Publicly-funded Family Planning: Lessons from California, before and after the Affordable Care Act’s Medicaid Expansion

Abstract
California has a long tradition of providing state-funded family planning services to low-income residents. The Affordable Care Act (ACA) increased contraceptive coverage in 2012, and in January 2014, extended Medicaid eligibility by (1) increasing the income cut-off from 100% to 138% of the federal poverty level (FPL) and (2) allowing childless individuals to enroll. We assessed the impact of the ACA’s Medicaid expansion on low-income Californian women’s receipt of health insurance, and needed health care, including contraceptive counseling, and prescription contraception, using data collected between 2013 and 2016 from low-income (<=138% FPL) Californian women aged 18-44 years (n=4,567). After the ACA expansion, the proportion of uninsured low-income women in California decreased significantly, while Medicaid enrollment increased. However, the proportion reporting use of healthcare and family planning services remained unchanged. Despite the ACA’s explicit attention to contraceptive services, improvements in family planning service delivery have yet to be fully realized in California.
Introduction

In the U.S, nearly half of all pregnancies are unintended.¹ Unintended pregnancies are particularly common among low-income women,¹ who often face challenges accessing family planning services. The World Health Organization (WHO) recognizes that “family planning allows people to attain their desired number of children and determine the spacing of pregnancies” and supports that these services are fundamental to reproductive health.² Studies have shown that increasing access to family planning services reduces the incidence of unintended pregnancies and abortions³ and improves birth outcomes.⁴,⁵ As a result, states that invest in family planning services have been shown to accrue considerable cost savings, estimated as a 7 to 1 return on investment.⁶,⁷

State and federal policies regarding family planning services have evolved over the past five decades. In 1969, Republican President Richard Nixon wrote to Congress: “It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them.” Following this request to Congress, in 1970, President Nixon signed into law the Title X Family Planning Program under Title X
of the Public Health Service Act. For the last 48 years, the Title X program has provided grants for family planning services, training, research, and informational and educational materials. At the heart of the Title X program, and emphasized by Congress at the time, is the belief that many low-income individuals want family planning services that they are unable to afford.\(^8\) In 1972, family planning services for low-income individuals expanded again, when Congress amended the Medicaid program, requiring that all state Medicaid programs include family planning services.\(^9\) With this expansion, Medicaid became the nation’s main funding source for family planning services for low-income individuals, funding more family planning services than the Title X program.\(^10\)

In 1996, California further expanded provision of state-funded family planning services, with the creation of the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by California’s Office of Family Planning (OFP). This limited benefit program provides low-income California residents who have no other coverage for family planning services access to a year’s supply of contraception, as well as screening for and treatment of sexually transmitted infections, at no cost. Over the years, considerable attention has been paid to ensuring Family PACT provides high quality reproductive health services.\(^11\) For instance, after demonstrating that providing a 1-year supply of oral contraceptives (instead of a 3-month supply) decreased
rates of unplanned pregnancy and abortion, this became standard practice. More recently, same-day access to long-acting reversible contraceptives has been a priority. Eligible individuals can enroll in Family PACT at any one of the state’s thousands of participating clinics. Although Family PACT was originally funded by the California State General Fund, between December 1999 and June 2010, California received additional funding for Family PACT from the Centers for Medicare and Medicaid Services (CMS) through a Section 1115 Demonstration Waiver. In 2010, 86% of funding for family planning services in California came from the Medicaid program, 11% from the state of California, and 3% from the Title X program. In Fiscal Year (FY) 2012-2013, 74% of Californian women who received publicly-funded contraceptive services were served by Family PACT, 20% were served by Medi-Cal, and 6% were served by both programs over the course of the year. Although the Medi-Cal and Family PACT program formularies were aligned in 2015, these programs have a number of important differences (Exhibit 1). For example, Family PACT provides services to women and men whose immigration status precludes Medi-Cal eligibility and is limited in scope.

In March 2011, as part of the Patient Protection and Affordable Care Act (ACA), California transitioned Family PACT into a Medicaid State Plan, retroactive to July 2010. In January 2014, another large ACA policy change took place;
Medicaid expansion extended eligibility by (1) increasing the income cut-off from 100% to 138% of FPL and (2) allowing individuals without dependent children to enroll. In California, these provisions resulted in over 4 million Californians enrolling in Medi-Cal managed care plans, including some women who had previously participated in the Family PACT program. Indeed, between FY 2013-14 and 2014-15, there was a decrease in the number of Family PACT clients from 1.7 million to 1.4 million.

