The Role of Publicly Funded Family Planning Sites In Health Insurance Enrollment

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CONTEXT: *Publicly funded family planning providers are well positioned to help uninsured individuals learn about health insurance coverage options and effectively navigate the enrollment process. Understanding how these providers are engaged in enrollment assistance and the challenges they face in providing assistance is important for maximizing their role in health insurance outreach and enrollment.*

METHODS: *In 2014, some 684 sites participating in California's family planning program were surveyed about their involvement in helping clients enroll in health insurance. Weighted univariate and bivariate analyses were conducted to examine enrollment activities and perceived barriers to facilitating enrollment by site characteristics.*

RESULTS: *Most family planning program sites provided eligibility screening (68%), enrollment education (77%), on-site enrollment assistance (55%) and referrals for off-site enrollment support (91%). The proportion of sites offering each type of assistance was highest among community clinics (83–96%), primary care and multispecialty sites (65–95%), Title X–funded sites (72–98%), sites with contracts to provide primary care services (64–93%) and sites using only electronic health records (66–94%). Commonly identified barriers to providing assistance were lack of staff time (reported by 52% of sites), lack of funding (47%), lack of physical space (34%) and lack of staff knowledge (33%); only 20% of sites received funding to support enrollment activities.*

CONCLUSIONS: *Although there were significant variations among them, publicly funded family planning providers in California are actively engaged in health insurance enrollment. Supporting their vital role in enrollment could help in the achievement of universal health insurance coverage.*

Publicly funded family planning providers are well positioned to participate in health insurance outreach and enrollment efforts. With funding from federal and state sources, they provide critical family planning services for individuals who lack health insurance or who cannot use their health insurance because of concerns about confidentiality.[1] In 2015, nearly half (48%) of family planning clients at health centers funded by the federal Title X program were uninsured.[2] Family planning providers that receive public funding also serve a large number of women who play an instrumental role in assuring that their family members have insurance coverage.[3] In addition, they tend to offer comfortable environments in which sensitive issues can be discussed, so they may be able to help individuals overcome the stigma that is often attached to enrolling in public insurance programs.[4]

Through their participation in state Medicaid family planning expansions, many family planning providers have developed successful outreach and enrollment practices.[5,6] Twenty-seven states have federal approval for programs that extend Medicaid eligibility for family planning services to individuals who would not otherwise be eligible.[7] The nation's largest expansion program, California's Family Planning, Access, Care and Treatment (Family PACT) program, provides comprehensive family planning services at no cost to residents with incomes of up to 200% of the federal poverty level who have no other source of insurance coverage for family planning services. In fiscal year 2013–2014, Family PACT served 1.7 million women and men who were uninsured or underinsured.[8] A key feature of Family PACT is that clients are allowed to enroll at the point of service. Site personnel have experience walking clients through the application, certifying their eligibility and enrolling them on-site on the day they receive services.

Publicly funded family planning providers' involvement in health insurance enrollment likely varies by the characteristics of the sites and their patient populations. In fiscal year 2013–2014, Family PACT services were offered through a diverse network of more than 2,000 providers, including specialists in family planning, obstetrics and gynecology, women's health, general and internal medicine, family practice, adolescent medicine and school health, as well as multispecialty practices.[8,9] Government and not-for-profit providers served about two-thirds of Family PACT clients; private solo and group medical practices served the rest.[8] The profile of clients served varied markedly between public- and private-sector Family PACT providers. On average, clients at public-sector providers were younger and had lower incomes, smaller families and lower parity than clients at private-sector providers.[8] In addition, a higher proportion of clients were Latino at private-sector providers than at public-sector providers (83% vs. 55%).[8]

Resources and the motivation for and barriers to supporting insurance enrollment also may differ by provider type, specialty and other site characteristics. In addition, involvement in enrollment may vary by geographic location; research has found rural-urban variations in site characteristics, patient characteristics and the provision of family planning services.[10]

In light of the potentially important role of publicly funded family planning providers in insurance enrollment, this study examined their outreach and enrollment activities under the Patient Protection and Affordable Care Act (ACA), which aimed to reduce the number of uninsured individuals through expansions of Medicaid and the private insurance market. We used data from a survey of sites participating in Family PACT to assess their involvement in helping clients enroll in insurance through California's Medicaid program (Medi-Cal) or health insurance exchange (Covered California), as well as the barriers to such involvement. Also, capitalizing on the diversity of participating provider sites, we identified the characteristics of sites best equipped to facilitate enrollment in comprehensive insurance.

