Low-Income Women's Access to Contraception After Massachusetts Health Care Reform

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About Ibis Reproductive Health
Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide. We accomplish our mission by conducting original clinical and social science research, leveraging existing research, producing educational resources, and promoting policies and practices that support sexual and reproductive rights and health.

About the Massachusetts Department of Public Health Family Planning Program
The Massachusetts Department of Public Health (MDPH) Family Planning Program seeks to prevent unintended pregnancy and sexually transmitted diseases, promote sexual and reproductive health, and build support for and access to reproductive health services for low-income and uninsured populations throughout Massachusetts.

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EXECUTIVE SUMMARY

Background

In 2006, the Commonwealth of Massachusetts passed legislation aimed at improving access to affordable, high-quality health care by mandating all residents have health insurance by July 2007. Following health care reform, residents with incomes less than or equal to 300% of the federal poverty level who are not Medicaid or Medicare eligible or do not have employer-sponsored insurance are able to enroll in government-subsidized private insurance plans called Commonwealth Care. Massachusetts' groundbreaking effort to expand access to health care for its residents offers a unique opportunity to examine how health care reform affects women's access to contraception and reproductive health services.

In the Commonwealth, low-income women without health insurance have access to contraception and other reproductive health services on a sliding-scale basis through freestanding family planning clinics and community health centers funded by the Massachusetts Department of Public Health (MDPH), the federal Title X program, Medicaid (MassHealth), and other funding streams.

This project was prompted by anecdotal reports from Massachusetts family planning providers indicating that some of the changes after health care reform, including new prescription requirements, increased copayments, wait times to see primary care providers, and complicated formularies, may adversely affect women's access to and uptake of contraception.

This project had three aims: (1) document the perspectives and experiences of low-income women seeking contraceptive services and of MDPH-funded family planning agencies and clinics providing contraceptive services before and after health care reform in Massachusetts, (2) identify potential *new* barriers to accessing contraception for low-income women under health care reform, and (3) highlight gaps in knowledge about the impact of health care reform on reproductive health services and outcomes and propose areas for future research. This study was supported by the National Institute for Reproductive Health and the Title X Regional Office for New England.

Methods

Data collection for this project included four components:

1. *Systematic review of Commonwealth Care plans*: We reviewed the websites of the four Commonwealth Care plans to assess a potential new user's ability to determine her/his eligibility for a plan and access information on reproductive health coverage and cost.
2. *Survey of family planning agency staff:* We surveyed senior administrative staff at ten of the 12 MDPH-funded family planning agencies using a self-administered questionnaire. The questionnaire assessed knowledge of and opinions about health care reform and examined the impact of reform on administration and service provision at the agency level.
3. *In-depth interviews with family planning agency and clinic staff:* We conducted 16 in-depth interviews with clinic and agency staff. Interviews assessed knowledge of and opinions about health care reform and examined the impact of reform on administration and service provision at the clinic level.
4. *Focus group discussions with low-income women:* We conducted nine focus groups with low-income English- and Spanish-speaking women across Massachusetts. Focus group topics included participants' knowledge of and opinions about health care reform, health insurance history, and experiences with using and obtaining contraceptives before and after health care reform.

Findings

Providers (clinic and agency staff) and women in our study reported both positive and negative aspects of health care reform generally and of working with the Commonwealth Care plans specifically. Our participants also noted a number of challenges to ensuring and maintaining low-income women's access to insurance and to contraception.

Providers and women reported that they support and have high hopes for the overall idea of health care reform. In general, providers in this study reported that they felt that reform has improved access to affordable health care for their clients. Focus group participants also reported many positive aspects of health care reform, including access to affordable insurance, the ability to seek both preventive care and general reproductive health care, and the reduced stigma and other emotional and psychological benefits of having insurance.

Providers and women identified a number of challenges to working with and managing the Commonwealth Care plans. For providers, challenges included a lack of clarity on how to verify eligibility of clients and what services are covered under the Commonwealth Care plans as well as increased administrative burdens associated with billing and contracting with the plans. For low-income women, concerns regarding the criteria and the paperwork necessary to prove and maintain eligibility were paramount.

Providers and women reported most low-income women had "easy" access to contraception *both before and after* health care reform, but also identified some new challenges to ensuring access to contraception. Some women reported experiencing barriers to accessing contraception using a prescription at pharmacies. These barriers included women's general unfamiliarity with prescriptions (as many had previously accessed contraceptive methods on site at family planning clinics), limits on the amounts of contraceptives dispensed at one time, travel time, pharmacies in inconvenient locations, and pharmacists' lack of accurate information about contraceptive prescription coverage under various insurance plans. Though our systematic review of subsidized health insurance plans showed that most forms of contraception are covered by the Commonwealth Care plans, providers reported that some clients could not afford the copays for their contraception.

Providers and women reported that for some populations of women, access to health care has not improved or has gotten worse since health care reform. Some groups of women including immigrants, young women, those with unstable employment or income, and those experiencing common life changes, have been "left out" of health care reform. For undocumented immigrants, inability to provide evidence of legal residency means they are ineligible for coverage, and fear of being asked to provide this documentation may deter some women from seeking care in general. Providers reported that young women face new challenges in accessing confidential reproductive health care. Women with variable employment often move in and out of eligibility for subsidized plans depending on changes in their income. In addition, women whose employers offer insurance are categorically ineligible for subsidized Commonwealth Care plans, but in some cases women found that the premiums for employer-sponsored insurance were prohibitively expensive. Finally, women experiencing common life changes such as pregnancy, starting or finishing college, or moving reported it was difficult to keep up with the paperwork required to document eligibility for subsidized care.

Family planning providers play critical roles in mitigating barriers to health care. MDPH-funded family planning providers are an integral part of the public health safety net in Massachusetts, providing specific outreach to and services for hard-to-reach and underserved populations facing significant barriers to accessing health care. Family planning providers have helped women navigate the health insurance system by assisting with enrollment and explaining insurance paperwork and pharmacy benefits. However, many providers reported that providing these services has taken an administrative and financial toll.

Insurance is complex; many challenges remain for successful administration and utilization of the Commonwealth Care plans. We identified a number of areas in which both women and providers appeared to be misinformed about some aspects of Commonwealth Care plans. Women need more information on how to enroll in and recertify eligibility for plans, how to apply for hardship waivers, and which contraceptive methods are covered under the plans. Many providers voiced a need for information and training on certification of client enrollment in the plans, services covered by the plans, and general billing procedures.

Recommendations

The findings from this study highlight a number of priority areas for further action:

1. Improve outreach to health care providers and pharmacists to better educate them on Commonwealth Care plans.
2. Develop user-friendly information that can be accessed through the mail, call centers, and websites on coverage of contraception under Commonwealth Care plans.
3. Ensure family planning clinics are included as a point of entry for clients seeking preventive health care.
4. Develop mechanisms to ensure that all populations at or under 300% of the federal poverty level have access to publicly funded family planning services.
5. Expand access to and encourage continuous use of contraceptive methods by allowing women to receive multiple cycles of hormonal contraception, minimizing copays for contraception, and covering the full range of effective methods.
6. Continue research about low-income women's access to contraception and other reproductive health services in the context of health care reform.

Conclusion

Although health care reform appears to have increased access to health care for many women, we identified a number of barriers to access that remain for low-income women in need of publicly funded contraception. Both women and providers report challenges working with and using the Commonwealth Care plans. In addition, some groups of women who are not eligible for insurance coverage under reform or who move in and out of eligibility are unable to continuously maintain coverage and may face significant barriers to accessing health care generally and initiating or continuing to use contraception specifically. MDPH-funded family planning providers continue to provide needed services to low-income women and also play a critical role in helping women navigate the new insurance system. Contraception is an essential preventive health service; it is critical that women have access to the complete range of methods and that women and health care providers have accurate information about contraception and insurance coverage of reproductive health services.

CHAPTER ONE: INTRODUCTION

Background

Ibis Reproductive Health and the Massachusetts Department of Public Health (MDPH) Family Planning Program undertook a project to assess whether health care reform in the Commonwealth of Massachusetts has had or is likely to have an impact on low-income women's access to contraception. The project was prompted by anecdotal reports from Massachusetts family planning providers indicating that new prescription requirements, increased copayments, wait times to see primary care providers, and complicated formularies may adversely affect women's access to and uptake of contraception.

In this chapter, we present background on women's access to insurance coverage, an overview of health care reform in the Commonwealth, and a brief history of publicly funded family planning providers, along with information about the people they serve and the role they play in Massachusetts. We describe the research methods used in the study in Chapter 2 and present the results in Chapters 3 through 6. Finally, in Chapters 7 and 8, we summarize and synthesize the overall study results and make recommendations for improving access to contraception in the wake of health care reform in Massachusetts.

Unique Issues Affecting Women's Access to Health Insurance

A large body of research has documented differences in access to insurance coverage and health care utilization between women and men [1-3]. Although women are insured at roughly the same rate as men, women face unique barriers to obtaining and paying for health insurance. Compared to men, women are more likely to be unemployed or work part-time, and so have less access to employer-sponsored insurance and are more likely to have insurance through their spouse [4]. Women are also more likely than men to be on Medicaid, and often face higher premiums than men when purchasing individual policies [5]. For these reasons, and because women on average earn less than men [5], health care reform that includes individual health insurance mandates could pose significant financial and access burdens for some low-income women.

Since health care reform was enacted in Massachusetts, the number of uninsured in the Commonwealth has been cut in half [6]. After health care reform, many Massachusetts residents who once relied on the public health infrastructure for free or reduced-cost care gained access to subsidized private health insurance. We investigated the impact this shift has had on provision of and access to contraception services. Massachusetts' groundbreaking effort to expand access to health care 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.

Health Care Reform in Massachusetts

Massachusetts has a longstanding tradition of working to expand access to health care for Commonwealth residents, and many key incremental improvements were in place prior to the implementation of health care reform in 2006. Health care reform was built upon a comprehensive Medicaid program (MassHealth) which has historically covered all contraception and abortion services.

Private health insurers in Massachusetts are subject to requirements regarding certain key health services. In 2003, Massachusetts enacted "contraceptive equity" regulations which required insurers that provide outpatient benefits to cover hormone replacement therapy and all FDA-approved contraceptive methods under the same terms and conditions that apply to other outpatient services [7]. Massachusetts law also requires insurers that provide pregnancy-related benefits to provide coverage for the diagnosis and treatment of infertility [8]. Although these regulations apply to many public and private insurers in the Commonwealth, it is important to note that religious organizations and self-insured employers[1] are exempt from these requirements[2] [11].

Furthermore, prior to health care reform, Massachusetts had a relatively low rate of uninsured residents and a robust public health system designed to address the needs of the uninsured. Massachusetts has historically had fewer uninsured residents than many other states. On average during 2004 and 2005, prior to health care reform, Massachusetts ranked eighth among U.S. states with 10.3% of residents uninsured [12]. In April 2006, just prior to the implementation of health care reform, approximately 650,000 Massachusetts residents were uninsured [6]. Massachusetts has also made significant investments in public health infrastructure to care for uninsured and low-income residents, including a strong network of more than 50 community health centers, expanded Medicaid eligibility beyond federal minimums, and specific public health programs addressing certain key health needs, including public health safety net services such as the MDPH family planning program, described below.

In this context, the legislature of the Commonwealth of Massachusetts passed Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care.* The legislation aimed to improve access to comprehensive health care by increasing health insurance coverage, restoring previously cut programs, expanding access to Medicaid, and improving health care quality. After several previous attempts at realizing health care reform, policymakers in Massachusetts incorporated a range of strategies when crafting this piece of legislation. Reform in the Commonwealth included fines for employers of 11 or more employees who do not insure their workers, expansion of public programs (such as MassHealth for those up to 19 years old), insurance market reforms, the launch of publicly subsidized private insurance, and a mandate that all residents have health insurance (if they can afford it) or face a penalty. All Massachusetts residents were obligated to obtain health insurance by July 2007, or apply for a hardship waiver exempting them from this requirement.

Chapter 58 also established the Commonwealth Health Insurance Connector Authority (Health Connector), an independent state agency that has several roles in facilitating effective implementation of health care reform [13, 14]. The Health Connector administers many of the key aspects of health reform legislation, including setting standards for affordability and for minimum creditable coverage (MCC; standards that insurance plans must meet to provide subsidized insurance coverage in Massachusetts), enforcing fines for employers not offering insurance coverage to employees, and overseeing Commonwealth Choice and Commonwealth Care insurance plans. One of the most significant insurance reforms implemented by Chapter 58 was the merging of the individual and small-group insurance markets; individuals can now purchase insurance at the same

[1] As of March 2009, over 100 businesses were self-insured in Massachusetts [9].
[2] Of insured residents, 68% are covered by employer-sponsored insurance, 17% are covered by public or other coverage, and 15% are covered by Medicare [10].

rates offered to small groups. Coverage included in these plans is approved by the Health Connector and these plans are known as Commonwealth Choice plans. In addition, the Health Connector also offers subsidized private health insurance plans to low-income residents; these plans are known as Commonwealth Care plans [13].

Table 1: Characteristics of the Commonwealth Care Plans

	BMC HealthNet	Fallon Community Health Plan	Neighborhood Health Plan	Network Health
Areas served	All of Massachusetts except Martha's Vineyard and Nantucket	Central & Eastern Massachusetts	Central, Eastern, Northern, Southeastern, and Western Massachusetts	Central, Eastern, Northern, Southeastern, and Western Massachusetts
Network type	Broad	Limited	Broad	Broad
Has medical providers in	• Community health centers • Hospital-based group practices • Multi-specialty group practices • Private group or individual offices	• Multi-specialty group practices	• Community health centers • Hospital-based group practices • Multi-specialty group practices • Private group or individual offices	• Community health centers • Hospital-based group practices • Multi-specialty group practices • Private group or individual offices
Commercial members vs. public sector members [3]	Public sector only	Primarily commercial	Primarily public sector	Public sector only

Commonwealth Care is a subsidized, low- or no-cost insurance program for low-income residents. To qualify for Commonwealth Care, an individual must be a Massachusetts resident with an income at or below 300% of the federal poverty level (FPL),[4] without access to employer-sponsored health insurance, and not eligible for other public insurance (such as MassHealth). At the time of this study, Commonwealth Care offered eligible Massachusetts residents the option of one of four managed care plans: Boston Medical Center (BMC) HealthNet, Fallon Community Health Plan, Neighborhood Health Plan, and Network Health.[5] All four of these plans had previously contracted with MassHealth, and benefits were modeled on MassHealth benefits. Through Commonwealth Care, many Massachusetts residents who once relied on the public health infrastructure for free or reduced-cost care now have subsidized private health insurance that covers primary and preventive care, prescription medications, inpatient services, mental health treatment, substance abuse services, and family planning services including prescription contraceptives and abortion care.

Each of the Commonwealth Care plans has different service regions and network types and includes health care providers that work in several different kinds of health care practices. As shown in

[3] Commercial members include employer-sponsored coverage and other coverage that is not publicly subsidized. Public sector members include Medicaid (MassHealth) and Commonwealth Care members (Health Connector, email to authors, 26 August 2009).

[4] For a family of one, an eligible individual's income would be between $16,248 and $32,496. For a family of four, qualifying annual income would be between $33,084 and $66,156.

[5] As of March 12, 2009, a new plan (CeltiCare) has been approved by the Health Connector [15]; this plan is not discussed as it was not available at the time of our research.

Table 1 above, three of the four plans have very similar structures and one (Fallon Community Health Plan) has a limited network, meaning it only contracts with certain providers in fewer service delivery areas[6] [16].

