

Building It Is Not Enough: Family Planning Providers Poised for Key Role in Helping People Obtain Coverage Under the Affordable Care Act

By Kinsey Hasstedt

The Affordable Care Act (ACA) provides a path to health insurance for millions of people previously uninsured by expanding eligibility for public and subsidized private coverage programs. Despite numerous legal, political and practical obstacles to implementation since the law was enacted in 2010, millions have indeed obtained coverage under the ACA. The Department of Health and Human Services (DHHS) recently estimated that 6.7 million people are enrolled in and paying premiums for private plans purchased through the ACA's health insurance marketplaces, and 9.1 million additional individuals had obtained public coverage through Medicaid and the Children's Health Insurance Program.^{1,2}

Expanded eligibility alone, however, is not enough to make people aware of the coverage options available to them, to help individuals determine the best plan for them and their families, and to get them signed up for coverage. Accordingly, the ACA provides for on-the-ground help through different types of assisters—namely so-called navigators and certified application counselors—in every state. These programs are designed to reach the uninsured, aid consumers in understanding available coverage options and financial supports, and facilitate plan enrollment.

Community-based and safety-net organizations, such as family planning centers, are perfectly positioned to serve as the backbone of these enrollment assistance programs, because they are often the first point of entry into the health care system for the very populations that stand to gain the most. Yet, even the best-positioned entities are experiencing challenges, especially

those located in states that are politically hostile to the ACA—many of which have been erecting barriers to enrollment assistance as part of their strategy to thwart the law's effectiveness. Recent federal court rulings and regulations from the Obama administration may help ensure that state policymakers do not impede assisters' work. Regardless of the politics surrounding the ACA, maximizing the number of people benefitting from health insurance should be a broadly accepted goal. Facilitating enrollment assistance, therefore, is key. Rather than stand in the way, government at all levels should provide additional support and funding toward implementation efforts—looking especially to the network of family planning centers and other safety-net providers—to facilitate this process so more people can obtain the health care they need.

The Role of Family Planning Providers

Safety-net health centers that provide family planning care, including Title X–funded sites, are well-situated to connect people to health insurance coverage (see box, page 8). First, this provider network serves exactly those individuals the ACA prioritizes: Sixty-four percent of patients seen at Title X sites are uninsured, and 62% are aged 18–29.³ Young adults are historically more likely than other age-groups to lack coverage, and enrolling typically healthy young people in marketplace plans is critical to balancing the higher costs commonly required to care for older enrollees with more complicated health care needs. Furthermore, by design, the vast majority of people served by Title X and other safety-net family planning centers are from low-income households and are therefore often eligible for subsidies to purchase marketplace plans or for

Making a Difference as Enrollment Assistors

Philadelphia: Initially, the Women's Care Center at Drexel University's College of Medicine in Philadelphia did not plan on serving as an enrollment assister. However, in January 2014, the center won an enrollment assistance grant from the National Family Planning and Reproductive Health Association, a nonprofit provider membership organization, which enabled it to launch an effective program. Within a matter of weeks, two of the organization's own staff had received the required training to become certified assistors. Executive and Medical Director Sandra Wolf says that relying on in-house counselors turned out to be important because clients know and trust them, and for their part those clinicians are knowledgeable about patterns of uninsurance among their clients. Wolf also says that having the additional resources to conduct this important work has been essential; staff must take time out to be trained, and it takes time to help people obtain coverage—about an hour per client.

Wolf also highlights how valued this new service is by the clients themselves. She recalls one young woman who burst into the waiting room yelling, "I came for Depo, and I got health insurance [too]!" Yet, during the last enrollment period, too many clients fell into the coverage gap created by Pennsylvania's initial decision to not expand Medicaid; they were often too poor to qualify for subsidies to purchase coverage through the marketplace, yet had incomes too high to qualify for public coverage.

Given these coverage gaps and the short time since the launch of the Women's Care Center's program, the number of people connected to coverage in-person fell far short of the center's hopes this past year. However, Wolf sees several reasons why they are poised for greater success going forward. They have already laid the groundwork with clients who may now be eligible for coverage under the state's newly instituted Medicaid expansion program. In addition, improvements to the federal online marketplace should eliminate many of the problems experienced by the center's clients in 2014. Moreover, the center aims to significantly boost its impact through better-tailored outreach efforts, as well as through new partnerships under which other Title X sites will refer clients to the center for enrollment assistance. Wolf is committed to continuing this work because she believes "it is one of the most important initiatives we have ever done."

