

What Happens to the Women Who Fall Through the Cracks of Health Care Reform? Lessons from Massachusetts

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In 2006 the Commonwealth of Massachusetts passed health care reform legislation, known as Chapter 58 of the Acts of 2006, that was aimed at improving access to affordable, high-quality health care for residents. The state's groundbreaking efforts offer a unique opportunity to examine how health care reform has affected women and their access to services, specifically access to politically stigmatized services such as reproductive health care. Moreover, lessons learned about the experiences of low-income women and reproductive health care providers under Massachusetts reform provide many valuable lessons for national health care reform under the Patient Protection and Affordable Care Act (PPACA).

We focus on women's experiences with reform for a number of reasons. First, women have specific reproductive and lifelong health needs and play essential roles as managers of family health. In addition, a large body of research has documented disparities in access to insurance coverage and health care utilization between women and men (Bertakis et al. 2000). Further, compared with men, women are more likely to be unemployed or work part time and so have less access to employer-sponsored insurance; they are therefore more likely to be in need of and eligible for government-subsidized insurance plans (Patchias and Waxman 2007). It is reasonable to believe that health care reform efforts in the Commonwealth would resolve some of these challenges by expanding access to insurance and health services for uninsured low-income women; however, evidence is needed to determine if the policy change has met its intended goals.

In this article we outline how reform evolved in Massachusetts and discuss what evidence has emerged of the successes and challenges related to reform. We then share the original research conducted jointly by Ibis Reproductive Health and the Massachusetts Department of Public Health

(MDPH) family planning program and analyze which populations fall through the cracks of reform and the impact of being left out of reform. We close with a discussion of the implications of our findings for national health care reform.

The Development and Initial Success of Health Care Reform in Massachusetts

Prior to health care reform in Massachusetts, there were several policies and programs in place designed to ensure that low-income women could access reproductive health care. First, a comprehensive Medicaid program (known in Massachusetts as MassHealth) has historically covered all contraception and abortion services at relatively low cost. Second, in 2003 Massachusetts enacted contraceptive equity regulations that required most health insurance plans that cover prescription medication to provide equitable coverage for all FDA-approved contraceptive methods (General Court of the Commonwealth of Massachusetts 2011). Massachusetts law also requires insurers that provide pregnancy-related benefits to also provide coverage for the diagnosis and treatment of infertility (Massachusetts General Law 2011a). Although these regulations apply to many public and private insurers in the Commonwealth, religious organizations and self-insured employers are exempt from the requirements (Massachusetts General Law 2011b). Low-income women without health insurance have had long-standing access to family planning and other reproductive health services on a sliding scale basis through freestanding family planning clinics and community health centers funded by the MDPH. Many of these MDPH-funded family planning clinics also receive significant funding from Title X, the federal family planning program, as well as reimbursement from MassHealth. (Data regarding funding sources of MDPH-funded family planning clinics were provided directly from the MDPH Family Planning Program and are not available in a published format.)

It is in this context that the Massachusetts legislature passed Chapter 58, an act aimed at improving access to comprehensive health care in the Commonwealth. Key elements of Massachusetts reform parallel national reform efforts. These include an individual mandate for coverage, expansions of MassHealth, the development of a health insurance exchange, and the creation of Commonwealth Care.

Commonwealth Care is a subsidized, low- or no-cost insurance program for low-income residents. To qualify for the program, an individual must be a Massachusetts resident with an income at or below 300 percent of the federal poverty level (FPL), with no access to employer-sponsored health insurance, and not eligible for other public insurance (such as MassHealth). The plans' benefits were modeled on MassHealth benefits and cover primary and preventive care, prescription medications, inpatient services, mental health treatment, substance abuse services, and family planning services, including prescription contraceptives and abortion care. Several insurance companies offer Commonwealth Care plans, and the costs of the available plans are similar. None of the plans have deductibles, and premiums and co-pays vary based on the individual's income (table 1).

Table 1 Commonwealth Care Summary of Costs by Plan Type (Omitted)

Between 2006 and 2010 the number of nonelderly adults with insurance rose from 86.6 percent to 94.2 percent (Long, Stockley, and Dahlen 2012). Most of the increased coverage since reform is the result of increased enrollment in public insurance programs, such as MassHealth and Commonwealth

Care (Blue Cross Blue Shield of Massachusetts Foundation 2011). During this time, access to and use of health services also rose. These changes appear to have led to gains in health: four years after reform, the number of nonelderly adults reporting that their health status was very good or excellent rose to 53.2 percent from 46.7 percent before reform (Long, Stockley, and Dahlen 2012).