The costs associated with the plans are similar**.** None of the plans have deductibles, and premiums and copays vary based on the individual's income. As of August 2009 each plan includes three different types of insurance coverage which have different costs associated with them (see Table 2) [17].

Eligibility for the plans is checked annually, though individuals are required to report changes in income, family status, or address within two weeks of the change [16].

Table 2: Commonwealth Care Summary of Costs by Plan Type

	Plan Type 1	Plan Type 2	Plan Type 3
Available for incomes at	≤ 100% FPL	100%–200% FPL	200%–300% FPL
Monthly premium (for lowest-cost plan)	$0	$0 to $39	$77 to $116
Office visits (PCP/Specialty)	$0	$10 / $18	$15 / $22
Prescription drugs (Generic/Preferred/ Not Preferred)	$1-2 / $3 / $3	$10 / $20 / $40	$12.50 / $25 / $50

Role of Family Planning Providers in Massachusetts

In the Commonwealth, low-income women without health insurance have had longstanding 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 the federal family planning program (Title X), as well as reimbursement from MassHealth. The Title X family planning system was established in the 1970s and provides general operating support to family planning providers throughout the United States. Established in the early 1990s, the MDPH Family Planning Program was built on the existing Title X structure and oversees the use of Commonwealth funds to support family planning services for uninsured low-income clients and confidential family planning care for adolescents. Research has demonstrated that publicly funded family planning programs are a cost-effective investment; for every dollar invested in family planning services, approximately four dollars are saved in Medicaid costs for pregnancy-related and newborn care [18].

The Family Planning Program in Massachusetts supports community-based agencies to provide comprehensive, client-centered family planning services to low-income populations. The 12 MDPH-funded family planning agencies, which operate more than 80 clinics throughout Massachusetts, served a total of 104,838 clients in fiscal year 2006 [19] and 98,291 clients in fiscal year 2007 [20]. Family planning clients tend to be young, female, and low-income: in fiscal year 2007, approximately 90% of all family planning clients were at or below 200% of the federal poverty level, 86% were under age 35, and 91% were female [20]. For many low-income women, family planning clinics may be their only source of primary and reproductive health care. Services offered

[6] Limited networks are only open to certain providers and provider locations; broad networks are open to all providers who are interested in contracting with the insurer (Health Connector, email to authors, 26 August 2009).

include gynecological exams; provision of contraceptive supplies; pregnancy testing; STD screening, diagnosis, and treatment; counseling and education; and other reproductive health care and referrals. Family planning clinics provide a wide range of contraceptive methods (prescription and non-prescription) at the clinic at no or low cost. Ninety-eight percent of clients at risk for unintended pregnancy exited the clinic with a contraceptive method at the time of their visit in 2007 [21].

Study Objectives

This project was undertaken to assess how access to contraception for low-income women (*i.e.*, women at or below 300% of the federal poverty level) in Massachusetts has changed as a result of health care reform and to identify strategies to overcome potential barriers to access to family planning care in Massachusetts. Specifically, we aimed to:

- Document the perspectives and experiences of low-income women seeking contraceptive services and of MDPH-funded family planning agencies and clinics providing contraceptive services before and after health care reform in Massachusetts;
- Identify potential *new* barriers to accessing contraception for low-income women under health care reform; and
- Highlight gaps in knowledge about the impact of health care reform on reproductive health services and outcomes and propose areas for future research.

Lessons learned about the experiences of low-income women, family planning clinics, and family planning agencies in Massachusetts will inform the ongoing national debates about health care reform.

Study Funding and Collaborators

This study was supported by the National Institute for Reproductive Health and the Title X Regional Office for New England, and is a collaboration of Ibis Reproductive Health and the MDPH Family Planning Program. The project team worked in close collaboration to develop the study protocol and implement the study. Ibis was responsible for data collection from women, clinic staff, and family planning agency representatives to protect the confidentiality of all study participants.[7] The project team worked together to review the data, identify the key findings, and develop recommendations based on the findings.

[7] The family planning agencies and clinics receive funding from the MDPH Family Planning Program. Several confidentiality measures were put into place to ensure that the MDPH Family Planning Program did not have access to names or identifying information of any study participants. Study participants were informed of these measures to help ensure they would feel comfortable speaking openly.

CHAPTER TWO: METHODS

Study Components

This study included four components: (1) systematic review of subsidized health insurance plans, (2) self-administered surveys of MDPH-funded family planning agencies, (3) in-depth interviews with family planning agency and clinic staff, and (4) focus group discussions with low-income English- and Spanish-speaking women across Massachusetts.

1. Systematic review of Commonwealth Care plans: Throughout the summer of 2008, we conducted a systematic desk review of the websites of the four insurance plans available to low-income Massachusetts residents under the Commonwealth Care umbrella. Four independent reviewers collected pre-determined information on each of the plans from their English language websites. Reviewers examined the websites as if they were potential new users of the plans and did not log in to the members-only sections of the websites. Reviewers collected publicly available information on eligibility requirements, enrollment information, premiums, copays, deductibles, contraceptive drug formularies and drug coverage, and attempted to identify whether existing family planning providers were included as covered providers, and examined general ease of use of the websites. Each reviewer input information into an Excel data sheet.

2. Survey of family planning agency staff:: We asked a senior administrative staff person at each of the 12 MDPH-funded family planning agencies in Massachusetts to complete a self-administered questionnaire about their knowledge of and opinions about health care reform, how health care reform changed contraceptive services provided, their perceptions of the impact of health care reform on women's access to contraception, and the impact of reform on billing, payment, and administration of the clinics. The survey also asked for recommendations of clinic staff for in-depth interviews. The questionnaire was sent to agency heads via email and standard mail, and could be returned by email, mail, or fax. We followed up with non-respondents with two letters or emails and one phone call. No remuneration was offered for the completion of the self-administered survey. All responses to the survey were input into an Excel data sheet.

3. In-depth interviews with family planning agency and clinic staff: We assembled a list of all MDPH-funded family planning clinics in Massachusetts, including data on the number of client visits paid for with MDPH funds in the most recent fiscal year for which such data existed (FY06). We then randomly selected ten clinics from the largest 30 clinics by number of visits per year, and purposively selected five from the remaining clinics in order to include a diversity of clinic models (freestanding family planning clinics and community health centers) and geographic location.

We conducted 16 approximately 60-minute interviews via telephone between December 2008 and February 2009 that were audiotaped using a digital recorder.[8] We initiated contact with clinic and agency staff by phone or email to introduce the study and invite participation. Interviews were conducted by one of two trained interviewers. Prior to begin inning the interview, participants gave verbal informed consent. Interviewers used a semi-structured interview guide to ensure that the topics covered were similar across interviews. Topics covered in the interview included

[8] Handwritten notes were taken during all interviews in case the recording equipment malfunctioned; recording during one interview failed.

demographic information about the participant and the practice they represented, knowledge of and opinions about health care reform, and experiences with providing contraception to low-income women before and after health care reform. No remuneration for participating in the in-depth interviews was offered. All discussions were recorded and transcribed verbatim. One participant declined to be audio taped; comprehensive handwritten notes were used in place of a verbatim transcript.

4. Focus group discussions with low-income women: We conducted nine approximately 90-minute discussions across Massachusetts between November 2008 and March 2009. We recruited women for focus group discussions through community-based websites such as Craigslist and English- and Spanish-language fliers posted at community colleges and MDPH-funded clinics throughout Massachusetts. After encountering challenges recruiting Spanish-language speakers and Western Massachusetts residents, we also recruited clients of local community-based organizations: domestic violence shelters, food pantries, libraries, and English-as-a-second-language classes. Women were eligible to participate if they had lived in Massachusetts for at least one year, were over the age of 18, had income at or below 300% federal poverty level, spoke English or Spanish, and had sought contraception in the last year.

Focus groups were conducted by one of three trained moderators in English or Spanish. Prior to beginning the discussion, participants gave written informed consent. After obtaining informed consent, we distributed a brief survey to all participants asking for demographic information, what kind of insurance they had, and history of contraceptive use. Moderators used a semi-structured interview guide to ensure that the topics covered were similar across discussion groups. Topics included participants' knowledge of and opinions about health care reform, health insurance history, and experiences with using and obtaining contraceptives before and after health care reform. Study participants received $25 remuneration for their time. All discussions were digitally recorded, transcribed verbatim, and translated, when necessary, into English. Translated texts were reviewed by a bilingual English and Spanish speaker for accuracy and clarity.

Ethical Review

All study participants provided informed consent prior to participation. The study protocol, informed consent procedures, recruitment materials, and data collection instruments were reviewed and approved by the Northeastern University Institutional Review Board.

Data Analysis

Systematic review of Commonwealth Care plans: Each reviewer independently entered information collected about the plans into a standardized data collection form. We then conducted a content analysis of all collected information, noting the presence or absence of information using pre-determined categories and codes, and detailing where reviewers reported discrepant findings. When there were discrepancies among the reviewers, another member of the research team reviewed the identified information and, where possible, clarified the findings. Reviewers also made notes about their experiences searching for the information.

Survey of family planning agency staff: We calculated frequencies and summary statistics (median, mean, range) for responses to closed-response survey questions using Microsoft Excel 2007. Responses to open-ended questions were reviewed and common themes were identified.

In-depth interviews and focus group discussions: Two members of the study team developed, tested, and refined a codebook, using an iterative process until a common set of codes was agreed upon. To establish coding consistency at the beginning of the coding process, each of the coders coded the same transcript and jointly agreed on a common approach to resolve coding disagreements. The final codes were entered into the qualitative software analysis program ATLAS.ti version 5.5. Grounded theory [22] and thematic analysis approaches informed our coding and analysis strategy. Guided by our research questions, we developed thematic codes, identified and summarized important sub-themes, and extracted illustrative quotes from the interview and focus group discussion transcripts. In addition to the qualitative analysis of the focus group data, we calculated frequencies and summary statistics (median, mean, range) using the data on socio-demographic characteristics, insurance coverage, and contraceptive use from participants using Microsoft Excel 2007. For the in-depth interviews, we also calculated frequencies and summary statistics using data on socio-demographic and closed ended questions.

CHAPTER THREE: SYSTEMATIC REVIEW OF COMMONWEATLH CARE PLANS RESULTS

The websites of the four Commonwealth Care plans were systematically reviewed to assess a potential new user's ability to determine her/his eligibility for a plan and access information on reproductive health coverage and cost. We collected detailed information on which contraceptive methods were covered and, for prescription methods, at what tier level; reviewed coverage of other reproductive health services; attempted to identify whether existing family planning providers were included as covered providers; and reviewed information about how to enroll in the plan.

Eligibility and enrollment: In order to apply for a Commonwealth Care plan individuals must provide documentation of income and identity, which must be submitted by mail or processed in person. However, the websites did not consistently describe what documentation would qualify to establish income and identity (*e.g.*, ID requirements or proof of income) in order to be eligible for a specific plan. While all of the plan websites covered a range of eligibility and enrollment information, only two of the plans provided detailed income eligibility information, one plan referred clients back to the Health Connector website, and one required potential clients to call or submit a request for more information.

Participating health care providers: Overall, it was difficult for our reviewers to determine which providers accepted payment from Commonwealth Care plans or were part of a specific plan's network. Although all sites had a mechanism for determining coverage by ZIP code or neighborhood, some reviewers could find this feature on only two of the plans' sites. Only one website provided the option of searching by clinic name under the feature "find a doctor," but not all reviewers were able to locate this feature. Other sites did not have this function or required a phone call or patient enrollment kit to determine which providers accepted each insurance plan. No website allowed users to search for family planning clinics in general or as a specialty service. Information about which hospitals were covered also varied by each plan.

Premiums and copays: Information on premiums was limited; only two sites included any information on premiums, and only one gave a specific dollar amount. All sites included information on costs for office visits, although reviewers found conflicting information on one plan's website. All plans provided information on copays for prescription medications, which ranged from $1-40 for a 30-day supply depending on the plan type and tier of the medication; reviewers consistently found the same information on this topic. Three out of the four plan websites provided information about hardship waivers, which are available for people who are unable to afford prescription drug copays.

Determining contraceptive coverage: There was also no central source of information on the contraceptive options covered by any of the plans that would allow a woman to compare whether and how her method would be covered on each plan. However, all plans had an online formulary, or list of prescription drugs covered under the plan, with two providing a searchable electronic formulary and two a downloadable PDF document listing covered medications. Medications on the formularies were organized into three groups or tiers, with tier 1 having the lowest copay and tier 3 having the highest. Three out of the four formularies identified which tier a medication belonged to with the fourth providing no information on tiers. Organization of these formularies varied, making it difficult to identify whether a specific contraceptive method was covered. The two formularies in

PDF format only listed medications alphabetically by brand name whereas the electronic formularies could be searched by brand or generic names. None of the plans allowed the user to search by "birth control" or "contraception" and see a full list of methods, whether they were covered, and the cost.

Table 3: Contraceptive Method Tiers by Commonwealth Care Plans[9]

	Plan A	Plan B	Plan C	Plan D
IUD/IUS	Covered, no tier provided	Covered "FDA approved contraceptive methods," no tier provided	No Information	No Information
Implants	Covered, no tier provided	Plan 1: 1 Plans 2 & 3: 3	No Information	No Information
Injectable	IM and SQ[10]: 2	Generic IM: 1 Plan 1 SQ: 2 Plan 2 & 3 SQ: 3	2	No Information
Oral Contraception[11]	1-3	1-3	1-3	No Information
Vaginal Ring	Plan Type 1: 0[12] Plan Types 2 & 3: 2	Plan 1: 2 Plans 2 &3: 3	Plan 1: 0 Plans 2 &3: 3	No Information
Emergency Contraception[13]	1	2	3	No Information
Condoms	No Information	No Information	No Information	No Information
Cervical Barriers	Covered, no tier provided	No Information	3	No Information

All plans covered a wide range of prescription contraception options, but the tiers for each formulation or medication varied by plan (as seen on Table 3 above). Many generic oral contraceptive pills were available in tier 1 (with the lowest copay) but other longer-acting methods such as the vaginal ring and injectables were more commonly available in tiers 2 and 3. Only one plan included medroxyprogesterone (Depo-Provera®, the three-month injectable) in tier 1. Information on contraceptive devices such as intrauterine devices or intrauterine systems (IUDs or IUSs), implants, and diaphragms was inconsistent and difficult to find. For example, one site listed the Mirena®, a drug-releasing IUS, with 'pharmacy benefits' while another categorized it as a 'medical device.' Little or no information was available on any additional costs that would be associated with the clinic visit required for insertion of an IUD, IUS, or implant. Most plans covered a 30-day supply of any prescription medication obtained in person, although one plan offered a 90-day supply if clients filled their prescriptions at participating pharmacies, and all plans offered a 90-day supply if the prescription was filled through a mail order program. Emergency contraception (EC) was covered by all plans, but a prescription is required in order for the insurance

[9] Plans are listed in a different order than in previous tables to protect the confidentiality of the plans.

[10] IM: intramuscular, SQ: subcutaneous.

[11] Tier of oral contraceptives varied based on brand (or generic) and plan type.

[12] Some plans had an additional tier of "0" if there was no copay for the medication.

[13] Prescription needed for coverage of over-the-counter products.

company to pay for it[14] and the copay varied by insurer (ranging from tier 1 to tier 3). Condoms were not mentioned on any of the formularies.

