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Family Planning Centers Meet Health Care Reform: Lessons from Massachusetts

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Important lessons arising from Massachusetts' bold experiment with health care reform hold significant implications for community-based family planning health centers. Access problems presenting themselves in the state indicate that even after health care reform, these centers will continue to be needed as a critical source of high-quality, low-cost primary and preventive reproductive health care. At the same time, the Massachusetts example suggests that national health care reform opens the possibility for family planning providers to formalize and be compensated for another vital but under-recognized function they have long played—acting as an entry point to care for clients who may have had little or no other interaction with the health care system. The centers' ability to successfully play either of these important roles, however, likely will depend on the extent to which they are fully integrated into the emerging health care marketplace—a potentially daunting challenge.

The Massachusetts Experiment

In April 2006, a sweeping health care reform measure was signed into law by then-Governor Mitt Romney. The new law required all state residents to purchase insurance coverage by July 2007 and all employers with 11 or more employees to either provide and help pay for coverage for their employees or else pay a penalty to the state. The legislation also established the Connector, an exchange through which individuals and small businesses may access coverage and that subsidizes coverage for individuals whose family income is below 300% of the federal poverty level ($32,490 for a single person and $54,930 for a family of three).

Two years into the experiment, insurance coverage has increased significantly. In 2008, 2.6% of Massachusetts residents were uninsured, compared with 6.4% in 2006. Moreover, the Urban Institute reports that more Massachusetts residents now than before the law's implementation say that they have a usual source of medical care and that they made a medical visit in the last year.

Nonetheless, significant access problems remain. About one in five adults in the state reported that they did not get care they thought they needed in 2008. Notably, this proportion rose to nearly one in three among residents with an income under 300% of poverty. Similarly, one in five adults in the state said problems arose because physicians were either not accepting any new patients or not accepting patients with their type of insurance; rejection rates for low-income adults and those with public insurance were double the rates for higher-income residents and those with private coverage. These troubling findings underscore the continuing need for safety-net providers, even in the presence of universal or near-universal insurance coverage in Massachusetts or nationally. These providers can ease the impact of shortages and access problems caused in other parts of the system by the surging demand for care due to health care reform.

A critical question is whether community health centers (CHCs), the nation's recognized primary care safety-net providers, can alone provide adequate access to family planning for low-income and disadvantaged communities. There are strong reasons to believe that they cannot.

CHCs are mandated by federal law to provide family planning, and nearly all report doing so, making them an important piece of the family planning provision puzzle. But nationally, their role is comparatively small. CHCs comprise 27% of all publicly funded family planning providers nationwide, but serve only 12% of the clients. In other words, a large number of CHCs serve a comparatively small number of family planning clients. According to Guttmacher data, the average CHC identifying itself as a family planning provider serves 400 contraceptive clients a year, whereas the average Planned Parenthood center serves about 3,000 clients annually.

Even in states with significant numbers of CHCs, this pattern remains. In the 26 states with at least 100 CHCs in 2006, CHCs reported seeing only 13% of the clients served by the entire network of family planning centers. In none of these states did CHCs serve even as many as one in four of these clients. In Massachusetts, which has 306 CHCs, the fourth largest number of any state, CHCs accounted for 21% of the entire network's clients in 2006.

Moreover, anecdotal evidence emerging from Massachusetts indicates that health care reform does not reduce the need for dedicated family planning centers (i.e., those that primarily serve contraceptive clients): At least two large family planning providers have reported that their client numbers have either stayed level or increased. The total number of visits to providers at Tapestry Health Systems, a Title X grantee in western Massachusetts, remained essentially level from 2006 to 2009. At Health Quarters, a Title X grantee in the northeastern part of the state, visits fell initially and then rebounded; by 2009, total client visits were 15% above their 2007 level.

The difference since health care reform, however, is that both agencies have seen a large and growing proportion of clients covered by the newly established publicly subsidized health plans. Tapestry Health was billing roughly 125 clients per month in 2009, 8% of the agency's clients, most of whom were previously uninsured. At Health Quarters, these plans accounted for 16% of client visits in 2009, the large majority of the agency's privately insured clients.