New Hampshire: With six health centers covering about half of the health service areas in New Hampshire, Planned Parenthood of Northern New England (PPNNE) was well-situated to take on the role of navigator in the ACA's first open enrollment period. According to Jennifer Frizzell, Vice President for Public Policy, the demands of quality enrollment assistance are compatible with the way PPNNE delivers services to its patients every day: that is, not by making decisions for patients, but rather by being non-

judgmental and ensuring that they are "informed, secure and ready to make [their own] decision." Further, Frizzell says their patients are disproportionately those who would benefit from enrollment assistance. And like so many other safety-net family planning providers, PPNNE sees another promise of the ACA: Connecting more patients to coverage will result in more sustainable and more predictable revenue streams and reimbursements to help providers continue to provide needed care.

Frizzell says with the help of messaging and educational materials from its national office, PPNNE hit the ground running after receiving federal funding. PPNNE hired about 10 enrollment assistance staff at its six health centers, as well as a mid-level program manager to oversee the program and a call center staffer to field coverage questions and schedule enrollment assistance appointments via its existing patient scheduling hotline. PPNNE helped about 4,000 New Hampshire residents enroll in coverage in the ACA's first year—about one in every 10 people who enrolled in the state. Moreover, Frizzell argues that its success as an assister organization—particularly one with a strong brand among women and connections to young people—has increased PPNNE's influence with health insurers, at health insurance decision-making tables and with the state's insurance commissioner.

Medicaid coverage. That is particularly true in states that have taken up the ACA's option to broadly expand Medicaid eligibility to those with incomes up to 138% of the federal poverty level.

Second, these providers often serve as their patients' primary or even sole contact with the health care system. For four in 10 women who—despite having other provider options—visit a reproductive health-focused health center, that center is their only source of medical care throughout the year.⁴ Moreover, patients trust and choose these providers for a wide variety of reasons that coincide with the attributes of an effective enrollment assister, including being knowledgeable about women's health, taking the time to talk with patients and treating patients with respect.⁴

Third, many family planning centers are already adept in helping their clients obtain coverage through Medicaid and other public programs, particularly in states with expanded eligibility for Medicaid coverage of family planning services (apart from the ACA's broader Medicaid coverage expansions). Since the mid-1990s, more than half the states have implemented such programs, giving family planning providers valuable experience in helping low-income clients enroll in coverage. Even prior to the ACA, most family planning centers were equipped with Medicaid application forms to distribute to clients on-site and with staff to assist clients in completing those forms and submitting completed applications.⁵

Resistance in the States

Despite the importance of enrollment assistance and how well-suited family planning providers are to these efforts, some state policymakers are seeking to make it difficult for such work to successfully connect uninsured people to the coverage they need. Officials ideologically opposed to the ACA employ many political and policy tactics to thwart the law's implementation, and hampering assisters is one such tactic. At the federal level, enrollment assistance is one of myriad issues over which anti-ACA members of Congress have raised a ruckus, including publicly protesting federal navigator funds going to Planned Parenthood affiliates.⁶ Moreover, some state

officials—particularly in states openly resistant to the ACA—have enacted laws that clearly impede on-the-ground efforts to connect their uninsured population to coverage.

Assisters nationwide are held to certain standards under the ACA, such as providing unbiased information and protecting personally identifiable information. In the 34 states that have opted for the federal government to facilitate their insurance marketplace, DHHS funds organizations as navigators. Under these grants, individuals engaged in enrollment assistance must pass a criminal background check and complete about 20 hours of federally designed training on issues including health insurance and marketplaces, serving vulnerable populations and protecting clients' privacy. The federal government also has similar standards for the certification and training of other assisters in these states, such as certified application counselors, who fulfill essentially the same functions as navigators, but do not necessarily receive any funding for their efforts. In states running their own marketplaces, states themselves administer all assister programs; they may use the federal certification and training standards, but are not required to do so.

Federal law allows all states to implement additional certification requirements for enrollment assisters—so in states with federally facilitated marketplaces (FFMs), assisters may be subject to both federal and additional state-specific standards. Importantly, such state policies may not inhibit the enrollment assistance work the ACA requires of these entities.

According to the Commonwealth Fund, to date, 19 states with FFMs have enacted their own assister policies (see table, page 10).⁷ Of these, Commonwealth finds that portions of laws and regulations in at least 14 states “may impermissibly restrict consumer assistance.”⁷ (Notably, Commonwealth's analysis does not consider laws in states running their own marketplaces; these states have a vested interest in the ACA's implementation and are therefore less likely to pursue policies hampering enrollment.⁸) State policies that impose limitations or additional requirements on assisters generally fall into three

UNDERCUTTING THE AFFORDABLE CARE ACT

Federal regulations released in May 2014 suggest some states may inappropriately restrict enrollment assisters and their work.

| Type of Assister Restriction | States |
|--|--|
| Limiting what assisters may say | AR, AZ, GA, IL, LA, MO, OH, OK, TX, VA, WI |
| Sidelining entities with health plan contracts | AR, LA, MT, OH, WI |
| Mandating assisters obtain insurance bonds | IA, IL, TX, UT, WI |
| Excluding national organizations | IL, MO, WI |
| Requiring referrals to agents or brokers | IL, MO |

Notes: Analysis as of June 2014, limited to states with federally facilitated marketplaces. Missouri's assister law was enjoined in January 2014. Source: reference 7.

categories: who can serve as an assister, how assisters do their work, and what is required to become an assister.