Additional reproductive health services: All plans covered Pap smears and abortion care, but none mentioned specifics on abortion coverage by trimester (*i.e.*, differences in price or coverage by weeks of gestation), and reviewers found limited information on sterilization coverage. All plans allowed women to access an obstetrician/gynecologist (OB/GYN) without a referral from a primary care provider, but one plan restricted the number of routine, non-pregnancy related OB/GYN visits to one per year, potentially making follow-up care and adjustment of contraceptive methods more expensive.

Systematic Review of Commonwealth Care Plans Summary Results

Overall, we found that the websites for the Commonwealth Care plans were confusing and often difficult to navigate. Information on coverage and eligibility was available, but frequently hard to find and understand. Determining which clinics and hospitals accepted Commonwealth Care plans also proved difficult. Though there was a wealth of information about what reproductive health services are covered by the Commonwealth Care plans, much of that information was found in separate sections in the websites. The plans appeared to cover most hormonal contraceptives, yet finding a specific contraceptive method on the websites was challenging. Additionally, the cost of the medication and the number of months available at one time were different among the Commonwealth Care plans, and in most cases women could not access more than a one-month supply at a time through the pharmacy.

[14] EC, available under the brand name Plan B®, is approved by the FDA for individuals 17 years and older as an over-the-counter medication. However, many insurers, including all Commonwealth Care plans and MassHealth, will only cover EC if it is obtained with a prescription.

CHAPTER FOUR: AGENCY SELF-ADMINISTERED SURVEY RESULTS

We asked a senior administrative staff person at each of the 12 MDPH-funded family planning agencies to complete a self-administered questionnaire about their knowledge of and opinions about health care reform, how health care reform changed contraceptive services provided, their perceptions of the impact of health care reform on women's access to contraception, and the impact of reform on billing, payment, and administration of the clinics.

Respondent and practice characteristics: Ten of 12 agency administrators returned surveys. Reasons for not responding to the survey included not having time to fill out the survey and not being sure who at the agency should complete the survey. All of the survey respondents were female, had been working for the agency they were representing for an average of 17 years, and had worked in health care in general for an average of 25 years (see Appendix I, Table 1). Most respondents reported that the clinics they administered were freestanding family planning clinics (FPC). The respondents reported that they administered between one and 53 clinics[15] and served an average of 7,840 clients in their clinics in 2007. Most reported MDPH as their primary source of funding for client visits (see Appendix I, Table 2).

Impact of Health Care Reform on Client Visits, Funding, and Service Provision

Almost all respondents indicated that after health care reform, there was a decrease in overall client visits. All but two agencies reported contracting with at least one of the Commonwealth Care plans, although one plan did not contract with any of the agencies. Respondents also reported an increase in the number of clients covered by Commonwealth Care plans and MassHealth and a decrease in uninsured clients funded by MDPH.

Agency representatives reported that health care reform did not impact the *type* of contraceptive methods provided in family planning clinics in Massachusetts.[16] Agency staff reported that all of their clinics directly provided and/or prescribed a comprehensive selection of contraceptive methods both prior to and after health care reform.[17] Two agencies reported they did not provide implantable methods of contraception prior to or after health care reform. Approximately half of respondents reported that they were unclear about which methods were covered by the Commonwealth Care plans. Respondents were least certain about the coverage of sterilization and abortion and what was covered by the Commonwealth Care plans they did not contract with (see Appendix I, Table 4).

When asked about the timing of payment and reimbursement rates from Commonwealth Care plans, administrators reported mixed opinions about working with the plans. Administrators reported that timing of payment from Commonwealth Care plans was similar to that of other payers (such as MDPH and MassHealth) (see Appendix 1, Table 2). Opinions about the reimbursement rates from Commonwealth Care plans varied. Almost half of administrators noted that the

[15] Some clinics may have been counted by more than one agency resulting in the double-counting of some clinics.

[16] In-depth interviews with agency and clinic staff, reported below, further explored this area to determine if the *method* of provision of contraceptives was impacted by health care reform.

[17] These methods included cervical barriers such as diaphragms; emergency contraception; hormonal contraceptive methods such as the pill, the patch, or the vaginal ring; injectable methods; IUDs; and non-prescription methods such as male and female condoms.

reimbursement rates were similar to those of other payers; however, just as many reported difficulties being reimbursed for services. Difficulties reported included relatively low rates and slow or incorrect reimbursement. One respondent noted:

> Reimbursements are often less than what DPH or MassHealth would pay for, or services are just not covered. We provide all of the same services to our clients regardless of insurance [or] payment sources and this is a huge burden on the agency [FPC].

Receiving reimbursement from the various Commonwealth Care plans was made more challenging by the different paperwork requirements for each plan. As one respondent reported, "Often what is true for one plan is *not* true for another, making each relationship different and complex" [FPC]. Almost all respondents noted that the same level of care was provided to a client regardless of his/her insurance type or status. Given the current reimbursement practices of Commonwealth Care, providing the same level of care to all clients regardless of insurance status or type was consistently reported as placing a financial burden on the agencies.

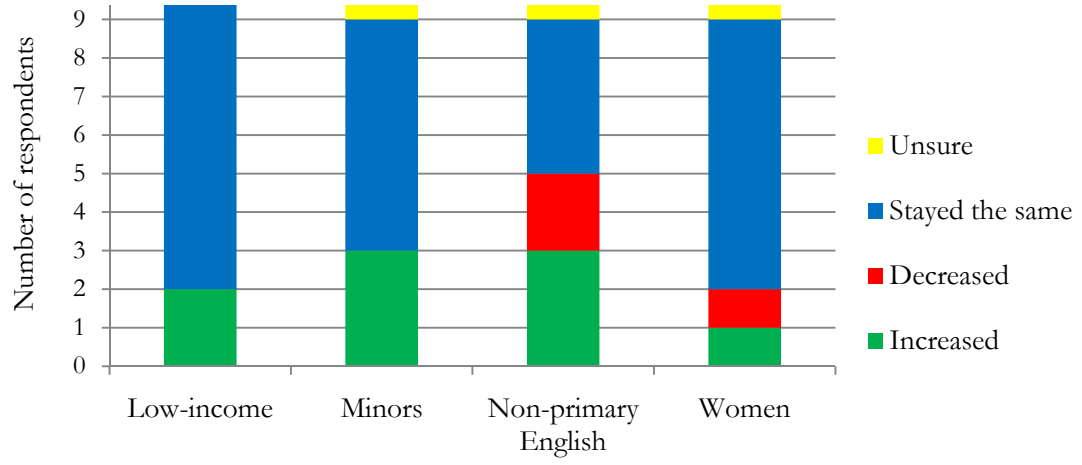
Despite these challenges, many respondents indicated they had positive relationships with the Commonwealth Care plans they contracted with; multiple respondents reported having an excellent relationship with one of the plans. However, a few noted consistent problems with another plan and all noted that not being able to contract with the plan that does not contract with MDPH-funded family planning agencies was a barrier to providing service under health care reform. As one provider wrote: "[One plan] absolutely refuses to contract with any freestanding family planning agency. [That plan] is located in all of our service areas and their refusal to contract with family planning has forced clients who opted to enroll in this plan to leave our practice" [FPC].

"[One plan] is located in all of our service areas and their refusal to contract with family planning has forced clients…to leave our practice."

Impact of Health Care Reform on Clients

The agency respondents reported that the majority of clients they served in the past year were low-income women (see Appendix I, Table 3), and indicated that the client demographics of their agency had not changed substantially since health care reform (see Figure 1). Three of ten respondents noted that the number of clients who primarily speak a language other than English had increased since health care reform and two respondents noticed a decrease in the same population; this was

Figure 1: Demographic Changes Reported by Administrators Since Health Care Reform



the only population with marked reported change. All but one respondent reported that less than half of their clients were new to the facility and most reported that a small number of clients had transferred their records to another facility since health care reform.

Agency respondents described a number of barriers to accessing contraception faced by their clients after health care reform; the most frequent barriers noted were high copays and finding a provider that accepts their plan in their area. They also indicated that their clients reported trouble accessing contraception from their primary care physicians (PCP) due to long wait times for appointments, a lack of PCPs who accept plans in their coverage area, and general discomfort seeking contraception from a PCP. Some respondents, on the other hand, were hesitant to make a final judgment about health care reform's impact on their clients. Respondents emphasized the potential benefits of health care reform for their clients while noting it was too early to fully understand the effects reform might have on their clients, both positive and negative. They also mentioned concerns about some populations not receiving care including undocumented immigrants, young women, and those who do not meet the income criteria for Commonwealth Care plans because they are living at or above 300% of the federal poverty level.

When asked for their overall recommendations, many respondents reported that access to contraception would improve for low-income women if MDPH-funded family planning programs were better supported both financially and politically. Additional, though less consistent, recommendations included reducing copays for all reproductive health-related services, mandating that all Commonwealth Care plans contract with all MDPH-funded family planning agencies, increasing and standardizing the reimbursement rates of the Commonwealth Care plans, and reducing the time women have to wait between establishing eligibility and being able to access services.

Agency Self-Administered Survey Summary Results

Survey respondents reported that since health care reform, the number of clients and visits covered by subsidized insurance (Commonwealth Care and MassHealth) plans had increased, though there was a reduction in the overall number of client visits. Responses about working with the Commonwealth Care plans, including the timing of payment and reimbursement rates from the plans, were mixed. Agency respondents also had mixed opinions about the impact of health care reform on their clients. Some respondents identified a number of different barriers to accessing contraception faced both by clients who are not eligible to enroll in a Commonwealth Care plan and also for those trying to access contraception using one of the plans. Finally, they recommended that access to contraception would improve for low-income women if the MDPH Family Planning Program was better supported and if family planning clinics were able to contract with all of the Commonwealth Care plans.

CHAPTER FIVE: CLINIC AND AGENCY STAFF IN-DEPTH INTERVIEWS RESULTS

We conducted one-on-one, semi-structured, in-depth interviews with clinic and agency staff[18] to assess knowledge of and opinions about health care reform and examine the impact of reform on administration and service provision at the clinic level.

Respondent and practice characteristics: We conducted in-depth interviews with 16 respondents representing 15 different facilities, with two participants reporting on the same facility[19]. Ten interviews were completed with clinic staff and six were completed with agency staff. All of the interview participants were women; respondents had worked with the clinic they were representing for an average of six years and had worked in health care in general for an average of 17 years (see Appendix 2, Table 1). Ten participants worked in a managerial or administrative role (AR) at their respective clinics or agencies and six participants worked exclusively in direct service (DS) as clinicians or family planning counselors. Of the ten respondents who worked primarily in managerial roles, two also spent a small portion of their time providing direct services to clients. The majority of respondents (56%, n=9) reported working at freestanding family planning clinics (FPC), 38% (n=6) worked at community health centers (CHC), and one respondent (6%) worked at a hospital. Beyond providing contraception, all clinics provided human immunodeficiency virus (HIV) testing and human papillomavirus (HPV) vaccinations, and the majority provided STI screening and treatment (see Appendix 2, Table 2).

"It's Not Always Smooth Sailing": Impact of Health Care Reform on the Administration of Family Planning Services

Though most providers reported that they felt that health care reform in Massachusetts is a good idea and has increased access to health insurance and health care overall for their clients, they also indicated that the implementation and day-to-day workings of reform were complex, bureaucratic, and difficult to fully understand. As one provider stated, "I think it was a good idea and I think it was not rolled out appropriately" [AR, FPC].[20] Another provider concurred, stating that reform in the Commonwealth has not "come to fruition yet" [AR & DS, FPC]. Much of the frustration with health care reform from in-depth interview respondents appeared to be related to a perceived increase in the administrative burdens experienced at their clinics. We identified three primary, and often overlapping, administrative challenges in working with the new plans reported by participants: information and training, billing, and contracting with plans.

Information and training challenges: Most of the providers interviewed reported that they felt generally well informed about health care reform in Massachusetts, but they and their clients needed more specific information about the Commonwealth Care plans.

[18] In this report, we define clinic staff as staff who provide direct services to the clients of family planning clinics, and agency staff as those who provide administrative oversight to all of the clinics operated by the agency. At some sites, staff roles were fluid and staff worked both in administrative and direct service capacities.
[19] Two participants from one facility participated in interviews because the first interviewee was not able to answer some of the interview guide questions and suggested that we interview a colleague.
[20] Some participants' quotations have been lightly edited for readability by eliminating unintentional repetitions, misspoken words, non-words, and miscellaneous filler.

Providers reported that clients were confused about the types of insurance plans for which they were eligible, when they were eligible, how to sign up, and what services were covered under the Commonwealth Care plans. As one provider indicated, the new insurance plans developed after health care reform created a "big circle of confusion for people and people just don't know what they're eligible for and what is covered or not" [AR, Hospital]. Providers described feeling "vague" about all of the "nuances" of the plans themselves and said they lacked clarity on how to verify client eligibility for insurance coverage, what services are covered under the Commonwealth Care plans, and general billing procedures.

Verifying client eligibility for their insurance was a concern for many of the respondents. As one provider said, "Just making sure people are on insurance…it's an ongoing battle" [DS, CHC]. Many providers mentioned front-desk staff had to spend more time with clients figuring out their insurance prior to their appointments because clients were confused about what type of health insurance they had and if they were currently enrolled: "All of that sometimes takes a little bit more time at the front desk of trying to sort out: are they insured [or] aren't they insured?" [AR, Hospital]. Many respondents described the challenges of determining a client's eligibility when they had received no formal training in how to do so: "We never had to do this stuff we do now…the training is definitely so hard. The only training we have is hands-on training" [AR, FPC]. Further, many respondents reported that the correct procedures for verifying eligibility were constantly changing and so had to be frequently relearned.

Many providers reported working extensively with clients to help them maintain their insurance status once they successfully enrolled in one of the Commonwealth Care plans, as clients were often unable to maintain their insurance status, due to requirements to submit paystubs and other paperwork to recertify their eligibility numerous times a year. One provider said, "Now we are doing a lot more maintaining someone's health insurance or assisting them with the responsibilities of maintaining their coverage" [AR, CHC]. A few providers reported some changes in their clinic's scheduling practices due to the need for additional time to talk to clients about their insurance and to meet the demands of the growing Commonwealth Care patient population. These changes included scheduling longer appointments to provide insurance counseling, expanding clinic hours, scheduling appointments farther out in advance, adding new clinics, establishing walk-in clinics, and hiring more staff.

Respondents reported that clients often relied on them, not only to provide information about their general insurance eligibility, but also to clarify what specific services the plans cover. However, many providers reported this was a struggle given that they themselves didn't have that information:

> With the different kinds of insurance here that people come in with it's like—they say to me, "What's covered?" And I have no clue. I have nothing here on my computer that tells me what, and I'm like, "You need to call them and talk to them" [DS, CHC].

Billing challenges: Billing for services proved especially burdensome for providers due to a lack of information on *how* to bill the plans and for *what* they can bill them. One provider reported, "There's a lot more nuance to the billing…[there is] a lot more work involved because it is so new. Many times there've been changes. We're doing it one way and two months later, oops we need to do it this way" [AR, FPC]. Another provider stated:

> *"We've had major struggles figuring out what they pay and why. We can only bill for one service even though four were provided that day."*

> We've had major struggles figuring out what they pay and why. For example, when we provide a client with a general exam that includes Pap smear, STD screening, maybe an HIV test, and say wart treatment, we can only bill for one of those services even though all four were provided that day [AR, FPC].

Navigating billing challenges came at a cost to many under-resourced and overburdened providers. As one said, "I've had to *hire* somebody…to be able to deal specifically with third party billing and I know that we are losing money with almost every visit as a result of us accepting these plans rather than getting paid through the state" [AR, FPC].