METHODS
Study Design
We conducted a survey of clinic managers and administrators at sites participating in the Family PACT program from June to September 2014. The 11-page survey included items about health insurance enrollment, provision of primary care services, experiences working with health plans, site capacity, and the need for training and technical assistance.

To be eligible, sites were required to be enrolled clinician sites (as opposed to pharmacies or laboratories) that billed for at least 50 Family PACT clients in fiscal year 2012–2013. Out of 1,711 eligible sites, 1,020 were selected using the simple random technique—20 for an initial pilot sample* and 1,000 for the full sample. During fielding, 57 sites were deemed ineligible because they had closed, were no longer enrolled in the program or were duplicates.

The surveys were distributed by regular mail and included a link for completion online. In total, 727 were returned online or by mail, resulting in a 77% response rate. On average, respondents served more Family PACT clients than nonrespondents, and a larger proportion of respondents than of nonrespondents received Title X funding. The final analytic sample comprised 684 sites; 86% of respondents were clinic managers. The Committee on Human Research

at the University of California, San Francisco, considered this study exempt from ethical approval.

Measures
•*Dependent variables.* We used several questions to assess sites' efforts to help uninsured family planning clients enroll in insurance plans. Respondents were asked whether their site checks if uninsured family planning clients meet eligibility criteria for Medi-Cal or a subsidized exchange plan. If the answer was yes, respondents were asked whether the site checks eligibility at nearly every visit and whether it uses specific tools to screen for eligibility (a script for staff, a flowchart for staff, an income eligibility chart, the Covered California online application portal and the Department of Health Care Services online eligibility portal). All respondents were asked whether their site educates uninsured family planning clients on enrollment in Medi-Cal or exchange plans. Also, we asked whether their site provides on-site enrollment assistance (e.g., by providing applications or submitting applications on behalf of clients). If they said that it does, respondents were asked whether the site has an on-site enrollment specialist, defined as someone whose "main job function" is helping clients enroll in Medi-Cal or exchange plans. Finally, all respondents were asked whether their site refers uninsured family planning clients to at least one source for off-site enrollment assistance (e.g., local enrollment offices, the exchange website).

Next, respondents were asked to describe the barriers to helping clients enroll in Medi-Cal or exchange plans at their site. We included five measures of barriers: lack of staff time; lack of funding (which could be interpreted as lack of funding for enrollment efforts or lack of funding in general); lack of physical space; lack of staff knowledge; and few eligible clients.

We also asked respondents whether the site receives funding to assist clients with insurance enrollment. The survey did not ask the specific source of such funding, because pilot testing indicated that respondents could not reliably report this information.

•*Independent variables.* Respondents were asked to describe the following characteristics of the site: provider type (private, community clinic, Planned Parenthood health center, other†); provider specialty (women's health/family planning, primary care/multispecialty); whether the site received Title X funding; whether the site had a contract with a health plan to provide primary care services;‡ and what type of health record the site used (only electronic, electronic and paper, only paper).

Using administrative and claims data from the California Office of Family Planning, which administers Family PACT, we obtained the number of Family PACT clients served (categorized as 50–174, 175–499, 500–999, or 1,000 or more). Location (rural, urban) was determined by geocoding the site address to a state-defined medical service study area (a geographic area created by aggregating census tracts that is approved by the federal government for

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*On the basis of the pilot test, some of the survey questions were modified to improve clarity and reduce item nonresponse.

†Community clinics are federally qualified health centers, rural health centers, Indian Health Services sites and other types of community clinics. "Other" provider types include, but are not limited to, hospital-based outpatient clinics and school-based health centers.

