Guttmacher Policy Review
GPR
Summer 2015 | Vol. 18, No. 3

Still Needed: The Family Planning Safety Net Under Health Reform

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HIGHLIGHTS

- *An investigation of trends in 32 Title X–funded family planning centers shows that the proportion of uninsured client visits fell after implementation of the ACA's coverage expansions began, from 41% in 2013 to 36% in 2014. Both the proportion of visits covered by Medicaid and the proportion covered by private insurance increased.*
- *Twenty-one of the 32 centers experienced large decreases in the proportion of uninsured family planning visits, including all six in states that had raised Medicaid eligibility levels for family planning services under the ACA.*
- *To continue this progress, policymakers will need to sufficiently fund the network of family planning centers and help ensure their inclusion in health plan networks; health plans will need to recognize the value of working with family planning centers; and centers will need to continue providing enrollment assistance to clients and become adept at working with health plans.*

Since its enactment with bipartisan support in 1970, the Title X national family planning program has been a central source of funding for a nationwide network of thousands of health centers serving low-income and underserved communities. Given the U.S. Supreme Court's recent decision in *King v. Burwell* upholding the Affordable Care Act (ACA) and its signature health insurance marketplaces, it seems increasingly clear that the law is here to stay. Thus, it is critical to better understand the implications of the ACA for the network of Title X–supported family planning centers and for the millions of individuals it serves each year.

The fundamental promise of the ACA is that by expanding coverage, it will increase access to services and help individuals afford the health care they need. Early evidence is showing important progress toward those lofty goals. Since late 2013, which saw the debut of the ACA's health insurance marketplaces and its broad expansion of Medicaid in more than half the states, about 14 million uninsured adults have gained coverage, and the uninsured rate has fallen by one-third, from 20% to 13%, according to estimates from the U.S. Department of Health and Human Services.[1] In addition, two million young adults gained coverage between 2010 and 2013 as a result of an ACA provision allowing them to continue on their parents' insurance plan until age 26. Together, that brings the total number of uninsured individuals who have gained coverage under the law to an estimated 16 million.

In addition to expanding who has coverage, the ACA has improved the nature of that coverage: Notably, the ACA's contraceptive coverage guarantee is specifically aimed at improving access to family planning services by ensuring that most private health plans cover contraceptive methods, services and counseling without cost-sharing for patients. The provision is already allowing large numbers of women to obtain highly effective contraceptive methods at no out-of-pocket cost.[2]

Although these coverage expansions and improvements have enormous potential to expand access to vital care, they also raise important questions about the ongoing role of the family planning safety net in a dramatically reshaped health care landscape. If expanded coverage brings a greater choice of health care providers,

will people still rely on this safety net? Will the clients served through this network increasingly use public or private insurance coverage for their care? And even if more clients have insurance, will there nonetheless continue to be large numbers of clients seeking services without insurance coverage for the care they need?

Clients Seeking Care

To begin to answer these important questions, the Guttmacher Institute is tracking the provision of and payment for family planning services at 32 health centers that receive Title X funding. These centers include sites operated by health departments, Planned Parenthood affiliates and independent agencies; they are located in 20 states throughout the country, including some states that have expanded Medicaid eligibility under the ACA and some that have not. Since the beginning of 2013, participating centers have provided quarterly data on two indicators: the number of visits for family planning services and whether those visits were paid for with public insurance, private insurance or no insurance. (Because of glitches in enrollment systems in late 2013, the initial enrollment period for the ACA's health insurance marketplaces was extended into the early months of 2014. Given that the first quarter of 2014 was therefore a transition period, the data presented here compare the last three quarters of 2013 with the last three quarters of 2014.)

Already, this small-scale investigation is showing that the nationwide network of safety-net family planning centers continues to serve as a vital source of care, not only for the growing proportion of clients who have insurance coverage for their visit, but also for the many clients who continue to lack coverage for the care they need.

First, in the wake of the ACA, some observers had questioned whether newly insured individuals with affordable access to a greater choice of health care providers would continue to rely on safety-net family planning centers. Findings from the analysis show that centers continue to remain a critical source of care in the communities they serve. In the last three quarters of 2014, the 32 study sites collectively provided 40,768 contraceptive visits—a 3% reduction from the 41,908 visits provided by the same sites during the last three quarters of 2013. Eighteen of the 32 sites reported a decrease in visits of at least 4%, while 11 indicated an increase of that size.