Contracting challenges: Delays in developing contracts or not being able to contract with certain Commonwealth Care plans were noted by several providers as inhibiting service delivery: "Getting contracts with the different providers took a long time…Initially [two plans] wouldn't do business with us" [AR, FPC]. A few respondents also reported that they lost clients because they were initially unable to contract with some Commonwealth Care plans and thus were unable to provide care to patients with these plans:

> We were trying to contract [with] one of the…Commonwealth Care [plans] and that was a long time so we had some patients that were automatically enrolled into this plan or selected this plan because it was the most affordable in the area. However, our providers were not yet contracted with that program. We are now but…we did lose some patients at that time [AR, CHC].

The majority of providers reported that they did not contract with one particular Commonwealth Care plan which has a limited service-delivery model and does not contract with providers outside of its network.

Impact of Health Care Reform on Clients

Family planning providers reported that their clients were in particular need of subsidized health care services (see Appendix II, Table 3 for perceptions of client characteristics). As one participant noted, "The population that we see here tends to be a population who is in greater need and has a lot more things going on in their life than maybe people that are seeking private care or services in the private sector" [AR, CHC]. Though overall respondents reported that access to insurance and to health care services has increased for most of their clients, some noted their clients reported experiencing barriers to seeking care with primary care physicians (PCPs), burdensome paperwork requirements required to keep up with the Commonwealth Care plans, and high costs associated with the plans.

Although providers were frustrated with some of the administrative aspects of health care reform, many recognized that it has benefited most of the clients they serve:

> I think it [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. Some people figure, well—it is embarrassing to them. 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 [AR, FPC].

"Mainly when we ask patients how and why they are coming in, a lot of it is because now they have insurance whereas they didn't have it before."

Some providers said that *more* clients were seeking care at family planning clinics since health care reform, and many attributed this to clients' knowledge about available plans and their ability to access insurance plans: "Mainly when we ask patients how and why they are coming in, a lot of it is because now they have insurance whereas they didn't have it before. They are following up more now than they were before" [AR, CHC]. In other cases, providers attributed increases in clinic volume to some clients' inability to seek care at a traditional PCP due to burdensome copays or an inability to get an appointment in a timely manner. As one respondent said, "We have a number of patients come back to us because they can't get in [to a PCP in] what they feel is a timely fashion" [AR, FPC]. Conversely, an equal number of providers reported that the overall number of client visits to family planning providers has *decreased* since health care reform and that many of the decreases were due both to providers not being able to contract with all of the Commonwealth Care plans (as described above) and to clients' new ability to access primary care providers for comprehensive care. As one provider stated, "Now that people have insurance, they're accessing comprehensive care, not just say reproductive health care…[they are] seeing a clinician for everything in case they have a cold or break a leg or something like that" [DS, FPC].

All providers agreed that access to care was hampered by the burdensome paperwork required to verify eligibility for Commonwealth Care plans. Providers reported that many of their clients were frequently dropped off of their insurance plans due to barriers in obtaining and submitting paperwork to the plans. Barriers mentioned included the high volume of paperwork sent by mail that was often not received or read by clients due to frequent changes in client residence and low literacy or inability to read English. Providers reported that undeliverable mail often results in an automatic termination of a member's insurance plan.

Finally, some providers also noted that health care reform has pushed some women to obtain health insurance plans with high premiums and copays that they cannot afford to pay. One provider stated, "Some clients, they are *forced* to get health insurance. They are forced to get a product they can't afford" [AR, FPC]. Another provider said that not being able to pay premiums came at a high cost to their clients: "There is the issue of not being able to continue paying the premium and then they are dropped from the roll and are not insured anymore" [AR, Hospital]. Other providers reported that clients had to "adjust to the change" of paying for part of their insurance: "A lot of individuals that went from free care to now being eligible for Commonwealth Care which entails them having to pay a copay…that has affected their payment—from people who have had to pay nothing and now do have to pay a copay per visit" [AR & DS, FPC].

Clients "Left Out" by Health Care Reform

A number of providers noted that "health care reform isn't working for many people" and that they have seen changes in the number of immigrant women, young women, and clients with erratic insurance coverage who sought care at their clinics since health care reform. Providers worried that these women have been "left out" of health care reform and encounter significant barriers to accessing health care services.

> *"Health care reform isn't working for many people."*

Immigrants: Providers frequently mentioned that immigrants[21] experienced new barriers to accessing health services under health care reform. Respondents reported three main barriers to health care access for immigrants: fear of deportation, lack of English language proficiency, and inability to legally access any type of insurance plan. They worried that these factors, along with immigrants' lack of information about being able to access care in family planning clinics even if they are not eligible for Commonwealth Care plans,[22] would prevent some clients from seeking care.

Some providers reported that fear of deportation had been heightened by health care reform because to be eligible individuals must provide proof of legal residency:

> 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 [AR, FPC].

"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."

Providers recognized that non-English speakers can face a multitude of barriers to accessing care, including the inability to access information and services in their native language. As one provider who primarily serves clients whose first language is not English said, "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" [AR, Hospital].

Finally, some providers noted that it seemed that many immigrants were no longer seeking care and were "leaving the system" because they assumed they were not eligible for any kind of health care after reform took place:

> There are issues around immigrants that don't understand whether they can come in [to family planning clinics]…They're not eligible for MassHealth or any of the other services so there is that confusion…They fall through the cracks and they may not come in for a regularly scheduled visit [AR, Hospital].

Young Women: Many providers also voiced concerns about access to care for young women. Providers reported that it is often assumed that young women are covered under their parents' health insurance, but this does not allow them confidential access to reproductive health care services since an explanation of benefits disclosing the services provided may be mailed to the primary insured member, usually her parents. A few providers mentioned seeing more teens who were seeking confidential care since health care reform took place. One provider noted:

> Health care reform essentially *left out* teenagers. Anybody who is under 18 is not eligible for Commonwealth Care plans, so it assumes that those kids are covered under their parents'

[21] During interviews, respondents referred to immigrants interchangeably as "undocumented immigrants" "immigrants," and in general terms that make reference to "people who don't speak English."

[22] As of September 1, 2009, only "qualified aliens" (individuals who are legal permanent residents or "parolees" who have had their status for a minimum of 5 years) will remain eligible for Commonwealth Care. Undocumented immigrants remain ineligible for coverage. Certain individuals meeting criteria for exception will retain eligibility. For a complete list of individuals who may remain eligible, see: http://www.compartners.org/pdf/news/2009-08-11_immigrant_checklist.pdf [23].

> insurance, but if clients are coming to family planning and they want confidential services we are not about to bill their parents' insurance [AR, FPC].[23]

Providers also reported concerns about a slightly older population of young women—those who are no longer minors, but are transitioning into adulthood and have difficulty obtaining insurance; usually referring to young women aged 19-24. One provider stated, "It's the 19, 20 [year-old] non-working, maybe college-age student or, unemployed, or has a job, but has no insurance, that falls through the cracks" [DS, CHC].

Clients with erratic insurance coverage: Providers reported that for some women, eligibility for coverage under health care reform constantly changes as life circumstances change, causing many women to be pushed on and off the plans. Providers reported that 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 face a number of barriers in maintaining their health insurance. Providers worried that many of these women regularly experience gaps in health insurance coverage and are often unaware when their eligibility begins and when they have been dropped by a plan.

According to providers, women with variable employment or those who are laid off from their jobs, work on a part-time basis, are seasonally employed, or who cannot afford their employer-sponsored health insurance, premiums, or copays make up the majority of the women with erratic insurance coverage. Women with variable employment also have variable income which affects their eligibility for Commonwealth Care plans: "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" [AR, FPC]. Additionally, despite employer-sponsored insurance being strongly encouraged by reform in the Commonwealth, some providers noted that women could not afford this coverage: "It [employer-sponsored insurance] is very, very expensive and it eats into so much of their pay checks that they decide to forego it" [AR, FPC]. Many providers also noted that the current economic crisis magnifies this problem of "on" and "off" coverage because many clients are losing their employment, and therefore losing their access to employer-sponsored insurance:

"Health insurance is following [not only] the ebb and flow of people's financial status, but also of their lives."

> 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 [AR, Hospital].

Pregnancy and motherhood were often mentioned as major life changes that affect women's eligibility for insurance plans. Providers reported that pregnant women might be unable to work and thus lose employer-sponsored insurance while others might become eligible for certain plans due to their new status. Other life transitions, such as changes in marital status, moving out of their

[23] Commonwealth Care plans are available to Massachusetts residents who are age 18 and older. Chapter 58 also implemented two additional options for young people: Young Adult Plans, unsubsidized insurance plans targeted to young people aged 18-26 who are over 300% FPL; and a change in the dependency statutes so that dependent children could remain on their parents' insurance to age 25 (or two years after leaving full-time school, whichever comes first) [24].

parents' home, and graduating from college, were factors mentioned by providers that also affect insurance eligibility. Summing all of these changes up, one provider stated of her client population:

> I think we have been seeing more people who are unemployed as of recently often working many jobs, going to school part-time. Their lives tend to be very fluid. They tend to move very often. 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 [AR, FPC].

Women who move frequently also experience barriers in maintaining coverage. One provider stated, "We have individuals that move every month, so their addresses are constantly changing, so we have a lot of women who are getting terminated from undeliverable mail who then have to come in, reapply or call back in and state, 'I do live there' or 'This is my new address'" [AR, CHC]. Providers reported that problems with receiving mail disproportionately affected low-income women, college students, and young adults who have recently graduated from college or are in a transitional stage of their lives.

Access to Contraception After Health Care Reform

Most in-depth interview respondents reported that health care reform generally increased access to contraception. As one respondent said, "Patients that are able to, that wouldn't have accessed [contraception] before based on lack of insurance coverage are more likely now to seek out services now that they have coverage" [AR, CHC]. Although the majority of providers agreed that access to contraception has increased as a result of health care reform, many reported that a number of barriers to contraception continue, and that some new barriers, beyond the administrative challenges noted above, have emerged. Respondents specifically mentioned that reform-related prescription requirements pose a challenge for family planning clients who are accustomed to receiving no- or low-cost supplies of contraception at the clinic and often in bulk.

The process of taking a prescription from a provider's office to a pharmacy, obtaining a one-month supply, and subsequently refilling that supply was reported by in-depth interview respondents as challenging, mainly due to the time and cost incurred by the client. One provider noted, "The majority of our patients are in very hectic periods of their lives and for some even having to go to a pharmacy separately than getting their method during their visit is, for many of them, very problematic" [AR, FPC]. One provider also reported that for some clients, managing prescription refills is a new 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 [DS, CHC].

Distance to a pharmacy was noted as a barrier, particularly for providers whose clients live in rural areas of Massachusetts. One provider reported that 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 or something like that" [AR, CHC].

Some providers reported that women experience obstacles at the pharmacy due to pharmacists' lack of knowledge about Commonwealth Care plans or pharmacists' attitudes towards dispensing contraception:

> Their pharmacy says, "Oh your insurance doesn't cover that." And then they're coming back…to see me and I'm calling the insurance company and I say, "Yeah they do cover it." I don't know what that's about because sometimes I get the feeling it's just that they don't want to be in the business of giving birth control [DS, CHC].

Many providers noted that clients often returned to the family planning clinics after being given a prescription they could not afford at the pharmacy: "They come back in and they're like, 'I can't afford this'" [DS, CHC]. Another explained the impact of high copays, asking, "If you have a choice between getting your medications or your prescriptions and paying for food, or paying for your bills, which would you choose? They choose not to get their prescriptions" [AR, FPC].

A minority of providers indicated these barriers result in clients not being able to access their first choice in contraceptive method. Further, a small number of providers believed these barriers may lead to delays in seeking contraception and an increase in unwanted pregnancies. One provider said, "There's definitely been an impact, because we do have patients coming in for pregnancy tests. They'll say, 'I just didn't get to the drug store, I just didn't get my pills.' That's what happens. The next thing, it's a pregnancy test" [AR, FPC].

Despite these concerns, it is important to note that some providers did not perceive that their clients had experienced any changes in contraception since health care reform, though many worried that future impediments to access were on the horizon. One provider noted,

> I think it [access to contraception] is exactly the same. I don't think anything has changed in terms of access. I think the barriers that are there have always been there…I think we'll start to see some changes because the methods are so expensive on certain plans at certain tiers [AR & DS, FPC].

"If you have a choice between getting your medications or your prescriptions and paying for food, or paying for your bills, which would you choose?"

Ongoing Barriers and the Role of Family Planning Providers

Many respondents emphasized that some changes in client visits and in their clients' access to health insurance and care were not related to health care reform**.** A number of providers credited the downturn in the economy with the changes in the number of client visits and in the demographics of their clients. There were also a number of other changes in the greater landscape that were unrelated to health care reform but nevertheless affected the family planning clinics. Clinics themselves had also made changes, including increasing outreach activities, hiring staff that could speak multiple languages, and working to build relationships with the community that may have played a role in the changes observed.

Many providers also stated that though reform may have increased access to insurance coverage, there are still many barriers outside of health insurance that prevent women from accessing contraception:

> Health care reform is excellent in providing people with health care, you know, having them be able to access health care, but some of the other chronic issues around all the socio-economic barriers aren't going to be resolved with health care reform [DS, FPC].

In the broader context of all of the barriers to care that low-income clients face (whether or not they are related to health care reform), family planning providers reported that they play a critical role helping their clients overcome barriers to access to contraception and that due to their dedication and service provision model, they are able to provide services for free or at reduced cost whether or not a woman has insurance. As one provider 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 [AR, CHC].

Another provider concurred, stating:

> I think that one of the things we do at family planning is do our best to buffer our clients from any of the state and federal funding fluctuations…our agency is absorbing the additional cost…so I'm hoping that our clients have not seen the change at all because we will take them if they are insured, we'll take them if they are not [AR, FPC].

Specifically, many providers reported that for those women moved off of the plans, family planning clinics might be their only way to access health care during their "off" period since it takes time for women's plans to become activated again. Many family planning clinic providers also reported that regardless of women's insurance status, family planning clinics will continue to provide them with services: "Nothing changes when they are off the plans for any reason. They just pay with the sliding scale" [AR & DS, FPC].

However, many worried about their ability to sustain offering services to clients in a climate of diminished resources and discussed the role of family planning providers post-health care reform in the Commonwealth. One provider said:

> I think for us the issue is: Are you considered uninsured if you have health insurance but you can't afford it…If you can't afford your prescription then you are still uninsured...Is there some kind of wrap-around that the family planning program provides? [AR, Hospital].

"Are you considered uninsured if you have health insurance but you can't afford it?"

Further, some worried that services and contraceptive access at family planning clinics may soon be compromised dramatically by looming budget cuts. Some providers viewed budget cuts as directly related to health care reform since the state might believe that there is no longer a need for funding family planning clinics now that everyone is believed to have health insurance. As expressed by one provider:

> We are just getting further budget cuts from the governor…I believe that the reason he thinks it is okay to cut as much as he has out of our particular line item is because he is under the impression that…everyone is supposed to have health insurance and shouldn't the health insurances be paying for our services? And the fact of the matter is, they're not, and so if we get cut we will not be able to sustain the level of care we have been over the years so far and so we'll have to reduce services and possibly clinic hours [AR, FPC].

Decreases in public funding were noted as leading to rapidly declining supplies of free contraceptives for clients, a decrease in HPV vaccinations available at reduced cost, the closing or merging of some clinics, and staff reductions; which were in turn seen as responsible for family planning clinics' inability to serve patients as they did before.