Given the potential savings associated with provision of publicly-funded family planning services, the number of Californian women in need of publicly-funded contraception has previously been estimated using data from the California Health Information Survey and California Women’s Health Survey. Women ages 20-44 are considered in need of publicly-funded contraception if they are at risk of unintended pregnancy (i.e., they are sexually active, able to become pregnant, and neither currently pregnant nor seeking pregnancy), and have an income at or below 200% of the FPL; adolescent females ages 15-19 are considered in need if they are sexually active, regardless of income. Unfortunately, the most recently published estimates indicate that in FY 2012-13 approximately 689,500 women, over one third of Californian women, were in need of publicly-funded contraception but received no contraceptive services. As it has
been hoped that California’s ACA expansion would increase access to comprehensive care, we examined the impact of the ACA’s Medi-Cal expansion on low-income Californian women’s receipt of health insurance, and needed health care, including contraceptive counseling, and prescription contraception.

Study Data and Methods
The California Health Interview Survey (CHIS) is a population-based telephone survey of California’s residential, noninstitutionalized population, sampling over 20,000 households a year. For this study, we analyzed CHIS data from 2013-2016, limited to women of reproductive age (18-44 years) with incomes less than or equal to 138% of FPL, as specified by the 2014 ACA Medicaid Expansion (n=4,567). Although the CHIS data did not specifically sample Family PACT clients, approximately 93% of Family PACT clients have incomes less than or equal to 138% of FPL. However, some Family PACT clients are not eligible for Medi-Cal because they are undocumented immigrants. Following the ACA expansion, Family PACT reported a nearly 18% decline in the number of clients served between FY 2013-14 and 2014-15 and attributed much of this decline to the ACA.

Outcomes: Access to Health Care and Family Planning Services
To assess whether there was a change in low income Californian women’s overall access to health care, we examined
three variables: (1) having a usual source of healthcare, (2) being able to obtain needed medical care, and (3) having timely access to prescriptions. Women were classified as having a usual source of care if they answered “Yes” to “Is there a place that you usually go to when you are sick or need advice about your health?” Women were classified as being able to obtain needed medical care if they answered “No” to “During the past 12 months, did you delay or not get any other medical care you felt you needed – such as seeing a doctor, a specialist, or other health professional?” We further examined the percent of women who reported “cost or lack of insurance” as a reason for delaying or not obtaining needed medical care.

Women were classified as having timely access to prescriptions if they answered “No” to “During the past 12 months, did you delay or not get a medicine that a doctor prescribed for you?” We identified women as having received contraceptive counseling if they reported “receiving birth control counseling or information from their doctor in the past year.” Women were classified as having received prescription contraception if they reported “receiving a birth control method or prescription from a doctor in the past year.”

**Predictors: ACA Years and Receipt of Health Insurance**

The prevalence of each of these outcomes in the years following implementation of the ACA Medicaid expansion (2014,
2015, and 2016) was compared to the year prior to the ACA (2013). We also examined changes in health insurance coverage, classified as uninsured, Medi-Cal, private (employment-based or privately purchased), or Other Public Program (e.g. Access for Infants and Mothers, Major Risk Medical Insurance Program, etc.).

**Statistical Analysis**

We calculated the proportion of low income women with health insurance coverage and access to health care and family planning services from 2013 to 2016. P-values from *t*-tests were used to test for differences in proportions between 2013 and 2016. Five models were used to examine the association between year and health insurance coverage and the five outcomes of interest (i.e. having a usual source of care, the ability to obtain needed medical care, timely access to prescriptions, receipt of contraceptive counseling, and receipt of prescription contraception). Adjusted prevalence ratios (APR) were obtained from the predicted marginals of logistic regression models (details shown in Appendix). Each model controlled for age (categorized as 18-25, 26-29, 30-34, 35-39, or 40-44 years), race/ethnicity (categorized as Latina, non-Latina White, non-Latina Black, non-Latina Asian/Pacific Islander, Other-including multi-racial), education (less than high school, high school or GED, some college, college graduate or more), income (0-50%, 51%-100%, 101%-138% FPL), and having children (yes or no). An
interaction term was included in each adjusted model to test whether the association between year and each outcome of interest varied by type of health insurance. We also performed analyses stratified by citizenship status (US-born and naturalized citizens versus non-citizens), age (18-34 versus 35-44 years), and income (0-138% FPL versus 139-200% FPL). Analyses stratified by citizenship status were adjusted for insurance, age, education, income, and family type. Analyses stratified by age were adjusted for insurance, race, education, income, and family type. Analyses stratified by income were adjusted for insurance, race, education, age, and family type. All analyses were weighted to account for differential sampling probabilities and response rates; standard errors were adjusted for the survey design using survey specific procedures in SAS 9.4 and SAS-callable SUDAAN 11.0.1.  

