if they are enrolled in either program [52].

The YAPs are provided by the same six health insurance carriers that administer the other Commonwealth Choice plans [5]. Each of these health insurance carriers provide two YAPs, one with outpatient prescription drug coverage and one without. All YAPs, including those without a prescription drug benefit, have been deemed qualified by the Health Connector to meet the MCC standards [5]. All of the YAPs cover inpatient and outpatient health services, as well as physical and mental health care and preventive services [4,48,53].

Young adult plans (YAPs) insurance carriers

- **Blue Cross Blue Shield of Massachusetts (BCBS-MA)**
- **Fallon Community Health Plan (FCHP)**
- **Harvard Pilgrim Health Care (HPHC)**
- **Health New England (HNE)**
- **Neighborhood Health Plan (NHP)**
- **Tufts Health Plan (Tufts)**

Each insurance carrier offers a prescription (with Rx) and non-prescription (without Rx) option, for a total of 12 YAPs.

The YAPs were specifically designed to provide young adults with access to affordable health insurance. This is reflected in their monthly premiums, which range from approximately $140 to $200 for non-prescription plans and from $170 to $220 for plans with a prescription drug benefit. These monthly premiums tend to be considerably lower than those of the Bronze, Silver, and Gold plans offered through Commonwealth Choice, which have monthly premiums ranging from $210 to $530 [5]. However, in order to keep the costs of plans low, the YAPs have been exempted from providing the range of services required of other qualifying health plans in the Commonwealth. As former State Representative Patricia Walrath (D), then co-chair of the Legislature's Committee on Health Care Financing, remarked on the features of the YAPs in the May 29, 2007 edition of the Boston Globe, "We thought this was one place where we could be a little experimental, because they are a very low-risk population" [30].

Nearly 100,000 young adults in Massachusetts are enrolled in a young adult-targeted health plan; over 90,000 young adults are enrolled in the SHP and approximately 5,000 young adults are enrolled in a YAP [51,54]. Data show that, as of August 2008, between 25 to 30 percent of all Commonwealth Choice subscribers are enrolled in a YAP and that approximately one third of YAP enrollees are in a plan that does not offer a prescription drug benefit [54]. Thus, two years after the implementation of Chapter 58, a significant number of young adults are receiving services and meeting the individual mandate through a young adult-targeted health plan.

Concerns have been repeatedly raised about the cost-sharing and containment features of the young adult-targeted plans in Massachusetts. Annual deductibles of $2,000, out-of-pocket costs, and annual benefit caps ranging from $50,000 to $100,000 (with the exception of deductibles) are characteristic of both the YAPs and the SHP. Similar caps are not permitted on plans that provide insurance to other age cohorts. A number of Massachusetts-based and national advocacy organizations have argued that setting a limit on young adults' annual benefits undermines their ability to pay for any

catastrophic health care needs that may arise and have noted that benefit caps place a young person who exceeds the annual maximum at risk of not only losing their health insurance and access to health care, but also of facing personal debt or bankruptcy [30,55]. While the YAPs include annual out-of-pocket maximums ($5,000 for an individual) that limit the amount that young adults must pay, these maximums do not apply to all out-of-pocket expenses [51]. And thus, even though the monthly premiums of the YAPs are low, the other cost burdens have given cause for concern.

The aforementioned efforts to keep the costs of young adult-targeted plans low also raise concerns about the comprehensiveness of the plans in meeting routine contraceptive and other SRH needs. Although discussion of the impact of health care reform on young adults has occurred and is ongoing, to date, little attention has been paid to the impact of Chapter 58 on young adults' access to SRH services. Indeed, the design and structure of the YAPs, as well as the exemption of both the YAPs and the SHP from some of the MCC standards, may create unintended barriers to SRH counseling and care. Of particular note, the Massachusetts "contraceptive equity law" only applies to health plans that contain a prescription drug benefit and exempts religiously-affiliated institutions from providing coverage [56].[7] Thus, young adult residents who are enrolled in a non-prescription drug benefit YAP or a student plan that does not provide prescription drug coverage may lack affordable access to prescription contraceptives and contraceptive devices. Further, students at religiously-affiliated institutions that exclude certain reproductive health services may not be receiving contraceptive counseling and care through the SHP.

Given the importance of SRH issues in general, and contraceptive services in particular, to the lives of young adults, our overall project aims to better understand the impact of health care reform on young adults' access to contraceptive services. The implementation of health care reform in Massachusetts serves as an important entry for more fully exploring and understanding young adults' contraceptive and other SRH needs in the Commonwealth and provides a window of opportunity for launching statewide initiatives at both the health systems and provider levels. Further, the experience in Massachusetts may offer valuable lessons that have the potential to inform discussions that are underway at the federal level.

About the REaDY Initiative

A coalition of Massachusetts health service providers, advocates, and researchers are collaborating on a unique, statewide project to reduce unplanned pregnancy among young adults in the wake of health care reform in the Commonwealth. The **Reproductive Empowerment and Decision Making for Young Adults (REaDY) Initiative** aims to prevent unplanned pregnancy and promote sexual health. This multi-pronged initiative is focused on better understanding the individual, community, provider, and structural factors that influence the contraceptive behaviors of young adults aged 18 to 26 and on developing strategies to ensure that this age group has the resources they need to lead healthy sexual and reproductive lives. This includes making decisions about whether and when to become parents. The first year of the initiative involves formative research, the results of which will inform actions undertaken in the second year to improve the health care system and better prepare health service providers to care for young adults.

[7] Contraceptive equity in Massachusetts is governed by a series of laws that pertain to different parts of the health system, including Massachusetts General Laws c. 175 § 47W, c. 176A § 8W, c. 176B § 4W, and c. 176G § 40. These laws, in combination, are often referred to as the "contraceptive equity law" [56].

The formative research of **REaDY** is being undertaken by Ibis Reproductive Health and is comprised of three primary components:

1. A systematic review of the reproductive health coverage of young adult-targeted health plans;
2. A statewide survey of health service providers serving young adult populations; and
3. Focus group discussions with young adults in different areas of Massachusetts.

We expect that the results from all three components of the project will be available in the fall of 2009. In this report, we present the results from the review of coverage of contraceptive and other SRH services in young adult targeted-health plans. After detailing the aims and objectives of the study, as well as the methods employed, we turn to our findings and recommendations generated through the assessment. Biographical information about the study team is provided in Appendix A.

Aims & objectives of the health plan review

The main aim of this component of the project was to conduct a rigorous, systematic review of health plans targeting young adults in Massachusetts in order to determine the plans' coverage of contraceptive services and counseling. To place these findings in context, we also reviewed the plan materials for information about a range of other SRH services. We conducted our assessment from November 2008 through March 2009 and aimed to address the following key questions:

1. What contraceptive and other SRH services are available to young adults in Massachusetts through different young adult-targeted plans, as reported in publicly available materials?
2. What information about the coverage of contraceptive and other SRH services is publicly available to young adults and how comprehensive and user-friendly is that information?
3. Have the design and structure of young adult-targeted plans created new and/or unintended barriers to young adults seeking contraceptive services?
4. If systems barriers do exist, how might they be addressed in the wake of health care reform in the Commonwealth?

We hypothesized that this assessment would reveal differences in how health plans communicate information about contraceptive and other SRH issues to young adults and that different plan types targeting young adults would report different degrees of contraceptive and SRH coverage.

Methods

Sample

Our study team conducted a systematic review of public information about 23 health plans available to young adults in Massachusetts. The sample consisted of all 12 YAPs, the SHP at seven institutions or "systems", and the four Commonwealth Care plans available at the time of the study. We purposively selected universities,

Universities, colleges & "system clusters" included in the study

- **Boston College**
- **The College of the Holy Cross**
- **Harvard University**
- **Massachusetts Community Colleges (system)**
- **Massachusetts Institute of Technology (MIT)**
- **Tufts University**
- **University of Massachusetts (all campuses)**

colleges, and "system clusters" that reflected variation in geographic location, size, source of funding (public vs. private), religious affiliation, and two- vs. four-year degree granting status. For the purposes of this report, we focus on the 19 young adult-targeted plans (the 12 YAPs and seven SHP plans) included in our review.