Clinic and Agency Staff In-Depth Interview Summary Results

Most providers seemed to agree that access to health care, including access to contraception, had increased after health care reform. In fact, many providers stated that patients have become more aware of their ability to access insurance and care and thus seek out services on a more consistent basis and are more likely to remain on a contraceptive method longer. However, many family planning providers have experienced greater administrative and financial stress as a result of health care reform. Many of the administrative and financial challenges were due to the complexity and eligibility requirements of the new health insurance system. When asked about suggestions to reduce these barriers, providers recommended increasing patient education regarding health care reform and Commonwealth Care plans as well as finding ways to ensure that groups left out of health care reform, like immigrant women, young women, and women with variable employment, are not left without access to health care. Family planning providers still see significant need for their services and report that at least some of their clients face significant challenges accessing contraception post-health care reform. They also perceive that they play a role in helping to mitigate those challenges for their clients.

CHAPTER SIX: FOCUS GROUP DISCUSSION RESULTS

To examine low-income women's experience with accessing contraception before and after health care reform, we conducted nine focus groups across Massachusetts between November 2008 and March 2009.

Participant characteristics: Four focus groups were conducted in English: two in Boston, one in Worcester, and one in Springfield. One of the English-language focus groups in Boston consisted only of women who reported they were currently enrolled in Commonwealth Care plans. Five focus groups were conducted in Spanish: three in Boston, one in Worcester, and one in Lawrence. An average of six participants (range 2-13) participated in each of the focus groups; 23 women participated in English-language focus group discussions and 29 in Spanish-language discussions.

All participants were female and the median[25] age was 23 (range 21-63). The large majority of participants had at least a high school education, though participants in the English-language focus groups reported, on average, higher education than participants in the Spanish-language focus groups (see Appendix III, Table 1). In the English-language focus groups, the majority of participants reported their race as white or black (61% and 35% respectively). In the Spanish-language focus groups, most participants stated they did not fit into any of the pre-defined racial categories on the survey; all women in these groups identified as Hispanic or Latina.[26] All participants in the English-language focus groups reported they were born in the United States; the majority of participants in the Spanish-language focus groups reported their native country was the Dominican Republic (see Table 4).

Table 4: Demographic Characteristics of Focus Group Participants

	Global	English	Spanish
Sample size, number (percent)	52 (100)	23 (100)	29 (100)
Race, number (percent)[24]			
No answer	20 (39)	0 (0)	20 (69)
White	18 (35)	14 (61)	3 (10)
Black	11 (22)	8 (35)	3 (10)
Other	5 (10)	1 (4)	4 (14)
Ethnicity, number (percent)			
Hispanic/Latina	30 (58)	1 (4)	29 (100)
Country of origin, number (percent)			
United States	25 (48)	23 (100)	2 (7)
Dominican Republic	17 (33)	0 (0)	17 (59)
Puerto Rico	3 (6)	0 (0)	3 (10)
Honduras	2 (4)	0 (0)	2 (7)
Colombia	1 (2)	0 (0)	1 (3)
El Salvador	1 (2)	0 (0)	1 (3)
Panama	1 (2)	0 (0)	1 (3)
Venezuela	1 (2)	0 (0)	1 (3)
No response	1 (2)	0 (0)	1 (3)

[24] Respondents could select more than one choice.
[25] The median is provided instead of the mean due to a skewed distribution in the ages of participants.
[26] Slightly more than one-third of participants (39%) did not respond to survey questions regarding their race; all non-responders were participants from the Spanish-language focus groups and defined their ethnicity as Hispanic, Latina, or of Spanish origin. For this reason, we present data on race separately for the English- and Spanish-language focus groups.

"It's Wicked Easy": Focus Group Participants' Knowledge of and Opinions About Reform

Almost all focus group participants reported that they had heard about health care reform prior to their participation in the focus groups, citing word of mouth as the primary way they had received information about it, in addition to hearing about health care reform on the radio or through other forms of advertising. Consistent with the results of the in-depth interviews with clinic and agency staff, focus group participants were less clear about the specifics of the various Commonwealth Care plans, and sometimes had trouble remembering which of the subsidized plans they were currently insured by—the Commonwealth Care plans, MassHealth, and other programs were often conflated.

Interestingly, many participants focused on the two elements of reform that they believed to be the key components of the legislation: the mandate to have insurance and potential penalties imposed in its absence. Frequently, participants described the insurance mandate in Massachusetts as a "law," a "requirement," or an "obligation" to have insurance in Massachusetts. They also mentioned concerns about the consequences of not having insurance. As one participant described her reaction after the first time she heard about health care reform, "I think it was more panic around the issue, that like 'oh my god if you don't have it, you're gonna be charged'" [Boston]. Some were frustrated by the mandate stating, "It's gonna cost something and then they're gonna fine you. That makes sense to me, but…that should be your own choice if you want to get it or not get it, unless the government is going to provide it for you" [Boston].

Though fear of fines or jail time loomed in the background of some of the focus group discussions, most participants reported positive opinions about health care reform. Participants described the law as "justo" [just/fair], and "importante" [important]. They stated that they felt "psyched," "really lucky," "happy," or "grateful" to have insurance, which they considered a "lifesaver" that gave them "peace of mind" and was "better than nothing." The importance of having insurance was articulated by one woman who stated, "A yo sí, eso le preocupa a todo el mundo porque el seguro es todo. La gente sin seguro no tiene vida. ¿Te enfermas, que va hacer?" ["Yes, 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?"] [Lawrence].

Many described the process of getting insurance as "wicked easy." One woman described graduating from college and leaving her college insurance plan: "I had to get insurance so I got Commonwealth Care and that was really easy. I couldn't believe that it was like, 'Oh yeah, sure you are in. Now you can get whatever you want'" [Boston].

Most also felt that reform in the Commonwealth had largely increased access to health care for women in their community. As one participant stated, "Ahora la gente va mas…si tienen seguro, aunque tengan que pagar, van con más confianza al doctor" ["Now people go more…if they have insurance, even if they have to pay, they go with more trust to the doctor"] [Lawrence]. Many participants also discussed that health care reform "was a step in the right direction" to improving preventive care. As one participant stated, "It [reform] was encouraging people to really focus on preventive care" [Boston].

Many participants stated that they felt confident in having health care since they lived in Massachusetts, though it is unclear if this was related to health reform, general opinions about good care in Massachusetts, or a combination of both. Some women, however, did recognize that even before health care reform was implemented, residents of Massachusetts had better access to health

care services than people in other states and they said that accessing health care has always been easy. For example, one woman said:

> I thought it was always easy to get care in Massachusetts…I didn't have any Massachusetts insurance or anything. They saw me and everything was fine…before the law change in 2006 so I kinda always thought that everyone had health care in Massachusetts [Boston].

"I kinda always thought that everyone had health care in Massachusetts."

Another participated stated, "I don't worry about that [access to services] in Massachusetts. I worry for women in the other parts of the country" [Boston].

"It's Really Confusing": Challenges with the Commonwealth Care Plans

Though most focus group participants expressed gratitude for having access to health insurance, many also identified barriers to accessing care under the Commonwealth Care plans primarily due to lack of information regarding the plans and difficulty maintaining coverage. Participants also described having difficulty getting help when they experienced challenges with their insurance.

Lack of information on enrolling in and maintaining coverage with the Commonwealth Care plans was challenging for many focus group participants. One noted, "I think there's not enough information. I feel like there's a lot of things that people don't know…it's hard to get information" [Boston]. Others reported it was "really confusing" to stay on the Commonwealth Care plans, in part due to burdensome eligibility certifications that occur after enrollment. These were frequently described as an "up and down process." One participant described spending seven months working to re-enroll in a plan:

> 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 [Worcester].

Participants also reported that maintaining coverage on the plans was difficult and worrisome as they were juggled on and off different health care plans with various benefits and different costs:

> I think it's changed, I mean I had a copay. I didn't at one point. Then I did. Now I don't because they switched my coverage again. But in the long run, I wonder how it is going to affect me. When will they decide that my coverage will change or will I get a really large bill in the mail? [Springfield].

Many participants were frustrated by the time and self-advocacy skills required to manage their health insurance plans. One participant stated:

> I spend more time on the phone here dealing with it and it's up to me to do the right work … it's up to me to find out all the health care plans and all the differences and stuff and it just pisses me off because I'm trying to find work. I can't spend fourteen hours a day on the phone [Worcester].

Some women noted that when they sought help from customer service representatives to address the instability of their coverage, the representatives often lacked helpful information: "I was just trying to figure out why I got kicked off…I've been calling everyday… And I get a different answer

every time…I think it's confusing for the people who are supposed to tell you what's going on" [Boston].

Finding a Plan and a Provider and Learning About Coverage

When asked how they picked their current plan, participants described it as "just a crap shoot" [Boston]. Others stated that the differences between the plans seemed relatively small and unimportant: "I had no idea what to pick and I felt like a lot of them seemed like they offered the same thing. But in the end, I didn't really care because I just wanted insurance" [Boston].

Some participants discussed the difficulties of getting in to see a provider, particularly as a new patient with a Commonwealth Care plan:

> I could not get into any primary care physician…I can't go to a gynecologist until I get my primary care physician and she recommends a gynecologist because of the way the plan is set up through Commonwealth Care [Worcester].[27]

Women frequently reported being told they had to wait approximately three months for appointments as new patients, though a small number mentioned that a few clinics were not taking any new patients or had very long wait times which made some participants unhappy. One woman reported being told at one large facility that she would have to wait one to two years to see a primary care physician (PCP) and she said that she "felt lucky" when she learned that another large facility could schedule her in three months. Participants primarily attributed the increased wait times to the swell in the number of new patients seeking care after health care reform, which was "overloading small clinics." However, some participants attributed it to the fact that they had a public health insurance plan and perceived that those on private plans were able to schedule appointments sooner.

Further, some participants reported that not all providers accept subsidized health insurance plans and felt that they had limited choices in picking a provider. One participant reported she found the process of choosing a doctor who accepted Commonwealth Care plans as disappointingly impersonal: "Once they put you…in the computer in a plan, it pulls up all the doctors within X amount of miles from your house. And, they pick the one who's got the least amount of patients" [Worcester]. A few participants reported they had switched providers when they learned their provider would not accept the Commonwealth Care plan in which they were enrolled.

Participants also described being unsure about what services were covered by their health plans and relying on health care providers, who were also often unsure about coverage, for help:

> I'm wondering if I'm going to get a bill from the emergency room because I'm wondering if Commonwealth Care won't cover it…[In the emergency room] they don't go in to specifics like that; they just make sure you sign the paperwork and if the insurance company don't pay for it then you are responsible for it [Springfield].

Insurance Affordability

Most participants described their insurance as very affordable. Cost was mentioned less frequently as a barrier to using insurance in the focus group discussions than it was by clinic and agency staff.

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[27] According to our desk review, women enrolled in any of the reviewed Commonwealth Care plans should be able to access routine gynecological care without a referral from their PCP unless the gynecologist is out of network or the woman has already received one annual exam in the year.

The cost of care does appear to have changed for some women since health care reform, though this change has not been uniform. Some women reported experiencing new copays and premiums, while others reported paying less now than they previously did.

Many participants described their public health insurance plans as affordable and were grateful for the relatively low cost of their copays. The majority of participants described the cost of their insurance and their copays as "nothing," "nada," "zero," "free," "gratis," or "very low." Some participants said that their copays had increased from $1 to $2 or from $2 to $3 after health care reform, but that this increase was manageable. As one participant stated, "El que paga uno, paga doble" ["If you can pay one, you can pay double"] [Lawrence].

However, some participants, particularly those whose incomes were closer to the top of the eligibility income range (300% of the federal poverty level), voiced concerns about the costs associated with their insurance plans. Women expressed frustration with having to document their income and the fact that if their income changed, their eligibility for specific subsidized programs or the type of plan within the Commonwealth Care system that they were eligible for changed, potentially requiring higher copays or premiums:

> It is always a fighting battle with this thing—with this income thing—and…I feel like you cannot win without losing [in the] situation because I'll never come up if every time I feel like I am coming up—if I have a couple of dollars somebody has to know about it, which will put me back somewhere else and at one point the Commonwealth was actually making me pay like $75 a month for my health insurance [Springfield].

Another participant articulated these struggles with an analogy, "Aquí viven dos, el rico y el pobre, el de medio no sale" ["Here live two, the rich man and the poor man and the one in the middle has no place"] [Worcester].

Some participants reported diverting money from groceries, rent, household bills, school bills, and Christmas presents or getting additional part-time jobs to pay for the cost of their insurance. One participant jokingly described throwing all of her bills in the air and picking which one she would be able to pay. Some participants also reported utilizing home remedies when they were unable to afford health care.

"God Help You If You Work": Expenses Related to Employment

Many participants worried about no longer being able to afford their insurance if they worked more hours than usual or began to earn more money: "I don't pay anything because of my income bracket so I don't have to pay. Now my, if my income goes up…then I'll have to pay for my own health insurance" [Boston]. Another participant stated:

> Si tu trabajas tienes seguro, pero el seguro no es tan bueno…como que más fácil tener seguro si tú no estás trabajando…no tiene que pagar nada y todo se hace más fácil…las que trabajan, tienen que pagar para todo [If you work you have insurance, but the insurance is not that good…it seems easier to have insurance if you do not work…you don't have to pay anything and everything becomes easier…those who work have to pay for everything [Boston].

"It seems easier to have insurance if you do not work. You don't have to pay anything and everything becomes easier. Those who work have to pay for everything."

Of participants who reported that cost was a barrier to accessing health care, many reported the burdensome costs were related to the high prices associated with employer-sponsored insurance:

> I'm worried about having to work, get on their insurance. There's no way it's gonna be as good and it's gonna cost me more money and I'm not making any money right now. And with copays for everything I'm really gonna be making no money. So, I'm really worried about that…Cause I don't want it! I can't afford it! I won't be able to afford to take care of myself [Boston].

Many participants who reported frustration with their employer-sponsored insurance described feeling they had no "options." As one participant stated:

> If they offer it, you have to take it. Doesn't matter how much it costs…If your company offers health insurance and the premiums are out of your price range, you have to still have to take it, cause it's Massachusetts, it's the state law, if you don't take it you get a penalty…Period, the end, it's not a matter of discussion [Worcester].

Finally, a small number of women reported that their employers urged them to work as close to full time as possible, but maintain their part-time status so that the employer would not have to pay for their insurance. One woman in this situation described being upset that she did not have insurance through her employer:

> They try to push their part-time people to get as close to that 40-hour mark without going over but that's not a full-time position…I just feel like it is always going to be a back-and-forth game…I never seem to be able to win [Springfield].

Stigma and Concerns About Quality of Service

Participants enrolled in government-funded health programs or subsidized health insurance plans frequently compared the care they received on those plans to the care received at a "normal doctor" or through "regular health insurance." One participant felt that her public plan was better than her previous private one. Another reflected: "It is just like having insurance… I have this piece of paper [insurance card]…it is good. It's like having real insurance, well, because it is" [Boston].

"It's like having real insurance, well, because it is."

Though many reported that having an insurance card reduced stigma associated with being uninsured or using free services, some also reported feeling that the quality of care they received through subsidized programs or insurance plans was of lower quality than services for people with private insurance:

> Yo tengo MassHealth, y yo hallo que…yo tengo el servicio, pero la cualidad de servicios para mi que es diferente, yo hallo que la gente que sí están pagando por su servicio y si tienen su seguro, yo hallo que la cualdidad de la atención que se le da es mucho mejor…la cualidad del servicio no creo que sea igual…hay que esperar mucho para recibir un appointment, hay que esperar meses [I have MassHealth, and I find that…I have the service, but the quality of service seems different to me, I find that people who are paying for their service and who do have insurance, the quality of care which they are given is much better…I don't think the quality of service is the same…you have to wait a long time to receive an appointment, you must wait months] [Boston].