Restricting Who Can Assist

Commonwealth finds that five FFM states prohibit entities that get any kind of reimbursement from insurers from serving as assisters, even if that payment is not associated with enrollment assistance activity.⁷ These laws should be of particular concern to the family planning network, because they could affect family planning and other providers that contract with insurance companies and receive payments for the health services they provide.

Such restrictions purportedly protect consumers from being pushed to a given plan simply because their health care provider contracts with that plan; however, the ACA already has clear directives about unbiased assistance, and existing federal regulations expressly prohibit all assisters from receiving compensation from health plans on the basis of enrollment. In practice, these state restrictions could stop the very organizations, such as safety-net family planning centers, that can best reach historically uninsured communities from helping consumers who need it most. For instance, last year in Ohio, a hospital-based medical center with plan contracts returned its navigator grant to the federal government because it was advised by the state that it was ineligible to be certified as a navigator by the

state, and providers who were originally part of another navigator grant collaborative also pulled out for fear of the same.⁹ Notably, federally qualified health centers are carved out of Ohio's reimbursement restrictions, but not other types of safety-net providers.

Some states have invoked the principle of "states' rights" to bar their own state institutions—such as health departments and universities—from aiding with enrollment efforts. For example, the Georgia Health Care Freedom Act prohibits all state entities and state universities from acting as assisters. In addition, the law precludes the state from establishing its own insurance marketplace and affirmatively blocks the state from acting to expand Medicaid. This law effectively ended the University of Georgia's assister program and also blocks the state's health department sites—including its family planning centers—from helping their clients to navigate their coverage options. Especially in Georgia, sidelining these particular providers presents serious problems for uninsured family planning clients: More than 200 of the state's approximately 300 publicly funded family planning centers are health department sites, which serve 76% of Georgia women who receive contraceptive care from safety-net providers.¹⁰

Limiting What Assistors May Say

The Commonwealth Fund reports that there are at least 11 FFM states limiting what advice assisters can give to consumers—for instance, prohibiting them from discussing the details of plan benefits or helping consumers to compare one plan with another.⁷ Furthermore, if assisters in Illinois are approached by someone who previously purchased private insurance through an agent or broker, state law requires them to refer that person back to the agent or broker.⁷ Proponents of such policies assert the ACA does not adequately equip or regulate assisters, so state regulation is necessary to protect consumers from misinformation or being pressured into a particular plan. These trends also seem driven in no small part by agents and brokers themselves, who perceive enrollment assistance efforts to be a business threat.¹¹

In practice, these types of restrictions could make it difficult for consumers to obtain the accurate, unbiased information they need, potentially confusing and stymieing their enrollment. For instance, Ohio law allows navigators to offer “general” information on plans, but prohibits them from offering “advice concerning the substantive benefits, terms, and conditions” of a given plan and from helping a consumer to compare plans in choosing the one best-suited to their needs.

Training and Certification Requirements

Most state-level assister policies add some sort of training or certification requirements to the existing federal mandates. States put such requirements in place to ensure that assisters understand state-specific insurance policies and programs. These policies can help assisters better guide consumers through their options, but taken too far, they can make it impossible for some qualified individuals and organizations to become assisters.

In Texas, for example, navigators must complete 20 hours of state-specific training on top of federally required hours, pass a background check and be fingerprinted.¹² Texas is also one of five FFM states forcing navigators to obtain bonds insuring them against allegations of misconduct—an unnecessary practice that may prove prohibitively costly or burdensome.⁷ These requirements and the possibility of stridently anti-ACA state lawmakers piling on more in the future led one family planning center, Access Esperanza, to decide not to apply for navigator funding. Rather, Access Esperanza applied for and received other grant funding enabling it to hire three full-time certified application counselors who must also receive appropriate training and can fully assist individuals, but are not subject to Texas’s additional requirements. Community Services Director Kathryn Hearn says although her organization sees the value in appropriate training, Texas’s navigator standards seem onerous and unnecessary, taking time away from the work of actually enrolling people and making it almost impossible to meet the required deadlines. Plus, on the issue of Texas lawmakers’ concerns about protecting consumers’ privacy, Hearn points out,

“Who understands confidentiality better than a family planning center?”

