



Young adults, health insurance & access to contraception in the wake of health care reform

**Results from focus group discussions 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 two-year 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. Formative research will inform actions led by a statewide, multi-agency Taskforce 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.

REaDY is led by an Executive Committee of multiple organizations and agencies within the Commonwealth. Ibis Reproductive Health is leading the formative research, and the Taskforce is chaired by the Massachusetts Department of Public Health Family Planning Program and coordinated by the Pro-Choice Massachusetts Foundation. These three agencies form an Executive Committee, which also includes the Massachusetts Family Planning Association, youth development specialist TiElla Grimes, and the Boston Public Health Commission.

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Acronyms, abbreviations & key terms

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|--------------------------------|---|
| Chapter 58 | Chapter 58 of the Acts of 2006, <i>An Act Providing Access to Affordable, Quality, Accountable Health Care</i> , also referred to as the Massachusetts 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 |
| Free Care | Former name of The Health Safety Net (HSN). HSN replaced the Uncompensated Care Pool (free care) on October 1, 2007. While not insurance, HSN is a program covering medically-necessary services for Massachusetts residents who are not eligible for health insurance or can't afford to buy it. |
| FGD | Focus group discussion |
| 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. |
| IUD | Intrauterine device |
| LARCs | Long acting reversible contraceptives |
| 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 |
| OCPs | Oral contraceptive pills |
| REaDY | Reproductive Empowerment and Decision Making for Young Adults |
| SHP | Student Health Program |
| SRH | Sexual and reproductive health |
| STI | Sexually transmitted infection |
| 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 this law in 2006 set in motion a series of reforms that considerably reduced the uninsurance rate, including individual and employer "mandates," expansion 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. 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 the loss of dependent status under 26 U.S.C. 106, whichever occurs first. There are also 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 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

To understand better young adults' access to contraceptive services in the wake of health care reform and to identify systems barriers to pregnancy planning in this age cohort, Ibis Reproductive Health conducted 11 focus group discussions (FGDs) with young women and men aged 18 to 26 (inclusive). Through these discussions we aimed to learn about young adults' experiences obtaining health insurance and information about various health plans, making decisions about and using contraception, and accessing contraceptive and other SRH services. We also aimed to explore young adults' opinions of health care reform in the Commonwealth and the ways in which the health system and health service providers could better address their contraceptive and other SRH needs.

Methods

In order to capture a range of perspectives and experiences, we aimed to conduct FGDs with young adults in different areas of the Commonwealth, from different racial/ethnic and socioeconomic

backgrounds, with a range of educational backgrounds, and enrolled (or not) in different types of health plans. From August through November 2009, we conducted 11 FGDs in Barnstable, Berkshire, Hampden, Middlesex, Suffolk, and Worcester counties, eight included both students and non-students and three targeted currently enrolled female students at purposively-selected institutions. We held nine FGDs with women (eight in English and one in Spanish) and two with men (one in English and one in Spanish). A total of 89 young adults participated in a 90-minute semi-structured discussion exploring issues related to health insurance, contraception, health care reform, and possibilities for improving service delivery in the Commonwealth. Eighty-six young adults also completed an exit survey focused on demographic characteristics, health insurance status, recent sexual history, pregnancy intentions, contraceptive use over the past month and past year, experiences with the Commonwealth Connector website, and feedback on their experiences in the study. We conducted a content and thematic analysis of all eleven FGDs using both *a priori* (e.g., pre-determined) categories and codes and inductive analysis techniques.

Key findings

In general, basic health insurance literacy was low. Participants repeatedly evinced confusion regarding health care reform and were typically familiar only with the individual mandate to obtain health insurance, not other reform measures such as the expansion of subsidized plans or changes in the dependency statutes. Young adults were also confused about the different types of health plans available in the Commonwealth, which plans they were enrolled in, and what contraceptive and other SRH services their plans covered; this confusion was particularly pronounced among college and university students. Similarly, students were often confused about their eligibility for services from on-campus health services and the billing structure for those services.

We identified three patterns of how young adults found their insurance. In the first, young adults chose their own health insurance plans; within that group, young adults who had used the Commonwealth Connector website reported difficulties finding relevant information. In the second, young adults relied on a family member (typically a parent); many young adults in this group reported that their parent(s) was/were not fully aware of their priorities and needs with respect to contraception and other SRH services. In the third, young adults reported that their options were constrained by broader institutional, employer, or socio-economic factors. Reports of uninsured status were typically related to broader life transitions, such as graduation from college or university. Financial barriers also limited young adults' ability to stay consistently enrolled in a health plan.

Insurance coverage of contraception was a significant factor in shaping women's decisions about contraceptive use and method selection; our results reveal that there are a number of systems gaps that impact the ability of young adults to access affordable and continuous contraceptive and other SRH services. Young adults who find themselves uninsured for transitional periods; young adults who are enrolled in health plans with religious restrictions on counseling, referrals, or service delivery; young adults who travel and seek routine care outside of their defined insurance coverage area; and young adults who are enrolled in non-prescription YAPs are among those populations that may find themselves "underinsured" with respect to contraceptive services. Young adults also felt that providers offered only limited information about the full range of contraceptive methods.

Finally, we also identified challenges that specific sub-populations experienced in accessing contraception. Our findings indicate that MassHealth enrollees, especially those living in non-urban areas of the Commonwealth, often face considerable difficulty finding and maintaining relationships

with providers who accept their insurance. In addition, students expressed concern about privacy in billing practices. Men in our FGDs saw themselves as largely left out of conversations about contraception and other SRH issues. Taken together, these findings underscore that, in order to be truly comprehensive, health care reform must consider young adults' SRH needs, including their contraceptive needs.

Recommendations

- **Create information resources to help young adults understand & navigate health insurance & contraceptive coverage in the Commonwealth.** Information about health care reform as well as the coverage of contraceptive and other SRH services can be more effectively and comprehensively communicated to young adults online and in print, both by the Connector and by other organizations that advocate for young adult populations.
- **Develop resources that can assist parental decision makers understand better the insurance needs of their young adult children.** These resources may include discussion guides to help parents navigate health plans on behalf of their young adult children and information about the changes in dependency statutes.
- **Develop mechanisms for providing contraceptive services to underinsured young adults & providing more affordable contraceptive services to insured young adults.** Mechanisms that would address this challenge include 1) requiring that all young adult-targeted plans 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), 3) expanding 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 purposes of preventing pregnancy; or 4) making contraceptives more affordable.
- **Address the barriers that many university & college students experience in obtaining contraceptive & other SRH services.** These obstacles could be addressed by 1) considering changes to billing procedures and service statements to protect students' confidentiality; 2) ensuring the transparency of information about on-campus health services and associated fees; 3) requiring that SHP plans disclose limitations and exclusions, including restrictions on SRH coverage; 4) alerting students to recent eligibility changes to both MassHealth and Commonwealth Choice plans; 5) considering revision of the eligibility requirements for Commonwealth Care plans to include otherwise-eligible students; or 6) helping students prepare for health insurance coverage after college graduation.
- **Increase the pool of SRH providers who accept MassHealth & Commonwealth Care Plans, especially in underserved areas.** Sustained efforts to increase the number of primary care SRH service providers who accept MassHealth, especially in underserved Western Massachusetts, Central Massachusetts, and Cape Cod, will allow young adults across the state to seek and receive the care to which they are entitled.
- **Encourage providers to engage young adult men in discussions about pregnancy prevention.** Engaging young adult men in discussion about the full range of contraceptive options could address a significant need.
- **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 service utilization, and uninsurance rates, as well as demographic information about those enrolled in the YAPs or other young adult-targeted plans.

Setting the context

An overview of health care reform in the Commonwealth¹

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 [1]. 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”[1]. The bill set in motion a series of initiatives geared toward providing (near) universal access to health care across the Commonwealth [1,2].

Chapter 58 set forth a mandate requiring Massachusetts residents to obtain health insurance coverage or risk financial penalties. With few exceptions, 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 [2]. The implementation of the “individual mandate” was coupled with a number of efforts to both establish and expand access to a greater range of affordable health plans [2,3]. These efforts included enacting market reforms and an employer mandate, expanding MassHealth, reforming dependency statutes, and establishing two portable health insurance programs: the Commonwealth Care Health Insurance Program (Commonwealth Care), a subsidized program available to Massachusetts residents who meet specific income and related eligibility requirements, and the unsubsidized Commonwealth Choice program [4,5,6].

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 and connecting individuals and small businesses to affordable health insurance plans [2]. The Health Connector oversees and administers both the Commonwealth Care and the Commonwealth Choice programs and educates the public about specific insurance options and health care reform more generally through the Commonwealth Connector website, a consumer health information website required by Chapter 58 [7].

The Health Connector is also responsible for establishing coverage standards to ensure that Massachusetts residents are enrolled in health insurance plans that are affordable and provide coverage for a number of key health services [2]. 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, or the Minimum Creditable Coverage (MCC) standards [8].² Yet several types of health plans that do not meet the standards

¹ A more detailed discussion of health care reform in the Commonwealth is included in the first report released by the REaDY Initiative study team: Agénor M, Havard J, Bessett D, Foster A. *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*. Cambridge, MA: Ibis Reproductive Health, 2009. This report includes a detailed overview of the different components of health care reform in the Commonwealth, including information about the eligibility requirements for the Commonwealth Care and Commonwealth Choice programs.

² As of January 1, 2009, these MCC standards include the following: prescription drug coverage; three visits for preventive care prior to charging a deductible; caps on deductibles and out-of-pocket spending for individuals (\$2,000, \$5,000) and families (\$4,000, \$10,000); no caps on benefits on a single sickness, during a single year, or on payment toward a single hospital day or stay; and a broad range of medical benefits [6]. For 2009, “a broad range of medical benefits” has been defined as including coverage of preventive and primary care, mental health and substance abuse

provided in 956 CMR 5.00 have also been deemed “qualified” by the Health Connector and thus enrollment in one of these plans also satisfies the individual mandate [9]. All Commonwealth Choice and Commonwealth Care plans are, by definition, qualified. Plans offered by the US Veterans Administration, AmeriCorps, Medicare Part A or B, the Student Health Program (SHP), 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 [8].

Health care reform in the Commonwealth has reduced the number of uninsured residents and expanded access to health care services. In the fifteen months after the mandate went into effect, nearly 440,000 Massachusetts residents became newly insured [10]. 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 US [6]. Although uninsurance rates are highest among Latinos (7.2 percent), low-income residents (5.0 percent), and the non-elderly (3.7 percent), increases in coverage have been most significant among communities of color, low-income adults, and young adults [10,11].

Young adults & health care reform in the Commonwealth

National studies have consistently demonstrated that young adults in the US are disproportionately uninsured compared to other age cohorts [12,13,14]. Consistent with these 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 [15]. 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 [13]. Students and young adults with higher incomes were more likely to be insured as compared to peers not enrolled in school and those who reported lower incomes, respectively [13]. Also consistent with national findings [16,17,18], these researchers identified significant racial and ethnic disparities in insurance coverage among young adult men in the Commonwealth, with young men of color less likely to have insurance than young white men [13].

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 [19]. 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 [20].

Health care reform efforts in the Commonwealth identified young adults, and specifically young men, as an important target group [15,21,22]. Many components of health care reform increased the availability of affordable health insurance for young adults in Massachusetts, including the expansion of MassHealth, the creation of the Commonwealth Care program, and the implementation of the

services, emergency and ambulatory care, and hospitalization. This range of benefits is expected to expand in 2010 to include additional services, including diagnostic imaging, screening, and chemotherapy.

employer mandate. However, Chapter 58 also included several initiatives that specifically targeted young adults. 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 the loss of dependent status under 26 U.S.C. 106, whichever occurs first [6]. This change in “dependency” marked an important mechanism for young adults to retain health insurance during a life phase characterized by considerable transition. Health care reform in the Commonwealth also included efforts to create plans specifically designed to meet the financial and health care needs of young adults. Under Chapter 58, the Health Connector established the Young Adult Plans (YAPs), tailored plans that extend affordable premiums to 18 to 26 year olds through the Commonwealth Choice program.³ 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; notably, all YAPs, including those without a prescription drug benefit, have been deemed qualified by the Health Connector to meet the MCC standards [6].