‡Health plans include Medi-Cal managed care health plans, Covered California health plans and private health plans other than those purchased through the state health exchange.

identifying health care workforce shortage areas). On the basis of state definitions, a medical service study area was considered rural if it contained fewer than 250 residents per square mile and no population centers exceeded 50,000 residents.[11]

Analysis

First, we described the characteristics of the sample, using chi-square tests and t tests to compare site characteristics by rural-urban status. Then, we calculated the proportions of all sites that performed enrollment activities and that reported barriers to facilitating client enrollment in insurance plans. Finally, we used cross-tabulations and bivariate logistic regression analyses to compare enrollment activities and barriers to facilitating enrollment by site characteristics, evaluating statistical significance using .05 level two-sided tests. Although one survey was collected per site, some sites were part of multisite provider groups. In the regression models, we used the cluster option in Stata to account for clustering by the 515 provider groups and obtain robust standard errors. Fewer than 6% of surveys had missing data on any of the independent variables, so we used listwise deletion to account for missing data.[12] All analyses were conducted in Stata version 13 and, except where noted, used weighted data to adjust for unit nonresponse.

RESULTS

Sample Characteristics

Forty-seven percent of the sites surveyed were private practice sites, 37% were community clinics, 8% were Planned Parenthood health centers and 9% were other provider types (Table 1). One-third of sites were women's health or family planning specialists, and the rest were primary care or multispecialty sites. Seventeen percent received Title X funding, and 74% had a contract with a health plan to provide primary care services. While 49% of sites used only electronic health records, 31% used electronic and paper records, and 20% used only paper records. More than half of sites (52%) served fewer than 500 Family PACT clients in 2012–2013. The mean number of Family PACT clients served at each site in 2012–2013 was 1,235 (not shown).

Eighty-five percent of sites were located in urban areas, and these differed in most respects from the 15% located in rural areas. While 80% of rural sites were community clinics, only 30% of urban sites were; 5% and 54%, respectively, were private providers. A larger proportion of rural sites than of urban sites were primary care or multispecialty providers (83% vs. 64%) and reported contracts to provide primary care services (87% vs. 72%). Seventy-five percent of rural sites used only electronic records, compared with 45% of urban sites. The average number of Family PACT clients served was significantly lower in rural areas (651) than in urban areas (1,337). The proportion receiving Title X funding did not differ by location.

TABLE 1. Percentage distribution of Family Planning, Access, Care and Treatment (Family PACT) sites participating in a survey on health insurance enrollment, by selected characteristics, according to location, California, 2014

Characteristic	All (N=684)	Rural (N=102)	Urban (N=582)
Provider type***			
Private	47	5	54
Community clinic	37	80	30
Planned Parenthood	8	4	8
Other	9	11	8
Provider specialty***			
Primary care/multispecialty	67	83	64
Women's health/family planning	33	17	36
Title X funding			
Yes	17	14	18
No	83	86	82
Contract for primary care**			
Yes	74	87	72
No	26	13	28
Health record type***			
Only electronic	49	75	45
Electronic and paper	31	21	33
Only paper	20	5	23
No. of Family PACT clients served***,†			
50–174	25	38	22
175–499	27	30	26
500–999	20	17	20
≥1,000	28	15	31
Total	100	100	100

**p<.01. ***p<.001. †In fiscal year 2012–2013. *Notes:* Differences between rural and urban sites were determined by chi-square tests. Percentages are unweighted and may not add to 100 because of rounding.

Facilitating Insurance Enrollment

Sixty-eight percent of respondents reported that their sites check whether uninsured family planning clients meet eligibility criteria for Medi-Cal or a subsidized exchange plan (Table 2). Of these, only 46% reported doing so at nearly every visit (not shown). The most commonly used tools to screen for eligibility were an income eligibility chart (69%), the state health insurance exchange online application portal (33%) and the state's Department of Health Care Services online eligibility portal (33%; not shown).

Seventy-seven percent of family planning program sites provided education on enrollment in Medi-Cal or subsidized exchange plans. Some 55% provided on-site enrollment assistance; among these, 74% had an on-site enrollment specialist (not shown). Nearly all (91%) sites referred uninsured family planning clients to at least one source for off-site enrollment assistance. Among sites that did not provide on-site enrollment assistance, 84% provided referrals for off-site assistance (not shown).