Limitations

This study is limited by the fact that CHIS did not collect data on family planning service delivery prior to 2013 and has not specifically collected data on participation in Family PACT, nor women’s prior or current use of contraception. Further, this study lacks information on the underlying fertility and pregnancy intentions of study participants and their partners. In addition, some less effective contraceptive methods, such as condoms and
emergency contraception, can be purchased without a prescription. However, at the population level, we expect that these factors remained stable over the study period.

Results

The demographic characteristics of low income Californian women aged 18-44 years, from 2013 to 2016, are shown in Appendix Exhibit A1. In 2016, half (49.3%) of the low-income Californian women we studied were younger than 30 years, most (59.2%) were Latina, 75.5% had incomes 0-100% FPL, 55.5% had no college education, and 57.1% had children. There were no substantial changes in demographic characteristics over time.

Between 2013 and 2016, the proportion of uninsured low-income women in California declined significantly from 29% to 11% (p<0.001), while the percent enrolled in Medi-Cal increased from 37% to 67% (p<0.001) (Exhibit 2). However, the proportion of women reporting a usual source of care (77% to 83%, p=0.09), the ability to obtain needed medical care (82% to 85%, p=0.31) or prescription medication without delay (85% to 89%, p=0.19) increased only minimally between 2013 and 2016 (Exhibit 3). Among women who reported not being able to obtain needed medical care without delay, the percent reporting this was due to “cost or lack of insurance” declined from 66% in 2013 to 37% in 2016 (p=0.004). Overall, receipt of contraceptive counseling (33% to
34%, p=0.78) and prescription contraception (29% to 30%, p=0.67) remained stable between 2013 and 2016 (Exhibit 3).

After adjusting for covariates, these findings remained unchanged, with no significant difference in utilization of healthcare or family planning services in 2013 compared with 2016 (Exhibit 4). Results from the multivariable models show that neither utilization of healthcare nor receipt of contraceptive counseling or prescription contraception changed for low income Californian women of reproductive age, between 2013 and 2016.

These associations did not vary by insurance status, citizenship, or income (Appendix Exhibits A3-A6). However, associations between usual source of healthcare and study year differed by age group (Appendix Exhibit A4). Specifically, although there was no change between 2013 and 2016 in reporting a usual source of care among women aged 35-44 years (86% to 81%, aPR=0.90, 95% CI: 0.79, 1.04), among women aged 18-34 years an increase was seen (73% to 84%, aPR=1.09, 95% CI: 1.00, 1.19).

When we examined insurance status, we found that women with Medi-Cal, private insurance, or other public insurance were more likely to report a usual source of care compared with women who were uninsured (Exhibit 4). However, coverage by Medi-Cal or private insurance was not associated with more contraceptive counseling or receipt of prescription contraception. Women
covered by other public insurance had an increased likelihood of receiving prescription contraception compared to uninsured women.

Discussion

This analysis of population-representative data from California, collected before and after the 2014 ACA Medi-Cal expansion, shows that despite significant growth in the proportion of low-income Californian women with health insurance following this policy change, there were no significant benefits in access to health care for women of reproductive age in these initial years following ACA implementation. Specifically, after this policy change, low-income Californian women were not more likely to obtain needed medical care or prescription medication without delay. Additionally, the ACA did not increase low-income Californian women’s receipt of contraceptive counseling or prescription contraceptives. Indeed, women who were uninsured were just as likely to receive contraceptive counseling and prescription contraception as women with Medi-Cal or private insurance. This is concerning given estimates that one of every three Californian women remains in need of publicly-funded contraception.14

The minimal changes in access to publicly-funded contraception seen in California after the ACA, may reflect California’s prior investments in family planning. Prior to the
ACA, uninsured low-income women in California had less unmet need for contraception than those in other states; nationally, it is estimated that more than half of US women of reproductive age have unmet needs for contraception. As such, the ACA may have greater impact on access to contraception outside of California. Nonetheless, in the 17 states including California which expanded their limited benefit family planning program into full scope Medicaid, studies such as this that evaluate the impact of this policy are warranted.