The YAPs were modeled after the Qualified Student Health Insurance Program (now SHP), the “student mandate” that has been part of the health system in the Commonwealth for more than two decades [24]. The SHP requires that all students enrolled at least 75-percent time (“full time” students) in an institution of higher learning participate in the institution’s health plan or provide proof of comparable coverage and that all colleges and universities provide a student health insurance plan [24]. 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). Full time 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.⁴ 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.

Since the implementation of Chapter 58, the uninsurance rate of young adults has decreased considerably 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). Notably, a significant number of young adults are receiving services and meeting the individual mandate through reforms, including the change in dependency statutes, and programs that target young adults. 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 [24,26]. Data show that, as of August 2008, between 25 to 30 percent of all

³ 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. YAPs target young adults who make more than 300 percent of the federal poverty level (\$32,496 for an individual in 2009) and are otherwise ineligible for subsidized programs, such as MassHealth, Commonwealth Care plans, or federally administered programs [6]. Young adults meeting the age requirement who are offered a health benefit from an employer are ineligible for a YAP [23].

⁴ Waivers may be granted on the basis of coverage through a parent’s or spouse’s private insurance or, as of June 2009, a school may deem enrollment in a YAP and/or MassHealth as providing comparable coverage for the purposes of the waiver [25]. Students who are eligible for the SHP are ineligible for enrollment in any of the Commonwealth Care plans, regardless of income.

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 [26]. 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, plans which may not provide prescription drug coverage or meet the MCC standards

Young adults & contraception: Needs, behaviors, access & knowledge

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 [27,28,29]. A number of sexual and reproductive health (SRH) issues, in particular contraceptive counseling and service provision, rank high among the age-specific health needs of young adults [30,31]. Indeed, 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 [32]. 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) [33]. Thus there is considerable need for comprehensive pregnancy prevention services among this age cohort.

The utilization of contraceptive services within this population also reflects the importance of pregnancy prevention in the lives of young adults. Nationally, oral contraceptive pills (OCPs) and condoms are the most commonly used contraceptive methods among young adults and approximately one in five contracepting women aged 20-24 use more than one method of contraception [29,34]. In contrast, a relatively small proportion of young adults use long acting reversible methods of contraception (e.g., IUDs or implants). National studies have also revealed different contraceptive utilization patterns among sub-populations of young adults [29,35]. Notably, contracepting women under the age of 25 are more likely to contracept sporadically and less likely to report uninterrupted use of an effective contraceptive method than older age cohorts [36]. Contraceptive utilization patterns in Massachusetts appear consistent with these broader trends [37]. A 2008 study in Massachusetts found that over 63% of non-pregnant women aged 18 to 24 were using at least one method of contraception at the time of the study [28].⁵

Previous research has provided important insights into why women do not (consistently) use contraception, including a number of individual, interpersonal, and structural factors [38,39,40,41]. This body of literature demonstrates that there are both significant barriers to and disparities in accessing contraception. 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 [42,43]. 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 contraception or no contraception at all [43]. Yet simply being insured does not guarantee access to prescription contraceptive; 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

⁵ This study does not provide information about whether or not respondents were sexually active but did exclude women who had undergone tubal ligations and women who reported that their current partner had undergone a vasectomy.

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 [44].

However, a number of studies have identified factors beyond health insurance that impact consistent use of contraception among young adults. Inconsistent use or non-use of contraception has been associated with women expressing ambivalence about becoming pregnant or not being satisfied with their contraceptive method [40,45]. Further, a study published in 2007 demonstrated that lack of communication between patients and providers also carries significant consequences; women who reported that providers were not available to answer method-related questions were more likely to report non-use or interrupted use of contraception [40]. The existing literature also documents considerable gaps in young people's knowledge of contraception. National surveys indicate that young adults frequently lack basic knowledge about reproductive health, such as being able to identify periods of peak fertility in a woman's menstrual cycle or knowing that sexually transmitted infections (STIs) can be transmitted through oral sex [46,47]. A 2009 study indicated that young adults (aged 18 to 29) are most familiar with male condoms and OCPs but have limited knowledge of other forms of contraception, including IUDs, implants, or injectibles [46].

Taken together, this research highlights the need to provide young adults with comprehensive, affordable contraceptive services and information about the full range of contraceptive options. Recent work on the impact of Chapter 58 on access to contraceptive and other SRH services suggests that some young adults continue to face unique challenges under the new system [27,48]. Concerns have been repeatedly raised about the cost-sharing and containment features of the young adult-targeted plans in Massachusetts [24,49].⁶ The aforementioned efforts to keep the costs of young adult-targeted plans low has also raised concerns about the comprehensiveness of the plans in meeting routine contraceptive and other SRH needs. 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 contraceptive counseling and care. Of particular note, the Massachusetts "contraceptive equity law" that pre-existed Chapter 58 applies only to health plans that contain a prescription drug benefit and exempts religiously-affiliated institutions from providing coverage, which may leave young adults in some YAP and SHP plans without affordable access to prescription contraception [50].⁷

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 to 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.

⁶ For example, benefit caps ranging from \$50,000 to \$100,000 are characteristic of both the YAPs and the SHP. Similar caps are not permitted on plans that provide insurance to other age cohorts.

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" [28, 50].

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. This two-year 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. Formative research will inform actions led by a statewide, multi-agency Taskforce 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.

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.

In this report, we present the results from the focus group discussion component of the study. After detailing the aims and objectives of the study, as well as the methods employed, we turn to our findings and present a series of recommendations. Biographical information about the study team is provided in **Appendix A**.

Aims & objectives of the focus group discussions (FGDs)

To understand better young adults' access to contraceptive services in the wake of health care reform and to identify systems barriers to pregnancy planning in this age cohort, Ibis Reproductive Health conducted 11 FGDs with young women and men aged 18 to 26 (inclusive). Through these discussions we aimed to learn about young adults' experiences obtaining health insurance and information about various health plans, making decisions about and using contraception, and accessing contraceptive and other SRH services. We also aimed to explore young adults' opinions of health care reform in the Commonwealth and the ways in which the health system and health service providers could better address their contraceptive and other SRH needs. In order to capture a range of perspectives and experiences, we aimed to conduct FGDs with young adults in different areas of the Commonwealth, from different racial/ethnic and socioeconomic backgrounds, with a range of educational backgrounds, and enrolled (or not) in different types of health plans.

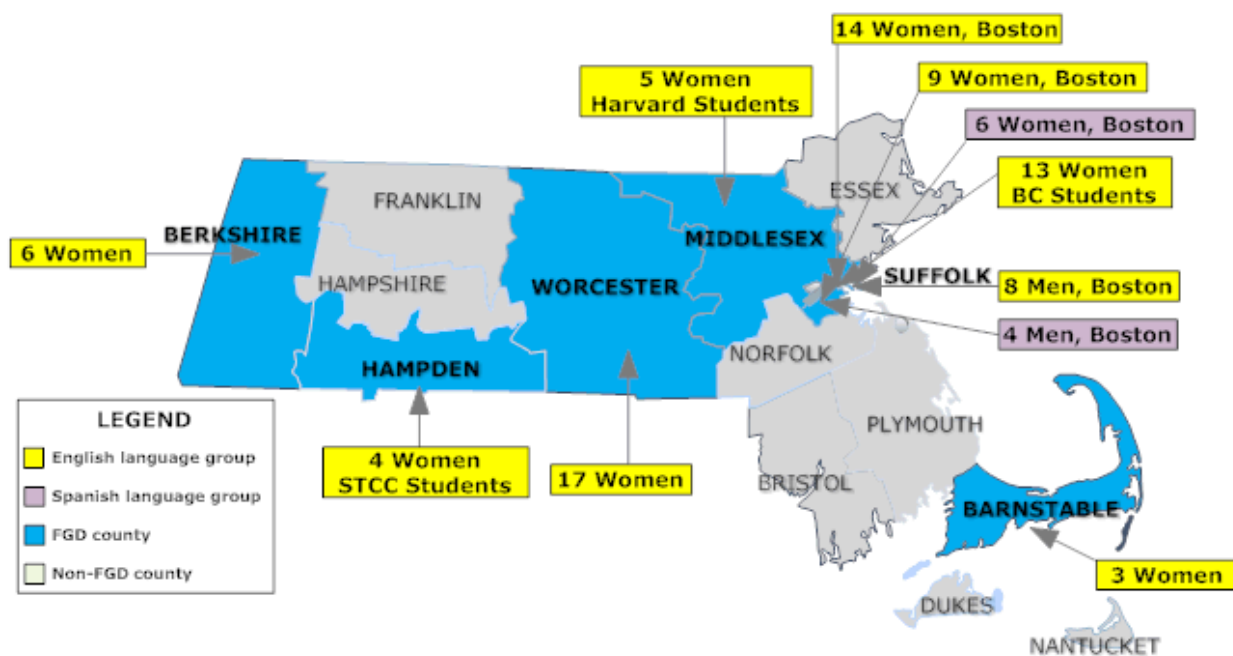
Methods

Sample

From August through November 2009 we conducted 11 FGDs across the Commonwealth. In order to capture a diverse array of perspectives we conducted our FGDs with young adults age 18 to 26 in

six of the fourteen counties in the Commonwealth: Barnstable, Berkshire, Hampden, Middlesex, Suffolk, and Worcester. These counties were selected based on their socio-demographic and geographic diversity as well as county-level differences in available health plans [27]. In order to foster open and free communication among participants, all of our FGDs were single-sex; we held nine FGDs with women and two FGDs with men. We conducted nine FGDs in English and two FGDs in Spanish; both Spanish-language FGDs were with residents of the Greater Boston Area. Finally, in order to better understand the experiences of college and university students, we conducted FGDs with currently enrolled female students at three purposively-selected institutions: Boston College, Harvard College, and Springfield Technical Community College (STCC).⁸ In total, 89 young adults participated in the FGDs. The location, language, and other characteristics of our eleven FGDs are presented in Figure 1.

Figure 1. Location, language & composition of FGDs



Eligibility & recruitment

Based on the Commonwealth’s definition of a young adult, all participants were required to be between the ages of 18 and 26 (inclusive). Additional eligibility requirements included sufficient fluency in either English or Spanish to be able to participate in the discussion, male or female gender identification, and current residency in the county/area of the FGD. In addition to meeting the age, gender identification, and language-eligibility requirements, participants in our student discussions were also required to be currently enrolled at Boston College (full time), Harvard College (full time), or STCC (full time or part time).⁹ For the eight groups that were not dedicated to students at a specific institution (e.g., general groups), participation was open to both non-students and students

⁸ The decision to include students from these institutions was informed by the findings of our review of young adult-targeted health plans [27].

⁹ Although both full time and part time students at STCC were eligible to participate, our FGD was comprised entirely of full time students.

at any institution of higher learning, as long as the other eligibility requirements were met.¹⁰ Finally, no individual could participate in more than one group.

All young adults who met the aforementioned requirements were eligible to participate regardless of citizenship, employment status, relationship, cohabitation or marital status, prior sexual or reproductive health history, contraceptive use, parity, or sexual orientation. We specifically aimed to include young adult participants from different racial/ethnic and socioeconomic backgrounds, with different education backgrounds, and who were enrolled (or not) in various health plans. However, there were no specific eligibility requirements related to any of these factors.

In order to include a broad range of participants from diverse backgrounds, we employed a multi-modal recruitment strategy. We recruited participants through English- and Spanish-language advertisements in online fora such as craigslist and Facebook, printed newspapers and community bulletins, and printed flyers. We posted flyers in a variety of venues, including the offices of REaDY Steering Committee members, local community organizations, and public locations (e.g., restaurants, bars, cafés, and community message boards). We also distributed flyers in public areas near Harvard College, Boston College, STCC, and community colleges in Berkshire and Barnstable counties but only posted flyers on-campus if administrative permission was obtained. Recruitment materials were tailored to the individual FGD and noted eligibility requirements, date and time of the discussion, and amount of payment for participation (\$50). The materials directed interested young adults to call or email the **REaDY** study team for more information about the project and to sign-up to participate. We also developed recruitment materials that specifically encouraged women and men of color and young adults who were currently uninsured to contact us.