Efforts to facilitate insurance enrollment varied by site characteristics. The proportion of sites offering each type of assistance was significantly higher among community clinics (83–96%) than among private providers (36–85%); the proportions offering patient education and referrals for enrollment assistance also were greater among Planned

TABLE 2. Percentage of Family PACT sites offering selected insurance enrollment assistance activities, by site characteristics

Characteristic	Eligibility screening	Enrollment education	On-site enrollment assistance	Referrals for off-site enrollment assistance
Total	**68**	**77**	**55**	**91**
Provider type				
Private (ref)	54	62	36	85
Community clinic	86***	91***	83***	96***
Planned Parenthood	58	96***	51	96**
Other	67	80**	41	97*
Provider specialty				
Primary care/multispecialty (ref)	75	85	65	95
Women's health/family planning	52***	60***	34***	82***
Title X funding				
No (ref)	66	73	52	89
Yes	79*	95***	72**	98**
Contract for primary care				
No (ref)	45	63	28	85
Yes	75***	81***	64***	93**
Health record type				
Only electronic (ref)	76	87	66	94
Electronic and paper	61**	71***	50**	90
Only paper	58**	62***	36***	84**
No. of Family PACT clients served†				
50–174 (ref)	67	68	48	90
175–499	70	73	56	88
500–999	66	83**	58	91
≥1,000	68	85***	57	94
Location				
Rural (ref)	76	91	71	97
Urban	66	74**	52**	90*

*p<.05. **p<.01. ***p<.001. †In fiscal year 2012–2013. Notes: Differences were determined by bivariate logistic regression, which accounted for clustering by provider. Percentages are weighted to account for nonresponse.

Parenthood (96% for each) and other health centers (80% and 97%, respectively) than among private provider sites (62% and 85%). Each enrollment activity was reported more frequently at primary care and multispecialty sites (65–95%) than at women's health and family planning specialty sites (34–82%). Similarly, the proportions reporting every enrollment activity were relatively high among Title X–funded sites (72–98%), among providers with contracts for primary care (64–93%) and among sites using only electronic health records (66–94%). Patient education was more commonly reported by sites that served 500 or more Family PACT clients in 2012–2013 than by sites that served fewer than 175 clients (83–85% vs. 68%). Rural sites were more involved in providing enrollment education, on-site enrollment assistance and referrals than were urban sites (71–97% vs. 52–90%), perhaps because of the preponderance of community clinics in rural locations. Among community clinics, enrollment activities did not differ by location; among urban sites, differences by provider type mirrored those for the full sample (not shown).

Among sites that screen for eligibility, there were no significant differences in screening at nearly every visit by site characteristic (not shown). Among sites that provide on-site enrollment assistance, the proportion with an enrollment specialist was higher at community clinics than at private providers (88% vs. 55%), at primary care and multispecialty sites than at others (81% vs. 46%), and at sites with primary care contracts than at those without such contracts (79% vs. 37%; not shown).

Barriers to Facilitating Enrollment
Overall, 52% of respondents reported that lack of staff time was a barrier to helping clients enroll in Medi-Cal or exchange plans at their site (Table 3). Forty-seven percent identified lack of funding as a barrier, 34% lack of physical space and 33% lack of staff knowledge. Eighteen percent of respondents stated that few of their site's clients were eligible for Medi-Cal or subsidized exchange plans.

Barriers to offering enrollment assistance varied significantly by site characteristics. Private practice sites reported barriers in all five domains in higher proportion than community clinics (31–62% vs. 10–40%); they also reported more frequently than Planned Parenthood health centers and other types of sites did that few clients were eligible for Medi-Cal or exchange plans. All domains except for eligible clients were more commonly reported by women's health and family planning specialists than by other specialties (44–64% vs. 24–47%), and were more frequently cited by sites without contracts to provide primary care services than by those with contracts (49–69% vs. 26–47%). Five

TABLE 3. Percentage of Family PACT sites reporting selected barriers to offering insurance enrollment assistance, and percentage receiving funding to provide enrollment assistance, by site characteristics