Data collection & analysis

We obtained information about the YAPs from the Commonwealth Connector website, as well as the websites of the six health insurance carriers involved with the YAPs. Given that all SHP plans in our sample consisted of an on-campus student health service as well as a health insurance plan provided by an external carrier, we gathered information about both components. For the five private institutions in our sample, we reviewed both the student health service and the external health insurance plan for each institution. For the University of Massachusetts system, we reviewed each campus' health service, as well as the external health insurance plan available at each individual institution. Finally, given the variation in reported health services among Massachusetts Community Colleges, we focused our analysis on the overarching health insurance plan available to all community college students in the Commonwealth. We obtained information about both the on-campus and external plans through a review of all publicly available materials on each institutional website as well as on the websites of the health insurance carriers involved with these SHP plans.

The study investigators initiated the assessment on the "homepage" of the plan and systematically reviewed all additional pages and publicly accessible documents and links available on its website (as applicable). We reviewed these materials with the aim of identifying:

1. **The types of contraceptive & other SRH services covered**. To this end, we assessed publicly available materials for information regarding the coverage of contraceptive counseling and services, including any reference to specific methods of contraception. We also reviewed the materials for information about other SRH services including prenatal, maternity and postnatal care, abortion care and counseling, infertility services, HIV/STI testing and treatment, and sexual assault and intimate partner violence services.
2. **The costs associated with various SRH services**. We collected information about the premiums, deductibles, co-payments, and co-insurance associated with each plan in the study and identified the costs associated with different "categories" of SRH services. For contraceptive services, we examined plan materials for information about the costs associated with contraceptive counseling, non-prescription contraceptives, prescription contraceptives, and contraceptive procedures.
3. **The type & location of the facility providing contraceptive & other SRH services**. We systematically reviewed the plan materials for information about the type(s) of facilities that provide referenced contraceptive and SRH services and identified where those facilities were located (if external to or separate from the principal facility).
4. **The comprehensiveness & accessibility of information provided by the plans**. In reviewing the materials, we conducted a "global assessment" of the information available to a young adult seeking information about contraceptive and SRH coverage. This assessment was based on a variety of factors including level of detail, ease of navigation and retrieval of information, and complexity of language.

Finally, to determine the geographic availability of the different YAPs, we entered a "young adult profile" (based on birth date) for each zip code in the Commonwealth.

Our method of collecting and recording information was informed by previous website content analysis studies [57,58,59]. We did not use search terms to identify or assess content. Rather, we read through all publicly available materials to identify content related to the focus of this study. All of the information collected about the plans in our sample was entered into a data collection form which was developed over the course of team meetings. Questions about classification were noted and discussed during those meetings. We conducted a content analysis of all the collected information. Content was assessed based on the presence or absence of information using *a priori* (i.e., pre-determined) categories and codes. Further, we used open analysis techniques to make global assessments of the information's accessibility.

This study involved an assessment of website content and other publicly available information. The research did not involve human subjects and Institutional Review Board approval was not required.

Results

Geographic variation in the availability of YAPs

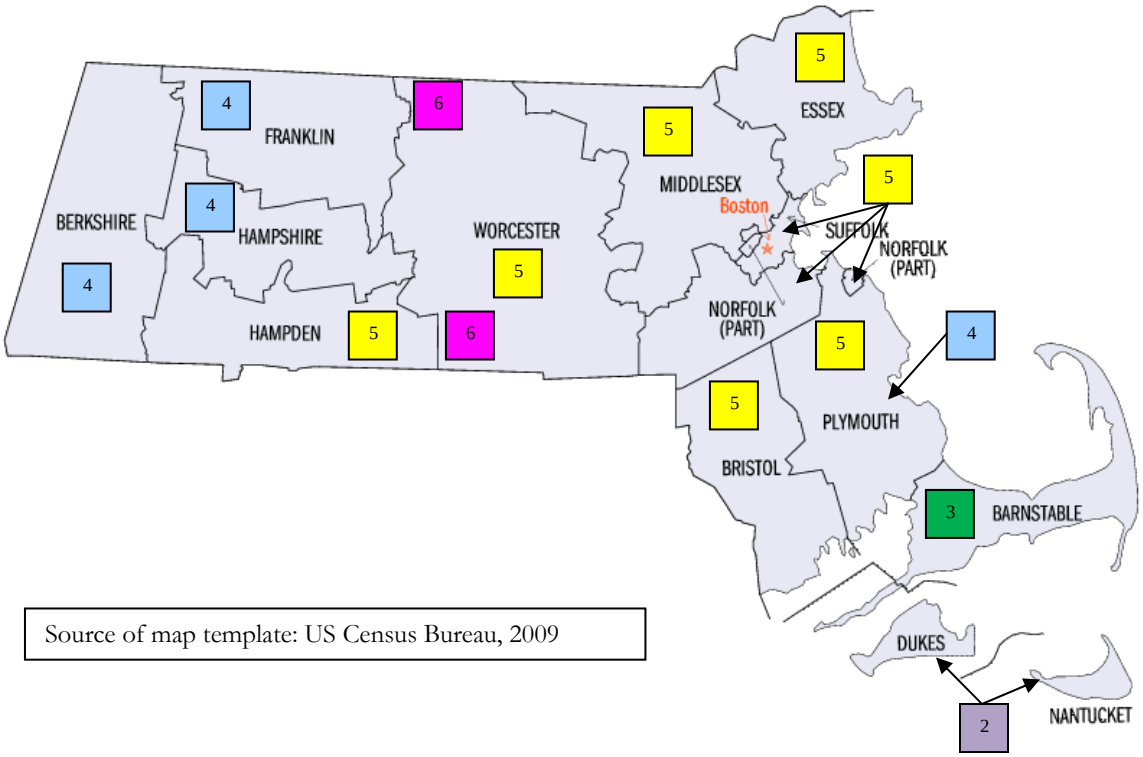
The 12 YAPs, which are comprised of six "pairs" of prescription and non-prescription plans, are not available in all areas of the Commonwealth, as shown in Table 1. Only BCBS-MA and HPHC are available in all counties of Massachusetts. Further, while young adults living in some areas of Worcester County have access to all six plans, only two plan types are available to those residing in Nantucket and Dukes counties (both located in the Southeastern region). Figure 1 maps the variation in YAP availability by county.

Table 1. Availability of YAPs in Massachusetts, by insurance carrier & county

	Health insurance carrier						
County		Blue Cross Blue Shield of MA	Fallon Community Health Plan	Harvard Pilgrim Health Care	Health New England	Neighborhood Health Plan	Tufts Health Plan
	Berkshire	X	X	X	X		
	Franklin	X	X	X	X		
	Hampshire	X	X	X	X		
	Hampden	X	X	X	X	X	
	Worcester	X	X	X	*	X	X
	Middlesex	X	X	X		X	X
	Essex	X	X	X		X	X
	Suffolk	X	X	X		X	X
	Norfolk	X	X	X		X	X
	Bristol	X	X	X		X	X
	Plymouth	X	X	X		*	X
	Barnstable	X		X			X
	Dukes	X		X			
	Nantucket	X		X			

X = YAP available (includes both the prescription and non-prescription plan offered by the carrier)
* = YAP only available in some parts of the county

Figure 1. Number of insurance carriers providing YAPs in Massachusetts, by county



Coverage of contraceptive & other SRH services, as reported by young adult-targeted plans

Our review of the reported coverage of contraceptive and other SRH services in young adult-targeted health plans revealed considerable variation. Overall, the majority of both the YAPs and the SHP plans reported in their publicly available materials that routine gynecological services and family planning consultations were included in their plan. However, the YAPs provided only general information about the range of covered contraceptive methods. Of course, half of the YAPs do not contain a prescription drug benefit, and thus contraceptive methods requiring a prescription are not covered. Further, the YAPs reported considerable variation in the costs associated with obtaining routine gynecological and family planning services, with routine, preventive gynecological exams ranging from no co-payment (FHCP) to a $25 co-payment (NHP) and family planning consultations ranging from a $10 co-payment (BCBS-MA) to a $40 co-payment after a $2,000 deductible (HNE).

Reported coverage of other SRH services also varied between the different YAPs. Five insurance carriers (BCBS-MA, FHCP, HNE, NHP, and Tufts) reported covering some form of maternity care; four carriers (BCBS-MA, FCHP, HNE, and NHP) reported including prenatal care within their plan and two (FHCP and NHP) reported postnatal care coverage. Only two health insurance carriers (HNE and NHP) reported covering infertility treatment, and only HNE reported providing coverage for HIV/STI testing and screening. None of the YAPs reported covering EC, safer sex methods (e.g., male/female condoms and dental dams), sexual assault and intimate partner violence services, or abortion counseling and care. We present a summary of these findings in Table 2, as well as further detail in Appendix B.