Consistent with our findings, other studies have previously found that the ACA decreased the percent of women without insurance and increased the percent covered by Medicaid. Previous studies have also shown that the ACA has increased access to care for adults overall, though our study found an increase in having a usual source of healthcare for younger aged adults and not older. Differences by age in the proportion of uninsured adults prior to the ACA likely contributed to this latter finding as other studies have reported greater decreases in the percent uninsured among adults aged 18-34 than older adults. Despite this, studies of low-income women of reproductive age have found little change in access to care, noting instead increases in the affordability of care, consistent with our results. Although obtaining health insurance should increase access to healthcare it does not make it easier
to find transportation, childcare or time off work when healthcare is needed. Therefore, insurance enrollment through ACA’s Medicaid expansion may not lead automatically to the use of health insurance for preventive and family planning services.

Results suggest that, overall, low-income, uninsured women who enrolled in Medi-Cal experienced minimal change in receipt of prescription contraception following the ACA’s Medi-Cal expansion. We were unable to specifically examine changes in access to intrauterine contraception and subdermal contraceptive implants. However, prior work has shown that women receiving care through Medicaid family planning expansion programs are twice as likely to receive these highly effective reversible contraceptives as clients served at other clinics. Despite funding included in the ACA to increase provider capacity, the number of primary care providers, and particularly primary care providers well-versed in family planning services, have not increased to match the influx of newly insured individuals post ACA. Family planning providers in California also report facing more fiscal challenges after the ACA Medi-Cal expansion, as reimbursement through Family PACT’s fee-for-service model was relatively straightforward, while participating in Medi-Cal managed care plans has required additional contracting, and often lower reimbursement rates. In California, three-quarters of Medi-Cal participants are now enrolled in managed care plans.
As some Medi-Cal Managed Care participants have reported being assigned to unfamiliar primary care providers, whose offices may not be accessible by public transportation, the state has commissioned an access assessment that is currently underway. Of further concern, few primary care providers routinely assess pregnancy intentions and contraceptive need and even fewer primary care providers have been trained to place intrauterine or subdermal contraception; fewer than 20% of family physicians report routinely placing or removing intrauterine or subdermal contraceptives. Additional barriers to providing family planning services in Medicaid Managed Care Organizations include churning in enrollment and the costs to clinics of stocking IUDs and contraceptive implants for placement when needed.

In addition, some managed care organizations (MCOs) still impose forms of utilization control (e.g. only covering one implant every 3 years) inconsistent with state and federal policy. Although Medicaid’s “freedom of choice” provision provides coverage for out-of-network family planning providers, awareness of this provision among program enrollees and providers may be limited. This is unfortunate as studies have shown that many women, particularly low-income women, are interested in using a more effective form of contraception than they are currently using.

**Conclusion**
In the three years following the 2014 ACA Medi-Cal expansion, low-income Californian women have experienced significant gains in insurance coverage. Although we found that the percentage of women with a usual source of care remained unchanged, overall, younger women were more likely to have a usual source of care following the ACA’s Medicaid expansion. Unfortunately, these gains have not resulted in increased receipt of healthcare or family planning services by women of reproductive age. Despite the ACA’s explicit attention to contraceptive services, improvements in contraceptive counseling and receipt of prescription contraception have yet to be realized in California.

Ongoing efforts to expand health insurance coverage in California must be combined with attention to clinician workforce and training as well as client education to ensure that all Californians in need of family planning services access timely and high quality care. The development of national quality measures related to contraceptive use that can be used by health plans and Medicaid programs may facilitate such monitoring. In addition, health plans must address reimbursement and other system issues that preclude some clinics from stocking all forms of contraceptive devices.
List of exhibits

EXHIBIT 1 (table)
Caption: Exhibit 1. California Family Planning Programs

EXHIBIT 2 (figure)
Caption: Exhibit 2. Percent of low income women 18-44 years with health insurance coverage
Source: Authors’ analysis of data from the California Health Interview Survey, 2013-2016
Notes: *p-value < 0.05 from t-test testing difference between 2013 and 2016

EXHIBIT 3 (figure)
Caption: Exhibit 3. Percent of low income women 18-44 years with access to healthcare and family planning services
Source: Authors’ analysis of data from the California Health Interview Survey, 2013-2016
Notes: All p-values > 0.05 for t-test testing difference between 2013 and 2016

EXHIBIT 4 (table)
Caption: Exhibit 4. Adjusted prevalence ratios (95% confidence intervals) among low income women 18-44 years, CHIS 2013-2016
Notes: Adjusted for year, health insurance, age, race/ethnicity, income, education, and family type.
* Indicates associations that were statistically significant (i.e., the 95% confidence interval does not include 1.00).
## Exhibit 1: California Family Planning Programs