A third large Title X grantee, Health Care of Southeastern Massachusetts, reports that it is losing family planning clients in some locations to nearby CHCs that do not receive Title X funds. However, Jenny Sheehan, director of reproductive health services at the agency, says that some of these CHC clients eventually return, either because they say they are more comfortable with the family planning staff they have known often for years, or because they want to obtain specific services. (For example, CHCs may not provide as wide a range of contraceptive methods, particularly long-acting reversible contraceptives, as do dedicated family planning centers.) Moreover, Sheehan makes the point that the CHCs in her area do not appear to be actively promoting their family planning services within the community, focusing instead on providing contraceptive services to their primary care clients. This reluctance to give their family planning efforts too high a public profile may essentially create a cap on CHCs' reach as family planning providers.

All indications are, then, that although health care reform may bring coverage to more individuals, dedicated family planning centers will remain a critical component of the health care provider network. These centers can promote themselves as a source of the confidential care so critical to teens. They can also serve as a consistent source of services to young adults whose insurance coverage can be inconsistent but who are—by virtue of their age and lifestyle—at especially high risk of unintended pregnancy. At the same time, these community-based providers can reach out to low-income and disadvantaged women who may otherwise be reluctant to come in for contraceptive services and can serve those likely to be left out of even the best-intentioned health care reform efforts, including many immigrants (see box, page 4).

An Emerging Role

As dedicated family planning centers are likely to continue to be looked to by their communities as trusted health care providers, they are also likely to serve yet another critical, long-standing function: as an entry point to the health care system. For young women especially, this makes perfect sense, because it is their reproductive health care needs that typically bring them to reenter

Uninsured, Despite Health Care Reform

Health care reform may hold the promise of greatly reducing the number of Americans who lack insurance coverage, but even at its best, it is unlikely to eliminate the problem altogether. Even though reform in Massachusetts has halved the state's level of uninsured residents, 2.6% remained uninsured as of 2008.

Nonetheless, more than twice that proportion, 5.9% of residents, were uninsured for at least part of 2008. Young adults, immigrants and low-income residents—groups who are disproportionately at risk for unintended pregnancy—were disproportionately likely to lack coverage at some point. Thirteen percent of residents who were low-income or who were aged 19–25 were uninsured for at least part of 2008—more than twice the level of state residents overall. Officially, 17% of noncitizens lacked coverage at some point, a level that almost certainly fails to capture the needs of those who are in the country illegally.

These data highlight the critical and ongoing role of community-based family planning providers committed to serving those who need care, regardless of whether they have coverage. For example, the number of visits from clients with no source of third-party coverage at Health Quarters in northeastern Massachusetts fell between 2007 and 2008, but then rose again in 2009, a trend mirroring the one seen for family planning visits overall. By June 2009, even as the agency was seeing more insured family planning clients, it was also serving more uninsured family planning clients than it had in 2007, highlighting the critical ongoing need for a source of care for those who continue to be left out, despite policymakers best efforts to secure universal coverage.

the system, post-pediatrics. Health care reform offers the opportunity for centers to formalize, and be compensated for, this role.

Because family planning centers serve a population often not yet connected to the health care system, they have long acted—largely unheralded—as a health care portal. The burgeoning Medicaid family planning expansions of recent years have allowed family planning providers to move into this role in a more formal way. Three states allow point-of-service enrollment into these expansion programs, meaning that enrollment actually occurs during a client's visit. Other states allow family planning center staff to assist clients in preparing their applications, and some even compensate the centers for the application assistance they provide.

Health care reform offers an opportunity to build on this foundation, by allowing family planning centers to not only connect clients to coverage for family planning, but to help them enroll in a comprehensive insurance plan as well. Tapestry Health has already taken an important step in this direction. Even before Massachusetts launched its health care reform effort, Tapestry Health received a small grant from the nonprofit Blue Cross Blue Shield Foundation in the state to assist clients in enrolling in Medicaid. This early funding enabled Tapestry Health to train its staff on how to use the state's new Internet-based enrollment system. Once health care reform arrived, the state reached out to community-based agencies to assist with outreach and enrollment, and Tapestry Health's prior experience positioned it to receive an outreach grant from the state.

This access enables Tapestry Health staff to assist clients in completing their application, submit applications for processing by the state and check the status of pending applications. Once clients are enrolled, says Suzanne Smith, director of health services at Tapestry Health, staff can help them compare insurance plan options, choose a health plan that meets their needs, change plans if necessary, help them select a primary care physician, and locate providers and labs that take their coverage. Tapestry Health staff can even help clients in an ongoing way, by assisting them to navigate plans' Web sites to access information about their coverage or claims and understand the information and notices they receive from either the state or their plans. They help them understand the out-of-pocket costs that will be required and what they

need to do to remain continuously enrolled. Since 2006, Tapestry Health staff has either enrolled or assisted almost 1,400 clients.