A number of participants in the Spanish-language focus group also described feeling that health care providers made judgments about their socio-economic class based on the type of insurance they had. Another participant in an English-language focus group stated, "You don't get the same respect and the same courtesy as somebody else who is coming in there with full insurance" [Springfield].

"Que Pasa con Nosotras las Mujeres?" ["What Happens with Us, the Women?"]: Client Views of Populations "Left Out" by Health Care Reform

Participants identified specific groups of women who they perceived encountered significant barriers in accessing health care services since reform. They often described firsthand accounts of their own struggles maintaining health insurance coverage since health care reform, but sometimes spoke of the experiences of other women in their lives. Like providers, women specifically mentioned that undocumented immigrants and young women faced obstacles to accessing health care.

Many women, particularly those in the Spanish-language focus groups, voiced concern about the impact of reform on undocumented immigrants. Overall, participants in the Spanish-language focus groups thought that health care reform has had a negative impact on undocumented women's access to care because prior to reform it was easy to access insurance and health care without proof of citizenship; however, now "preguntan todo" ["they ask everything"] [Lawrence]. One woman asserted that before health care reform, the government used to cover routine reproductive health care services; however after health care reform, this was no longer the case: "Antes te lo daban, cuando estaba embarazada, antes de la ley, te daban seguro aunque que no tuvieras documentos. Y ahora mira" ["Before, they gave it to you, when I was pregnant, before the law, they gave you insurance even if you didn't have documents. And now look"] [Lawrence]. Another participant confirmed, "No les preguntaban…si era legal o ilegal, nada le preguntaban…Ahora, preguntan todo. Si tú eres ciudadano tienes que demostrarlo. Antes no, tu decías soy ciudadano y ya. Esta muy mal en ese aspecto" ["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 aspect"] [Lawrence].

> *"Before the law, they gave you insurance even if you didn't have documents. And now look."*

Another woman stated that some women in her community no longer went to the doctor since health care reform has been implemented; "Muchas personas que dicen, 'uy! Yo no tengo papeles, yo no tengo un trabajo entonces no puedo ir a un médico.' ¿Qué pasa?" ["So many people say, 'uy! I don't have papers, I don't have a job and so I can't go to a doctor.' What happens?" [Boston].

Spanish-speaking participants in the focus groups did not report lack of English proficiency as a significant barrier, in contrast with providers' perceptions. Spanish-speaking women described getting assistance from Spanish-speaking providers to access more information about enrollment in health care plans and to help them read the Commonwealth Care correspondence in English—this assistance from providers may have helped Spanish-speaking women overcome the language barrier.

Focus group participants also noted concerns for some young women who they perceived may not be able to advocate for themselves when navigating the health care system. They maintained that access to health insurance may have increased, but "may not actually be taken advantage of." As one participant stated:

> I mostly have affiliated with graduate/college people or like higher education type of young, smart people…I feel like a lot of those people are able to advocate for themselves and really go get it. But 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 it's not going to do it [Boston].

Contraceptive Access After Health Care Reform

Although most women reported easy access to contraception before and after health care reform, some reported barriers to access, including challenges obtaining prescriptions at pharmacies and difficulty scheduling appointments for certain methods. A minority of women reported difficulties with contraception costs and obtaining their first choice of contraceptives under health care reform. Although lack of information about contraception coverage under their plans was reported as a barrier for some, the majority of women reported they rely on family planning providers for this type of information.

The majority of women reported that their access to contraception and their contraceptive method had not changed since health care reform and that access to their method continued to be easy: "No es difícil, fácil, todo el mundo lo [método anticonceptivo] consigue fácil" ["It's not difficult, everyone obtains it [contraception] easily"] [Boston]. Some believed that for themselves and for "other women," contraception is more affordable and accessible since health care reform. Many believed that the costs of copays related to contraception were reasonable. As one woman stated, "Aunque tenga que pagar un costo, pero mas mal es tener nada" ["Although they might have to pay a cost, it's worse to have nothing"] [Lawrence]. A small number of women noted that they began taking contraception for the first time after reform because they "could afford it." As one participant spoke about her friends' access, "I know a big factor for a lot of my friends—like the pill is just too expensive so they forego and they rely on other questionable methods and I think health care reform will help bring unplanned pregnancies and stuff like that down" [Springfield].

Some Spanish-language focus group participants stated that access to contraception was easy for them and for women in their community because health insurance companies were *eager* to pay for contraception. A number of participants reported that insurance companies "lo pagan [anticonceptivos] con gusto así no tienes hijos" ["pay for that [contraception] with pleasure so that you don't have children"] [Lawrence]. Some participants perceived the use of contraception to have small families as an American cultural value. As one woman said, "Que yo sepa en este país lo que queremos es que es controlar que las personas tengan tantos hijos" ["I know in this country what we want is to control that the people have so many children"] [Boston].

Challenges related to filling prescriptions for contraceptives at pharmacies were mentioned by many women. Women reported time-intensive "fighting" with their local pharmacy to prove they had insurance coverage or that their insurance covered their particular method. As one woman stated, "Muchas veces las farmacias dicen que el seguro no lo cubre y eso es mentira, yo tuve que pagar $54" ["Many times they say that the insurance doesn't cover it and it is a lie, I had to pay $54"] [Boston]. Some participants were also frustrated that their plan only covered a one-month supply of pills. This appeared to impact some participants' ability to continuously stay on oral contraceptives as it was sometimes difficult to go to the pharmacy on a monthly basis.

Barriers to scheduling appointments to receive contraception were also noted. Participants reported waiting times from one week to six months for a gynecological appointment and having their appointments frequently shuffled around and rescheduled; the majority indicated the wait was about 15 days. A number of participants in one focus group discussed the long waits to have an IUD inserted: "Es una lista grandotota que ponen IUD y tuve que esperar mes y medio, casi dos meses para poder tener un appointment para que me pusieran el IUD" ["It is a very big list for putting in IUDs and I had to wait a month and a half, almost two months to get an appointment so that they would give me the IUD"] [Boston]. Some participants also mentioned long wait times for follow-up appointments with primary care providers to address adverse reactions to their contraception. Some reported seeking care with nurse practitioners or with family planning providers who had more available appointments when they could not get in to see their PCP.

Only a minority of the focus group participants reported that the cost of insurance or cost of contraception was a problem for them. A number of women worried about the affordability of non-prescription methods. One woman said, "If you are going to get something like a diaphragm…the spermicidal jelly can be expensive and I don't know if that could be covered or if that is something you have to buy" [Boston]. Another woman asked, "Why do I always like the one [contraceptive method] that is the priciest?" [Springfield]. Many women also voiced the need for insurance coverage for condoms as they can be "wicked expensive" [Boston].

When asked, the majority of focus group participants reported being unsure about what contraceptive methods were covered under their health insurance plans. They described it as a "guessing game" with one woman stating, "you don't know until you're left with a prescription. Like, oh ok. I guess I can get that" [Springfield]. Many assumed that their health insurance would cover most forms of contraception and they reported relying on family planning providers to confirm for them which contraceptive methods were covered under their insurance plans. As one participant stated, "Every time I came into [the clinic] they tell me exactly what is covered with my insurance and what isn't and so…I never received a bill ever…I never had issues" [Worcester]. However, other participants reported having less luck when relying on their providers to inform them about what is covered: "I say to them…'Does my health insurance cover it?' [They say] 'We don't know. Can you call and find out?'…I was kinda surprised they didn't know…And, she [the provider] tells me, 'You can go home and call them'" [Worcester]. And some women reported they "learned over the years to always ask, 'is this covered by my insurance?'" due to receiving burdensome bills after having received a method they assumed was covered [Worcester]. Almost all participants reported they received no information from their insurance companies about what contraceptive methods were covered.

A very small minority of women indicated that they were not able to access their first choice of contraceptive method after health care reform because their insurance did not cover specific types of oral contraceptives or IUDs. One woman reported that her health insurance only "fully covered" one of two types of IUDs and that the IUD covered by her insurance was not the one she preferred. In the end she said, "I got the one that wasn't my first choice" [Worcester]. Another woman spoke about not being able to receive brand-name oral contraceptives: "Why is it that so many birth control pills, like, the good ones, so many people want are so expensive and the other ones that aren't brand name are cheap?" [Worcester].

Most participants indicated they were receiving publicly-subsidized health care both prior to and after health care reform. When they did not have access to insurance, both before and after health

care reform, either because their coverage had lapsed or they couldn't afford their copays, they often relied on family planning providers to provide contraceptive methods.

Role of Family Planning Providers

Many participants reported that they consistently and frequently rely on family planning clinics, or that the clinics are the "first place I would go" [Boston]. Particularly for reproductive health care, focus group participants relied heavily on family planning clinics, in part because they are a "trusted name" [Boston]. As one participant stated, "Honestly, for something like that I would just go right to [the clinic] because I know [the clinic] a lot better at this point than I know my own insurance" [Boston]. Others also described turning to family planning providers when they needed urgent and moderately priced care. Another participant described seeking emergency contraception and stated: "Yo estaba bien asustada…Me dijeron que la farmacia costaba $50, no sé si es verdad, y que en la clínica costaba como 20. Pero cuando fui a la clínica no me la cobraron, me la dieron. Gracias a Dios no quede embarazada" ["I was very scared…They told me that in the pharmacy they 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"] [Boston].

In one focus group, participants discussed access to contraception being easier in Massachusetts than in other states, in part due to a strong network of family planning providers. In another group, participants voiced a call for more family planning providers to help facilitate contraceptive access. The majority of comments about family planning providers were about the benefits of providers educating them about contraception, and about general positive experiences with accessing contraception due to the positive attitudes of the staff and due to women's ability to frequently access methods in bulk for free or deeply discounted prices at family planning clinics.

Focus Group Discussion Summary Results

Many women reported that they were grateful for access to health insurance and health care after health care reform in spite of barriers they encountered. Women reported that reform has led to enormous benefits for some women, but many women, such as undocumented immigrants, young women, and women with incomes at or around the financial cutoff for subsidized health care continue to face barriers in accessing care. Women identified multiple obstacles to maintaining insurance coverage, noting they frequently come on and off of coverage, which may affect contraceptive use. Additionally, they indicated they receive little information from their insurance plans about which contraceptive methods are covered. Finally, women reported relying on family planning providers not only for their care, but also for information about their insurance plans.

CHAPTER SEVEN: DISCUSSION

Health care reform in the Commonwealth was designed to dramatically expand access to affordable health insurance for Massachusetts residents. Consistent with other studies documenting the impact of Massachusetts health care reform [25-27], providers and women in our study reported significant increases in access to insurance coverage and health care services. However, family planning providers and low-income women in our study noted both positive and negative aspects of health care reform generally and of working with the Commonwealth Care plans specifically. Moreover, study participants noted a number of challenges to ensuring and maintaining low-income women's access to insurance and to contraception.

Providers and women reported that they support and have high hopes for the overall idea of health care reform. Similarly, other research has found that almost three-fourths of Massachusetts residents support and believe in health care reform [28]. In general, providers in this study reported that they felt that reform has improved access to affordable health care for their clients. Focus group participants also reported many positive aspects of health care reform, including access to affordable insurance, the ability to seek both preventive care and general reproductive health care, and the reduced stigma and other emotional and psychological benefits of having insurance.

However, many study participants identified a number of barriers to access to both insurance and health care services. For example, providers and women both identified challenges to working with and managing the Commonwealth Care plans. For providers, challenges primarily revolved around a lack of clarity on how to verify eligibility of clients and what services are covered under the Commonwealth Care plans as well as increased administrative burdens associated with general billing procedures and contracting issues with the plans. For low-income women enrolled in a variety of publicly funded health care programs and insurance plans including Commonwealth Care, concerns regarding their ability to prove and maintain eligibility were paramount. Both providers and focus group participants stated that they lacked information on how to resolve these problems. The challenges of complex enrollment and re-certification procedures have also been documented elsewhere and have been reported to be due to ineffective communication from the state and from the Commonwealth Care plans [28].

Although the majority of participants in our study reported that low-income women had "easy" access to contraception *both before and after* health care reform, they identified some new challenges after health care reform. In particular, concerns about working with prescriptions and pharmacies and the lack of clarity about methods covered by the plans were noted by both providers and focus group participants. For women who typically accessed contraception from MDPH-funded family planning providers before reform, prescription requirements may be especially challenging. MDPH-funded family planning providers are able to dispense some contraceptive methods directly to uninsured women, whereas many health insurance plans (including the Commonwealth Care plans) require that a prescription be filled at a pharmacy. A minority of the women who participated in our study reported several barriers to accessing contraception using a prescription at pharmacies, including travel time, pharmacies in inconvenient locations, general unfamiliarity with using prescriptions, limits on the amounts of contraceptives dispensed at once, and pharmacists' lack of accurate information about contraceptive prescription coverage under various insurance plans.

Reports of other barriers that may impact low-income women's access to contraception were less consistent. Though our systematic review of Commonwealth Care plans showed that most forms of contraception are covered by the plans, and most women described their insurance plans and copays as very affordable, providers reported that some of their clients could not afford the copays for their contraception. Some women in our study reported that they lacked information about contraceptive methods covered by the Commonwealth Care plans and had difficulty scheduling appointments for certain methods. They also voiced some concerns regarding the lack of coverage of certain types of oral contraceptive pills, IUDs, and non-prescription methods such as condoms and spermicides.

Although providers and women reported that health care reform has led to many improvements in access to health insurance and health care, for some populations of women access to health care has not improved or has gotten worse. Providers and women reported that immigrants, young women, those with unstable employment, and those experiencing common life changes have been "left out" of health care reform. For undocumented immigrants, inability to provide evidence of legal residency means they are ineligible for coverage under health care reform, and fear of being asked to provide this documentation may deter some women from seeking care in general. Young women, though they may be covered under a parent's insurance, may be unable to access reproductive health care confidentially and may therefore choose to forego care. Women with variable employment often move rapidly in and out of eligibility for subsidized plans depending on changes in their income. In addition, women whose employers offer insurance are categorically ineligible for subsidized Commonwealth Care plans, but in some cases women found that the insurance their employers offered was prohibitively expensive. Though hardship waivers exist for residents who are unable to afford insurance, no focus group participants reported applying for a waiver, perhaps highlighting the need for raising awareness about the waivers. Finally, women experiencing common life changes such as pregnancy, starting or finishing college, or moving reported it was difficult to keep up with the paperwork required to document eligibility for subsidized care. Many of these findings are consistent with previous research that has found that 25% of newly insured residents have experienced gaps in their insurance coverage; and that immigrants, those with limited literacy or English skills, and those with income or job changes are disproportionately more likely to experience barriers to enrolling in and staying on the Commonwealth Care plans [28].

Our research also illustrates the important role that family planning clinics play in mitigating barriers to contraception, assisting clients with enrolling in and understanding their health insurance plans, and in providing care to those who are uninsured, in between health insurance plans, or otherwise fall through the cracks of a health care system based on the private insurance model. MDPH-funded family planning providers are an integral part of the public health safety net in Massachusetts, providing specific outreach to and service provision for hard-to-reach and underserved populations facing significant barriers to accessing health care. Family planning providers help women to navigate the health insurance system by assisting with enrollment and explaining insurance paperwork and pharmacy benefits. Family planning clinics also continue to fill gaps in insurance coverage and provide access for women who have been "left out" of health care reform, who cannot afford contraception with or without insurance, who require confidential care, or whose insurance does not cover contraception (*i.e.,* companies that self-insure or that are religiously affiliated). Other policy reviews have also recognized the critical role that family planning providers play in ensuring access to affordable, high-quality reproductive health care, particularly for populations that remain uninsured in Massachusetts [29].