Upon contacting the **REaDY** study team potential participants completed a 10 minute phone interview. Our intake process was designed to verify eligibility, provide information about the discussion (content, structure, and the logistics), and finalize enrollment. Young adults who contacted us, even if they were ineligible to participate, were requested to tell their friends and colleagues about the project and to encourage others to contact the study team. During the intake interview we also reviewed the informed consent process and offered to email or post the informed consent materials in advance of the discussion. Young adults who signed-up to participate were reminded about the discussion one week and one day before the scheduled group (by email or phone, per their preference). We aimed to have 8-12 participants in each discussion. To account for attrition, we enrolled up to 15 young adults, and we set our minimum enrollment threshold at four.

Structure & content of the discussions

Per our study design, the FGD process took approximately two hours. The FGDs were held in quiet spaces in community health centers, partnering organizations, or public libraries and were facilitated by a trained member of the study team. A second member of the study team was present at each discussion to take notes and respond to individual questions. The facilitator began the discussion by reading aloud the informed consent document and responding fully to all questions. Upon receipt of the signed informed consent document, we provided participants with \$50 in appreciation of their participation. Participants were also given a copy of the informed consent materials to take home with them and offered snacks and drinks throughout the discussion.

¹⁰ With the exception of the English-language FGD with women in Barnstable and the Spanish-language FGD with men in Boston, all of the general groups had at least one student participant.

The discussion portion of each FGD lasted approximately 90 minutes. Using a semi-structured guide developed specifically for this project, the facilitator explored issues related to health insurance, contraception, health care reform, and possibilities for improving service delivery in the Commonwealth. The facilitator encouraged participants to respond to each other and addressed questions as they arose. We audio-recorded and took detailed notes of all discussions.

Domains of inquiry

- Insurance status & experience seeking/obtaining insurance
- Experiences with health plan/health services
- Contraceptive use, behaviors, experiences & preferences
- Contraceptive access & health care services
- Relationship with providers
- Responsibility for contraception
- Opportunities for change & improvement
- Opinions about health care reform

At the conclusion of each FGD, we asked each participant to complete a 35-item exit survey. The questionnaire was offered in English and Spanish and included questions related to demographic characteristics, health insurance status, recent sexual history, pregnancy intentions, contraceptive use over the past month and past year, and experiences with the Commonwealth Connector website. We also solicited feedback on both the discussion group and our recruitment efforts. Finally, we gave participants a separate postcard which could be filled out and returned (either at the FGD or via post) if they were interested in receiving information about the findings of the overall study.¹¹

Data entry & analysis

The two Spanish-language discussions were first transcribed verbatim and then translated into English for analysis. All English-language discussions were transcribed verbatim. Exit survey data were entered into an Access database. We conducted a content and thematic analysis of all 11 FGDs. Initially, FGD content was assessed using *a priori* (e.g., pre-determined) categories and codes based on research questions and study objectives. We also used inductive analysis techniques to identify emergent findings and themes. This iterative process was informed by a series of team meetings as well as debriefing sessions after each FGD. In the results section of this report, we present the main themes that emerged in our analysis of the data and use quotes from individual participants to illustrate key findings. Further, we present a series of vignettes that showcase the ways in which key concepts and themes were revealed by participants. We structure the results section of this report around these key themes and participant narratives. Our exit survey data were analyzed in Access using descriptive statistics, including frequencies and cross tabulations. We include a summary of the findings of this survey at the beginning of the results section.

Ethical review

We received institutional review board approval for this study from Allendale Investigational Review Board (Old Lyme, CT). Through our informed consent process, all study participants were made aware of their rights and given the contact information for both the Principal Investigator and Allendale IRB. In order to protect the confidentiality of our participants we have used pseudonyms throughout the report and have removed personally identifying information. Further, we do not include the names of other individuals (e.g., clinicians, partners, etc.) or the names of specific facilities mentioned during the discussions.

¹¹ Copies of all study instruments and materials are available on request.

Summary of participant characteristics

General socio-demographic characteristics of participants

Seventy-seven women and 12 men participated in our eleven FGDs. Ten of these young adults participated in our Spanish-language groups and the other 79 (89%) participated in an FGD conducted in English. Of the 89 young adult participants, 86 completed the exit survey (for a response rate of 96.6%) from which we were able to gather additional participant characteristics.¹²

The overwhelming majority of our participants (91%) were US citizens, with another 7% identifying as permanent or temporary legal residents. The average age of our participants was just under 22.5 years, with all ages in our eligibility range represented. Twenty-two percent of our participants identified as Hispanic or Latino/a, including all but one of the participants in the two Spanish-language groups. Our participants identified as being racially and ethnically diverse; 64% as White, 16% as Black or African-American, 5% as Asian or Asian-American, and 5% as American Indian or Alaska Native. An additional 10% identified as being of a racial or ethnic group not listed in the instrument (e.g., “Other”).

Over half of our participants (52%) were currently enrolled as either part time or full time students, including 36% of the 64 participants in our eight “general” FGDs. Nearly one-third of all participants reported having already completed at least a Bachelor’s degree and 43% reported having already completed an Associate’s degree or some college. About one-fifth of our participants reported having completed a high school diploma or GED and 6% reported having only completed some high school.

We asked participants for information about both their household income and their contribution to the household income. The average reported household income was slightly more than \$42,000 with a median of \$29,000. Over a third of our sample reported an annual household income of \$25,000 or less. Notably, 28% of all participants did not provide any information about household income. We provide a detailed table of these and other general participant characteristics as **Appendix B**.

Participant health insurance status

At the time of the FGD, 10% of our participants were uninsured. Of the 90% of participants (n=77) who were insured during the study period, 60% were enrolled in a private insurance plan and 26% were enrolled in a subsidized plan. Of those participants enrolled in a private insurance plan, 54% were enrolled as a dependent on a parental plan, 35% received insurance through an employer, 7% were insured through a Commonwealth Choice plan, and 4% were enrolled in a partner’s health plan. Of participants enrolled in a subsidized health plan, nearly two-thirds were enrolled in MassHealth (or a combination of MassHealth and Medicare), 25% were enrolled in a Commonwealth Care plan, and 10% were enrolled in another subsidized plan. In addition, 17% of our insured participants reported receiving all or some of their insurance through a student health program. Finally, approximately 6% of our insured participants knew that they were insured but weren’t able to specify the type of insurance.

¹² Three women left before the end of the discussion at the two English-language Boston FGDs and thus did not complete the exit survey. All other participants stayed for the full discussion and completed the exit survey.

Participant sexual relationships, pregnancy intentions & contraceptive use

The majority of our participants (84%) identified as heterosexual; 9% and 2% identified as bisexual and gay or lesbian, respectively. Roughly one-third of our participants reported being single, 28% identified themselves as being in casual relationships, and 41% reported being in committed relationships. Less than 10% of our participants were currently married or divorced. Ten percent of our participants reported having at least one child (range: 1-3).

Current relationship status of participants

- Single – 32%
- Casually dating one person – 19%
- Casually dating more than one person – 9%
- In a committed monogamous relationship – 40%
- In more than one committed relationship – 1%

We asked participants about the number of sexual partners they had had in the past month (range: 0-8) and the past year (range: 0-8). More than two-thirds of the sample (70%) reported having had one partner in the month prior to the discussion, 23% reported having had no sexual partners, and 9% reported having had two or more partners. In the year prior to the discussion, 44% of participants reported having had one partner, 16% reported having had no sexual partners, and nearly 40% reported having had two or more partners.

Nearly 90% of participants described themselves as not wanting to be pregnant at this time and 5% of our participants (or their partners) were currently pregnant or trying to become pregnant.¹³ In the year prior to the FGD, 84% of our participants reported having used at least one method of contraception. Over half of the participants reported having used condoms and/or OCPs and one in six reported having used withdrawal. Nearly 7% of women in our study reported having used an IUD in the past year, but only one woman reported use of an IUD in the past month. Other contraceptive methods, including, the NuvaRing®, Implanon™, and female condoms had all been used by less than 5% of participants (or their partners) in the last year. Sixteen percent and 15% of our participants reported having not used a method of contraception in the last year and month, respectively.¹⁴ We provide more detailed information about reported contraceptive use as [Appendix C](#).

Most frequently used contraceptive methods by our participants in the last year

- Condoms – 58%
- Oral contraceptive pills – 56%
- Withdrawal – 17%
- Emergency contraception – 13%

¹³ We offered different versions of the survey to our female and male participants. Women were asked to describe their current pregnancy status and men were asked to describe their feelings about their partner's current pregnancy status.

¹⁴ Only women reported having not used a contraceptive method in the last month and all but one of the young adults who had not used contraception in the past year were women. The group of women reporting non-use of contraception includes women who were not at risk for pregnancy (because they were currently pregnant or were not engaged in penile-vaginal intercourse), women who were trying to get pregnant, and women who were at risk for an unintended pregnancy.

Results

Young adults' knowledge of & attitudes toward health care reform in the Commonwealth

I'm also healthy and I don't really need to go to the doctor or anything, but I feel like with this reform, health reform, now I have this insurance for the young adult. I feel like I'm healthier...so I think that's really important. (Deann, English-language FGD, Boston)

The overwhelming majority of young adults in our FGDs reported that they were aware of health care reform in the Commonwealth. Yet upon additional probing, we found that for many participants, health care reform was synonymous with the “individual mandate” to be insured and few participants were able to describe other components of Chapter 58. As illustrated by Deann’s remark, participants who identified other reform measures, such as the creation of young adult-targeted plans, the creation of Commonwealth Care, or the changes in the dependency statutes, typically had personal experience with those programs.

The majority of participants viewed health care reform as an important and positive effort because it furthers broader social justice goals and provides societal benefits with respect to promoting preventive care. Comparing Massachusetts to her home state in the South, Natasha (Harvard) explained: “If every single, you know, resident of the state is required to have insurance to live here... we’ll have a much better, like healthier society and everyone will be able to have access to what they need. Especially if there are low income initiatives, I’m strongly, strongly, strongly for it... I think that it would be great if everyone could have health insurance because then, you know, we would definitely have some better lives.” However, most participants did not see themselves as having personally benefited from health care reform. A small number of informants indicated that they did not support health care reform because they were ideologically opposed to the individual mandate.

The single greatest concern expressed about health care reform involved the affordability of health insurance. Many supporters of health care reform felt strongly that the individual mandate should be accompanied by affordable, high-quality coverage that is within financial reach for everyone. As Ashley (English-language FGD, Boston) stated, “I don’t think it’s fair how they have it right now, that you’re mandated to have insurance, but they don’t really offer affordable or appropriate options.” However, few of these participants were aware of existing mechanisms designed to increase access to affordable health coverage. The discussions also revealed that there was little consensus on what constituted “affordability” or who should be eligible for subsidized insurance plans.

Young adults' knowledge of plan types, enrollment status & terminology

I have Free Care, but...at my job they gave me one [a health plan], but I don't remember the name. They just gave it to me, so I'm not sure...but I have Free Care, that's where I go. (Claudia, Spanish-language FGD, Boston)

Throughout the discussions we documented considerable confusion among young adults about the different types of health plans available in the Commonwealth and which plan(s) they were enrolled in. Each FGD began with a round of brief introductions; participants were asked to introduce themselves and state what kind of health insurance they had (if any) and how long they had been enrolled in that plan (if applicable). A significant portion of FGD participants were unable to state

the name of their insurance carrier and a number of our insured participants could not remember the type of insurance they were enrolled in (e.g., MassHealth, a Commonwealth Care plan, a private insurance plan through an employer, etc.). Several participants produced and referred to their insurance cards throughout the discussion. Not infrequently, participants interchanged “Commonwealth Choice” to describe a “Commonwealth Care” plan and *vice versa* and, like Claudia, several participants referred to being enrolled in “free care,” which is not technically an insurance program. The exit survey results further documented this confusion; not only were 6% of our insured respondents unable to specify their insurance plan type, a number of additional respondents indicated enrollment in two or more mutually-exclusive plans (e.g., simultaneous enrollment in MassHealth and a Commonwealth Care plan).