Characteristic	Barrier					Received funding
	Lack of staff time	Lack of funding	Lack of physical space	Lack of staff knowledge	Few eligible clients	
Total	**52**	**47**	**34**	**33**	**18**	**20**
Provider type						
Private (ref)	62	60	38	47	31	<1
Community clinic	40***	30***	26**	14***	10***	57***
Planned Parenthood	60	59	45	47	6*	14**
Other	52	47	40	37	7**	4*
Provider specialty						
Primary care/multispecialty (ref)	47	43	30	24	17	28
Women's health/family planning	64**	57*	44**	52***	19	4***
Title X funding						
No (ref)	55	50	35	35	21	15
Yes	40	34	31	21	5**	45***
Contract for primary care						
No (ref)	69	63	49	54	16	2
Yes	47***	42**	29***	26***	18	26***
Health record type						
Only electronic (ref)	46	42	33	28	11	34
Electronic and paper	58*	51	36	38	20*	10***
Only paper	60*	54	35	39	34***	5***
No. of Family PACT clients served†						
50–174 (ref)	58	49	39	36	13	16
175–499	52	48	36	33	25*	23
500–999	45*	42	25*	29	16	17
≥1,000	52	49	35	32	17	23
Location						
Rural (ref)	39	28	29	21	6	43
Urban	55**	51***	35	35**	20**	16***

*p<.05. **p<.01. ***p<.001. †In fiscal year 2012–2013. *Notes*: Differences were determined by bivariate logistic regression, which accounted for clustering by provider. Percentages are weighted to account for nonresponse.

percent of Title X–funded sites reported that few clients were eligible for coverage, compared with 21% of others. Higher proportions of sites using both paper and electronic health records or only paper records than of those using only electronic records reported lack of staff time (58–60% vs. 46%) and client ineligibility (20–34% vs. 11%) as barriers to assistance. There were no clear patterns in the relationship between the Family PACT client caseload and barriers to providing enrollment assistance. Finally, urban sites were more likely than rural sites to face barriers in the domains of staff time, funding, staff knowledge and client eligibility (20–55% vs. 6–39%).

Funding for Enrollment Assistance

Overall, 20% of sites received funding dedicated to assisting clients with insurance enrollment. The proportion was higher among community clinics (57%), Planned Parenthood health centers (14%) and other provider types (4%) than among private practice sites (less than 1%). Funding for enrollment assistance was more prevalent among primary care and multispecialty sites than among women's health and family planning specialists (28% vs. 4%), among Title X–funded sites than among those with-

out Title X funding (45% vs. 15%) and among sites with primary care contracts than among those without such contracts (26% vs. 2%). It was reported more frequently by sites using only electronic health records than by sites using both electronic and paper records or only paper records (34% vs. 5–10%), and more often by rural than by urban sites (43% vs. 16%).

DISCUSSION

For many clients, a family planning visit may be an opportunity to learn about potential insurance options and how to navigate the enrollment process. In a representative survey of sites participating in California's Family PACT program, we found that most sites are actively engaged in health insurance enrollment, yet opportunities for sites to expand and strengthen their role remain. Although 68% of sites screened for insurance eligibility, fewer than half of those did so at every visit. Screening for eligibility at each visit can help to minimize gaps in coverage and disruptions in the continuity of care that may occur as a result of changes in income or family circumstances.[13] In addition, 77% of sites provided education on enrollment in Medi-Cal or exchange plans; it would be relatively easy to increase

this proportion, especially if the state provided print educational materials, such as leaflets or posters. More than half of sites provided on-site enrollment assistance, and nine in 10 provided referrals to other organizations offering enrollment support. All of this suggests that there are missed opportunities to help uninsured individuals learn about health insurance coverage options available to them and effectively navigate the enrollment process. Furthermore, research is needed to understand the quality and effectiveness of sites' current enrollment efforts.

Publicly funded family planning providers require additional financial resources to reach their full potential for outreach and enrollment. About half of sites reported that lack of staff time and funding were barriers to facilitating enrollment, and only one in five received funding to support enrollment efforts. As expected, funding was by far most common among community clinics. In 2013, the Health Resources and Services Administration awarded over $150 million in outreach and enrollment grants to 1,159 community health centers.[14] In contrast, the Office of Population Affairs directed only $3.4 million in Title X funds for enrollment assistance to 22 grantees, which supported 85 family planning centers.[15] Additional federal, state or private foundation funding is needed to support enrollment activities at a greater number of family planning sites, including private-sector sites and public-sector sites that do not receive Title X funding.