Table 2. Summary of reported SRH coverage in YAPs, by insurance carrier

Health insurance carrier	Young Adult Plans*	Reported coverage of SRH services**	Costs associated with SRH services
Blue Cross Blue Shield of MA	Essential Blue YA with Rx Essential Blue YA w/o Rx	Routine GYN exam Family planning§ Prenatal care Inpatient maternity care	$10 co-pay, Tier 1†; $50 co-pay, Tier 2†† $10 co-pay, Tier 1; $50 co-pay, Tier 2 $0 co-pay, Tier 1; 60% co-insurance after $2,000 deductible, Tier 2 30% (Tier 1) or 60% (Tier 2) co-insurance after $2,000 deductible
Fallon Community Health Plan	FCHP Select Care Premium Saver 2000 YAP with Rx FCHP Select Care Premium Saver 2000 YAP w/o Rx	Routine GYN exam Prenatal care Postnatal care Maternity care	$0 co-pay $25 co-pay first visit only $25 co-pay per visit 25% co-insurance after $2,000 deductible
Harvard Pilgrim Health Care	Harvard Pilgrim Pulse Plan with Rx Harvard Pilgrim Pulse Plan w/o Rx	Family planning§	$25 co-pay, 1st 3 visits; 20% co-insurance after $2,000 deductible for all others
Health New England	My HNE YAP with Rx My HNE YAP w/o Rx	Routine prenatal care Well-child care Cervical cancer screening Chlamydia infection screening HIV infection screening Ob/GYN conditions screening Annual gynecological exam Family planning§ & infertility services Laboratory services Non-routine prenatal & postpartum care Delivery/hospital care for mother & child	$0 co-pay $0 co-pay $0 co-pay $0 co-pay $0 co-pay $0 co-pay $0 co-pay $40 co-pay after $2,000 deductible $0 co-pay after $2,000 deductible $40 co-pay after $2,000 deductible $500 co-pay after $2,000 deductible
Neighborhood Health Plan	NHPGreen Select with Rx NHPGreen Select w/o Rx	Family planning§ GYN exams Infertility services Prenatal & postnatal care Laboratory tests Inpatient maternity care Well-baby & pediatric care Routine nursery & newborn care	$25 co-pay $25 co-pay 20% co-insurance after $2,000 deductible $25 co-pay $0co-pay 20% co-insurance after $2,000 deductible $25 co-pay $0 co-pay
Tufts Health Plan	Advantage HMO Select YA with Rx Advantage HMO Select YA w/o Rx	Ob/GYN visits Outpatient maternity care Preventive Pap smears Non-routine Pap smears Well-child care	$35 co-pay $35 co-pay $0 co-pay $0 co-pay after $2,000 deductible $35 co-pay, PCP; $50 co-pay, specialist

* With the exception of the prescription drug benefit, the prescription and non-prescription versions of each YAP provide the same services with the same fee structure unless otherwise noted.
** If a specific SRH service is not included in the table, then it was not mentioned in the plan's publicly available materials.
† Also referred to as the Enhanced Benefit Tier, per BCBS; †† Also referred to as the Standard Benefit Tier, per BCBS.
§ Family planning co-payments refer to the cost of consultation alone. Co-payments for contraceptive prescription drugs and devices are determined by the plan's prescription drug benefit. More detailed information is provided in Appendix B.

In contrast to the YAPs, the university and college plans tended to provide details about a more robust range of contraceptive methods and services. These data are provided in Appendix C. Five of the seven SHP plans in our sample report prescription drug coverage and/or explicit coverage of prescription contraceptives through the on-campus health service, the external carrier, or both. These five colleges, universities, or "systems" in our sample provided explicit information about the coverage, cost, and availability of contraceptive services through one or both components of the insurance plan. One of these institutions, a private Catholic college, explicitly states that "materials for preventing conception" are not provided through on-campus health services but the external insurance carrier associated with this program reports coverage of family planning consultations (with a $20 co-pay) and prescription drugs (although contraceptives are not specified). For two SHP plans (including the other Catholic institution in our sample) no information about prescription drug coverage (in general) or about any contraception or family planning services was provided. Indeed, little information about SRH services, broadly defined, is provided in the publicly available materials of these two SHP plans.

Several plans made explicit reference to the coverage of individual contraceptive methods, including OCPs, contraceptive devices, EC, and non-prescription/safer sex methods. Three of the private institutions also made specific reference to offering free pregnancy testing and counseling services through on-campus health services. This level of detail was consistent with the reported coverage of other SRH services. Indeed, all five private institutions reported on the coverage of routine gynecological care and three private institutions reported that sexual assault services were available (with $0 co-pay) on-campus. Four of the SHP plans provided information about the coverage and costs associated with prenatal and/or maternity care and four made explicit reference to the coverage of STI screening and/or HIV testing. Only two plans (one private, one public) reported coverage of infertility services. Finally, almost all of the SHP plans provided explicit information about abortion care, with four institutions reporting at least partial coverage for the elective termination of pregnancy and one explicitly reporting that abortion counseling and care were not provided.

Comprehensiveness & accessibility of information provided by the plans

We observed considerable differences in how young adult-targeted health plans communicate information about their coverage of contraceptive and other SRH services. The YAPs tended to use brief factsheets (one to four pages), which could be accessed through the Commonwealth Connector website or from the insurance carrier's website, and information was available only in English. Compared to all of the other insurance carriers that offer YAPs, HNE, which is only available in Western portions of the Commonwealth, provided particularly extensive information about its coverage of SRH services for young adults.

The Commonwealth Connector website groups information about the YAPs into a number of subheadings, including annual out-of-pocket maximum, routine medical office visits, prescription drugs, routine vision, and mental health benefits. Details about SRH services are not grouped together and are often distributed across several distinct categories. Assembling the information in order to ascertain the comprehensiveness of SRH coverage in a particular plan is time-consuming and challenging. Moreover, the Commonwealth Connector website neither provides specific information about SRH services through a frequently asked questions (FAQs) section of the website nor specifies that non-prescription YAPs do not provide coverage of OCPs or other contraceptives requiring a prescription. Last, it is difficult to determine where certain types of services (e.g.,

intrauterine device (IUD) insertion) fit within the groupings used to provide further details about a plan's coverage. However, all of the YAP factsheets available on the Commonwealth Connector website included the health insurance carrier's contact information, such that potential subscribers could, theoretically, ask follow-up questions about each plan's coverage prior to enrollment.

In contrast to the YAPs, the SHP plans provided young adults with considerably more information about both the contraceptive and other SRH services offered within their system. SHP plans provided information through a range of formats, including institutional websites, detailed handbooks, and links to related sites. Overall, the information provided through these plans was easier to navigate, the language was clearer and more descriptive, and related services were grouped more intuitively.

Discussion

The Health Care Reform Law in Massachusetts represents a ground-breaking effort to increase access to affordable, high quality health care. In the two years since the individual mandate was enacted, the Commonwealth has established a series of reforms and programs that have resulted in a significant decrease in the uninsurance rate. Young adults, a population that has historically been disproportionately uninsured, have been proactively incorporated into health care reform efforts and many have undoubtedly benefited from components of this initiative [47]. Efforts to expand affordable health care to young adults through targeted programs are laudable.

We undertook this study in order to better understand how contraceptive services and counseling are provided by plans targeting young adults and to evaluate how effectively information about the coverage of contraceptive and other SRH services is being communicated to young adults seeking insurance. Further, we aimed to explore the design and structure of young adult-targeted health plans (specifically, the YAPs and the SHP plans) to determine whether there are "gaps" in the system or unintended barriers to SRH services. The results of this study raise concerns that some of the young adults enrolled in a YAP or SHP plan may not have access to comprehensive contraceptive services. Moreover, our results suggest that young adults may be unaware of the limitations in their plans and may also not know where affordable services are offered.

Are young adult-targeted plans reporting coverage of contraceptive & other SRH services?