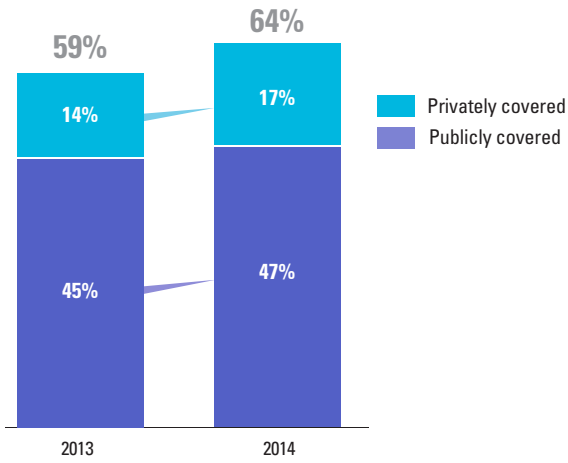
The modest drop in overall visits appears to continue a trend among Title X–funded centers that predates the ACA's major coverage expansions: Between 2010 and 2013, the number of clients served at Title X sites nationwide declined at least 4% each year.[3] Indeed, there are a number of factors unrelated to the ACA that likely contributed to the small decline in overall visits to the 32 participating centers. First, the increasing use of long-acting reversible contraceptive (LARC) methods has decreased the frequency with which many women need to visit family planning centers for contraception, even as it may mean a higher level of contraceptive protection.[4] Second, recent changes to standards for cervical cancer screening—which obviate the need for screening for many teens and young adults and call for less frequent screening for adults—may also reduce clinic visits without compromising quality of care.

In addition to evolving medical guidelines for quality family planning care, cuts to family planning funding streams—including Title X—may be limiting centers' capacity. Plus, local-level factors may play a role, such as difficulty in recruiting and retaining trained, qualified staff or changes in where services are delivered within a given area. For example, according to Tara Thomas-Gale, practice administrator of community health services at the Denver Health Hospital Authority, Denver Health began offering contraceptive services at school-based health centers; this might have reduced the number of adolescent clients served at other sites.[5] The agency also expanded availability of contraceptive services at its primary care centers, in part by utilizing health educators for contraceptive counseling.

Interestingly, 11 of the 12 participating health department sites indicated declines in family planning visits. This may reflect the fact that county health departments have long lagged behind other types of publicly supported family planning providers in securing contracts with health plans.[6] In addition, they may face the steepest challenges in

IMMEDIATE IMPACT

In the first year of the Affordable Care Act's major coverage expansions, participating centers collectively saw an increase in the proportions of both publicly and privately covered family planning visits.



Note: Data are from 32 participating health centers, from the final three quarters of each year.

affording the staffing and infrastructure changes needed to adapt to the changing marketplace.

Despite variations in the change in number of family planning visits at individual sites, the general trend is clear: Overall, these centers continue to see thousands of women even after implementation of the ACA's coverage expansions. That demonstrates the ongoing importance of safety-net family planning providers to millions of women, men and teens.

Paying for Care

Another key question for safety-net family planning centers was whether, because of the ACA, more of their clients would have insurance coverage—either private coverage or Medicaid—for their care. According to the investigation, that does seem to be the case. At the 32 participating centers, the overall proportion of visits paid for with some form of public or private insurance increased from 59% during the last three quarters of 2013 to 64% during that same period in 2014 (see chart).

The overall increase in insured visits resulted from both more visits paid for by Medicaid and more visits paid for by private insurance. This defies many experts' expectation that safety-net centers would see a much more concentrated increase in Medicaid visits given their client composition: In 2013, seven in 10 Title X clients had incomes at or below the federal poverty threshold, which means that most of them were eligible for public coverage in any state that expanded Medicaid under the ACA.[3]