However, many providers reported that providing these services has placed new administrative and financial burdens on family planning agencies and clinics. Working with more insurers has increased administrative costs, decreasing funding available for direct services. Although some MDPH-funded family planning providers have been awarded separate grants to assist low-income clients with insurance enrollment, the majority of providers in our study reported increasing their work in this area without sufficient compensation for the staff time involved. In addition, MDPH-funded family planning providers have been subject to several other changes outside of health care reform that have impacted their ability to serve low-income women. Like many other agencies funded by the Commonwealth, by the middle of 2009, MDPH-funded family planning providers had experienced budget cuts approaching 20% [30]; some providers with whom we spoke speculated that family planning services received deeper cuts than other MDPH-funded programs because of the assumption that these services were no longer needed in light of health care reform. Also, a 2007 cost analysis by the MDPH Division of Health Care Finance and Policy examined the costs of providing family planning visits and contraception and determined it was necessary for MassHealth to increase the rate of reimbursement for visits and contraceptive methods. The increase in reimbursement rates coupled with the increasing cost of contraceptive methods, have effectively reduced the "purchasing power" of MDPH funding [31]. In sum, MDPH-funded family planning clinics have an increasing set of responsibilities at the same time they are experiencing decreases in funding. These concerns about the cost of providing health care after reform are not unique to MDPH-funded family planning providers; the Commonwealth has grappled with the cost of care in many health care sectors [26].

The complexity of health care reform, and the challenges of understanding the many aspects of utilizing and administering the Commonwealth Care plans, emerged throughout our study. We identified several areas in which both women and providers appeared to be misinformed about some aspects of health care reform. Areas in which women are in need of education include how to enroll in and recertify eligibility for plans, how to apply for hardship waivers, how plans cover visits to different providers and whether they need referrals, and which contraceptive methods are covered under the plans. Many providers voiced a need for information and training on certification of client enrollment in the plans, services covered by the plans, and general billing procedures. Given that all the providers in our study previously worked with MassHealth and that the benefits of the Commonwealth Care plans are modeled after MassHealth, it is surprising that providers were not better informed about or prepared for working with the plans. Some of the challenges may be due to the newness of reform, inconsistent communication between the plans and providers, and constantly changing standards and rules related to reform; some may not be unique to Commonwealth Care at all, but due to the general complexity of health insurance. More research is needed to evaluate whether some of the challenges we identified can be reduced over time and with more experience with the new plans. Additional research to understand the impact of reform on contraceptive use and reproductive health outcomes for other groups of women not included in this study, and research with women and men who are successfully navigating the Commonwealth Care plans are also needed.

As health care reform on the national stage moves forward, policymakers, health care advocates, and other stakeholders will need to consider the lessons learned from the Massachusetts experiment, and this study may have implications for the national debate. In particular, if future reform efforts are modeled in part or in full on the Massachusetts model, creative solutions to challenges around complex enrollment and re-certification procedures, populations excluded from health care reform, administrative and financial burdens placed on health care providers, and costly copays and

premiums need to be identified. Additionally, multiple tools should be utilized to help ensure that the initial uptake and administration of health care plans under reform run smoothly, and that clients and health care providers can access the information they need. Finally, though a cost-benefit analysis is beyond the scope of this study, many providers voiced the importance of balancing the need to control costs with the need to provide high-quality care in the wake of a severe economic recession.

The provision of contraception is a critical preventive health service that is highly cost-effective [18], and national health care reform efforts should explicitly include ways to ensure or improve access to contraception. Our research shows that innovative solutions to make sure that women and providers have clear information about the full range of methods, and also that the full range of methods are covered and easily accessible, are critical. Some strategies to be considered include making contraception copays affordable, creating incentives for insurers to cover more than one month's supply of contraception, and ensuring women have consistent access to contraceptive methods and services so that they can avoid gaps in their contraceptive use and reduce their risk of unintended pregnancy. Taking advantage of existing infrastructure and relationships that clients have with their current family planning providers can help to address some of the challenges in moving to a new system.

The Commonwealth's efforts to reform health care should be commended for leading the way in expanding health care access for residents; we hope national reform efforts move in a similar spirit.

Limitations

The findings from this study must be viewed in the light of several limitations. This study was designed to provide preliminary data on the impact of health care reform on contraception provision and access; it was limited in size and was not designed to provide generalizable data. Also, there have likely been some changes since the completion of our research. The websites and benefits of some of the Commonwealth Care plans may have improved and anecdotally we have heard that the Commonwealth Care plans are now contracting with more agencies and clinics. Also, as more people lose their jobs and unemployment rises, more women may be enrolling in the Commonwealth Care plans or other subsidized health care programs, which, combined with strains on the Commonwealth's finances, could lead to policy changes that could affect our results and conclusions.

Also, as women and providers articulated, there are multiple factors outside of health care reform that affect women's ability to access and maintain insurance coverage. Low-income women face many structural barriers to obtaining many kinds of resources, including but not limited to health care. Providers also noted several factors that adversely affect their ability to provide care, such as an increased need for bilingual staff and budget cuts impacting family planning providers' ability to provide services. In addition, the impact of the worldwide economic collapse has been significant for both providers and low-income women. It is not clear to what extent some of these factors are related to health care reform. Also, we asked participants to describe their experiences with insurance and contraception "before and after" health care reform. However, the experiences that people described were often very fluid and did not always reflect changes that could be directly associated with health care reform.

We encountered a number of challenges in the recruitment of participants, particularly clinic staff for participation in in-depth interviews and Spanish-speakers and residents of Western Massachusetts for the focus group discussions. We were unable to recruit as many providers for in-depth interviews as we intended; of the 25 clinics we approached, nine declined to participate, a 64% response rate. Although we initially planned to conduct the interviews exclusively with clinic staff, we had trouble identifying and scheduling interviews with appropriate respondents at some clinics and in some cases conducted the interviews with agency-level staff; this may have led to an over-representation of challenges experienced at the administrative level. Further, we did not interview front-desk staff at the clinics; therefore, we do not have direct data on the impact of health care reform specifically on clinic intake or initial interactions with clients. Additionally, two of the 12 MDPH-funded agencies did not return surveys, though we did complete interviews with clinic staff who work for both of those agencies.

The majority of focus group participants had incomes at or below 100% of the federal poverty level (and therefore qualified for health programs with very low copays), were located in greater Boston, were urban residents, and were clients of MDPH-funded family planning clinics. We expected many of the women recruited from family planning clinics to be clients of the clinics, but many of the low-income women recruited through other methods (such as online postings) were also family planning clients. Women who have used the MDPH-funded family planning clinics to get contraception may have had better access to contraception prior to health care reform, and so we were not able to document the impact of health care reform on women who did not have access to or know about those services. We conducted focus groups only in English and Spanish; the experiences of women who are not fluent in either language are not represented. Additionally, though some findings suggest there may be geographic differences in contraceptive access, the focus groups we conducted outside of the Boston metropolitan area were too small in number to clearly explore the issue. In addition, this study did not assess the impact of health care reform on health outcomes, like unintended pregnancy or sexually transmitted infection rates.

Finally, our findings reflect providers' and focus group participants' reported experiences with health care reform. As detailed in the above discussion, we find that there are several aspects of health care reform about which both providers and women are consistently unclear and in need of additional information. Throughout this report, we have added footnotes to clarify misinformation, though the lack of clarity in some areas and an inability to return to study participants to clarify confusing statements may have affected our findings.

Though our results must be interpreted in light of the above limitations, the findings from the desk review, providers, and women were consistent with one another and with other research (cited in the discussion), which bolsters our confidence in these results. We have successfully met our original study aims: to explore how low-income women have accessed contraception before and after health care reform, to learn about the experiences of family planning providers in providing care after the implementation of reform and the impact they perceived health care reform has had on their clients, and to outline critical areas in need of future research.

CHAPTER EIGHT: RECOMMENDATIONS

Health care reform in Massachusetts has successfully reduced the number of people who are uninsured in the Commonwealth, and providers and women generally believe it has increased access to health care. Our results, however, show that there are still barriers to accessing contraception. Providers and women report a lack of information about how to manage the Commonwealth Care plans. Some women have been left out of health care reform entirely, and others face challenges managing the paperwork and staying enrolled in subsidized programs or health insurance plans, while others report that getting a prescription filled or accessing refills has been challenging.

Contraception is a critical primary health care service. On average, women spend nearly 30 years of their lives preventing pregnancy, and many of the most effective contraceptive methods require a prescription [32]. Choosing whether and when to bear children is an essential part of a woman's health, and these decisions have wide-ranging impacts on women, their partners, families, and society as a whole. As federal, state, and local legislators grapple with state and federal health care reform, it is critical that access to quality, comprehensive reproductive health services including family planning is a part of whichever reform proposal is ultimately signed into law.

The findings from our study highlight a number of priority areas for further action to ensure continued contraceptive access for all low-income women in Massachusetts. We outline below recommendations for policymakers, advocates, and other stakeholders that emerged from our research findings.

Improve outreach to health care providers and pharmacists to better educate them on Commonwealth Care plans. Working with the plans is confusing for many providers; there are particular challenges around determining client eligibility for plans, the plans' coverage of contraception and other reproductive health services, and billing procedures and policies. Women reported that they rely on providers for assistance with enrollment and benefits information; providers reported that they lack enough information needed to fill this role. Women and providers also reported that pharmacists frequently lack information on which contraceptive methods and brands are covered by the Commonwealth Care plans. In order to increase understanding about plan eligibility, policies, procedures, and coverage, we recommend the following:

- Develop a range of user-friendly tools for health care providers to improve information on policies and procedures, including billing practices and pharmacy formularies. Possible materials could include paper and web-based summaries or fact sheets, and online tutorials for providers and pharmacists; these materials should be regularly updated to reflect plan changes.
- Encourage outreach by the Health Connector or Commonwealth Care plans to health care facilities to provide information and support dealing with the plan paperwork and policies, including enrollment, coverage, and billing.

Develop user-friendly information that can be accessed through the mail, call centers, and websites on coverage of contraception under Commonwealth Care plans. Information about health care reform, Commonwealth Care plans, and contraception coverage, in general, is difficult for consumers to navigate and obtain. User-friendly information about what types of contraception are and are not covered by the different Commonwealth Care plans and how much each method costs will help clients choose a plan that covers their preferred method. We list here a few ways that

information on contraception coverage could be more effectively and comprehensively communicated to all women:

- Develop culturally relevant and accessible materials with information about the types and brands of contraception covered under the plans. These materials could take the form of fact sheets, patient mailings, websites, and presentations.
- Create a central repository of family planning information (either living on or linked to the Health Connector website) that would enable women and providers to compare the contraceptive coverage for each plan and determine which plan best meets their or their clients' needs.
- Create website accessibility standards regarding family planning and contraception information to be met by each plan contracting with the Health Connector. For example, website search engines of the Commonwealth Care plans could be modified to enable contraception searches by brand, generic, and lay names (*e.g.*, Ortho Tri-Cyclen®, Tri-Sprintec, and "the pill").
- Aid clients in continuing to access care from a provider that they know and trust and that is close to where they live by modifying website search engines of the Commonwealth Care plans to include searches for providers by facility name/type as well as by provider name.

Ensure family planning clinics are included as a point of entry for clients seeking preventive health care. Family planning is an extremely cost-effective intervention and increased access to family planning will save health care dollars [18]. MDPH-funded family planning clinics have served as patient navigators, pharmacy-access coordinators, community educators, and cultural translators for low-income women. These agencies have long been instrumental in linking low-income women to insurance coverage or publicly subsidized care. However, family planning providers reported difficulty contracting with some Commonwealth Care plans, and reported administrative barriers to providing quality and accessible care. In order to ensure the highest quality of care and best access to family planning services for all patients, we recommend the following:

- Explore ways to support family planning providers' efforts to serve as the point of access for health insurance, family planning, and other primary care services for low-income women and families.
- Provide additional funding to MDPH-funded family planning programs, agencies, and clinics to provide insurance enrollment outreach and assistance and help newly insured clients navigate their health plans.
- Require all Commonwealth Care plans to contract with family planning providers.

Develop mechanisms to ensure that *all* populations at or under 300% of the federal poverty level have access to publicly funded family planning services. Our findings suggest that young women, undocumented immigrants, people whose primary language is not English, and people with erratic insurance status experience barriers to accessing affordable and confidential care under health care reform. At the same time, funding for publicly funded health programs that primarily serve these populations has decreased. While health care reform has increased the number of insured, some populations are still in need of publicly subsidized contraceptive services. Although we recognize the many challenges of addressing the lack of access to health care by these populations, we recommend the following:

- Ensure that populations "left out" of health care reform continue to have access to confidential, comprehensive family planning services.
    - Identify ways to ensure access to confidential family planning services for young women and others who need confidential care. This could be accomplished by continuing to support access through family planning clinics, and encouraging Commonwealth Care plans and other insurance plans to help women get family planning without notifying her family or the primary insured person in the household.
    - Include undocumented women in health care reform, including eligibility for Commonwealth Care. Or, if that is not possible, continue to fund family planning providers to deliver linguistically appropriate and culturally competent care.
    - Simplify the process for maintaining eligibility so women are not moving on and off the Commonwealth Care plans as frequently.
    - Provide more funding to family planning clinics so that they can provide services for women who are waiting to enroll or get confirmation on eligibility (through, for example, a presumptive eligibility system for family planning), or who cannot afford their copays or are otherwise uninsured for family planning (*e.g.,* their workplace policy does not cover family planning).
- Continue to fund family planning agencies to provide services for women "left out" of health care reform.

Expand access to and encourage continuous use of contraceptive methods by allowing women to receive multiple cycles of hormonal contraception, minimizing copays for contraception, and covering the full range of effective methods. In addition to our participants' reports, research evidence shows that consistent contraceptive use is improved when women are provided with more supplies of their chosen method (for example, giving multiple months' worth of hormonal contraception at once, rather than dispensing one month at a time) [33-35]. There are examples of this service delivery model among commercial insurance providers; many employer-sponsored insurance plans offer a mail-order pharmacy benefit where maintenance medications can be filled three months at a time for a reduced copay, and one of the existing Commonwealth Care plans offers 90-day supplies of medication when prescriptions are filled at select participating pharmacies. Also, cost of contraception can affect uptake and continuation; the majority of providers reported that the cost of contraception was prohibitive for many of their clients. Finally, a small number of women reported experiencing some difficulties with accessing their preferred contraceptive method; barriers to accessing the full range of effective contraceptive methods should be addressed. We recommend the following:

- Require all plans that contract with the Health Connector to dispense at least a three-month supply (ideally 12-month supply) of contraception at pharmacies and clinics.
- Identify innovative ways to keep contraception free or low cost such as coordinating bulk purchases of contraceptive methods and making all contraception "tier 1" (lowest copay) medications to minimize copays.
- Explore strategies to ensure that women have access to the full range of effective contraceptive methods, including encouraging Commonwealth Care and other insurance plans to provide non-prescription contraceptive methods such as condoms to their clients, particularly those who are low-income, at low or no cost. Ensuring the provision of information and access to highly effective, longer-acting methods, such as IUDs, should also be explored.