Our review of the publicly available materials provided by 19 young adult-targeted health plans suggests that there is considerable variation in the coverage, location, and affordability of SRH services. On average, university and college insurance plans provided more detailed information about the scope of services covered (or in some cases, not covered). In addition, publicly available materials suggest that a wide range of services are incorporated into the majority of the SHP plans, including gynecological care, contraception provision, HIV/STI testing and treatment, abortion care and counseling, and sexual assault services. Of notable exception were the two religiously-affiliated colleges included in this study; one provided very little information about any SRH issues and the other provided explicit information about the exclusion of services.

In contrast, far less detail about SRH coverage, in general, and contraceptive coverage, in particular, is provided by the YAPs. The majority of the YAPs reported that family planning consultations were covered, but the co-pays associated with these consultations varied considerably. The fact that six of

the 12 YAPs do not include a prescription drug benefit limits young adults' access to affordable and effective contraceptives. Presumably, the lack of a prescription drug benefit also impacts the coverage of other SRH services, including antibiotic and antiviral treatments for STIs. Reported coverage of infertility treatment, HIV/STI testing and treatment, abortion counseling and care, and sexual violence services is limited. Finally, the elevated deductible associated with the YAPs ($2,000), as well as the co-payments and co-insurance fees attached to many of the covered SRH services, may compromise some young adults' access to contraceptive and other SRH services. Further research on the ways in which young adults utilize contraceptive services through the YAPs and identification of barriers to accessing SRH care in these plans appears warranted.

Is information about SRH coverage in young adult-targeted plans understandable & accessible?

Information about detailed aspects of health care coverage is complicated and can be difficult to communicate effectively. A study from 1998 demonstrated that young adults often have an incomplete understanding of their health insurance plans, including how bills are paid and costs are covered [60]. Chapter 58 recognizes the challenges associated with communicating accurate and accessible information about health care reform in the Commonwealth and specifically called for the creation of a website "to assist consumers in making informed decisions regarding the medical care and informed choices between health care providers" [23]. Policymakers further noted that "information shall be presented in a format that is understandable to the average consumer" [23]. The Health Connector launched the Commonwealth Connector website in response to this need and in order to help connect consumers with affordable health plans, including the YAPs.

Yet, the information provided about the YAPs on the Commonwealth Connector website is limited and, in general, issues surrounding contraception and other SRH services receive minimal attention. Unlike information about mental health benefits, details about SRH issues are not grouped together and young adults who are specifically looking for a plan that covers routine SRH services (e.g., contraception, HIV testing, STI treatment) would have difficulty finding this information. Moreover, as discussed in detail below, the contraceptive implications for enrollment in different plan types (e.g., a non-prescription YAP) are not made explicit on the Commonwealth Connector website. Thus, unless young adults contact the health insurance carrier directly, they likely lack the full information that they need to make informed decisions about their contraceptive and other SRH coverage. Further, the information about YAPs is only available in English. Latino residents face the highest uninsurance rate of any racial or ethnic group in the Commonwealth, and the lack of Spanish language information may be one of the factors limiting access to health care coverage [61]. Finally, while one of the religiously-affiliated SHPs in our sample explicitly noted on its website that it did not cover specific SRH services (including materials for "preventing conception"), the other made no reference to the coverage of any contraceptive or SRH services.

The internet provides an important vehicle for communicating health information and education, particularly for young adults and adolescents. These populations are especially likely to consult online resources for information about SRH issues [62,63]. Features such as FAQs sections, virtual resource centers, and interactive databases can help users navigate websites and access information. Our findings suggest that there are multiple ways to improve the manner in which youth-friendly information about the YAPs in general, and about their coverage of contraceptive and other SRH services in particular, is communicated.

Are there statutory & structural barriers to contraceptive services?

While the Health Connector has deemed that both sets of young adult-targeted health plans (i.e., the YAPs and the SHP) meet the individual mandate requirement, they are exempt from the MCC standards that require qualified plans to offer a prescription drug benefit. Consequently, half of the YAPs do not offer a prescription drug benefit, and approximately one third of YAP enrollees are in one of these six plans [55]. Although the majority of college and university plans offer prescription drug benefits, this is not a requirement and the level of coverage, as well as the associated out-of-pocket expenses, varies widely [49,51].

The lack of prescription drug coverage decreases the monthly premiums associated with the YAPs. However, the lack of prescription drug coverage also has significant implications for women's access to affordable contraceptive services. Diaphragms, most hormonal contraceptive methods, and all long acting reversible contraception (LARC) methods (e.g., IUDs and Implanon™) currently require prescriptions. Thus, young women who desire contraception but are enrolled in non-prescription young adult-targeted plans will not receive contraceptive coverage through these programs. The cost of a twelve-month supply of OCPs or procurement of a highly effective LARC method is considerable. A 2003 study of nine contraceptive methods found that the levonorgestrel-releasing (20 μg/day) intrauterine system (LNG-20 IUS), the Copper T 380A IUD, and a three-month injectable contraceptive had a five-year cost of $1646, $1678, and $2195, respectively [64].[8] The cost of contraceptive services as currently reported by Planned Parenthood varies considerably, with up-front costs for LARCs ranging from $175 to $800 [65].[9,10] For many young adults, paying these out-of-pocket costs would be prohibitive.

Cost of contraceptive services, as reported by Planned Parenthood

- **Hormonal contraceptives: $180 to $600 per year**
  - **Includes OCPs, Ortho Evra ("the patch"), and Nuva Ring ("the ring")**
- **Depo-Provera: $140 to $400 per year**
  - **Annual cost for four injections, examination fees may be additional**
- **IUSs/IUDs: $175 to $500 one-time, up front**
  - **Includes the Mirena® (effective up to five years) and ParaGard® (effective up to twelve years)**
  - **Fee includes initial exam, device, and insertion**
- **Implanon™: $400 to $800 one-time, up front**
  - **Contraceptive implant (effective up to three years)**
  - **Fee includes initial exam, device, and insertion**

As shown in Table 3, the difference in monthly premiums between prescription and non-prescription benefit YAPs from the same health insurance carrier ranges from approximately $18 (Tufts) to $35 (NHE) [5]. Thus, if a young woman is looking to enroll in a YAP and intends to use hormonal contraceptives, all of which are more effective at preventing pregnancy than non-prescription methods, it would likely be cost-effective for her to enroll in a plan with a prescription drug benefit. However, women may not think about contraception as a prescription drug, particularly if the contraceptive method is a device, implant, or injectable. Although young women could certainly make an informed choice to enroll in plans that do not provide contraceptive

[8] Although these three methods were the most cost-effective methods over a five-year period when compared to other contraceptive methods (such as OCPs), the one-time, up-front cost of both IUD types is considerable.

[9] The cost of services at Planned Parenthood varies by health insurance status and income level. For a young adult enrolled in a non-prescription drug benefit YAP with an annual income of more than 300% of the FPL, the costs associated with contraception would be at the higher end of the reported range.

[10] Although ParaGard® (also known as the Copper-T IUD) was approved by the US Food and Drug Administration for up to ten years, recent evidence demonstrates that it is effective for at least twelve years. Many organizations that provide contraceptive services, including Planned Parenthood, use this evidence-based protocol [66].

benefits, information provided about the YAPs does not explicitly discuss contraceptive coverage. As a result, it is very likely that young women are enrolling in the least expensive plan options without realizing that the out-of-pocket costs associated with contraception will be significant. Further research is needed to determine if these costs influence method selection and contraceptive use patterns.

Table 3. Monthly premiums for YAPs with & without a prescription drug benefit, by insurance carrier

Health insurance carrier	Young Adult Plans with Rx	Young Adult Plans without Rx	Difference in monthly premiums (Rx vs. no RX)
Blue Cross Blue Shield of MA	$221.60	$197.98	$23.62
Fallon Community Health Plan	$190.00	$156.00	$34
Harvard Pilgrim Health Care	$170.90	$142.57	$28.33
Health New England	$189.04	$153.76	$35.28
Neighborhood Health Plan	$175.86	$153.10	$22.76
Tufts Health Plan	$191.65	$173.86	$17.79

Contraceptive coverage (or the lack thereof in certain cases) raises important questions about gender (in)equity in health care financing. As noted above, if a young adult woman intends to use hormonal contraceptives, it would be most cost-effective if she enrolled in a YAP that has a prescription drug benefit. By enrolling in a prescription benefit YAP, a young woman will pay between $216 and $420 more each year in premiums (depending on the specific carrier) than if she enrolled in the parallel non-prescription plan, in addition to any co-pays associated with obtaining the contraceptive method itself [5]. In contrast, a young man with no chronic illnesses and with otherwise comparable health status and health service needs would, all else equal, likely enroll in the non-prescription plan since he does not require prescription contraceptives. Thus, young women who choose to use more effective contraceptive methods for preventing pregnancy will pay more in both premiums and out-of-pocket expenses than their male counterparts.