Though the above shows that there have been marked increases in insurance, access to health services, and residents' health status, little is known about how low-income Massachusetts women seeking contraceptive services have been affected by health care reform. Likewise, little is known about how family planning providers, who have traditionally been important safety net providers for low-income women in Massachusetts, have been affected by health care reform. This article seeks to fill this gap.

* * *

Reports from study participants show that though health care reform has led to significant improvements in access to health insurance and health care for Massachusetts women, there are still challenges in accessing insurance and benefits. Access to health care has not improved or has gotten worse for some populations of women. The populations that women and providers identified as facing barriers to care under reform were remarkably similar: immigrants, young women and minors, those with erratic insurance coverage, and those not living in urban areas were reported to have been “left out” of health care reform. After discussing participants' overall assessments of how access to insurance and benefits has changed since health care reform, we focus on the specific challenges faced by populations that have fallen through the cracks of reform and remain in particular need of support to consistently access health care services. Table 5 shows a summary of the article's main findings and quotations illustrating those findings.

Table 5 Primary Study Findings and Illustrative Quotations (Omitted)

Access to Insurance and Benefits Improved Overall

The agency and clinic staff (collectively referred to here as family planning providers) and women in our study reported a number of improvements in access to care for low-income women since health care reform, though participants also identified continuing challenges. We have written elsewhere about these findings (Dennis et al. 2012; McIntosh, Tsikitas, and Dennis 2012) and briefly outline the successes and challenges for individuals eligible for insurance below.

Participants reported that overall access to insurance has increased, subsequently increasing access to both preventive and emergency health care services. Women in the focus groups reported increases in access to insurance coverage that they said made it easier for them to visit a range of health care providers. Many women said they were “grateful” to have insurance, which they considered a “lifesaver” that gave them “peace of mind.” The importance of having insurance was articulated by one Lawrence woman who stated, “That worries everyone in the world because insurance is everything. People without insurance don't have a life. You get sick. What are you going to do?”

Likewise, family planning providers reported seeing similar increases in access to insurance that resulted in expanded access to services among their clients. As one family planning administrator said:

I think [health care reform] has probably increased access because when people have health care, they'll use it. Whereas a lot of people do not want to come in for something and ask for it for free, even if it is available for free But if they can come in and they have a card and they know that they are covered then they feel better about it They feel like they are contributing so it is OK for them to ask for services.

Challenges Remain in Accessing Insurance and Benefits

While most participants felt that reform increased women's access to insurance and health services, some described barriers for low-income women in using their insurance. Confusing eligibility requirements and enrollment challenges made it difficult for women to obtain and maintain insurance coverage. One woman in a Worcester, focus group described problems understanding what insurance plan she was eligible for:

They're making it as difficult as possible. Every week, I had to send paycheck stubs. I had to get documentation from my employer when I got laid off. I had to get documentation from here. I had to get documentation from there. And I wasn't eligible for this. And I wasn't eligible for that. And I wasn't eligible for the other thing.

Further, the results of our desk review and interviews with women revealed that information on the health insurance websites was difficult to wade through to determine benefits available under the plans. In addition, women found it difficult to schedule a timely appointment with a health care provider; some providers in the Commonwealth do not take any of the subsidized insurance plans, and many health care facilities have long waiting periods for new clients.

Though some women and family planning providers reported increased access to prescriptions since health care reform, barriers were also revealed. Focus group participants and providers reported that pharmacy locations were often inconvenient and that some pharmacists did not know what prescriptions were covered by the new subsidized plans. Some women were unfamiliar with how to use prescriptions, particularly for contraception, because they were used to obtaining contraception in person, on a sliding scale, and often in bulk from family planning providers. One direct service family planning provider described this challenge:

I have patients come in here that don't even know about prescriptions They say, "I don't have any more birth control pills."... I say, "No you have three refills Your insurance only allows you to get one [pack a] month. Each month you have to go to the pharmacy and get another."They just--they don't even know that; they're thinking that there is a problem.