Confusion regarding plan types and enrollment status was particularly pronounced among college and university students and fell into two broad categories: waivers and on-campus health services. First, a number of students received health insurance through both their parents and their school and were uncertain as to why they were enrolled in two different plans. As Arielle (English-language FGD, Boston) stated, “I’m a student also and I have to get insurance through my school. And I have insurance through Mass – like, here – and I guess I’m just like kind of ignorant about it. I don’t even understand why I have both or what would cover which, you know?” The majority of students were unfamiliar with the waiver system, even if their health insurance status suggested that they (and their parents) had received a waiver from participating in the external health insurance component of their institution’s SHP.

A second common area of confusion among university students involved on-campus health services. Although the majority of the students in our FGDs were enrolled in institutions with on-campus health services, only one student was able to accurately articulate what services were covered and how it complemented the external insurance component of the SHP. In one of our student discussion groups, only three out of the five participants were aware that they had been billed for (and presumably paid for) the mandatory on-campus health fee. Several participants suggested that the billing structure, either through a term bill or bundled with other “student activities” fees, contributes to confusion.

Finally, throughout the discussions, participants evinced a weak grasp of health insurance terminology. Participants often used words like “co-pay,” “premium,” and “deductible,” interchangeably and inaccurately, and they frequently asked the facilitator to explain such terms, as Aisha (English-language FGD, Boston) did: “When you say deductible do you mean like co-pay, or...?” Not surprisingly, participants with complicated medical histories and more interaction with their health insurers were better versed in the language of health insurance. However, our FGDs revealed that basic health insurance literacy among these young adults is quite low.

Barriers to finding & “choosing” an insurance plan

When I started college, I had to look for health insurance. And it was just so hard. I went on the Commonwealth website, and I basically just picked one...I was trying to like, you know, see which one was better, but I really couldn't tell. (Blanca, Worcester)

Participants in our FGDs repeatedly stated that they lacked adequate knowledge to make an informed decision about their health insurance. Many also expressed significant interest in having more resources to help them identify affordable and appropriate health plans. Based on the FGDs, we identified three patterns of how young adults found their insurance; they chose the insurance

themselves, a family member (typically a parent) made the decision for them, or they had no choice in selecting a plan because of socioeconomic, employer, or educational institution constraints.

Young adults who chose their own insurance plan ranked premium cost very highly in their deliberations over which plan to choose. Among those who were generally healthy and expected to have few office visits, most were willing to pay higher co-pays in favor of lower premiums. A number of women specifically noted that they primarily used the health system to obtain contraceptive services. Women who were choosing a plan themselves generally assumed that their OCPs would be “covered” by any health plan, but they rarely could predict the cost of the co-pays for that specific medication based on the “tier” chart presented in print and online materials. Women reported being unsure as to which prescriptions fell under which tier and found it difficult to find information about the pills they used. In contrast with OCPs, women did not generally speak about prescription devices (such as IUDs, Implanon™, etc.) in relation to their decision making about insurance coverage.

Overall, 17% of our participants indicated they had visited the Commonwealth Connector website in choosing their plan; nearly one-third of these participants ultimately chose their health insurance plan through the website. Several participants indicated that they had begun the process of applying for health insurance online but became sufficiently flummoxed by the Commonwealth Connector website’s presentation of eligibility requirements that they ended up using the helpline/call center instead. Others indicated that the website provided useful information and had great potential to educate consumers, but, as Anka (English-language FGD, Boston) explained, were confused by the organization of the website, “I just felt like all the information wasn’t in one place, like, a large table with all the options, would have been helpful.” Participants also described difficulty navigating the online materials of some private insurers and being able to compare different options within a plan.

Nearly one-third of all of our insured participants (and over half of those enrolled in a private insurance plan) are enrolled as a dependent in a parental plan. In almost all of these cases, young adults described themselves as not having participated in the decision making about their health insurance. Roxy’s (Boston College FGD) description of how she selected a health insurance plan when she enrolled in college is reflective of this broader theme: “My parents handled [everything]. Yeah, I’m not even sure of the intricacies in my health plan at all...no idea.” The other students in Roxy’s FGD responded with laughter and general agreement. The role of parents, and particularly mothers, as surrogate decision makers is not limited to those situations in which the young adult enrolls as a dependent on a parental plan, as Sophie’s (English-language FGD, Boston) experience choosing a health plan reveals, “I...was kind of like, ‘I can’t deal with this right now, it’s overwhelming. Like, whatever you [mom] say, I’ll do.’” In general, these young adults reported having little input on or explanation of the decision, but assumed it was made in their best interest.

Finally, a number of our participants explained that their health insurance options were constrained by broader institutional, employer, or socio-economic factors. As Lauren (English-language FGD, Boston) put it, “At my job it was basically like Blue Cross Blue Shield or Blue Cross Blue Shield, there was no choice. Like this is the plan, we’ll pay 75%, you pay 25%, and that’s all there is to it. If you want it, sign here, if not, you’re on your own.” A number of young adults in subsidized plans expressed frustration at having been “placed” in a particular plan without being given additional information behind the rationale.

Rick's story: 26 years old, Spanish-language FGD, Boston

Rick moved from Costa Rica to study music at a Boston-area university. A horn player, Rick's scholarship covered both his health services fee and the most basic external health insurance plan offered by his university. Rick described his options as "very, very limited"; the university offered two other external plans, but they cost "a lot more money." When he suffered a complex fracture of his little finger, he was shocked that his share of the surgery costs exceeded \$1,000, "You have to pay the anesthesiologist separately, all the bills...they add up." Rick felt he simply "did not have the coverage" on the student insurance plan to which he was bound. Since then, Rick limits his use of health services and forgoes routine STI testing, and he purchases medications in Costa Rica when he goes home for the holidays because they are significantly cheaper. Rick recently graduated and is now uninsured.

Transition & misinformation: Experiences of the uninsured

Currently, technically, I'm uninsured. I just started working about two months ago and I'm not eligible for [employer] coverage until [next month], which I'm signed up for, but I've been uninsured for about two months. And prior to that I was, as a student, I fell under my father's health insurance policy, whatever that was... When I graduated, the time between my graduation and being eligible for my employment benefits, is the time that I've been uninsured. (Audrey, Barnstable)

Although 10% of our participants reported being uninsured at the time of the FGD, a substantial number of older participants shared their recent experiences of having been temporarily uninsured. These uninsured periods were typically related to broader life transitions, in particular graduation from college or university. Nearly all of those who reported going without health insurance would have preferred being insured; only one woman in our study, a substitute teacher, described herself as having made a calculated decision not to purchase insurance during periods when her employer-based insurance lapsed. Young adults also expressed significant anxiety about the possibility of becoming uninsured upon graduation or transition to a new job. As Mathilda (Worcester) explained, "I think it's difficult for students who are graduating – you're trying to find a job with benefits, but if you can't find a job, how can you pay to get health insurance? It's just kind of lose-lose."

Notably, few young adults in our study were aware of mechanisms that had been enacted under health care reform to help young adults weather these transition periods. Amanda's decision to enroll in another educational program in order to remain a dependent on her father's plan underscores the lack of knowledge that many young adults had about the change in dependency statutes and highlights the lengths to which young adults will go to retain health insurance.

Amanda: 23 years old, Worcester

Amanda started taking OCPs when she was 15 to help regulate her periods and now uses OCPs as her primary method of contraception. She's been on 7-8 different OCP brands over the years and describes herself as "being on a keeper" for now. She has a close relationship with her primary care doctor whom she describes as being "invested" in her experience on OCPs.

When Amanda was working toward her Associate's degree she was insured as a dependent on her father's plan. However, as graduation approached she was terrified she would soon lose her health insurance and thus her access to her primary care doctor and to affordable OCPs. Upon graduation she decided to enroll in further education so that she could remain on her father's health insurance. She still feels anxiety about what will happen when she's done with her current program, "...because once I'm done with school, when I'm done for the summer, then what do I do about health care?"

Finally, a number of young adults signaled that financial barriers impacted their ability to stay consistently enrolled in a health plan. As Andrew (English-language FGD, Boston) explained, “I’ve only been on Aetna for less than a month. I was on what my parents were on until I was 18. At that point I was on Blue Cross Blue Shield; there were a lot of co-pays. Then I dropped off the health plan for two years...and then I decided to go to school, so I was able to hop back on my parents’ health care.” Again, Andrew’s story suggests a lack of clarity as to the available options for young adults in the Commonwealth.

Systems & institutional factors affecting young adults’ contraceptive access & behaviors

Well, like, because like I have the Medicare too, it makes a lot of things difficult for me. Like I was on the patch and they decided that they weren’t going to cover it anymore and then I switched to the pill and then a month later they decided they weren’t going to cover that for me anymore. So I’m like outta luck. (Micaela, Barnstable, enrolled in Medicare as a result of a disability)

Young adults in our groups associated their use of contraception to a multiplicity of individual, interpersonal, community, and structural factors. Participants discussed their use of contraceptive and other SRH services in the context of their sexual orientation, sexual activity, relationship status, pregnancy desires, prior SRH experiences, and gender. In addition to these factors, our FGD participants identified a number of health system and institutional factors that impact both access to contraception and method selection.

Insurance coverage of contraception was a significant factor in shaping women’s decisions about contraceptive use and method selection. A number of women in the discussions reported having discontinued OCPs upon becoming uninsured or changing health plans. Others discontinued OCPs subsequent to coverage changes in their existing plan. Micaela (Barnstable) found that she was unable to secure consistent coverage for her OCPs through Medicare; she began using withdrawal and felt anxious about it: “I use birth control when I have it, otherwise I like don’t use anything and I know that’s like not safe.” A number of other women reported forgoing OCPs because the required co-pays became onerous. As Katie (Pittsfield) explained, “My husband was just laid off...my co-pays for pills are like thirty bucks...That’s on top of antidepressants and I have a whole bunch of other [medications]...By the end of the month, that’s over a hundred bucks, not even counting birth control. So we’re, we’re using condoms.”

Consistent with Katie’s experience, the cost associated with various contraceptive methods was repeatedly identified as a factor influencing method choice. Participants in the FGDs, particularly women, found the co-pays associated with OCPs, the ring, and the patch especially burdensome and both men and women reported the cost of good-quality, over-the-counter condoms to be prohibitive. As with insurance premiums, there was a wide variety in what young adults considered to be expensive and what level of co-pay would be reasonable for prescription contraceptives, although there seemed to be agreement that prescription drug co-pays of more than \$20 were excessive and presented a barrier to access.

Many private insurers place restrictions on receiving routine care outside of a defined coverage area. Several women reported that these restrictions placed burdens on women using OCPs who spent periods of time away from that area. Notably, this particularly impacts students, who described having to juggle prescriptions from one pharmacy to another, change their address repeatedly for

prescriptions delivered by mail, ask their parents to send pill packets, or “load up” during breaks at home and hope that they wouldn’t run out before their return. Maud’s story reflects this challenge.

Maud: 21 years old, Boston College

Maud is in the nursing program at Boston College. She has been on OCPs since she was 17 and is enrolled as a dependent on her parents’ health plan. Maud’s family lives in a New England state and, like many students, she often spends summers and vacations outside of Massachusetts.

Boston College prohibits both distribution of and referrals for contraception. Thus, to fill her OCP prescription, Maud had to travel to an off-campus pharmacy, which she described as “a pain.” But it has been especially challenging for her to get consistent access to OCPs over the summer. Her current health plan won’t allow her to obtain several months of OCPs at once and only allows her to buy prescription medications at pharmacies in a limited geographic area. This past summer she began to order her OCPs by mail. However, a late shipment resulted in her missing several pills and she ultimately discontinued using OCPs and “just kind of gave up on the whole thing.”