The situation created by the YAPs stands in stark contrast to the Commonwealth's longstanding commitment to contraceptive equity. As discussed previously, Massachusetts mandates that health plans providing prescription drug coverage and outpatient services must provide comparable coverage for any FDA-approved outpatient prescription method of contraception [36]. Because the MCC standards developed by the Health Connector require that qualifying plans include both a prescription drug benefit and outpatient services, contraceptive equity has been incorporated into the Health Care Reform Law.

However, the structure of young adult-targeted health plans and the exemptions that have been afforded to the YAPs and SHP are unintentionally promoting contraceptive inequity. By allowing young adult-targeted plans to opt out of providing a prescription drug benefit, a system of

inequitable access to contraceptive methods in particular and affordable health care in general is being fostered between young men and women. Further, religiously-affiliated organizations continue to be exempt from providing contraceptive care, which in turn promotes contraceptive inequity between young adults who receive care from institutions with a religious affiliation and those who do not. If a young adult receives coverage from an employer (either as an employee or as a dependent of an employee) and the employer's offering is through a religiously-affiliated health plan, a similar inequity emerges. The importance of SRH in general, and pregnancy prevention in particular, for young adults suggests that efforts should be undertaken to make sure that all young adults in the Commonwealth have access to a full range of affordable contraceptive services.

Do religious exemptions & eligibility requirements create barriers to contraceptive services?

Since 1988, young adults who are enrolled in an institution of higher learning (at least 75 percent time) have been required to enroll in the SHP (formerly QSHIP) or demonstrate proof of enrollment in a comparable health plan. Institutions are given great latitude in determining what constitutes a "reasonably comprehensive benefit" and which alternative plans offer comparable coverage, and religiously-affiliated institutions are exempt from providing equitable contraceptive coverage [15]. Further, religiously-affiliated colleges and universities are not required to provide counseling or referrals to SRH services that are not provided through their plan [17]. These exemptions have long posed both logistical and financial burdens on students (especially women) seeking comprehensive reproductive health care in the Commonwealth [67]. In our study, one of the Catholic colleges reported that contraceptive services were not offered through their on-campus student health service and did not refer students to the external component of the SHP plan that covers family planning consultations and provides a prescription drug benefit. The other Catholic institution in our sample made no mention of contraceptive counseling or services in their publicly available materials.

The Health Care Reform Law has inadvertently created additional challenges for a subset of young adults seeking contraceptive coverage. Students who are eligible for enrollment in the SHP are barred from enrolling in Commonwealth Care programs, even if they otherwise meet the eligibility requirements. Young adults who are offered an employer health benefit are ineligible for enrollment in the YAPs. These criteria make it difficult for a young adult who is eligible for a religiously-affiliated plan that excludes SRH services (either through the SHP or through an employer) to enroll in affordable alternatives. As of the 2009-2010 academic year, eligibility for the SHP no longer precludes enrollment in a YAP – a policy change welcomed by student health advocates.[11] This reform marked an important step toward addressing the needs of students who are effectively uninderinsured with respect to contraception. However, students attending institutions that do not consider that YAPs constitute comparable coverage, students who are unable to afford the YAP monthly premiums (in addition to any applicable mandatory institutional fees), or young adults eligible for an employer plan that is religiously-affiliated continue to have limited options for obtaining affordable contraceptive coverage. Again, this differentially imposes financial and access burdens on young women.

[11] During a public hearing on the Student Health Program (then QSHIP), hosted by the Massachusetts Division of Health Care Finance and Policy on April 28, 2009, the ACT Coalition, Access Project, and Student Health Organizing Coalition raised several concerns about the SPH, many of which have since been addressed by the Commonwealth.

Study limitations

There are several limitations to our study. First, we only examined materials that were publicly available on the Commonwealth Connector website, institutional websites (in the case of SHP plans), and through the health insurance carriers themselves. Additional detailed information about the plans, including contraceptive SRH coverage, may be available to young adults upon enrollment. However, as a young adult "shopping" for a YAP or trying to understand the distinctions between different plan options at a college or university would only be able to access publicly available documents and websites, our review represents the information accessible to this population of consumers. Second, reported coverage may differ from actual coverage. Indeed, an absence or lack of information provided by a plan about a particular service does not necessarily mean that the service is not provided. Similarly, the "differences" that we observed between individual YAPs and between YAPs (in general) and the SHP plans (in general) may not reflect actual disparities in coverage but disparities in reported coverage. We appreciate this limitation and hope to better understand actual differences in coverage as we move forward with the other components of our formative research. However, young adults are expected to make informed choices about health insurance plans based on the information available from these same sources. Thus, evaluating reported coverage is critical. A final limitation is inherent to the medium of online materials. Websites are dynamic and, as such, are often routinely updated and modified. As our study took place during a defined period, we are unable to capture changes that have been made to these websites after the study period. Thus, we caution that our results reflect the information that was publicly available over the November 2008 to March 2009 period, content that may have subsequently been modified or revised.

Recommendations

The findings from our study highlight a number of priority areas for further research, advocacy, and action. We outline below a number of recommendations for moving forward.

1) **Create information resources to help young adults understand & navigate coverage in the YAPs.** Information about young adult-targeted health plans, in general, is often difficult to navigate and contraceptive coverage is often unstated or unclear. It is critical that information about what is and is not covered in plans focusing on young adults be transparent, accessible, and communicated in a youth-friendly way. There are a number of avenues by which information on contraceptive and SRH coverage can be more effectively and comprehensively communicated to young adults:

    a. Modification of the Commonwealth Connector website such that descriptions of the YAPs include a section dedicated to SRH coverage, including the full range of contraceptive methods and services. Ideally, users would be able to compare plans based on contraceptive and other SRH coverage. Explicit language stating that non-prescription drug benefit YAPs do not cover OCPs, LARCs, and other prescription contraceptives, should be included on the website.
    b. Creation of a FAQs directory on the Commonwealth Connector website that allows young adults to readily obtain information about the contraceptive and other SRH services covered in each of the YAPs.

c. Development of a compendium or guide that can supplement information on the Commonwealth Connector website. We recommend that this guide include a FAQs section (as listed above), "scenarios" that walk young adults through the costs associated with contraceptive use under each plan, and a list of available resources for young adults who need SRH services that are not covered by their plan. This guide could be available directly through the Commonwealth Connector website, as well as through independent organizations and health service providers.

2) **Address the "gaps" in the YAPs by ensuring contraceptive coverage.** There are important trade-offs when balancing affordability and coverage. Keeping the cost of plans for young adults low by exempting plans from providing a prescription drug benefit has important implications for young adults' access to contraceptive services and raises concerns about gender (in)equity in health care financing. There are a number of possible ways that the "gaps" created by the dual-tier YAP system can be addressed:

a. Require that all YAPs meet the MCC standards as conceived and provide prescription drug coverage. This would ensure that all YAP enrollees have access to the full range of contraceptive methods, as well as other medications. However, moving to a model where all YAPs provide drug coverage would effectively limit the number of YAPs to the six plans that currently provide a prescription drug benefit. Assuming that there are no other adjustments, this would increase premiums by $218 to $420 a year, depending on the carrier. This would have an impact on the affordability of the plans and may in turn lead to financial hardship for young adult consumers.
b. Consider revising the MCC standards such that all YAPs are required to provide coverage of a limited "young adult formulary." Coverage of medications and devices that are of particular importance to this age cohort (e.g., diabetes and asthma medications, antibiotics, vaccines, and prescription contraceptives, including LARCs) could be mandated. The "young adult formulary" would be available at low cost through the YAPs and prescription medications outside of the formulary would either be excluded or made available through additional cost-sharing mechanisms. This measure could potentially keep the costs of the YAPs low, while still providing young adults with a range of needed services.
c. Consider expanding coverage of subsidized contraceptive medications and devices to young adults who are enrolled in a qualified plan that does not provide a prescription drug benefit. For example, the scope of participants eligible to receive government-funded contraception from the Massachusetts Department of Public Health Family Planning Program (MDPH-FPP) could be extended to include young adults enrolled in a YAP with no prescription drug coverage. Currently, eligibility criteria for receiving subsidized MDPH-FPP clinic-based services include being an uninsured Massachusetts resident with an income that is equal to or less than 300 percent of the FPL, being under the age of 20 (regardless of income), or receiving MassHealth Limited Coverage [68]. Extending subsidized coverage to young adults through the age of 26 who are effectively underinsured, regardless of income or plan type, could address this gap and ensure that young adults receive the contraceptive services they need. This would also ensure that all young adults in the Commonwealth have access to affordable family planning services (see below). We recommend that the MDPH-FPP review their eligibility requirements and assess funding levels to determine if the program can be expanded.