Findings related to service affordability were mixed. While most women in the focus groups said that one of the primary benefits of health care reform was the affordability of services and prescriptions, many family planning providers reported that insurance-related expenses were burdensome for their

clients. We believe this incongruity may be related to limitations in our focus group sample. Indeed, most of the women in our groups had incomes that qualified them to have \$0-\$3 co-pays for services or prescriptions. We suspect that women in different tiers of subsidized plans with co-pays of up to \$22 for office visits and up to \$50 for prescriptions may have different experiences with affordability.

Challenges Accessing Health Services: Immigrant Women

Health care reform in the Commonwealth excluded undocumented immigrants, who remain largely ineligible for coverage. Immigrants without legal documentation can obtain MassHealth Limited, which covers only urgent and emergency care, and Health Safety Net, which is not considered insurance coverage and is accessible only in certain settings, such as hospitals and community health centers, and only for medically necessary services (Health Law Advocates 2010). Because the Massachusetts immigrant population is largely made up of young Latinas of reproductive age (Clayton-Mathews, Karp, and Watanabe 2009), we explored their access to services and insurance under reform. Table 4 shows that all participants in the Spanish-language focus groups identified as Latina, as did one woman in an English-language group.

We found that health care reform has spurred tremendous misinformation about the availability of health care and insurance coverage for both documented and undocumented immigrants. Four primary challenges to health care access for immigrants generally and foreign-born Latinas specifically were documented: lack of access to Spanish-language health insurance information; the inability of some immigrants to legally enroll in any type of insurance plan; fear of deportation; and unawareness of the continued availability of services at public health clinics for individuals who remain uninsured.

Family planning providers and women recognized that non-English speakers can face a multitude of barriers to accessing care, including the inability to get information about their health care plan in their native language. According to one hospital-based provider, who primarily serves clients whose first language is not English, "Notices [from insurance companies] and things that they get, [they] are not ... able to read, and then they have to bring it somewhere to have it translated." Indeed, many Spanish-speaking participants in the focus groups described getting assistance from Spanish-speaking providers to access information about enrollment in health care plans and to read Commonwealth Care correspondence that was sent to them in English. In a Boston focus group, one woman described bringing papers she received from Commonwealth Care to a local family planning provider. She described needing to fill out the papers to verify her eligibility: "To renew the insurance contract, that's the only thing I do I get the papers at home and I don't open them, I bring them right to the clinic, I don't know what they do with them there, I don't take care of that, I just take them out of the mailbox and bring them to the clinic."

Provider assistance appeared to help many Spanish-speaking women overcome the barrier of receiving insurance materials in English. Focus group participants and family planning providers voiced concerns about the reform's impact on undocumented immigrants. In particular, participants in the Spanish-language focus groups believed that health care reform had a negative impact on immigrant women's access to care because before reform it had been easy to get insurance and health care without proof of citizenship; however, women now felt that excessive documentation was required. One woman in a Lawrence group described this change: "They didn't ask ... if you were legal or illegal, they didn't ask anything Now, they ask everything. If you are citizen you have to

show it. Before you didn't, you said 'I'm a citizen,' and that's it. It's really bad in that respect.”

The accumulation of these barriers led some women to stop seeking health care altogether. One Boston focus group participant described how paperwork and citizenship requirements of the health care reform have led some women in her community to stop going to doctors. She said: “So many people say, ‘Uy! I don't have papers ... so I can't go to a doctor.’ What happens?” Likewise, family planning providers expressed concern that many immigrants had stopped seeking care because they feared they would be fined or deported if it was discovered that they were undocumented and without health insurance. One family planning provider described how fear of deportation or other general legal action had been heightened since reform, and the negative fallout of the fear:

Some of our clients are undocumented When it became mandated for individuals to have health insurance, people were afraid to come to medical facilities because they were under the assumption that if they didn't have health insurance they were going to be reported to the authorities.

Some providers reported that women even stopped seeking care from family planning clinics where care is provided regardless of income, insurance, or immigration status and are instead “leaving the system.” One hospital-based provider summarized these challenges: “There are issues around immigrants [who] don't understand whether they can come in [to family planning clinics] There is that confusion They fall through the cracks.”

Challenges Accessing Health Services: Minors and Young Women

Because of challenges that young people commonly face in getting and keeping insurance, efforts were made in Massachusetts to ensure consistent access to insurance. Such changes included extending the age at which young adults could stay on their parents' health plan and designing health plans to meet young adults' health care needs (Health Connector n.d.). Despite these laudable efforts, we found that minors and young women faced unique challenges, specifically in accessing reproductive care.