While Maud was the only woman to report discontinuing OCPs as a result of difficulties with a mail order prescription drug service, several young women who had studied abroad also reported having to discontinue OCPs because they could not obtain approval from their insurance company for an advanced supply of OCPs sufficient to meet their needs. As Melissa (English-language FGD, Boston) explained, “I was going [abroad] for four months, and they [the health insurance company] only let me do three months, so I had to go off [oral contraception] for a month. And it wasn’t a problem with, like, being sexually active because I was studying abroad and my boyfriend wasn’t there, but my body doesn’t like to have to restart.” Women, both students and non-students alike, also noted that being required to schedule an office visit and have a gynecological exam in order to refill OCP prescriptions was burdensome and unnecessary and increased the costs associated with using OCPs.

Young adults also expressed both a need for and an interest in having more comprehensive and reliable information about the full range of contraceptive methods. Friends, television advertisements, and the internet offered information about contraceptive options, but young adults found it difficult to evaluate the accuracy of that information, especially with regard to the internet. Not infrequently in discussions, participants made claims that were at odds with medical evidence. When the facilitator asked whether anyone had considered IUDs during the Worcester FGD, the group struggled to identify the device; Lucy asked if it was “the new thing” before (incorrectly) asserting, “It’s in like every year, you put it in there.” The women in Worcester were not alone in their confusion; a number of women reported being especially uninformed about long acting reversible contraceptives (LARCs), including both Implanon™ and IUDs. By way of example, when Lee (English-language FGD, Boston) related that she was using Implanon™ most of the other women in the group indicated that they had never heard of an implant and asked a range of questions about what it was, how it worked, and what the insertion procedure was like. Several women asked if they could touch Lee’s arm and “feel” the rod.

Many young adults reported feeling that providers rarely gave them information about the full spectrum of contraceptives methods. As Arielle (English-language FGD, Boston) explained, “I think they should inform a little more...I didn’t even know you could get an implant...They [providers] might, you know, let you know what new options are coming out.” A number of young women enrolled in private insurance plans felt as though they had been pushed toward OCPs and away

from other methods, including LARCs. Audrey (Barnstable) explained that her provider discouraged her from stopping the pill, despite Audrey's ongoing difficulties with side effects: "The thing of it is, I wanted to get the little copper, the IUD, and my doctor, it wasn't my insurance that wouldn't cover it, my doctor was struggling against it to a point where she was like 'I'm not going to do that for you,' because I'm not married and I don't have children and the fact that it could potentially make [me] sterile."¹⁵

In contrast with these experiences, women enrolled in MassHealth and women who sought their care at Title X clinics or Planned Parenthood were much more likely to report being offered a variety of contraceptive methods than other groups. Nicole (Pittsfield), one of the few participants using a Mirena®, had high praise for the range of contraceptive services available through MassHealth. "I don't take birth control [pills] because I have the best birth control in the world. I don't need to worry about taking a pill every day or counting prescriptions. MassHealth covers the IUD so every five years they cover the appointment for me to get it." Alyssa (Barnstable) echoed her appreciation for the scope of services, "I've always had good experiences with like family planning places. They've never not given me what I wanted or what I needed because I couldn't pay them, which is good. I think they are a good thing to have in that they don't tell parents and stuff."

Population-specific barriers & challenges to accessing contraceptive services

Their general rule is that they [health services at a Catholic university] will provide no birth control counseling. So like you kind of just tell them that you're only using it for reasons other than contraception, so kind of let it slide, but they don't generally provide any [forms of contraception]. (Courtney, Worcester)

In general, participants across plan types reported feeling a great deal of security in having insurance. The diversity of participants in our study allowed us to gain valuable insight into the challenges that specific sub-populations of young adults experience in accessing contraception. In addition to those challenges described above, we highlight here some of the specific barriers experienced by women in non-urban areas of the Commonwealth, women enrolled in MassHealth and other subsidized plans, college and university students, and young adult men.

Some young adults in non-urban areas of the Commonwealth described a lack of good options for providers within their immediate geographic area, especially those who used MassHealth. Participants in these areas also bemoaned the lack of "auxiliary" services such as Planned Parenthood and Title X clinics. A number of women in our Barnstable and Pittsfield groups described having to travel especially long distances to obtain affordable prescriptions or meet with providers, but these challenges were present in the accounts of a number of women who lived outside of urban areas. Anna (Worcester) explained, "Where I used to live in Dudley, they really didn't have a MassHealth, a NetworkHealth there, so like I had to come all the way out here to Worcester just to find a doctor for my kids, and that was awful, I really did not like that."

For those enrolled in Commonwealth Care plans or MassHealth, the low cost of prescription contraceptives and the range of contraceptive services were highly valued. However, young adults enrolled in these plans found the frequent administrative changes challenging, especially as it could

¹⁵ Once inserted, the IUD can serve as a highly effective contraceptive method for up to 5 years (progestin-releasing) or up to 12 years (copper-bearing). Unmarried and nulliparous women can safely and effectively use IUDs and, despite enduring myths, there is no evidence of a causal relationship between currently available IUDs and infertility [51].

sometimes translate to higher prescription drug costs without warning. Additionally, participants enrolled in subsidized insurance plans reported that the frequent need to re-certify their eligibility for benefits through paperwork sent by mail was cumbersome and often at odds with their need to change addresses frequently. For some women, this resulted in gaps in contraceptive services and impacted continued use of a preferred method. Finally, women enrolled in subsidized plans in Pittsfield, Worcester, and Barnstable indicated they had difficulty finding providers who would accept MassHealth for themselves or for their children, as Alyssa's story reveals.

Alyssa: 24 years old, Barnstable

Alyssa enrolled in MassHealth after the birth of her son five years ago. She currently uses condoms as her primary mode of contraception. Alyssa isn't particularly happy with condoms: "They're inconvenient, they break. They're just not reliable really. They help, I mean they're better than nothing, but that's about it." However, when she was previously on OCPs she experienced side effects that "made [her] nutty."

Alyssa also had difficulties filling her prescriptions. She gets her care from a "family planning place" on Cape Cod and she's always had positive experiences at the clinic. However, per their protocol she had to contact the clinic each month, a week before the end of her pill cycle, to have them reissue her prescription. This made it difficult for her to use OCPs continuously; sometimes she would forget to call until she finished her packet of pills, and then she wouldn't be able to start the next cycle without a gap. She says she was often "stuck for a week" without her OCPs.

Alyssa had various other challenges when she was on OCPs. The amount that she had to pay for her pills was variable and depended on her income over the previous three months. "So sometimes it's high and sometimes it's low. And that kind of fluctuates without them [MassHealth] even telling me." She reported that there were times when she went to pick up a prescription only to learn from the pharmacist that her co-pay had changed: "I've just been unprepared before when I have to go pick up prescriptions or at the doctor's office sometimes there's a co-pay, sometimes there's not. They're always changing what kind of MassHealth you have."

Alyssa has been uninsured for the last three months, but she is trying to get re-enrolled in MassHealth. "I missed my re-certification. I didn't send [in] my thing; I moved so I didn't get my packet in time." As someone who changes addresses frequently, Alyssa has had difficulties keeping up-to-date with the required paperwork.

College students also experienced several unique challenges in accessing contraceptive services. In addition to the confusion around insurance waivers and on-campus health fees, the anxiety about securing health insurance post-graduation, and the challenges created by religiously-affiliated institutions that refuse to provide contraceptive counseling, referrals, or services, a number of our student participants also expressed concerns about privacy. Students in our discussions were all over the age of eighteen and many were living independently for the first time in their lives. Yet, a number of our participants expressed concern about the ways in which insurance statements or bills were directed to their parents. Some students expressed concern that their parents would learn about (or infer) their sexual activities and use of contraception by reading a letter or statement from an insurer. As a result, some college students sought care at "auxiliary" care locations, but others expressed frustration that their local options were so limited. Further, a number of students indicated that most newly matriculated students are unaware of alternatives, or the lack thereof. Sarah (Boston College), an out-of-state underclasswoman, was interested in obtaining contraception, but felt unprepared to go off campus to find it: "I was thinking about going on birth control pills for a while... but um, but I don't know where to go, where to start, and, you know, I think there's a place called Planned Parenthood. I mean is it gonna help me out, maybe if I call a hotline, but I don't know where to even start..."

Finally, although only 12 men participated in this study, there was near unanimity among male participants that men rarely receive information from their providers about contraceptive methods and services. Marcelo (Spanish-language FGD, Boston) felt that information was as much of a problem for men as was the expense of contraception: “Being a man, I was only told ‘condom’ and now, and now that I am with a partner, she knows a lot about her options, but I do not, so we cannot have that conversation. I have to go to the internet to do research and read lots of information and et cetera, et cetera.” Although men spoke at length about their feelings of responsibility for using condoms and getting tested for STIs, our male participants had little knowledge of contraceptive methods other than condoms and OCPs. As Cruz (Spanish-language FGD, Boston) explained, “...When I had a girlfriend, she was on the pill, but we used a condom anyway. This past year I have had several, uh, partners then no, I do not know necessarily know what they are taking.”

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 and a half years since Chapter 58 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 the initiative [42,52]. Efforts to expand affordable health care to young adults through targeted programs and changes in the dependency statutes are laudable.

Our study aimed to understand better young adults’ access to contraceptive services in the wake of health care reform and to identify systems barriers to pregnancy planning in this age cohort. Through discussions with a geographically, socio-economically, and racially/ethnically diverse groups of young adults insured (or not) through a variety of health plans, we hoped to learn about young adults’ experiences obtaining health insurance and health plan information, making decisions about and using contraception, and accessing contraceptive and other SRH services. We also aimed to explore young adults’ opinions of health care reform in the Commonwealth and the ways in which the health system and health service providers could better address their contraceptive and other SRH needs. The results of this study suggest a number of avenues for improving contraceptive and other SRH services to young adults at the system and provider levels.

Is information about health care reform & SRH coverage understandable & accessible?

Information about health care reform and health plans is complicated and can change frequently. Our research found that many of the young adults who participated in this study demonstrated considerable health insurance illiteracy and lacked knowledge about health care reforms in Massachusetts. Further, many participants were confused about their own coverage of contraceptive and other SRH services as well as about some methods of contraception.

Efforts to expand affordable health care to young adults through targeted programs are commendable, and we found strong support for the Commonwealth’s efforts to increase access to health care in our discussions. This support was especially strong among those who had benefitted directly from the reforms, either through the ability to stay on a parents’ plan after graduation or

through enrollment in a subsidized and young adult-targeted plan. That a significant proportion of young adults felt both that they had been unaffected by health care reform and that the mandate was a potential burden on others reflects other poll findings [53]. Our results suggest that many of the concerns about affordability are rooted in a lack of awareness about the different components of Chapter 58. While a majority of young adults, especially those who had lived in the state for more than a year or two, indicated that they knew about the individual mandate, they did not know about the accompanying reforms designed to make this mandate affordable for Massachusetts residents, including: the creation of subsidized and young adult-targeted plans, increased eligibility for MassHealth, and the changes in dependency statutes. In a number of cases, we found that young adults made life decisions (including enrolling in additional schooling) or had been uninsured for a period of time because of misinformation surrounding their eligibility to remain on a parental health plan.

Taken together, these findings demonstrate that the messaging about health care reform has not resounded with many young adults, despite efforts to communicate through young adult-modalities such as social networking sites, college and university newspapers, and MTV and in collaboration with the Red Sox and the MBTA [54,55]. The consistent confusion about plan types and coverage documented in this research suggests that the categories employed by the state (especially for Commonwealth Care and Commonwealth Choice plans, but also for various forms of MassHealth) do not resound with young adults. Further, health care reform messaging and enrollment materials may presume a greater degree of health insurance literacy than young adults currently possess, thereby limiting the effectiveness of outreach efforts.