3) **Develop mechanisms for providing contraceptive services to underinsured young adults.** As our findings reveal, gaps in family planning and other SRH coverage are not solely located within the YAP system. Indeed, some SHP plans may restrict counseling, referrals, and care for a range of SRH issues (including contraception) and still be deemed to meet the MCC standards by the Health Connector. Availability of these plans precludes students from enrolling in the Commonwealth Care plans that they might otherwise be qualified for. A similar challenge exists for young adults who are offered a health benefit from an employer that includes religious restrictions, as these young adults are precluded from enrolling in a YAP. This creates a population of young adults who are effectively underinsured with respect to contraceptive services. There are a number of mechanisms that would address this challenge:

   a. As noted above, determine the feasibility of expanding subsidized coverage through the MDPH-FPP to young adults who are underinsured. This expansion of eligibility would help ensure that all young adults have access to affordable family planning services. In addition to providing subsidized services for enrollees in the non-prescription YAPs, the program could also be extended to young adults enrolled in religiously-affiliated plans (whether through educational institutions or employers) that have SRH exclusions.
   b. That students are now eligible to enroll in the YAPs is laudable. The Health Connector should also consider revising the eligibility requirements for the Commonwealth Care plans such that students (enrolled at least 75 percent time) who are otherwise eligible (based on income) can enroll in this program. Similarly to YAP enrollment, institutions could determine that participation in a Commonwealth Care plan constitutes "proof of comparable coverage" for purposes of the SHP.
   c. The individual mandate that requires students to enroll in health plans offered through their institution of higher learning was developed in 1988 (as QSHIP), nearly 20 years before the Health Care Reform Law. All plans developed under the SHP have effectively been "grandfathered" in as student health plans that meet the MCC standards, even though a number of their benefits, including prescription drug coverage, financing, and "reasonably comprehensive coverage" may be different than those established by the Health Connector. While the efforts underway to reconcile the SHP requirements with the MCC standards are commendable, ensuring that the SHP plans provide young adults with contraceptive and other SRH coverage is critical.

4) **Require health plans to disclose limitations & exclusions, including restrictions on contraceptive coverage.** Many religiously-affiliated plans do not offer a full range of SRH services, with contraception a frequent and notable exclusion. Further, some religiously-affiliated health plans do not provide information about or referrals to excluded services. As of June 1, 2009, the SHP plans are required to provide students with information regarding benefits and covered services, including all limitations and exclusions. This mandate extends to religiously-affiliated institutions and, presumably, SHP plans that exclude contraceptive or other SRH services will now make this information available to prospective and current enrollees. Although it is premature to assess the implementation and impact of the disclosure requirements, this effort is commendable and serves as a model for ensuring transparent communication about the services that are (and are not) available. However, it is imperative that all young adults, not just students, be made aware of any contraceptive and other SRH exclusions in qualified health plans. We recommend that disclosure requirements be extended such that all plans, including those that are religiously-affiliated, are required to disclose any departures from the MCC standards, as well as any other limitations or exclusions. This information should be provided to

both current and potential enrollees and the information about exclusions should be complete, accurate, and accessible. The Commonwealth Connector website should also provide information about any exclusion involving either the insurance carriers or the networks associated with the Commonwealth Care and Commonwealth Choice plans (including the YAPs). Finally, if young adult-targeted health plans (either the YAPs or the SHP) place restrictions on contraceptive services, alternative forms of affordable coverage should be made available, and avenues through which a young adult can obtain comprehensive contraceptive coverage must be made clear.

5) **Collect more robust data on young adults & health care reform.** Young adults have undoubtedly benefited from many aspects of health care reform [47]. However, little information has been provided by the Health Connector about this age cohort. Young adults have both specific health service needs and separate mechanisms for meeting the individual mandate. Better understanding enrollment patterns, health service utilization, and uninsurance rates will allow policy makers, researchers, service providers, and advocates to identify strengths in the current system, as well as develop strategies for improvement at the systems level. Collecting demographic information (gender, race/ethnicity, socioeconomic status, and geographic location) about young adults enrolled in the YAPs, as well as other young adult-targeted plans, would be especially valuable. These data would aid in the identification of any disparities in access that have been exacerbated or created under the Health Care Reform Law.

6) **Learn from the experiences & perspectives of clinicians & young adults.** Although our study reveals important information from the systems perspective, it is critical that we learn from and listen to both clinicians and young adults. Over the next few months, the REaDY Initiative will be conducting research with clinicians who provide care to young adults, as well as with young adults who are enrolled in different types of health plans in several areas of the Commonwealth. We expect to have preliminary findings from both studies available in the fall of 2009.

Conclusion

Although the YAPs provide young adults with important new options for health insurance coverage, their design and structure may inadvertently undermine young adult residents' ability to obtain the full range of contraceptive methods. In light of our findings, we have made a number of recommendations toward ensuring that young adults in Massachusetts receive comprehensive information about the coverage of contraceptive and other SRH services in different health plans, as well as access to a full range of contraceptive services. This report also underscores that, in order to be truly comprehensive, health care reform must consider young adults' SRH needs, including their contraceptive needs. As Massachusetts is leading the nation on health care reform, the decisions made in the Commonwealth and lessons learned from the initial implementation of the Health Care Reform Law will likely serve as a model for other states in the years to come.

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Appendix A: Biographies of the study team

Madina Agénor, MPH, is a Research Assistant at Ibis Reproductive Health and joined the organization in 2008. Ms. Agénor holds a Master of Public Health (MPH) in Sociomedical Sciences from Columbia University's Mailman School of Public Health and a Bachelor of Arts (AB) in Community Health and Gender Studies from Brown University. Her research interests pertain to the social and policy determinants of women's sexual and reproductive health, with a particular focus on low-income women and women of color. While at Columbia, she conducted research on the welfare reform family-cap policy and poor women's sexual and reproductive health and rights. Ms. Agénor is currently pursuing a Doctor of Science (ScD) degree in Society, Human Development, and Health at the Harvard School of Public Health. Ms. Agénor is contributing to all components of the formative research and is leading the health plan review and the provider survey.

Julia Havard joined Ibis Reproductive Health as an intern in 2008. An undergraduate student at Harvard College she is in the pre-med track studying History and Science. Her previous research experience includes work in a cognitive and social psychology lab at Harvard and a cognitive psychology lab at Stanford University. She is a peer counselor for Room 13, a resource for the Harvard community that provides contraceptive education, nondirective counseling, and supplies. Ms. Havard is also on the student alliance for the Office of Sexual Assault Prevention and Response which works to spread awareness about sexual assault and provide services for survivors. Ms. Havard is contributing to all components of the study and is assisting the study team with data collection and data management.

Danielle Bessett, PhD, is an Ellertson Social Science Postdoctoral Fellow at Ibis Reproductive Health. She received her PhD and Master's in Sociology from New York University. She also holds a Bachelor's degree in English Literature from Mount Holyoke College. Dr. Bessett has taught at Suffolk University, Williams College, Mount Holyoke College, and New York University. She has published articles on music audiences and qualitative methodology in peer-reviewed journals, among other publications. Her current research focuses on inequality and the construction of normalcy in pregnancy, how women's reproductive careers affect subsequent pregnancies, and the consequences of economic barriers to sexual and reproductive health services. Dr. Bessett is contributing to all components of the study and is leading the focus group discussion component of the formative research.