Providers reported that though many people in the community believe young women can obtain health care through a parent's insurance, it is important to note that when using parents' insurance, a young woman may not be able access reproductive services confidentially. For those covered as dependents under their parents' plans, an explanation of benefits disclosing the services provided might be mailed to the primary insured member, usually the parent(s). A few providers mentioned seeing an increase in teens who were seeking confidential care. One family planning administrator noted that “health care reform essentially left out teenagers. Anybody who is under eighteen is not eligible for Commonwealth Care plans, so it assumes that those kids are covered under their parents' insurance, but if clients are coming to family planning and they want confidential services we are not about to bill their parents' insurance.” Participants reported that these women face challenges accessing reproductive care confidentially and often do not feel empowered to advocate for themselves when navigating a complex and sometimes bureaucratic health care system.

Providers and women also noted concerns about a slightly older population-- those young women aged 19-25 who are no longer minors but are transitioning into adulthood. Focus group participants believed that these women may be less skilled at advocating for themselves when navigating the health care system because they have traditionally relied on their parents to do so. While technically

access to health insurance may have increased, it “may not actually be taken advantage of” by young women. As one Boston-based woman reported, “I feel like some other young women who are just really needing this type of health insurance to get contraceptives, if they don't know about it and they don't know how to go about these really confusing things, then [they're] not going to do it.”

Because of these challenges, women and providers feared that minors and young women choose to forgo seeking reproductive health care, even in circumstances where they may be able to obtain it confidentially through family planning providers.

Challenges Accessing Health Services: Women outside Urban Areas

The majority of study participants lived or worked in urban areas, but our limited data suggest that women living in rural areas faced more challenges accessing health care services compared with those in urban areas. Women living outside urban areas often had difficulty finding a provider who accepted their insurance plan and was accepting new clients. Distance to a pharmacy was also noted as a barrier to accessing contraception and other prescription medication. One family planning provider said she perceived relatively easy access to contraception in urban areas like Boston but that “it's a whole different ball game if you're out in the Berkshires [rural western Massachusetts] or something like that.” This was confirmed in our focus groups, as women in Boston described relatively better access to services than women in more rural areas of the Commonwealth.

Challenges Accessing Health Services: Women Facing Common Life Transitions

A theme that emerged strongly in the data is that low-income women of reproductive age face problems maintaining continuous enrollment in insurance for a number of complex reasons related to the frequent financial, social, and biological transitions that are common in their lives.

Financial transitions that affect eligibility occur among women who are laid off from their jobs, work on a part-time basis, are seasonally employed, or cannot afford their employer-sponsored health insurance, premiums, or co-pays. One family planning provider pointed out that women with variable employment also have variable income, which affects their eligibility for subsidized insurance: “We serve the Cape and Island population--and that is a very transient population, as is their work ... health insurance is following [not only] the ebb and flow of people's financial status, but also of their lives.” In addition, despite employer-sponsored insurance being strongly encouraged by reform, the recent economic crisis has magnified the problem of moving on and off coverage, because many people are losing their employment and therefore losing their access to employer-sponsored insurance. One hospital-based family planning provider described the situation:

People working may be eligible and enrolled in Commonwealth Care and then they begin working at a place that offers them health insurance and ... their employer says that they have to have that health insurance ... and so they do that and then a few months later they lose their job and now they have to reapply for insurance.

The social changes women experience, such as marriage, starting or finishing college, or moving, also play a role in their eligibility and coverage changes. Summing up all these changes, one family planning administrator noted of her client population:

They are living in very complicated periods of their lives when they are making transitions from living with their parents to living with a boyfriend or getting married or having children there are lots of changes and some of those changes tend to affect how things like insurance and government relate to that.

Biological changes such as pregnancy were also often mentioned as major life events that affect women's insurance eligibility. Providers reported that pregnant women may be unable to work and thus would lose their employer-sponsored insurance, while others may become eligible for certain plans based on their new status. Women in focus groups described becoming pregnant as an important change that often made them eligible for insurance. Many described “lucking out” by being pregnant at the time they were seeking insurance because it “fast-tracked” them to enrollment. However, some of these same women were surprised when they were dropped by their insurance carriers shortly after having a baby, as they only later learned that after giving birth their eligibility for insurance coverage changed.