The development of the Commonwealth Connector website is a particularly appropriate vehicle for communicating health information and education to young adults, a population that is especially likely to consult online resources for information about both general health and SRH issues [56,57]. Yet our participants frequently reported that the Commonwealth Connector website was difficult to use, both for determining eligibility and for comparing different types of plans. Our informants also felt that the Commonwealth Connector website, along with many private insurance websites, failed to keep key elements, such as contact information for in-network providers, up to date. Coverage for contraception and other SRH services also received minimal attention in online materials. Thus young adults who sought to compare plans on the basis of SRH services, and specifically the coverage and costs of different OCPs, were unable to obtain this information. This represents a missed opportunity to make efficient use of the website and engage young adults.

Finally, we found young adults often lack information on the full array of contraception available to them. This includes costs and coverage of various methods, but also basic information about medications and devices other than OCPs and condoms. This lack of information constrains the ability of young adults to choose methods that are most cost-effective and most likely to meet their needs. Many young adults in our study expressed dissatisfaction with their current contraceptive method, and in particular with OCPs, and dissatisfaction has repeatedly been associated with both discontinuation and less consistent use of contraceptive methods [40,45]. Our results suggest that young adults may be unaware of alternatives to the method(s) they are currently using and that providing comprehensive contraceptive information to those who want to initiate a method along with those who are currently contracepting would be welcomed. Finally, young adults in our study, particularly women on private insurance and men, indicated that they would welcome greater education about methods of contraception as well as the broader array of SRH services.

Are young adults making their own decisions about health insurance?

The majority of insured young adults in our study were not the primary decision makers with respect to health plan selection. In addition to the constraints related to employer and school-based insurance and income eligibility for subsidized plans, parents of young adults were a driving force in health plan selection. In our study, parents, and particularly mothers, motivated young adults to obtain insurance in order to comply with the individual mandate or school requirements and/or to receive the benefits that health insurance can bring. Although they often go unrecognized as decision makers, parents made decisions about their young adult children's health insurance in about half of the cases in this study. This delegated decision making is in part responsible for participants' lack of awareness and confusion about their own coverage, as we found that young adults who chose their own health plans and those who collaborated in decision making about health insurance were most likely to be knowledgeable about the various options that were available to them, the guidelines of their plans, and the benefits to which they were entitled. More often, delegated decision makers chose insurance plans for young adults without discussing the rationale for this choice with them. We found that this put young adults at a disadvantage, in terms of both knowing the parameters of their coverage and being able to effectively communicate their needs in light of the possibilities available to them. While many young adults expressed relief that their parents agreed to take on the onerous task of comparing health insurance options, they often felt they had to "live with" arrangements that did not best fit their needs, especially when it came to more sensitive topics like contraceptive and other SRH services. In some cases, these needs emerged over time, for example as young adults became increasingly sexually active and needed prescriptions for OCPs or other contraceptives. Our participants, especially students who were living away from home, suggested it was often difficult to raise these issues with parents.

Our findings also suggest that parents are typically unaware of the potential consequences of choosing health insurance for their young adult children without involving them in the decision making process. Beyond the fit of insurance to young adults' emerging needs, young adults who were not engaged in the decision making process appeared to face real challenges when their coverage did not extend to services they had previously received and or when they were required to advocate for themselves. Further, they expressed a lack of confidence in choosing insurance when they later transitioned to a situation in which they had to select their own coverage. While we focus on parental decision making here, organizations and advocates that help young adults enroll in plans (i.e., those who assist young adults in enrolling in subsidized plans) should also be encouraged to engage young adults in the decision making process. Working with this population to "choose" insurance and communicating to young adults the rationale behind their placement in specific plans could help increase the number of educated health insurance consumers in Massachusetts.

Do young adults experience unique challenges in obtaining health insurance?

Two years after the implementation of health care reform, the Commonwealth had the lowest uninsured rate in the country, just 2.6% [26,60]. In our study, 10% of young adult participants were uninsured at the time of the discussion group, a rate more consistent with the uninsured rates for young adults in Massachusetts [60]. In addition, a sizeable proportion of our participants discussed having been temporarily uninsured in the previous two years (the post-Chapter 58 period). Being uninsured was almost always associated with a significant transition such as graduating from college, the loss of a job or start of a new one, moving residence, or a birthday and was almost always involuntary. Yet transitions characterize the lives of young adults. The "snapshot" of current enrollment provided in this report only partially reveals the myriad experiences and complicated

histories many participants have had with health insurance. Nearly 20% of our participants had enrolled in their current health plan within the last year; 14% had been on their current plan for six months or less. Further, a significant proportion of our participants had had three or more insurance types (including being uninsured) in the past two years.¹⁶ It appeared that some individuals in this study might have been able to maintain their insurance coverage had they been aware of provisions in Chapter 58 to extend the “dependency” of young adults. We found that a lack of knowledge about these options rather than calculated risk analysis characterized periods of uninsurance.

Do young adults face systems barriers to obtaining contraceptive services?

Our study reveals that young adults’ access to contraceptive services and utilization of specific contraceptive methods is tied to broader issues of insurance coverage and cost. Although specific populations of young adults face particular barriers to obtaining consistent access to contraceptive and other SRH services, the dynamics of being transitionally uninsured and/or moving between health plans within this age cohort impacts consistent and affordable access to contraception. Further, the co-pays associated with obtaining prescription contraceptives (particularly OCPs) were onerous for many young adults, particularly those in private insurance plans. Most young adults who are enrolled in a private insurance plan are not eligible for subsidized care or other more affordable services, yet the high co-pays for prescription drugs and office visits made their preferred contraceptive method prohibitively expensive. These costs directly impacted young adults’ decisions about method utilization and generally resulted in young adults turning to less reliable methods of pregnancy prevention or non-use altogether. Finally, as noted previously, young adults in our study repeatedly reported that they were unable to find reliable, current, and age-accessible information about contraceptive coverage in various health plans and that they lacked information about the full range of contraceptive options. For many young adults in our study, their primary interaction with health service providers and the health system more generally was in relationship to contraceptive and other SRH services. And for many women, their use of prescription drugs was limited to hormonal contraceptives. These findings suggest that young adult-targeted efforts could be better tailored to address the challenges of health service utilization expressed by this population.

Our results also reveal that in the wake of health care reform, several specific sub-populations of young adults are experiencing particular challenges to accessing contraception. Below we discuss the specific systems and provider barriers that college and university students, enrollees in subsidized health plans, and young adult men have experienced.

College & university students

Full time college and university students in the Commonwealth have long been required to have health insurance. For some, the status of student facilitates insurance coverage and offers an important mechanism of affordable insurance in the form of the SHP. Yet there are limitations in the coverage that SHPs provide, particularly at religiously-affiliated institutions, and some students found themselves unable to enroll in affordable alternatives. Recent modifications that now allow students who are otherwise eligible to enroll in or continue on both MassHealth and Commonwealth Choice plans were welcomed by our student participants as providing them with important continuity of coverage and consistent relationships with their providers. However, several

¹⁶ In contrast, 15% of our participants reported having been on their current insurance for 10 years or more. For participants who were continuously enrolled on their parents’ health insurance plan or who were enrolled in MassHealth in both childhood and young adulthood comments like “I’ve had it forever,” “since I was born,” and “for as long as I can remember” were not uncommon.

students mentioned that even if otherwise eligible, they are still prohibited from enrolling in or staying on a Commonwealth Care plan. For young adults enrolled in SHP plans that do not provide a full range of SRH counseling, referrals, and services, the inability to enroll in affordable alternatives results in paying out-of-pocket for contraception, which can be financially prohibitive.

Yet there are other challenges associated with being a student, especially for those who are living in an unfamiliar place for the first time and/or who have limited transportation options. For example, students who lacked knowledge of the local area and nearby resources reported difficulties in identifying SRH service providers. Further, students who had geographic restrictions on their in-service networks reported difficulty in being able to see a provider or get an adequate advance supply of OCPs. These challenges were especially true for students attending religiously-affiliated institutions that provide neither on-campus SRH services, including contraception, nor referrals to area providers. Further, we found that students who enrolled in these institutions were frequently unaware of these restrictions and the limitations of SRH services available on-campus until they were needed. Participants in our Boston College group reported that the stigmatization of contraceptives and other SRH services extended to women's health services in general, and it was extremely difficult to know what types of care were "allowed" and which were "forbidden."

The lack of clarity about what types of services were offered by an on-campus health facility was not limited to students at religiously-affiliated institutions. Students at a range of institutions reported and evinced confusion about how their on-campus services and external coverage (either through the school or through enrollment in a parental plan) fit together. Students were also not always sure what would be billed to external insurance and what services they were entitled to through their campus health services fee and were unclear as to what information their parents would receive or have access to. That the parents of adult children may receive statements or bills that provide information about health services utilization raises significant concern about confidentiality and privacy and may undermine students' ability to access affordable contraceptive care.

Colleges and universities have a unique responsibility to provide clear and transparent information about the health services they cover, not only because of their role *in loco parentis* (e.g., in place of a parent) to ensure that students are able to receive off-campus health care safely, but also because students are often mandated to pay fees for health services and can be limited in their choice of plans as a result of enrollment. Our study suggests that information for students about their health services is far from transparent. Further, although colleges and universities do much to ensure that their students are well-positioned to succeed in post-graduation pursuits, we did not find that these institutions provided much information about the effects of this transition on students'/graduates' insurance status or eligibility for coverage. Given that students often expressed considerable anxiety about this transition and that graduation precipitated brief periods of uninsurance, new graduates would likely appreciate resources to help them better meet this challenge. As Sophie (English-Language FGD, Boston) suggested, "If there was some way to, I don't know, to have, like, a health fair day... for these different insurance companies, where people who either don't have insurance yet, or have just signed up can learn more about it and actually talk to people."

Enrollees in subsidized plans

That health care reform measures included expansion of MassHealth eligibility and the creation of Commonwealth Care plans has undoubtedly benefited many young adults in the Commonwealth [61]. Indeed, young adults enrolled in MassHealth were particularly appreciative of the affordability of contraceptive services. Yet young adults enrolled in MassHealth were more likely than any of our

other participants to report being dropped from their insurance plan for reasons that were primarily administrative; they were also more likely to report being dropped by their current provider and subsequently encounter difficulty finding another provider they liked who also accepted their insurance. This was especially true of participants in areas of the Commonwealth such as Barnstable and Pittsfield, where the pool of primary care providers in general is more limited. This dynamic of instability made it difficult for some women to consistently access contraceptive and other SRH services. The young adults enrolled in Commonwealth Care plans were less likely to report being dropped by their providers, but noted that frequent administrative changes and different cost-sharing arrangements were often instituted with little or no notice. For some women, this represented a significant barrier to accessing contraceptive services, as the cost of obtaining a monthly supply of OCPs could vary dramatically. Several women reported making the visit to the pharmacy only to learn that their co-pay for OCPs had doubled; while some were able to cover the difference, more than one woman reported that on occasion she had to leave empty-handed.

Finally, a number of MassHealth enrollees reported experiencing stigma in their interactions with providers and within the broader health system. Several enrollees in MassHealth felt that this made it more difficult to obtain comprehensive SRH services. In two notable instances, participants expressed concern that services that limited their fertility were more likely to be covered than those in support of family creation, such as infertility treatment. That not all SRH services were felt to be covered to the same extent and that providers reacted very differently when an enrollee wanted to be pregnant than when she wanted to prevent pregnancy contributed to an overall sense of stigma.

Young adult men

The majority of men in our FGDs saw themselves as largely left out of conversations about contraception and other SRH issues. Nearly all of our male participants reported that they had seen a provider for routine STI screening and more than half appeared to be doing that on a regular basis. Male participants reported that they regularly used condoms, particularly with new or casual partners. Men generally described themselves as taking responsibility for condom use in the context of disease prevention, and one young man was particularly emphatic about the use of condoms to prevent pregnancy, regardless of whether his partner was using another modality of contraception. Yet in discussions about longer term relationships and pregnancy prevention practices, men were less clear on their role. Men consistently expressed the desire to actively support their female partner(s) and several referenced accompanying their partners for contraceptive services or paying co-pays and other expenses related to contraceptive methods other than condoms. But none of these men described themselves as having had extensive conversations with their own providers about contraceptive options and they possessed little knowledge of methods other than condoms and OCPs.