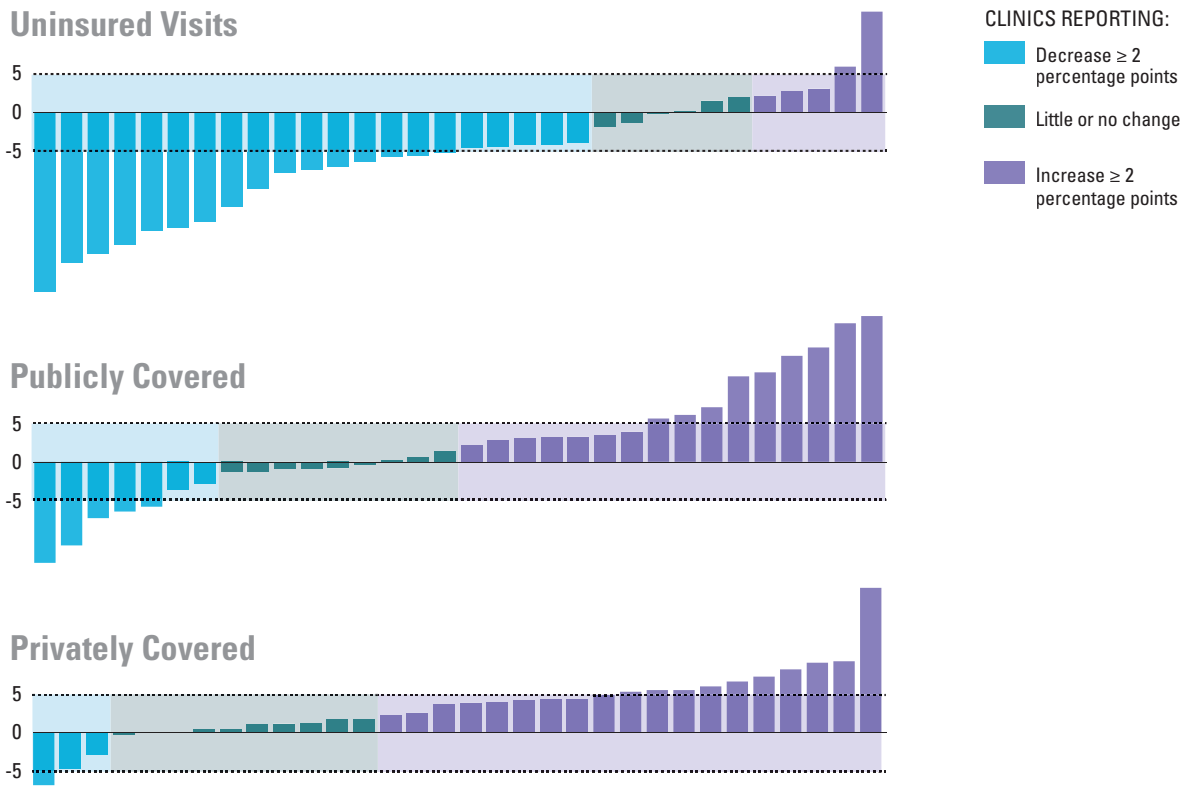
In reality, however, not many states have actually increased Medicaid eligibility levels for family planning services as a result of the ACA. This is in part because half of the states had already expanded Medicaid eligibility specifically for family planning services prior to 2014.[7] Further, not all states have yet availed themselves of the opportunity to expand Medicaid eligibility more broadly under the ACA. This is reflected in findings from the analysis: Only six family planning centers, located in five states, experienced an actual increase in Medicaid eligibility levels for family planning care from 2013 to 2014.

Overall, the proportion of visits paid for by Medicaid at the 32 centers rose from 45% in the last three quarters of 2013 to 47% during the same period in 2014. About half of the sites saw an increase in the proportion of visits covered by Medicaid, as nine experienced an increase of at least five percentage points, including six that saw an increase of at least 10 percentage points (see chart, page 59).

Centers operated by health departments were especially likely to see large increases in visits covered by Medicaid. For example, a family planning center operated by the Monongalia County Health Department in West Virginia reported a 19–percentage point surge in the proportion of visits covered by Medicaid. Staff at the center attribute the change largely to the substantial increase in the state's Medicaid eligibility level.[8] Prior to the ACA, the income ceiling for Medicaid in West Virginia was 31% of the federal poverty level for working parents, and no coverage was available for adults without children; in January 2014, the level rose to 138% of poverty for adults, regardless of whether they have children.[9] In addition, Cindy Graham, program manager of public health nursing at the agency, points to a vigorous

SHIFTING PAYER MIX

Twenty-one of 32 participating centers reported a decrease in uninsured visits from 2013 to 2014, driven by increases in both publicly and privately covered visits.



Notes: Data are from 32 participating health centers. Dotted lines represent threshold of five percentage point change in the proportion of visits paid for by each payer type, between the final three quarters of 2013 and the final three quarters of 2014.

effort to enroll eligible clients. The West Virginia Department of Health and Human Resources automatically enrolled residents it determined to be eligible for Medicaid; it also mailed enrollment materials directly to other residents who might be eligible. For its part, the health center began using software to instantly determine whether clients had Medicaid coverage. According to Graham, this has allowed the center to, in some cases, inform clients who thought they were uninsured that they were actually covered by Medicaid.

The trend for privately insured visits paralleled the trend for publicly insured visits: The proportion of all visits at the 32 sites paid by private coverage increased from 14% in 2013 to 17% in 2014. Of these sites, 19 experienced an increase in the proportion of visits covered by private insurance. Most of these increases, however, were smaller than the increases in Medicaid visits: Ten centers had an increase of more than five percentage points on the private insurance side; only one of these had an increase of more than 10 percentage points. Sites operated by health departments were the least likely to indicate a large increase in privately insured visits.

Many Remain Uninsured

In answer to a third major question, despite the gains in the number of clients using insurance, all 32 sites continued to serve substantial numbers of clients who lack insurance coverage for the care they need. The proportion of all visits for which no insurance was billed fell from 41% in 2013 to 36% in 2014. At the individual site level, 21 of the 32 sites reported a decrease in the proportion of uninsured visits. Sixteen sites saw their uninsured visits fall by at least five percentage points—half of which saw decreases of at least 10 points. Notably, all six centers located in states where Medicaid

eligibility levels for family planning rose under the ACA showed a large decrease in the proportion of uninsured visits.