Angel M. Foster, DPhil, MD, AM, is a Senior Associate at Ibis Reproductive Health and joined the organization in 2002. A 1996 Rhodes Scholar from Oregon, she received her Doctor of Philosophy degree (DPhil) in Middle Eastern studies from Oxford University. Dr. Foster also holds a Doctor of Medicine (MD) degree from Harvard Medical School and both a Master's degree (AM) in international policy studies and a Bachelor's degree (BAS) from Stanford University. Dr. Foster has extensive experience in designing and implementing both qualitative and quantitative research projects, including a number of studies dedicated to health professions training, and has authored or co-authored over thirty articles, book chapters, and reports on sexual and reproductive health. Dr. Foster also has extensive reproductive health advocacy experience. She has previously served on the Physicians for Reproductive Choice and Health (PRCH) Board of Directors and as the 2003-2004 President of the board of directors of Medical Students for Choice. In 2004 she was named one of Choice USA's "30 Under-30 Activists for Reproductive Freedom." As Principal Investigator of the project, Dr. Foster is responsible for all aspects of the formative research, including study design, data collection and analysis, and presentation and dissemination of the results.

Appendix B: Reported coverage of SRH services in YAPs, by insurance carrier

Health insurance carrier	Young Adult Plans (YAPs)*	Reported coverage of SRH services**	Costs associated with SRH services
Blue Cross Blue Shield of MA	Essential Blue YA with Rx Essential Blue YA w/o Rx	Routine exams (including one GYN exam/calendar year) Family planning§ Prenatal care Inpatient care (including maternity care) Rx benefit w/BlueValue Rx Formulary‡ (up to 30-day supply) *Tier 1 (drugs with generics)* *Tier 2* *Tier 3* Rx benefit through designated mail service pharmacy‡ (up to 90-day supply) *Tier 1 (drugs with generics)* *Tier 2* *Tier 3*	$10 co-pay for Tier 1†; $50 co-pay for Tier 2†† $10 co-pay for Tier 1; $50 co-pay for Tier 2 $0 co-pay for Tier 1; 60% co-insurance after $2,000 deductible for Tier 2 30% (Tier 1) or 60% (Tier 2) co-insurance after $2,000 deductible $15 co-pay 50% co-insurance 50% co-insurance $30 co-pay 50% co-insurance 50% co-insurance
Fallon Community Health Plan	FCHP Select Care Premium Saver 2000 YAP with Rx FCHP Select Care Premium Saver 2000 YAP w/o Rx	Routine physical exams Prenatal care Postnatal care Maternity care Rx‡ (including OCPs) (30-day supply) *Tier 1* *Tier 2* *Tier 3* Rx refills through mail order program‡ (90-day supply) *Tier 1* *Tier 2* *Tier 3*	$0 co-pay $25 co-pay first visit only $25 co-pay per visit 25% co-insurance after $2,000 deductible $10 co-pay $50 co-pay $100 co-pay $20 co-pay $100 co-pay $200 co-pay
Harvard Pilgrim Health Care	Harvard Pilgrim Pulse Plan with Rx Harvard Pilgrim Pulse Plan w/o Rx	Outpatient medical office visit (including family planning§) Prescriptions‡ (30-day supply) *Tier 1* *Tier 2* *Tier 3* Prescriptions‡ (90-day supply) *Tier 1* *Tier 2* *Tier 3*	$25 co-pay for 1st 3 visits; 20% co-insurance after $2,000 deductible for all others $15 co-pay $250 deductible w/ 50% co-insurance $250 deductible w/ 50% co-insurance $30 co-pay 50% co-insurance 50% co-insurance

Health insurance carrier	Young Adult Plans (YAPs)*	Reported coverage of SRH services**	Costs associated with SRH services
Health New England	My HNE YAP with Rx My HNE YAP w/o Rx	Routine prenatal care	$0 co-pay
		Well-child care	$0 co-pay
		Cervical cancer screening (Pap)	$0 co-pay
		Chlamydia infection screening	$0 co-pay
		HIV infection screening	$0 co-pay
		Ob/GYN conditions screening	$0 co-pay
		Annual gynecological exam	$0 co-pay
		Family planning§ services & infertility treatment	$40 co-pay after $2,000 deductible
		Laboratory services	$0 co-pay after $2,000 deductible
		Non-routine pre/postnatal care	$40 co-pay after $2,000 deductible
		Delivery/hospital MCH care	$500 co-pay after $2,000 deductible
		Drug Copayments‡	$10/$30 (performance formulary)
Neighborhood Health Plan	NHPGreen Select with Rx NHPGreen Select w/o Rx	Family planning§ services	$25 co-pay
		GYN exams	$25 co-pay
		Infertility services	20% co-insurance after $2,000 deductible
		Prenatal & postnatal care	$25 co-pay
		Laboratory tests	$0 co-pay
		Inpatient maternity	20% co-insurance after $2,000 deductible
		Well-baby & pediatric care	$25 co-pay
		Routine nursery/newborn care	$0 co-pay
		Rx at participating pharmacy‡ (up to 30-day supply)	
		Deductible per calendar year	$100
		Generic drugs	$15 co-pay
		Preferred brands	50% co-insurance
		Non-preferred brands	50% co-insurance
		Rx w/mail order program‡ (up to 90-day supply)	
		Deductible per calendar year	$100
		Generic drugs	$30 co-pay
		Preferred brands	2 times 30 day-supply retail cost
		Non-preferred brands	2 times 30 day-supply retail cost
Tufts Health Plan	Advantage HMO Select YA with Rx Advantage HMO Select YA w/o Rx	Ob/GYN visits	$35 co-pay
		Outpatient maternity care	$35 co-pay
		Preventive Pap smears	$0 co-pay
		Non-routine Pap smears	$0 co-pay after $2,000 deductible
		Well-child care	$35 co-pay w/ PCP; $50 co-pay w/spec.
		Rx drug coverage‡ (up to 30-day supply at participating retail pharmacy)	
		Annual deductible	$250
		Tier 1 (most generics)	$20 co-pay
		Tier 2	$50 co-pay
		Tier 3	$75 co-pay

* With the exception of the prescription drug benefit, the prescription and non-prescription versions of each YAP provide the same services with the same fee structure unless otherwise noted.

** Language used in the table to describe SRH services is that used in publicly available materials from the plan itself. If a specific SRH service is not included in the table, then it was not mentioned in the plan's materials.

† Called Enhanced Benefit Tier by BCBS; †† Called Standard Benefit Tier by BCBS; ‡ Rx costs only apply to the YAPs that offer an Rx benefit.

§ Family planning co-payments refer to the cost of consultation. Co-payments for Rx contraceptives are determined by the plan's Rx benefit.

Appendix C: Reported coverage of SRH services in SHP plans, by institution

Student health plan*	Reported coverage of SRH services**	Costs associated with SRH services	Location of services & other notes
Boston College			
University Health Services at Boston College		Annual undergraduate & graduate student campus health fee: $402/year; $201/semester Alternative for graduate students only: Fee-for-service ($70/PCP visit; $80/spec. visit)	As stated on the website: "Because of the moral values that Boston College espouses, University Health Service, by policy, does not provide materials for the purpose of preventing conception or counsel that would encourage abortion."
	Routine gynecology services	$0 co-pay	
	Pregnancy testing & counseling	$0 co-pay	
	Routine STI screening & treatment	$0 co-pay	
	Confidential HIV testing, counseling & education	$0 co-pay	
	Outside referrals for anonymous HIV testing	$0 co-pay	
	Contraception services & counseling	Not provided	
	Abortion services & counseling	Not provided	
	Outside referrals	Not provided	
	Lab tests	Not provided	
Blue Care Elect Preferred (PPO) (Blue Cross Blue Shield of Massachusetts)		Annual premium: $1,678 for full year; $738 fall only; $940 spring only Out-of-network (OON) plan-year deductible (ded): $200 OON plan-year co-insurance (co-ins) maximum: $1,000	
	Annual routine gynecological exam (including lab tests)	In-network (IN): $20 co-pay/visit ($0 co-pay for routine tests); OON: 20% co-ins after ded	
	Family planning services† (office visits)	IN: $20 co-pay/visit; OON: 20% co-ins after ded	
	Inpatient care (including maternity care)	IN: $0 co-pay; OON: 20% co-ins after ded	
	30-day supply of Rx from designated retail pharmacies		
	Tier 1	IN: $10; OON: not covered	
	Tier 2	IN: $25; OON: not covered	
	Tier 3	IN: $45; OON: not covered	
	90-day supply of Rx from designated mail service pharmacy		
	Tier 1	IN: $20; OON: not covered	
	Tier 2	IN: $50; OON: not covered	
	Tier 3	IN: $90; OON: not covered	
College of the Holy Cross			
Holy Cross Health Services		Annual health participation fee: amount not listed	
	Routine gynecological care	$0 co-pay	
Student Health Insurance (Bollinger Insurance, Inc.)		Annual premium: $740; $470 spring only Annual OON deductible: amount not listed	