Our findings are consistent with other research [47]. Men are especially likely to enter young adulthood with limited education on SRH issues: a 2002 study found that, although two-thirds of male adolescents had received a physical examination in the year prior to the survey, fewer than 20% reported having received counseling or advice from a provider about contraception or STIs, including HIV [57]. A national study published in 2009 found that 76% of young women surveyed reported learning “a lot” or “some” about sexual health and relationship issues from health care providers (among other sources), but only 45% of young men reported the same level of education from providers [44]. Providers can play a critical role in educating young adults about SRH issues, but a body of research demonstrates missed opportunities, particularly with men. Also consistent with other studies, men in our groups expressed considerable interest in getting more information

about both contraception and general SRH issues [47]. Strategies to help providers engage with young adult men about contraception appear particularly welcome.

Study limitations

Qualitative research provides an excellent opportunity to conduct an in-depth exploration of informants' experiences, behaviors, and beliefs and can not only give voice to those experiences but provide important guideposts for advocacy and future research. Because this type of research relies on the self-reported experiences, opinions, and ideas of participants, our findings speak to what participants know or think they know about the health system in Massachusetts, insurance eligibility and coverage, and factors influencing their experiences with health insurance and contraception as well as to how they feel about and perceive these systems and issues. As we have documented throughout this report, these understandings were often conflicting and reflected partial knowledge and cannot necessarily be taken as a statement of “the way things are” in the Commonwealth. Rather these results provide an important window into the ways that young adults in Massachusetts understand their options and experiences.

As is true of research based on FGDs, one of the limitations of our study involves social desirability bias. Participants in our discussions may have altered their responses based on their desire to provide politically or socially acceptable responses to the study team or to the group of young adults participating in the discussion. Further, the variation in the size of our FGDs may also have informed differences in the content and interactions across groups; for this reason, we are careful not to draw comparisons across the different groups, except where participants made explicit comments about the importance of their geographical location or student status.

Like all qualitative research, this study was designed to provide information about the experiences, opinions, and behaviors of individuals and our findings are not intended representative or to be generalizable. Further, because little information about this age cohort (such as their enrollment and utilization patterns, demographic breakdown, etc.) has been provided by the Health Connector, we cannot fully contextualize our sample and findings within the broader population and experiences of young adults in the Commonwealth. However, the diversity of our informants, in terms of insurance type, geographic location, background, and age within the target cohort, is exceptionally rich for this type of study and reflects many of the important variations that we would expect to be most salient in young adults' experiences.

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 health insurance & contraceptive coverage in the Commonwealth.** In our FGDs, young adults repeatedly evinced confusion regarding health care reform, their insurance plans, and the coverage of contraceptive and other SRH services. Those who had used the Commonwealth Connector website reported difficulties finding relevant information. There are a number of avenues by which information about health care reform as well as the coverage of contraceptive

and other SRH services can be more effectively and comprehensively communicated to young adults, both by the Connector and by other organizations that advocate for young adult populations.

- a. Create information resources to help young adults navigate the health system in the Commonwealth. The guide should include information about the various components of health care reform that impact young adults (including specific information about the changes in dependency statutes) and be pitched toward young adult consumers. This information resource could be incorporated into the Commonwealth Connector website and/or be available as a supplementary resource.
- b. Modify the Commonwealth Connector website such that descriptions of the YAPs and Commonwealth Care plans 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.
- c. Add to the FAQ directory on the Commonwealth Connector website so as to allow young adults to readily obtain information about the contraceptive and other SRH services covered in different plan types.
- d. Develop a compendium or guide on contraceptive and other SRH services that can supplement information on the Commonwealth Connector website. We recommend that this guide include a FAQ section (as listed above), “scenarios” that walk young adults through the costs associated with contraceptive use under each plan, provide evidence-based information about various contraceptive options, 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) Develop resources that can assist parental decision makers understand better the insurance needs of their young adult children. The results of the FGDs revealed that for many young adults, decision making around health plan enrollment rests with parents. Many young adults in our sample reported that their parent(s) was/were not fully aware of their priorities and needs with respect to contraception and other SRH services. Recognizing that this dynamic is important, creating resources to help parent(s)/caregiver(s) navigate health plans on behalf of their young adult children could address a significant need.

- a. Create a discussion guide to help young adults and their parents communicate about enrollment in health plans in the Commonwealth. This guide should provide information about key considerations in selecting a health plan and about how young adults’ contraceptive and other SRH needs and priorities may evolve over time.
- b. Raise awareness about the changes in the dependency statutes that resulted from Chapter 58. Messages should target both young adults and their parents/caregivers, who are often making or sharing in health care-related decisions.

3) Develop mechanisms for providing contraceptive services to underinsured young adults & providing more affordable contraceptive services to insured young adults. Our results reveal that there are a number of systems gaps that impact the ability of young adults to access affordable and continuous contraceptive and other SRH services. Young adults who are enrolled

in health plans with religious restrictions on counseling, referrals, or service delivery, young adults who are enrolled in non-prescription YAPs, and young adults who find themselves uninsured for transitional periods are among those populations that may find themselves “underinsured” with respect to contraceptive services. There are a number of mechanisms that would address this challenge:

- a. Require that all young adult-targeted health plans, including the SHP and the YAPs, meet the MCC standards as currently conceived. This would include a requirement that all young adult targeted plans include a prescription drug benefit.
- b. Consider revising the MCC standards such that all young adult-targeted plans 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, asthma, and mental health medications, antibiotics, vaccines, and prescription contraceptives including LARCs) could be mandated. Medications outside of the formulary could either be excluded or made available through additional cost-sharing mechanisms.
- c. Consider expanding coverage of subsidized contraceptive medications and devices to young adults who are enrolled in a qualified plan that does not cover prescription contraceptives. 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 and to young adults enrolled in religiously-affiliated plans (whether through educational institutions or employers) that have SRH exclusions. 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 Federal Poverty Level, being under the age of 20 (regardless of income), or receiving MassHealth Limited Coverage. As many young adults find themselves transitionally uninsured, typically in the wake of graduation and/or while awaiting employer benefits to kick in, extending coverage, regardless of income, would meet a significant need. Further, extending subsidized coverage to young adults through the age of 26 who are effectively underinsured, regardless of income or plan type, could address a significant systems gap and ensure that young adults receive the contraceptive services they need. We recommend that the MDPH-FPP review their eligibility requirements and assess funding levels to determine if the program can be expanded.
- d. Redouble efforts to make contraceptives more affordable for young adults enrolled in private insurance plans and young adult-targeted plans. Many young adults in our study found their co-pays for prescription contraceptive methods (particularly OCPs) to be prohibitively expensive. Further, both students and non-students noted that being required to schedule an office visit and have a gynecological exam in order to refill OCP prescriptions was burdensome and unnecessary and increased the costs associated with using OCPs. Efforts should also be undertaken to ensure that both student and non-student populations have better access to high-quality, affordable condoms and other non-prescription contraceptives.

4) Address the barriers that many university & college students experience in obtaining contraceptive & other SRH services. 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 implementation of Chapter 58. While the efforts underway to reconcile the SHP requirements with the MCC standards are commendable, the results of our FGDs with students enrolled at different institutions reveal that many students face barriers to accessing contraceptive and other SRH services. There are a number of methods by which these obstacles could be addressed:

- a. Review the impact of billing procedures and service statements on students' privacy and consider changes that would ensure that the default systems of disclosure protect students' confidentiality.
- b. Ensure that information about on-campus health services is transparent to both prospective and enrolled students. Students should be aware of the services they are entitled to use, particularly when health service fees have been bundled with other tuition and educational costs.
- c. Establish and enforce requirements that SHP plans disclose limitations and exclusions, including restrictions on contraceptive coverage, to both students and prospective students. Many religiously-affiliated plans do not offer a full range of SRH services, with contraception a frequent and notable exclusion. If SHP plans place restrictions on contraceptive counseling, referrals, or services, alternative forms of affordable coverage should be made available, and avenues through which a young adult can access these services (and where those services are located in relationship to the campus) must be made clear.
- d. Alert students to the recent eligibility changes to both MassHealth and Commonwealth Choice plans. That full time students who are otherwise eligible now have the option of enrolling in MassHealth or the YAPs is laudable, but many students appear unaware of these policy changes. 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. Institutions could determine that participation in a Commonwealth Care plan constitutes "proof of comparable coverage" for purposes of the SHP.
- e. Help students prepare to obtain or maintain health insurance after graduation. Educational resources targeted at soon-to-be graduates should clearly explain the health insurance options available to them, including the option of remaining on a parental plan for up to two years or until the age of 26.

5) Increase the pool of SRH providers who accept MassHealth & Commonwealth Care Plans, especially in underserved areas. Our findings indicate that MassHealth enrollees often face considerable difficulty finding and maintaining relationships with providers who accept their insurance. These challenges were especially acute for those in Western Massachusetts, Central Massachusetts, and Cape Cod, where long distances to providers are common and alternative SRH care facilities are limited. Sustained efforts to increase the number of primary care SRH service providers who accept MassHealth will allow young adults across the Commonwealth to seek and receive the care to which they are entitled.

6) Encourage providers to engage young adult men in discussions about pregnancy prevention. Men in our FGDs expressed interest in receiving additional information about the full range of contraceptive options. However, the majority of men in our FGDs saw themselves as largely left out of conversations about contraception and other SRH issues and they possessed little knowledge of methods other than condoms and OCPs. Developing strategies to engage

young adult men in discussion about the full range of contraceptive options, particularly at the provider level, appears warranted.

- 7) **Collect more robust data on young adults & health care reform.** Young adults have undoubtedly benefited from many aspects of health care reform. 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 to 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 Chapter 58.

Conclusion

Health care reform in the Commonwealth has provided young adults with important new options for health insurance coverage that can facilitate access to comprehensive SRH care, but many young adults are unable to take advantage of these opportunities because of a lack of information or structural barriers. In light of our findings, we have made a number of recommendations toward ensuring that young adults in Massachusetts receive accessible and population-specific 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. Given the unique role of Massachusetts in shaping national health care reform, the decisions made in the Commonwealth and lessons learned from young adults' experiences of 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

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 and 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. 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 formative research of **REaDY** and led the FGD study, including study design, data analysis, and dissemination activities.

Joanna Prager, MAWH served as an Intern at Ibis Reproductive Health in 2009. She completed her Master of Arts in Women's Health (MAWH) at Suffolk University, where she focused her studies on health care and outcome disparities, with an emphasis on reproductive health. She also holds a Bachelor of Arts (BA) in Psychology and Women's Studies from University of Massachusetts-Boston. While at Suffolk, she served as a research assistant for a longitudinal study of health outcomes and health and social service utilization of post-incarcerated women in the Commonwealth. Ms. Prager served as a research assistant on the FGD study, conducting background research and contributing to data management.

Julia Havard joined Ibis Reproductive Health as an Intern in 2008. Pursuing a Bachelor of Arts at Harvard College, she is concentrating in History and Science with a focus on the social aspects of mental health and the history of women's health. 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 formative research and assisted with FGD recruitment and co-facilitated a number of discussions.

Danielle Murphy served as an Intern at Ibis Reproductive Health in 2009. She is currently pursuing a Bachelor of Arts in Government from Connecticut College, with a concentration in Gender and Women's Studies. She has held internships with Planned Parenthood of Connecticut, the Women's Center of Southeastern Connecticut, and Congressman Edward J. Markey's office. Ms. Murphy is the Student Coordinator of the Connecticut College Women's Center. After completing her undergraduate degree she looks forward to working in the reproductive justice movement, exploring further the politics of reproductive health care as a human right. Ms. Murphy contributed to the design and implementation of the FGD study and developed multi-modal strategies for recruitment.