Our findings also highlight a need for training support. One-third of sites reported that inadequate staff knowledge was a barrier to enrollment efforts. Policymakers could help increase staff knowledge by providing training or linking family planning program sites to other organizations that provide relevant training. Also, simplifying the processes for determining eligibility and enrollment would save staff time, reduce administrative costs and minimize training needs.

In addition, investments in clinic infrastructure and capacity, including clinic-based technology, may support insurance enrollment activities. Sites using only electronic health records were more likely than others to provide all forms of enrollment assistance. And sites are open to using technology for their enrollment efforts, as evidenced by the frequency of reliance on online resources for eligibility screening. Sites that have invested in more sophisticated technology for information and communication also may have greater capacity to use technology for insurance outreach and enrollment.

At the same time, it is important to recognize that some publicly funded family planning providers may be less motivated than others to support health insurance enrollment. The proportion of sites offering each type of enrollment assistance was relatively high among community clinics, primary care and multispecialty sites, and sites with contracts to provide primary care services. The ability to seek reimbursement for services from health plans and maintain continuity of care with patients who enroll in comprehensive insurance may help motivate sites to participate in outreach and enrollment. Also, a substantial proportion of sites reported that few clients are eligible for Medi-Cal or subsidized exchange plans. Although the survey did not assess the reasons why clients are not eligible, immigration status may be a primary factor; sites serving large numbers of undocumented immigrants, who are not eligible for Medi-Cal or insurance through the state exchange, may be less engaged in enrollment than other sites. Additional research is needed to better understand perceptions of clients' eligibility for insurance coverage and, more broadly, how to incentivize the diverse network of publicly funded family planning providers to participate in enrollment.

As reaching and enrolling the remaining uninsured becomes more difficult, it will become even more crucial for states to partner with family planning administrators and providers in enrollment efforts. The California Office of Family Planning set an overarching goal in 2015, the year after the survey was conducted, to "aid in the transition of eligible clients from Family PACT to comprehensive health medical coverage per ACA mandates."[16] Furthermore, the state's 2015–2016 budget established a new requirement that providers in limited health care benefits programs, including Family PACT, provide clients with information on how to apply for comprehensive benefits programs like Medi-Cal or subsidized coverage through the state health insurance exchange. Policymakers in other states and at the national level may consider replicating these policies. Our results suggest that most sites already meet the new requirement; their experiences should be used to identify and disseminate best practices for enrollment, as well as strategies for overcoming impediments to enrollment. Efforts to support and strengthen provider involvement in enrollment should focus on the types of sites that face the most barriers to enrollment—private providers, women's health and family planning specialists, and those that do not have contracts to provide primary care services.

Limitations

This study has three main limitations. First, it was restricted to sites enrolled in California's Family PACT program, and thus, our findings may not be generalizable to other states. California was an early leader in expanding Medicaid coverage, through its Bridge to Reform section 115 Medicaid demonstration waiver, which received federal approval in 2010.[17] Since then, California has implemented new initiatives to increase Medi-Cal enrollment, as well as streamlined enrollment and renewal policies and processes.[18,19] Thus, family planning sites in other states may face even greater challenges to offering enrollment assistance.

Second, we relied on self-reported data from clinic managers and other administrators, whose knowledge about some topics, such as funding for enrollment assistance, may be limited. Nonetheless, these respondents are likely the most knowledgeable about health insurance enrollment activities at their sites, so we believe their responses to be valid.

Third, because of the timing of the survey, we may have underestimated sites' involvement in insurance enrollment. The survey was conducted shortly after the 2013–2014 open enrollment period for the state health insurance exchange, and sites may have been more involved in enrollment activities during that open enrollment period. Also, the state budget amendment that requires Family PACT providers to educate clients about comprehensive insurance options took effect after the survey period.

Conclusion

At the time this article went to press, the future of the ACA was uncertain. Republicans, who won the presidency and retained control of the U.S. House and Senate, have pledged to repeal and replace the ACA. Regardless of changes in the ACA, publicly funded family planning providers will continue to play a vital role in reducing the number of uninsured people and ensuring health care access. Women will continue to need contraceptive care and a wide array of preventive health services. In turn, publicly funded family planning providers will remain a gateway to comprehensive insurance coverage for those who are eligible for Medicaid or other insurance coverage, and a safety net for the uninsured and for those who cannot use their insurance because of confidentiality concerns or other barriers.

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