Student health plan*	Reported coverage of SRH services**	Costs associated with SRH services	Location of services & other notes
Harvard University			
Harvard University Health Services (HUHS)		Student health fee: $1,426/yr; $713/semester	
	Routine Pap smear	$0 co-pay	
	Routine gynecological exams	$0 co-pay	
	Infertility Services	Not covered	
	Maternity care	$0 co-pay if w/HUHS Ob/GYN	
	Voluntary termination of pregnancy	$300 towards cost	Outside facility w/ referral from HUHS
	Birth control devices	$0 co-pay for most	On-campus, HUHS pharm & participating pharmacies
	Medco prescription drug benefit		HUHS pharm & participating pharmacies
	Maximum benefit	$3,750/year; $1,875/term	
	Generic	$10	
	Preferred brand name	$20	
	Non-preferred brand name	$35	
	Anon HIV counseling & testing	Suggested $10 co-pay	
	Conf HIV counseling & testing	$0 co-pay	
	STD screening & information	$0 co-pay	
	Pregnancy testing & counseling	$0 co-pay	
	Sexual assault prevention & response	$0 co-pay	
	Condoms, lubricant, dental dams & sexual health literature	$0 co-pay	
Blue Cross Blue Shield of Massachusetts		Annual premium: $1,404; $702 fall/spring only	
		Annual deductible: IN: $0; OON: $200	
	Routine Pap smear	Not covered	
	Routine gynecological exams	Not covered	
	Family planning†	IN: $10 co-pay; OON: 20% co-ins after ded	
	Infertility services	IN: $10 co-pay; OON: 20% co-ins after ded ($5,000 benefit limit)	
	Maternity care (prenatal, postpartum, delivery)	IN: covered in full; OON: 20% co-ins after ded	
	Voluntary termination of pregnancy	IN: $50 co-pay; OON: 20% co-ins after ded	
	Birth control devices	Not covered	
Massachusetts Community Colleges			
MA Community Colleges Student Accident & Sickness Insurance Program (Nationwide Life Insurance Company)		Annual premium: $840; $575 for spring only	
	Outpatient miscellaneous benefit	IN: 100% of fees covered w/$10 co-pay; OON: 80% of fees covered w/$10 co-pay ($1,500 maximum)	
	Elective abortion	Paid as any other Sickness	

Student health plan*	Reported coverage of SRH services**	Costs associated with SRH services	Location of services & other notes
Massachusetts Institute of Technology (MIT)			
MIT Student Medical Plan		Student health fee: $0 (with tuition)	
	Annual gynecologic exam	$0 co-pay	
	Routine gynecology exams	$0 co-pay	
	Routine Pap smear	$0 co-pay	
	Emergency contraception	$0 co-pay	
	Safer sex supplies	$0 co-pay	
	Prenatal care	$0 co-pay	
	Maternity care/obstetrics	Not covered	
	Sexual assault	$0 co-pay	
	Confidential HIV testing	$0 co-pay	
	Referral to anonymous HIV testing	$0 co-pay	
	Pregnancy testing & counseling	$0 co-pay	
	HPV vaccine	$20 co-pay per injection; $60 co-pay for series	
	Birth control prescription drugs	Not covered	
	Prescription birth control devices	Not covered	
	Voluntary termination of pregnancy	Not covered	
MIT Student Extended Insurance Plan (Blue Cross Blue Shield of Massachusetts)		Annual premium: $1,570; $654 fall; $916 spring Annual deductible: IN: $0; OON: $250 Annual out-of-pocket maximum: $1,000	
	Inpatient maternity care	IN: $100 co-pay; OON: 40% co-ins after ded	
	Maternity care (prenatal/delivery)	IN: covered in full; OON: 40% co-ins after ded	
	Prescription birth control devices	IN: $45 co-pay per device; OON: not covered	MIT Pharmacy
	Birth control prescription drugs	$15 co-pay IN & OON	MIT Medical
	Annual routine Pap smear	IN: 10% co-ins; OON: 40% co- ins after ded	
	Routine gynecology exams	Not covered	
	Voluntary termination of pregnancy	Covered in full at PPLM; OON: not covered	PPLM Boston
Tufts University			
Tufts University Health Service		Student health fee: $620 per year	
	Emergency contraception	$0 co-pay	
	HPV vaccine	$150 co-pay per shot; $405 co-pay for series	
	Routine GYN exam	$0 co-pay	
	Sexual assault resources	$0 co-pay	
	STI testing		
	Chlamydia; Gonorrhea	$75; $75	
	Hepatitis	$38	
	Herpes	$81 (culture); $91 (blood test)	
	HIV	$20	
	HPV/genital warts	$45 (Pap smear)	
	Pelvic Inflammatory Disease	$21	
	Urethritis	$62 (urine test); $27 (urethra smear)	
	Routine GYN lab tests		
	Chlamydia; Gonorrhea	$75; $75	
	Cholesterol	$30	
	Pap smear (Thin Prep w/Imaging)	$70	
	Vaginal Infection Preparation	$30	
	Birth control pills		
	Generic	$10 co-pay	
	Brand name	$25 co-pay	

Student health plan*	Reported coverage of SRH services**	Costs associated with SRH services	Location of services & other notes
Tufts University continued			
Tufts University Student Accident and Sickness Plan (Aetna Student Health)		Undergraduate annual premium: $1,389; $866 spring or summer only Graduate annual premium: $1,505; $937 spring or summer only Policy year maximum: $100,000 for any covered Accident or Sickness Non-preferred care deductible: $100/policy yr.	
	Physician's office visit	Preferred care (PC):100% of Negotiated Charge covered w/$15 co-pay (w/referral from Tufts Health Service); Non-preferred care (NPC): 80% of Negotiated Charge covered w/$30 ded/visit (w/referral from Tufts Health Service)	
	Maternity care	Payable on the same basis as any other Sickness	
	Voluntary termination of pregnancy	PC: 80% of Negotiated Charge; NPC: 70% of Reasonable Charge covered	
	Prescription contraceptives	Payable on the same basis as any expense	
	Prescription drugs *Maximum benefit*	$1,500 per year	
	Generic	PC: $10 co-pay; NPC: 80% of Reasonable Charge covered after $10 ded for each Rx drug	
	Brand-name	PC: $25 co-pay; NPC: 80% of Reasonable Charge covered after $25 ded for each Rx drug	
	Women's health (annual Pap)	Payable as any outpatient expense	
	Follow-up, medically necessary, diagnostic Pap smears	Covered on the same basis as any outpatient expense	
University of Massachusetts			
Blanket Student Accident and Sickness Coverage Plan (Aetna Student Health)		Aggregate maximum benefit per covered person per Accident or Sickness: $75,000 Deductible amount: $200 (for care received elsewhere w/no referral from UHS only)	
	Physician's office visit	PC: 90% & $10 co-pay; NPC: 80% & $20 co-pay	
	Prescribed Med: Max benefit *Brand name*	$1,800 per year PC: Covered in full w/$20 co-pay; NPC: 80% covered w/$20 co-pay	
	Generic	PC: Covered in full w/$10 co-pay; NPC: 80% covered w/$10 co-pay	
	Voluntary sterilization	Covered in full	
	Maximum benefit	$175	
	Pap smear screening	Covered as any other outpatient service	
	Infertility diagnosis/treatment	Payable on the same basis as any other Sickness	
	Outpatient contraceptive services	Covered as any other outpatient service	

* The student health plans for all of the private institutions in our sample have two components: an on-campus University Health Service (shaded grey) and an external health insurance plan for coverage of off-campus services (shaded white). Information about the blanket insurance plan for the two public "systems" in our sample is shaded green. All student health fees, premiums, and other costs are for the 2008-2009 policy year, with the exception of costs for the University of Massachusetts Blanket Student Accident and Sickness Coverage Plan, which were current as of October 12, 2007. Any changes for the 2009-2010 academic year are not reflected in this table.

** Language used in the table to describe SRH services is that used in publicly available materials from the plan itself. If a specific SRH service is not included in the table, then it was not mentioned in the plan's materials.

† Family planning co-payments refer to the cost of consultation alone.