Beyond being the interface between clients and their broader health insurance coverage, family planning centers' role as a health care portal allows them to be the interface between clients and their broader health care needs. As clients come in, they present with a range of needs. Family planning centers can directly address their reproductive health needs. For the broader range of care and services clients need, family planning centers can facilitate access by developing referral arrangements with other providers in the community. The difference after health care reform is that there is now a source of payment for these broader services.

Ensuring Access

To serve this important role as a health care portal, family planning providers will need to be an integral part of health plans' provider networks. Being part of plan networks will allow them to be reimbursed for the contraceptive and closely related preventive care for which clients come to them. Moreover, it will facilitate and provide compensation for handing off clients for services beyond what family planning providers are able to offer directly.

According to data for 2003, this critical integration of family planning centers into health plans was uneven, at best, and there is no reason to believe that the situation has changed appreciably since then. Although 58% of family planning agencies nationwide had a contract with a plan to serve Medicaid enrollees in 2003, only 28% had a contract with a private plan. About half of private, nonprofit providers, such as those operated by Planned Parenthood affiliates or CHCs, had a contract with a private plan, but only 5% of health department providers indicated they had a private contract.

Given these currently low levels of contracting, moving the network of family planning centers into the future will be a daunting challenge. Clearly, some agencies have considerable experience with health plans and the intricacies of third-party reimbursement systems. Tapestry Health in Massachusetts, for example, has contracts with three of the four insurance plans created to serve low- and moderate-income individuals. But many have little to no experience. Only about half of the Title X–funded service sites in Arizona have any type of third-party payment arrangement, according to Karen Ford Manza of the Arizona Family Planning Council. "It's the little agencies that were developed in direct response to community needs," said Manza. "They're the ones that don't have outside payer arrangements, but they're also the ones critical to getting people the care they need where no one else is available."

The health care reform legislation winding its way through Congress provides an important opportunity to facilitate this transition. Of primary importance would be to include family planning centers among the types of "essential community providers" that health plans are required to include in their provider networks. This would preclude the unfortunate situation that has arisen in Massachusetts, where one of the four newly created subsidized health plans has declined to contract with family planning centers, limiting enrollees' access to these trusted providers. In addition, it is critical that the legislation ensure that family planning centers are eligible for any assistance being targeted to aid community-based providers in modernizing their health information capability and putting in place the staffing configurations needed to become adept at third-party billing.

Once health care reform legislation is enacted, moreover, important implementation challenges will remain. One of the most critical will be to ensure that providers continue to be able to provide confidential care to those for whom the guarantee of confidentiality is essential to their willingness to seek services. Unfortunately, the typical mechanics of insurance plan operation—notably the practice of sending an explanation-of-benefits form to the primary policyholder—can preclude dependents from receiving confidential care. It is crucial that plans and providers work together to recalibrate plan processes to best balance plan transparency with

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confidentiality for those who need it and who may be unwilling to seek services in its absence.

The mechanics of plan operation may also need to be adjusted so that enrollees are able to obtain services in a timely fashion—avoiding delays or roadblocks if providers refuse to offer services related to contraception or decline to guarantee confidentiality (related article, page 6). To address this concern, many plans give enrollees the ability to obtain direct access to a reproductive health provider without first having to secure permission from a primary care provider. Most states, in fact, have laws requiring plans to provide at least some direct access. However, these policies and laws can provide only limited protection. For example, they often limit direct access to one visit per year. Although that enables a woman to get her annual visit, it does little to meet the need for contraceptive or STI services, which do not neatly correspond to an annual schedule.

Finally, family planning centers themselves may need to examine their operations, to maximize their role as an entry point to care for many of their clients. This might include implementing programs to assist clients in enrolling and accessing care, such as Tapestry Health's efforts as an enrollment facilitator. It might also lead providers to consider expanding the breadth of the health assessments and screenings they provide at that point of first contact, to enable them to effectively refer clients for a broader range of follow-up care.

Without doubt, these challenges are significant. Overcoming them will require government support as well as a new level of cooperation between payers and community-based providers. But the payoff could be substantial. Health care reform, if properly structured and implemented, could open the door to a sustainable model for meeting clients' reproductive health care needs, while leveraging the unique ability of community-based family planning centers to connect clients with both the coverage and the care they need. That would certainly appear to be a potential that more than justifies the effort. www.guttmacher.org