Women going through all these common life transitions were prone to experiencing gaps in health insurance coverage and were often surprised to see how these changes affected their ability to enroll or maintain their eligibility in a plan. As one clinic manager said, “We are seeing a higher number of patients who are ... no longer insured, but they think they are At any given point, there are a certain number of people who are insured, but by the next day, a large proportion of those are probably uninsured again.” Similarly, many women in the focus groups said they did not know why they were dropped from their plans and that they found it difficult to re-enroll once their coverage was terminated. After losing her job and employer-sponsored health insurance, one Boston-based woman enrolled in a Commonwealth Care plan said, “I've been kicked off twice. For me, it wasn't hard to get on; it's getting kicked off I'm actually dealing with that right now. It's just been really, really--it's always really confusing.” Indeed, many focus group participants described a time-intensive, paperwork-heavy process when trying to recertify their eligibility for Commonwealth Care.

Getting on and staying on an insurance plan through common life transitions caused a number of hardships for women. They reported considerable stress in managing their health insurance and an inordinate amount of time addressing eligibility problems. Women also reported waiting to see their primary health care providers until they got back on a plan, using emergency rooms to obtain routine care, or reaching out to public health clinics such as family planning providers for health care. Changes in enrollment therefore affected not only women and their families but also the health system.

Role of Family Planning Providers in Mediating Challenges

Our research suggests that the care offered by family planning providers is critical not only to ensure that low-income women have access to family planning services but also to mitigate health reform-related problems that may affect women's overall health. Several features of the Massachusetts family planning care model contribute to this, including affordability, willingness to offer services regardless of a client's insurance status, comprehensiveness of services offered, and provider expertise in reproductive health.

Because of their service provision model, family planning providers can offer services free or at reduced cost regardless of whether a woman has insurance. As one administrator said, “We are a community health center. The services that we have offered have been offered all along, and we serve insured and uninsured folks the services that are available have always been available and have always been provided regardless of someone's insurance status.”

Women in focus groups consistently described turning to family planning providers when they needed urgent and moderately priced care. One Boston-based participant described seeking emergency contraception and stated: “I was very scared They told me that in the pharmacy [emergency contraception pills] cost \$50, I don't know if this is true, and that in the clinic they cost about \$20. But when I went to the clinic they didn't charge me, they gave them to me. Thank God I didn't become pregnant.”

Family planning providers also mitigated the impact of women moving on and off plans both by helping women understand their insurance plans and by directly providing services. Specifically, for women whose insurance coverage has lapsed, family planning clinics might be the only way to obtain health care during their “off-plan” periods, since it takes time for plans to get reactivated.

Many women reported that they consistently and frequently rely on family planning clinics or that the clinics are the “first place I would go.” The majority of comments about family planning providers involve the benefits of providers educating them about contraception, generally positive experiences in obtaining contraception because of the staff's positive attitudes, and women's ability to get multiple months of contraceptives for free or at deeply discounted prices at family planning clinics. As one Boston-based participant stated, “Honestly, for something like that I would just go right to [the clinic] because I know [it] a lot better at this point than I know my own insurance.”

Because of the strong network of family planning providers, many participants felt that access to family planning was easier in Massachusetts than in other states. In one focus group, participants called for more family planning providers to help facilitate contraceptive access.

Discussion

Health care reform in the Commonwealth was designed to dramatically expand access to affordable health insurance for Massachusetts residents. Indeed, reform has reduced the already low uninsured rate in the state; in 2010 Massachusetts had the lowest rate of uninsured residents in the nation, and 97 percent of women were insured (Massachusetts Division of Health Care Finance and Policy 2010; Long et al. 2010). Despite these increases in coverage, reform is not without its challenges. Though very close to having 100 percent of residents covered by insurance, social and financial constraints caused some populations to be excluded from the benefits of reform either explicitly or by oversight.

Undocumented immigrants were explicitly left out of health care reform (though as stated above they can get some covered services through MassHealth Limited and Health Safety Net) (Health Law Advocates 2010). Further, our research shows that documented immigrants eligible for public or subsidized insurance had problems understanding what programs and services they were eligible for and as a result sometimes delayed or stopped seeking care from primary health care providers and

family planning clinics.