Missouri’s navigator law is another extreme example that excludes health care providers from becoming assisters, imposes state-specific licensure requirements, allows only agents and brokers to discuss plan details or comparisons, and disallows assisters from talking to individuals with existing private coverage. Planned Parenthood of the St. Louis Region and Southwest Missouri (PPSLR) helped lead a group of assisters in filing a lawsuit against the state, claiming its law obstructed their ability to do the work required of them by the ACA.¹³ As PPSLR CEO Paula Gianino puts it, “Safety-net providers are hanging by our fingernails, taking care of people who don’t have health insurance,” but “the state wants nothing more than to stop [the ACA].”

Connecting Consumers to Coverage

In January 2014, a federal judge agreed with PPSLR, finding that Missouri’s law was in conflict with the mandates of the ACA and stopping it from implementing its restrictive rules. Although the state has appealed the decision, Gianino says that the ruling has given their assisters more freedom to do their work. PPSLR is moving forward with a team of trained staff and volunteers to assist consumers in its health centers and administrative offices, as well as out in the community.

More recently, in May 2014, DHHS addressed state assister laws head-on in final regulations on various aspects of the ACA’s health insurance marketplaces for the coming year and beyond. The new rules provide updated federal training, certification and consumer protection requirements for assisters. In addition, they clarify that although states can still establish their own standards for enrollment assistance, they cannot impede assisters from engaging in enrollment assistance activity. The federal rules also specifically prohibit many of the restrictions that states have been imposing (see table, page 12).

Enrollment assistance efforts will only become more necessary and more challenging in the

LETTING ASSISTERS ASSIST

Federal regulations released in May 2014 identify certain state policies that inappropriately restrict enrollment assisters' ability to do the work required of them, potentially keeping people from coverage.

States may not...

Prohibit health care providers from being assisters because they contract with health plans

Prohibit national organizations from working in states on outreach and enrollment work

Constrain assisters' ability to provide complete, unbiased information about individual plans

Limit who assisters may help, including individuals who may already have but want to change their coverage

Prevent assisters from helping consumers to compare plans

Force assisters to refer consumers to agents or brokers who may not be in a position to offer unbiased advice

Require all assisters to become licensed as agents or brokers themselves

Impose any regulation that in practice prevents assisters from carrying out their duties defined by federal law

future given that, by definition, the remaining uninsured are the most difficult to reach. Safety-net providers on the front line of providing services and enrollment assistance are acutely aware of this. During the ACA's first open enrollment period, Planned Parenthood Votes Northwest ran assistance programs in three different states, with a particularly robust and successful effort in Washington. Director of Public Policy Jennifer Allen believes they and other assisters in Washington are now at the forefront of taking on a more labor- and resource-intensive "second wave" of enrollment, and says the more demanding nature of enrollment assistance work "is something we should all be thinking about."

The very people the ACA is designed to connect to affordable, comprehensive health coverage and care are the people walking through the doors of family planning centers every day. The staff at these health centers are well-positioned and eager to help, and many are determinedly doing so even in politically hostile states and often with paltry or no additional resources to devote to this work.

The federal government has the authority and responsibility to help family planning centers

realize their full capacity to connect clients to coverage. DHHS can start by actually enforcing its own rules prohibiting states from unlawfully restricting assistance efforts. Second, the federal government must allocate additional funding to support the staffing, time and technology that family planning centers need to conduct robust enrollment assistance programs. Despite the experience and client demographics that make family planning centers prime candidates to be assisters, federal funding has been concentrated toward the network of federally qualified health centers. These providers received more than \$200 million devoted to outreach and enrollment efforts for the ACA's first enrollment cycle and, starting in FY 2015, are slated to receive ongoing funding specifically for outreach and enrollment efforts as part of their annual federal grants.¹⁴

Federal support for specialized family planning centers is comparatively lacking. The Office of Population Affairs, however, is doing what it can to support the Title X network: In 2014, it directed \$3.4 million in Title X funds for enrollment assistance work to 22 grantees already receiving funding for family planning services—supporting programs in 85 individual family planning centers across the country.¹⁵ Many sites are using the

funds to train or hire new staff as assisters, purchase or upgrade needed technology and create resources promoting their availability to connect clients to coverage. However, the Title X program itself is woefully underfunded, and these providers' efforts would benefit greatly from additional enrollment-specific support.

Creating the ACA and expanding eligibility for affordable health coverage are simply not enough for the uninsured to actually get health insurance. Helping people to become aware of their coverage options and navigate the system lie at the very heart of the promise of the ACA—and that cannot be realized without supporting the work of knowledgeable, trusted entities, such as the nation's network of safety-net family planning providers. www.guttmacher.org

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