<table>
<thead>
<tr>
<th></th>
<th><strong>Medi-Cal</strong></th>
<th><strong>Family PACT</strong></th>
</tr>
</thead>
</table>
| **Eligibility**        | • California Resident  
                          • Income for family size <138% federal poverty level                      | • California Resident  
                          • Income for family size <200% federal poverty level  
                          • No other coverage for family planning services with needed level of confidentiality |
| **Exclusion**          | • Lacks proof of legal residence (unless pregnant)                           | • Pregnant  
                          • Other insurance  
                          • Unable to become pregnant                                                                 |
| **Application**        | • 4 pages  
                          • Cannot be completed at clinic; completed online, by mail, or at county social services office  
                          • No same-day enrollment                                                        | • 2 pages  
                          • Can be completed at clinic  
                          • Same-day enrollment                                                                 |
| **Provider Reimbursement** | • Mostly (75%) Managed Care (6 different models of managed care)             | • Fee-for-Service (through Office of Family Planning, California Department of Health Care Services) |
| **Family Planning Benefits (with no out-of-pocket cost)** | • All FDA classes of contraception, including female sterilization  
                          • Vasectomy  
                          • Pregnancy testing  
                          • Sexually transmitted infection testing and treatment  
                          • Cervical cancer screening  
                          • Preconception counseling, screening and | • All FDA classes of contraception, including female sterilization  
                          • Vasectomy  
                          • Pregnancy testing  
                          • Sexually transmitted infection testing and treatment  
                          • Cervical cancer screening  
                          • Preconception counseling but no |
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<tr>
<th>Service</th>
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</thead>
<tbody>
<tr>
<td>vitamin supplements</td>
<td>• Limited infertility services</td>
<td>screening or vitamin supplements • Limited infertility services</td>
</tr>
<tr>
<td>Onsite contraceptive dispensing</td>
<td>• No</td>
<td>• Yes</td>
</tr>
<tr>
<td>Onsite placement of IUD or implant</td>
<td>• Rare</td>
<td>• Fairly common</td>
</tr>
<tr>
<td>Pregnancy care</td>
<td>• Yes</td>
<td>• No</td>
</tr>
<tr>
<td>Primary and Specialty Care</td>
<td>• Yes</td>
<td>• No</td>
</tr>
<tr>
<td>Provider choice</td>
<td>• Provider contracted with Managed Care program (unless client invokes right to access an out of network provider for family planning services).</td>
<td>Any provider</td>
</tr>
<tr>
<td>Family Planning Provider Locator</td>
<td>• Variable</td>
<td>• Online web-based tool</td>
</tr>
<tr>
<td>Quality monitoring of family planning service delivery</td>
<td>• Variable</td>
<td>• Reported annually</td>
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Exhibit 4. Adjusted prevalence ratios (95% confidence intervals) among low income women 18-44 years, CHIS 2013-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Access to health care</th>
<th>Family planning services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Usual source of healthcare</td>
<td>Able to obtain timely medical care</td>
</tr>
<tr>
<td>2013</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>2014</td>
<td>0.96</td>
<td>1.00</td>
</tr>
<tr>
<td>2015</td>
<td>0.99</td>
<td>0.99</td>
</tr>
<tr>
<td>2016</td>
<td>1.02</td>
<td>1.05</td>
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<table>
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<tr>
<th>Health insurance</th>
<th>Access to health care</th>
<th>Family planning services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>ref</td>
<td>ref</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>1.43*</td>
<td>0.99</td>
</tr>
<tr>
<td>Private</td>
<td>1.55*</td>
<td>1.02</td>
</tr>
<tr>
<td>Other, public</td>
<td>1.39*</td>
<td>1.04</td>
</tr>
</tbody>
</table>

Adjusted for year, health insurance, age, race/ethnicity, income, education, and family type

* Indicates associations that were statistically significant (i.e., the 95% confidence interval does not include 1.00).

Source: Authors’ analysis of data from the California Health Interview Survey, 2013-2016


12

13

14

15


http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx.


To access the Appendix, click on the Appendix link in the box to the right of the article online.

SAS Institute, Cary NC.

Research Triangle Institute, Research Triangle Park NC.


41

42

43

44

45

46
.Kaiser Family Foundation. Share of Medicaid population covered under different delivery systems [Internet]. KFF; 2017 Jul [cited 2018 Mar
1]. Medicaid Managed Care Market Tracker, California. Available from https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22california%22:%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D


51

52

53