This is disturbing because the policies and programs specific to immigrants affect a large number of people in the Commonwealth. Massachusetts has the eighth-largest proportion of immigrants (defined as persons living in the United States who were not US citizens at birth) in the United States, making up approximately 13 percent of the population in 2009 (Camarota 2007; Gryn and Larsen 2010). Latinos comprise the largest group of immigrants in Massachusetts (34 percent) and also the largest group of recently established immigrants (43 percent) who are least likely to be eligible for insurance (Clayton-Mathews, Karp, and Watanabe 2009). Indeed, recent estimates suggest that Latinos are uninsured at over twice the rate of their non-Latino counterparts (Blue Cross Blue Shield of Massachusetts Foundation 2011). Our findings suggest that this low rate of insurance coverage may be due in part to a lack of clarity about which health insurance programs immigrants are eligible to enroll in.

Our research also shows that some minors and young women were unable to use their insurance because of the difficulties of navigating a complex health care system. The life transitions that minors and young adults commonly go through appeared to affect their eligibility for insurance, rendering an already complicated system even more confusing. We also found that certain positive features of health care reform (such as young people's ability to stay on their parents' insurance until age twenty-six) may have unintended negative consequences: young people on their parents' plans cannot access health care confidentially and may forgo care as a result.

Other research confirms our findings about the specific challenges young people face as they go through multiple life changes in early adulthood that affect their insurance eligibility. Indeed, Bessett et al. (2010) found that because such transitions are often accompanied by additional paperwork and waiting periods for enrollment, young people may experience gaps in their insurance coverage.

Our findings also suggest that women living outside urban areas may have difficulty finding a health care provider who accepts one of the Commonwealth Care plans and scheduling a timely appointment with that provider. However, these findings must be viewed with caution, since most of the study participants worked or lived in urban areas, and the majority of the Massachusetts population lives in one of a number of urban areas in the state (Kaiser Family Foundation 2010).

At the same time, our findings about women living outside urban areas are supported by previous studies showing that 7 percent of the population lives in areas of the state that are medically underserved and face documented health care provider shortages; these areas tend to be outside major urban areas (Kaiser Family Foundation 2012; Rural Policy Research Institute 2009).

This study showed the specific challenges facing women with variable employment, women going through common life changes (e.g., pregnancy, marriage, starting or finishing college, leaving home), and women whose primary residences frequently change; these women were prone to regularly experiencing gaps in health insurance coverage and were often unaware of when their eligibility began or when they had been dropped by a plan. The findings are supported by evidence showing that a sizable number of people in Massachusetts frequently come on and off insurance programs. In fact, one study found that 28 percent of MassHealth enrollees experienced at least one gap in coverage during a three-year period (Seifert, Kirk, and Oakes 2010). In addition, in an average month more

than twelve thousand individuals are dropped from either MassHealth or Commonwealth Care for administrative issues such as failing to return paperwork to document income or employment status (ibid.).

It also became clear that family planning providers are key health care providers for many of the populations discussed above and will continue to be critical resources for ensuring that women can access insurance and health services, both inside and outside family planning. Other analyses have confirmed this finding, showing that safety net providers, including community health centers, hospitals, and family planning providers, are critical for helping the newly insured navigate their insurance plans while also providing affordable services to those who are ineligible for subsidized plans or who are temporarily uninsured (National Association of Public Hospitals and Health Systems 2009; Gold 2009). Moreover, a recent analysis found that demand for care at safety net facilities in Massachusetts (defined as facilities that provide a significant level of care to low-income, uninsured, and vulnerable populations) continues to rise and that most clients of these facilities prefer the care they receive at these locations (Ku et al. 2011).

More research is needed to determine whether the findings from this exploratory study reflect the experience of a broader population of low-income women across Massachusetts. However, it seems clear that those populations left out of health care reform have encountered significant barriers to health care service access, barriers that may be mitigated by family planning providers.

Implications for National Health Care Reform

Because national health care reform has been modeled on the Massachusetts approach, many of the successes and challenges described above are likely to arise as national implementation efforts move forward.