Catriona Reynolds, Clinic Manager of the Kachemak Bay Family Planning Clinic in Homer, Alaska, attributes the 12–percentage point drop in uninsured visits there to the staff's efforts to both enroll clients in marketplace coverage and educate them about using their insurance.[10] The clinic trained administrative and clinical staff as certified application counselors, so that, according to Reynolds, "when questions come up in the clinical setting, we can just roll the client over to the insurance side," where the clinic is making a concerted effort to educate clients about their new or existing coverage and how to use it. Staff provide basic information about insurance, inform clients that they can use their coverage at the clinic and explain that they may receive covered family planning services with no out-of-pocket payment. "People used to think that this was the place to come if you had no insurance," noted Reynolds. "Now they know that they can come here and use their coverage."

In contrast to the experience at Kachemak Bay, where the drop in uninsured visits came largely because of an increase in privately insured visits, Planned Parenthood staff in Oregon attribute their 6–percentage point drop to increases in both publicly and privately insured visits.[11] The state undertook a vigorous effort to promote Medicaid enrollment, including a large marketing campaign with creative television ads and grants to community groups throughout the state to provide enrollment assistance. In addition, according to Rian Frachele, vice president of patient services at Planned Parenthood Columbia Willamette, the coordinated care organizations around which the state's Medicaid program is organized "understand the importance of family planning and especially locally here in Portland work hard to encourage enrollees to seek care."[11] On the private coverage side, Planned Parenthood increased its participation with private plan networks, launched a public outreach campaign emphasizing that it accepts all insurance carriers and used online tools to connect clients to marketplace coverage.

Forward Directions

Despite its limited size and scope, this analysis echoes other, broader reports that the ACA is on track in achieving one of its key objectives: reducing the number of individuals who are uninsured. Family planning visits to these 32 family planning centers by clients who had no source of insurance reimbursement for their care dropped after the law's coverage expansions went into effect at the beginning of 2014, and the proportion of visits covered by either Medicaid or private insurance increased.

To continue this important progress, family planning providers need to be positioned to recoup reimbursement from public and private insurance plans. Doing so will require federal and state policymakers to ensure inclusion of these essential community providers in health plan networks. Health plans will need to realize the important contributions family planning providers can make in helping them achieve the network adequacy standards to which they are being held, and be open to contracting with these providers and adequately reimbursing them for the care they provide enrollees (see "Marketplace Plans' Provider Networks Are Just Not Adequate Without Family Planning Centers," Spring 2015). And for their part, family planning centers will need to become adept at working with health plans, including by upgrading their health records systems so they can interface with plans, becoming skilled at negotiating contracts and developing expertise in the nuts and bolts of reimbursement systems, such as billing, coding and provider certification (see "Becoming Adept at Working with Health Plans a Necessity for Family Planning Centers," Summer 2012).

These findings also show that family planning centers continue to play a critical role in providing access to care. Visits to these sites in 2014 were almost on par with pre-ACA levels. This provides more evidence for why it is imperative that Title X's flexible funding be maintained. These grants are the backbone of the nationwide network: They enable centers to keep their doors open and during hours that work for their clients, to make sure the supply cabinets are stocked, to invest in the new technologies and staff training necessary to be viable in an evolving health care

system, and to provide the time-intensive family planning counseling and care their clients need.

The continuing stream of uninsured clients also makes clear the need for family planning centers to be major players in enrollment assistance efforts (see "Building It Is Not Enough: Family Planning Providers Poised for Key Role in Helping People Obtain Coverage under the Affordable Care Act," Fall 2014). Finally, this analysis highlights the imperative to better understand the gaps in coverage that persist even as the ACA takes hold. For example, millions of immigrants are ineligible for various forms of coverage solely because of their immigration status (see "Toward Equity and Access: Removing Legal Barriers to Health Insurance Coverage for Immigrants," Winter 2013). Others may experience difficulties navigating the complicated insurance system or may not be able to afford coverage—especially in states that have not expanded Medicaid eligibility. And some individuals may have coverage they feel they cannot use when seeking sensitive services because of confidentiality concerns. Fully understanding the scope of these gaps is a critical first step toward crafting policy solutions and to finally creating the seamless safety net all individuals deserve.

This article is based on data collected with funding from the Office of Population Affairs, U.S. Department of Health and Human Services under grant FPRPA006058. The conclusions and opinions expressed in this article, however, are those of the authors and the Guttmacher Institute.

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Guttmacher Policy Review

From the Guttmacher Institute's policy analysts
Editorial Office: Washington, DC
policy@guttmacher.org

ISSN: 2163-0860 (online)
http:/www.guttmacher.org/archive/GPR.jsp