Madina Agénor, MPH served as a Research Assistant at Ibis Reproductive Health from 2008 to 2009. 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. 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) in Society, Human Development, and Health at the Harvard School of Public Health. Ms. Agénor led the systematic health plan review and contributed to the recruitment and facilitation of the FGDs.

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, 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" and in 2009 she received the Outstanding Young Professional Award from the American Public Health Association's Population, Sexual, and Reproductive Health Section. As Principal Investigator of **REaDY**, 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: General participant characteristics, overall & by FGD, n (%)¹⁷

| | All FGDs (N=86) | Individual FGDs (E=English-language, S=Spanish-language, W=Women, M=Men) | | | | | | | | | |
|---|--------------------|---|-----------------------|-----------------------|-----------------------|---------------------------|---------------------------|---------------------------|---------------------|------------------------|--------------------|
| | | Boston EW (n=20) | Boston EM (n=8) | Boston SM (n=4) | Boston SW (n=6) | Pittsfield EW (n=6) | Worcester EW (n=17) | Barnstable EW (n=3) | STCC EW (n=4) | Harvard EW (n=5) | BC EW (n=13) |
| Race/Ethnicity | | | | | | | | | | | |
| Hispanic or Latino/a | 19(22) | 0(0) | 2(25) | 4(100) | 5(83) | 2(33) | 2(12) | 0(0) | 2(50) | 1(20) | 1(8) |
| American Indian, Alaska Native, Native Hawaiian, Other Pacific Islander | 5(6) | 2(10) | 0(0) | 1(25) | 0(0) | 0(0) | 1(6) | 0(0) | 0(0) | 0(0) | 1(8) |
| Asian/Asian-American | 4(5) | 2(10) | 0(0) | 0(0) | 0(0) | 0(0) | 1(6) | 0(0) | 0(0) | 1(20) | 0(0) |
| Black/American-American | 14(16) | 2(10) | 1(13) | 0(0) | 0(0) | 0(0) | 2(12) | 0(0) | 1(25) | 1(20) | 7(54) |
| White | 55(64) | 15(75) | 6(75) | 2(50) | 1(17) | 6(100) | 12(70) | 3(100) | 1(25) | 3(60) | 6(46) |
| Other | 9(10) | 0(0) | 1(13) | 1(25) | 2(33) | 1(16) | 1(6) | 0(0) | 1(25) | 1(20) | 1(8) |
| Don't know | 2(2) | 0(0) | 0(0) | 0(0) | 1(17) | 0(0) | 0(0) | 0(0) | 1(25) | 0(0) | 0(0) |
| Citizenship | | | | | | | | | | | |
| US citizen | 78(91) | 19(95) | 8(100) | 1(25) | 2(33) | 6(100) | 17(100) | 3(100) | 4(100) | 5(100) | 13(100) |
| Legal resident | 6(7) | 1(5) | 0(0) | 2(50) | 3(50) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) |
| Undocumented resident | 1(1) | 0(0) | 0(0) | 1(25) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) |
| No response | 1(1) | 0(0) | 0(0) | 0(0) | 1(17) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) |
| Religion | | | | | | | | | | | |
| Agnostic/Atheist | 10(12) | 5(25) | 2(25) | 0(0) | 1(17) | 0(0) | 1(6) | 1(33) | 0(0) | 0(0) | 0(0) |
| Catholic | 28(33) | 6(30) | 1(12) | 2(50) | 3(50) | 1(16) | 7(41) | 0(0) | 1(25) | 1(20) | 6(46) |
| Jewish | 6(7) | 2(10) | 2(25) | 0(0) | 0(0) | 1(17) | 1(6) | 0(0) | 0(0) | 0(0) | 0(0) |
| Protestant | 8(9) | 3(15) | 0(0) | 0(0) | 0(0) | 1(17) | 0(0) | 0(0) | 0(0) | 2(40) | 2(15) |
| Other | 26(30) | 2(10) | 2(25) | 2(50) | 1(17) | 3(50) | 5(29) | 3(100) | 2(50) | 2(40) | 4(30) |
| None | 13(15) | 4(20) | 1(12) | 1(25) | 1(17) | 1(17) | 3(18) | 1(33) | 1(25) | 0(0) | 0(0) |
| Sexual orientation | | | | | | | | | | | |
| Bisexual | 8(9) | 2(10) | 1(12) | 0(0) | 0(0) | 3(50) | 2(12) | 0(0) | 0(0) | 0(0) | 0(0) |
| Gay/lesbian | 2(2) | 1(5) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 1(8) |
| Heterosexual | 72(84) | 16(80) | 7(87) | 4(100) | 6(100) | 3(50) | 14(82) | 3(100) | 3(75) | 5(100) | 11(85) |
| Unsure/other/no response | 4(5) | 1(5) | 0(0) | 0(0) | 0(0) | 0(0) | 1(6) | 0(0) | 1(25) | 0(0) | 1(8) |

¹⁷ We conducted two English-language FGDs with women in Boston. These groups had identical eligibility criteria and the exit survey results from these two FGDs are combined on this table.

| | All FGDs (N=86) | Individual FGDs (E=English-language, S=Spanish-language, W=Women, M=Men) | | | | | | | | | |
|--------------------------------------|--------------------|---|-----------------------|-----------------------|-----------------------|---------------------------|---------------------------|---------------------------|---------------------|------------------------|--------------------|
| | | Boston EW (n=20) | Boston EM (n=8) | Boston SM (n=4) | Boston SW (n=6) | Pittsfield EW (n=6) | Worcester EW (n=17) | Barnstable EW (n=3) | STCC EW (n=4) | Harvard EW (n=5) | BC EW (n=13) |
| | | Marital status | | | | | | | | | |
| Never-married | 68(79) | 15(75) | 7(87) | 3(75) | 4(67) | 2(33) | 13(76) | 3(100) | 3(75) | 5(100) | 13(100) |
| Cohabiting | 10(12) | 2(10) | 1(12) | 0(0) | 1(17) | 3(50) | 2(12) | 0(0) | 1(25) | 0(0) | 0(0) |
| Married/domestic partner | 5(6) | 2(10) | 0(0) | 1(25) | 1(17) | 1(17) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) |
| Divorced/other | 3(3) | 1(5) | 0(0) | 0(0) | 0(0) | 0(0) | 2(12) | 0(0) | 0(0) | 0(0) | 0(0) |
| Household income | | | | | | | | | | | |
| ≤\$25,000 | 30(35) | 5(25) | 4(50) | 3(75) | 4(67) | 4(67) | 4(24) | 1(33) | 2(50) | 0(0) | 3(23) |
| \$25,001-50,000 | 19(22) | 8(40) | 1(12) | 0(0) | 0(0) | 1(17) | 6(35) | 0(0) | 0(0) | 1(20) | 2(15) |
| \$50,001-75,000 | 4(5) | 2(10) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 1(20) | 1(8) |
| \$75,001-100,000 | 3(3) | 1(5) | 0(0) | 0(0) | 0(0) | 0(0) | 1(6) | 0(0) | 0(0) | 0(0) | 1(8) |
| >\$100,000 | 6(7) | 1(5) | 0(0) | 0(0) | 0(0) | 0(0) | 1(6) | 1(33) | 1(25) | 0(0) | 2(15) |
| Unknown/No response | 24(28) | 3(15) | 3(37) | 1(25) | 2(33) | 1(17) | 5(29) | 1(33) | 1(25) | 3(60) | 4(31) |
| Student status | | | | | | | | | | | |
| Full time student | 38(44) | 5(25) | 3(37) | 0(0) | 1(17) | 0(0) | 7(41) | 0(0) | 4(100) | 5(100) | 13(100) |
| Part time student | 7(8) | 1(5) | 1(12) | 0(0) | 3(50) | 1(17) | 1(6) | 0(0) | 0(0) | 0(0) | 0(0) |
| Not a student/no response | 41(48) | 14(70) | 4(50) | 0(0) | 2(33) | 5(83) | 9(53) | 0(0) | 0(0) | 0(0) | 0(0) |
| Education completed | | | | | | | | | | | |
| Some high school | 5(6) | 0(0) | 1(12) | 0(0) | 0(0) | 1(17) | 2(12) | 1(33) | 0(0) | 0(0) | 0(0) |
| High school diploma/GED | 16(19) | 0(0) | 2(25) | 0(0) | 1(17) | 3(50) | 5(29) | 0(0) | 1(25) | 3(60) | 1(8) |
| Associates/some college | 37(43) | 4(20) | 3(37) | 1(25) | 3(50) | 2(33) | 5(29) | 2(67) | 3(75) | 2(40) | 12(92) |
| Bachelors degree | 21(24) | 11(55) | 2(25) | 2(50) | 2(33) | 0(0) | 4(24) | 0(0) | 0(0) | 0(0) | 0(0) |
| Some graduate school/graduate degree | 7(8) | 5(25) | 0(0) | 1(25) | 0(0) | 0(0) | 1(6) | 0(0) | 0(0) | 0(0) | 0(0) |

Appendix C: Contraceptive use in the last month and year, total & by gender¹⁸

| Contraceptive method | Total (N=86) | | Women (n=74) | | Men (n=12) | |
|-----------------------------|--------------|-----------|--------------|-----------|------------|-----------|
| | Past month | Past year | Past month | Past year | Past month | Past year |
| | n(%) | n(%) | n(%) | n(%) | n(%) | n(%) |
| I did not use contraception | 13(15.1) | 14(16.3) | 13(17.6) | 13(17.6) | 0(0) | 1(8.3) |
| The pill | 33(38.4) | 48(55.8) | 29(39.2) | 42(56.8) | 4(33.3) | 6(50.0) |
| The patch | 0(0) | 5(5.8) | 0(0) | 4(5.4) | 0(0) | 1(8.3) |
| The shot | 1(1.2) | 3(3.5) | 0(0) | 2(2.7) | 1(8.3) | 1(8.3) |
| The ring | 2(2.3) | 4(4.7) | 2(2.7) | 4(5.4) | 0(0) | 0(0) |
| The implant | 2(2.3) | 2(2.3) | 2(2.7) | 2(2.7) | 0(0) | 0(0) |
| The IUD | 1(1.2) | 5(5.8) | 1(1.4) | 5(6.8) | 0(0) | 0(0) |
| Emergency contraception | 2(2.3) | 11(12.8) | 2(2.7) | 9(12.2) | 0(0) | 2(16.7) |
| Male condoms | 28(32.6) | 50(58.1) | 20(27.0) | 41(55.4) | 0(0) | 9(75.0) |
| Female condoms | 2(2.3) | 4(4.7) | 2(2.7) | 4(5.4) | 0(0) | 0(0) |
| Diaphragm or cervical cap | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) |
| The sponge | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) |
| Spermicide | 1(1.2) | 2(2.3) | 1(1.4) | 2(2.7) | 0(0) | 0(0) |
| Sterilization | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) | 0(0) |
| Withdrawal | 8(9.3) | 15(17.4) | 7(9.5) | 12(16.2) | 1(8.3) | 3(25.0) |
| Natural family planning | 2(2.2) | 3(3.5) | 1(1.4) | 2(2.7) | 1(8.3) | 1(8.3) |
| Other | 1(1.2) | 2(2.3) | 1(1.4) | 2(2.7) | 0(0) | 0(0) |

¹⁸ Participants were asked to identify any and all methods of contraceptive they (or their partner) had used in the past month and the past year. For clarity, multiple terms (including some brand names) were given for many contraceptive methods on the list. Participants were also asked to specify any “other” method.



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 two-year 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. Formative research will inform actions led by a statewide, multi-agency Taskforce 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.

REaDY is led by an Executive Committee of multiple organizations and agencies within the Commonwealth. Ibis Reproductive Health is leading the formative research, and the Taskforce is chaired by the Massachusetts Department of Public Health Family Planning Program and coordinated by the Pro-Choice Massachusetts Foundation. These three agencies form an Executive Committee, which also includes the Massachusetts Family Planning Association, youth development specialist TiElla Grimes, and the Boston Public Health Commission.