First, the barriers to health care experienced by both documented and undocumented immigrants in this study raise a number of concerns about the impact of the PPACA on immigrants throughout the United States. Almost 13 percent of the US population is composed of foreign-born individuals, and well over half (56 percent) of those individuals are not current US citizens (Gryn and Larsen 2010). Estimates suggest that there are 3.7 million low-income undocumented immigrants in the United States and that the majority are uninsured (Blewett 2010). This will not change under national reform; undocumented immigrants will not be able to participate in the health care exchange, with a few exceptions: income-eligible individuals will be able to receive emergency care, and states will have the option to cover prenatal care for pregnant women. Our results suggest that immigrants who do not qualify for coverage may be unaware that they can continue to get low- or reduced-cost care at safety net providers. Documented immigrants may also be confused about their eligibility for insurance or afraid to apply for it, and face challenges obtaining public or subsidized care. For these reasons, special efforts will be needed to make sure that immigrants eligible for health insurance under the PPACA are aware of their options, and those not eligible must be advised of their continued ability to access health care.

Second, it is critical to address difficulties that minors and young adults are likely to face under the PPACA. Nationally, low-income minors and young adults are at particular risk for not having

insurance (Kriss et al. 2008). Though reform will probably increase insurance coverage for these individuals, it is unclear if the coverage will lead to gains in access to services because of the complexities of navigating the health insurance system and the many transitions these populations face in their lives when they may temporarily lose insurance. In addition, while health care reform will expand access to private and public health insurance for adolescents and young adults, it does not guarantee that confidential care will be available to this newly insured segment of the population. Proactively monitoring minors' and young adults' access to insurance coverage under the PPACA is warranted. Policy solutions are also needed to make certain that those insured under their parents' policies can access health services confidentially.

Third, while national reform holds the promise of greatly reducing the number of uninsured, challenges of maintaining enrollment in health plans may render the available insurance coverage largely unusable. Our results suggest that the federal requirement that insurance providers routinely recheck their clients' eligibility must be balanced with the realities of individuals' lives; the health system appears to struggle to accommodate common life transitions that affect individuals' eligibility for insurance programs as well as those that do not. Other scholars have suggested a number of ways to guarantee retention in Medicaid programs, including simplifying the forms required to verify eligibility or extending the period between eligibility checks (Seifert, Kirk, and Oakes 2010). We support these recommendations because continuous access to insurance is required for continuation of and timely access to prescription contraception as well as other health care services. In addition, reducing the volume of individuals transitioning on and off insurance plans would reduce administrative costs in the long run (*ibid.*).

Fourth, the accessibility of health care providers who accept insurance plans developed under national reform must also be considered. Women in our study had difficulty finding providers who accepted plans developed under Massachusetts reform. This challenge was exacerbated in rural areas but was also experienced by participants in Boston, which has what could be considered a large and established network of health care facilities. Women living in other localities throughout the nation with fewer health care providers, or with health care providers who do not accept public or subsidized health plans, may find it increasingly difficult to make health care appointments. More work is needed to document gaps in health services under national reform and to develop program solutions to ensure that those living in underserved areas can still access health care in a timely manner.

This study highlights the critical importance of integrating current safety net systems into national health care reform efforts and continuing to support those systems to meet the needs of populations who fall through the cracks or have trouble negotiating the health care system. The perception that there will be nearly universal insurance coverage under national health care reform presents an important communication challenge for safety net providers, which must be able to justify their relevance in the post-health care reform environment. Our results suggest that safety net providers will continue to deliver care to those who remain uninsured or underinsured, usually with the support of public funds. The specific role of family planning providers in this context needs to be emphasized in light of recent attempts to cut funding to Planned Parenthood, one of the nation's largest providers. Though a measure to defund Planned Parenthood failed in April 2011, some legislators have suggested that there will be further efforts to defund the organization (Somashekhhar 2009). It is crucial to stress that for many low-income women, family planning clinics may be their only source of primary and reproductive health care, so any reduction in revenue streams is likely to reduce these

providers' capacities to fill gaps in the PPACA. At the same time, it may become financially difficult for safety net providers to continue to provide these services. Ongoing financial support from the public health infrastructure and safety net providers, which deliver care to populations that fall through the cracks of a complicated system or that have been left out of health care reform altogether, must be a critical policy priority under the PPACA.

The groundbreaking effort in Massachusetts to expand health care access for its residents offers a unique opportunity to examine how health care reform policies that build on the existing private health insurance system affect women's access to contraception and reproductive health services. Lessons learned about the experiences of low-income women, family planning clinics, and family planning agencies in Massachusetts can inform the continuing national debates about health care reform.

References (omitted)