Continue research about low-income women's access to contraception and other reproductive health care services in the context of health care reform. This project has suggested a number of areas for future research, including:

- Assess the impact of health care reform on specific populations that have not been well served by health care reform: immigrants, young women, and people with erratic insurance status.
- Further explore the concrete and psychological benefits of health insurance coverage, including reduced stigma associated with being insured.
- Monitor contraceptive uptake, continuity of use, and unintended pregnancy for women on subsidized health programs and insurance plans.
- Continue to explore the difficulties patients experience accessing prescription contraception from the pharmacy.
- Evaluate the impact of reform on reproductive health care disparities, long-term reproductive health, and general health outcomes.
- Document the experiences of low-income women who are not currently receiving care from a family planning clinic, and asses access to and use of contraception among women who primarily access contraception through a primary care provider.
- Investigate the differences between publicly funded health insurance models (*e.g.*, MassHealth) and private health insurance models (*e.g.*, Commonwealth Care) and the effects these models have on participant satisfaction, access to health care, and health outcomes.

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Appendix I: Agency Self-Administered Survey Tables

Table 1: Demographic Characteristics of Agency Self-Administered Survey Respondents	
Gender, number (percent)	
Female	10 (100)
Age in years, mean (range)	46 (26-62)
Education,[28] number (percent)	
Bachelors	4 (40)
Graduate	6 (60)
Clinical Training	6 (60)
Years in health care, mean (range)	25 (4.5-38)
Years in agency, mean (range)	17 (1.5-37)

Table 2: Agency Practice and Funding Characteristics					
Number of clinics,[29] mean (range)	10.4 (1-53)				
Type of clinics administered,[28] number (percent)					
Community health center	4 (40)				
Freestanding family planning clinic	6 (60)				
Hospital	2 (20)				
Number of clients served in 200, mean; median (range)	7,849; 3,966 (2,200-29,000)				
Primary sources of funding, number (percent)					
Commonwealth Care plans	2 (20)				
Department of Public Health (DPH)	8 (80)				
Free Care/Uncompensated	1 (10)				
MassHealth	2 (20)				
Private health insurance	1 (10)				
Title X	1 (10)				
Commonwealth Plans accepted, number (percent)					
Boston Medical Center Health Net (BMC)	7 (70)				
Fallon	0 (0)				
Neighborhood Health Plan (NHP)	6 (60)				
Network Health	8 (80)				
Time, in days, to reimbursement from insurance plans, number (percent)	BMC	DPH	Mass Health	NHP	Network Health
0-30	2 (20)	4 (40)	1 (10)	0 (0)	2 (20)
31-60	3 (30)	3 (30)	6 (60)	3 (30)	3 (30)
61-90	1 (10)	0 (0)	1 (10)	1 (10)	2 (20)
91+	0 (0)	1 (10)	0 (0)	0 (0)	0 (0)
NR or NA[30]	4 (40)	2 (20)	2 (20)	5 (50)	3 (30)

[28] Respondents could select more than one choice.
[29] Some clinics might have been counted by more than one agency resulting in the double-counting of some clinics.
[30] NR: No Response, NA: Not Applicable.

Table 3: Perceptions of Client Characteristics					
% of patients in the last 12 months who were: number (percent)	0-25%	26-50%	51-75%	76-100%	NR
Low-income (≤300% FPL)	1 (10)	1 (10)	1 (10)	7 (70)	1 (10)
Minors (<18 years old)	4 (40)	3 (30)	2 (20)	0 (0)	1 (10)
New	3 (30)	6 (60)	1 (10)	0 (0)	0 (0)
Speakers of a language other than English	3 (30)	3 (30)	2 (20)	2 (20)	0 (0)
Transferred records to another provider	7 (70)	0 (0)	0 (0)	0 (0)	3 (30)
Women	0 (0)	0 (0)	1 (10)	9 (90)	0 (0)

Table 4: Perception of Coverage of Contraception and Abortion under Commonwealth Care Plans				
Number (percent)		BMC	Neighborhood	Network
Abortion	Yes	3 (30)	1 (10)	2 (20)
	No	0 (0)	0 (0)	0 (0)
	Unsure	4 (40)	5 (50)	4 (40)
	No Response	3 (30)	4 (40)	4 (0)
Sterilization	Yes	1 (10)	0 (0)	1 (10)
	No	0 (0)	0 (0)	0 (0)
	Unsure	5 (50)	6 (60)	5 (50)
	No Response	4 (40)	4 (40)	4 (40)
IUD (Mirena®, Paragard®)	Yes	5 (50)	4 (4)	6 (60)
	No	0 (0)	0 (0)	0 (0)
	Unsure	2 (20)	1 (10)	1 (10)
	No Response	3 (30)	5 (50)	3 (30)
Implants (Implanon®)	Yes	2 (20)	3 (30)	4 (40)
	No	1 (10)	0 (0)	0 (0)
	Unsure	3 (30)	2 (20)	2 (20)
	No Response	4 (40)	5 (50)	4 (40)
Injectables (Depo-Provera®)	Yes	5 (50)	5 (50)	6 (60)
	No	0 (0)	0 (0)	0 (0)
	Unsure	2 (20)	1 (10)	1 (10)
	No Response	3 (30)	4 (40)	3 (30)
Oral Contraception	Yes	5 (50)	5 (5)	6 (60)
	No	0 (0)	0 (0)	0 (0)
	Unsure	2 (20)	1 (10)	1 (10)
	No Response	3 (30)	4 (40)	0 (0)
Other hormonal methods	Yes	5 (50)	5 (50)	6 (60)
(Nuva Ring®, OrthoEvra®)	No	0 (0)	0 (0)	0 (0)
	Unsure	2 (20)	1 (10)	1 (10)
	No Response	3 (30)	4 (40)	3 (30)
Emergency Contraception	Yes	3(30)	3 (30)	3 (30)
(Plan B®)	No	1(10)	1 (10)	1 (10)
	Unsure	2 (20)	2 (20)	2 (20)
	No Response	5 (50)	5 (50)	5 (50)
Cervical barriers (diaphragm,	Yes	3 (30)	3 (30)	4 (40)
cervical cap)	No	1 (10)	1 (10)	1 (10)
	Unsure	3 (30)	2 (20)	2 (20)
	No Response	2 (20)	4 (0)	3 (30)
Non-prescriptive methods	Yes	2 (20)	1 (10)	2 (20)
(male & female condoms)	No	1 (10)	1 (10)	1 (10)
	Unsure	3 (30)	3 (30)	3 (30)
	No Response	5 (50)	5 (50)	5 (50)

Appendix II: Clinic and Agency Staff In-Depth Interview Tables

Table 1: Demographic Characteristics of In-Depth Interview Respondents	
Gender, number (percent)	
Female	16 (100)
Age in years, mean (range)	47 (28-65)
Education,[31] number (percent)	
High School	1(6)
Associates	1 (6)
Bachelors	6 (38)
Graduate	9 (56)
Clinical training	5 (31)
Years in health care, mean (range)	17 (2 -38)
Years in agency, mean (range)	9 (1-37)
Years in clinic, mean (range)	6 (0-20)

Table 2: Clinic Practice Characteristics	
Practice type, number (percent)	
Community health center	6 (38)
Freestanding family planning clinic	9 (56)
Hospital	1 (6)
Number of days practice open, mean (range)	5 (1-7)
Number of client seen per day, mean (range)	44 (5-200)
Number of clients seen per year, mean (range)	17,587 (500-80,000)
Provide the following services,[31] number (percent)	
HIV care	6 (38)
HIV testing	16 (100)
HPV vaccination	16 (100)
Other vaccinations	9 (56)
Primary care	7 (44)
STI screening/treatment	15 (94)

Table 3: In-Depth Interview Respondent Perceptions of Client Characteristics					
% of patients in the last 12 months who were: number (percent)	0-25%	26-50%	51-75%	76-100%	NR/DK
Minors	6 (38)	3 (19)	1 (6)	1 (6)	5 (31)
New in the last 3 months	8 (50)	3 (19)	0 (0)	0 (0)	5 (31)
Speakers of a language other than English	3 (19)	2 (13)	3 (19)	4 (25)	4 (25)
Women	0 (0)	1 (6)	5(31)	9(57)	1(6)

[31] Respondents could select more than one choice.

Appendix III: Focus Group Tables

Table 1: Demographic Characteristics of Focus Group Participants			
	Global	**English**	**Spanish**
Gender, number (percent)			
Female	52 (100)	23 (100)	29 (100)
Language of focus group, number (percent)			
English	23 (44)		
Spanish	29 (56)		
City of focus group, number (percent)			
Boston	31 (60)	13 (57)	18 (62)
Worcester	13 (25)	6 (26)	7 (24)
Lawrence	4 (8)	0 (0)	4 (14)
Springfield	4 (8)	4 (17)	0 (0)
Age in years, median[32] (range)	23 (21-63)	28 (21-51)	30 (21-63)
Education, number (percent)			
Less than high school	3 (6)	0 (0)	3 (10)
High School/GED	31 (60)	11 (48)	20 (69)
Associates	1 (2)	1 (4)	0 (0)
Bachelors	9 (17)	7 (30)	2 (7)
Graduate	6 (12)	4 (17)	2 (7)
No answer	1 (2)	0 (0)	1 (3)
Other	1 (2)	0 (0)	1 (3)

[32] The median is provided instead of the mean due to a skewed distribution in the ages of participants.

Table 2: Health Insurance Status and Contraceptive Use of Focus Group Participants			
	Global	**English**	**Spanish**
Health insurance,[33] number (percent)			
MassHealth[34]	28 (54)	8 (35)	20 (69)
Commonwealth Care	13 (25)	10 (43)	3 (10)
None	4 (8)	2 (9)	2 (7)
Private	4 (8)	3 (13)	1 (3)
No answer	4 (8)	1 (4)	3 (10)
Medicare	1 (2)	1 (4)	0 (0)
Don't know	1 (2)	0 (0)	1 (3)
Current contraceptive use,[33] number (percent)			
Sterilization	3 (6)	0 (0)	3 (10)
IUD	7 (13)	2 (9)	5 (17)
Implant	1 (2)	0 (0)	1 (3)
Injection	2 (4)	0 (0)	2 (7)
Pill	12 (23)	6 (26)	6 (21)
Ring	4 (8)	2 (9)	2 (7)
EC	1 (2)	1(4)	0 (0)
Diaphragm	1 (2)	0 (0)	1 (3)
Condoms	14 (25)	9 (39)	5 (17)
Rhythm method	2 (4)	2 (9)	0 (0)
None	12 (23)	4 (17)	8 (28)
Past contraceptive use,[33] number (percent)			
IUD	8 (15)	2 (9)	6 (21)
Implant	1 (2)	1 (4)	0 (0)
Injection	16 (31)	7 (30)	9 (31)
Pill	31 (60)	14 (61)	17 (59)
Ring	7 (13)	4 (17)	3 (10)
Patch	10 (19)	6 (26)	4 (14)
EC	9 (17)	6 (26)	3 (10)
Diaphragm	3 (6)	2 (9)	1 (3)
Sponge	1(2)	1 (4)	0 (0)
Cervical cap	1 (2)	1 (4)	0 (0)
Condom	28 (54)	17 (73)	11 (38)
Rhythm method	9 (17)	4 (17)	5 (17)
Spermicidal	1 (2)	1 (4)	0 (0)

[33] Respondents could select more than one choice.

[34] During the Spanish language focus groups, many participants who said they had MassHealth explained they had MassHealth Limited. MassHealth Limited is emergency medical coverage for noncitizens who are not eligible for other MassHealth programs because of their immigration status. The benefits provided under MassHealth Limited are free, but for emergency medical care only [36].

Appendix IV: Biographies of the Study Team

Kelly Blanchard, President of Ibis Reproductive Health, holds both a Master of Science in Population and International Health and a Bachelor's degree in social studies from Harvard. Ms. Blanchard held a Fulbright Scholarship in Ghana. Prior to joining Ibis, Ms. Blanchard worked at the Population Council as a Program Associate, where she managed a growing program on reproductive health in South Africa and the Southern Africa region. Her most recent research has focused on contraception, medical and surgical abortion, microbicides, and cervical barriers for HIV/STI prevention. Ms. Blanchard has authored or co-authored over 40 articles on reproductive health topics in developed and developing countries. In 2006 Ms. Blanchard won the Outstanding Young Professional Award from the American Public Health Association's Population, Family Planning and Reproductive Health Section. Ms. Blanchard is the recipient of the 2009 Darroch Award for Excellence in Sexual and Reproductive Health Research, sponsored by the Guttmacher Institute.

Jill Clark is the Assistant Director of the Family Planning Program at the Massachusetts Department of Public Health. She provides contract management and monitoring for family planning agencies including budgeting, site visits, routine reporting, and performance measures. Ms. Clark also leads initiatives on the integration of violence screening and HIV testing into family planning settings and research into the impacts of health care reform on family planning service provision and access. Previously, she was a Public Health Analyst at the Centers for Disease Control and Prevention, providing program support and technical assistance to 15 U.S. jurisdictions for prevention of mother-to-child transmission of HIV infection. Ms. Clark holds a Master of Public Health from Emory University and a Bachelor of Arts from Wesleyan University.

Denisse Córdova holds a Master of Public Health degree, with concentrations in Health Law and International Health, from Boston University, and a Bachelor of Arts degree in International Studies and French from the University of Miami. Her interests lie at the intersection of health and human rights, with a particular focus on immigrant rights issues. While at Ibis Reproductive Health, Ms. Córdova contributed to research on the impact of health care reform on low-income women's access to contraception in Massachusetts, low-income and immigrant women's experiences with self-induced abortion in the U.S., and providers' experiences obtaining public funding for abortions. She has also contributed to the design and implementation of a refugee health clinical rotation program for medical residents at Boston University Medical School and worked on a variety of advocacy and education efforts affecting refugee and immigrant communities in Florida and Massachusetts. Ms. Córdova is presently pursuing a Juris Doctor degree at the University of Pennsylvania Law School.

Amanda Dennis is a Project Manager at Ibis Reproductive Health. Among her current projects, Ms. Dennis is conducting in-depth interviews with abortion providers to document their experiences with obtaining funding for abortions under the federal Hyde Amendment. She is also conducting focus group discussions with low-income women to gauge their interest in obtaining hormonal contraception over-the-counter and to assess the impact that health care reform in Massachusetts has had on contraceptive access. Prior to joining Ibis, she worked as a counselor at an ambulatory surgery center specializing in second-trimester abortion care and as a counselor at a domestic violence shelter. Ms. Dennis holds a Bachelor of Arts from Hampshire College and a Master of

Bioethics from the University of Pennsylvania. She is presently pursuing her Doctorate in Public Health, specializing in social and behavioral aspects of health care, at Boston University.

Karen Edlund has been the Director of the Massachusetts Department of Public Health's Family Planning Program since 1992. In this position, she has developed and managed the state's family planning program, which provides clinical, and community education and outreach services in over 80 sites statewide. She has been responsible for developing and shaping the program standards and systems such as billing, reporting, monitoring, and evaluation. She has served as the Region I delegate to the national State Family Planning Administrators (SFPA) Steering Committee since 1996, serving as its Chair from 1998-2001 and receiving its SFPA Annual Award in 2002.

Prior to coming to the Department of Public Health, Ms. Edlund worked for Medicaid in a variety of roles including Director of the EPSDT program. Ms. Edlund has a background in maternal child health nursing with experiences in community health care settings such as the Visiting Nurses and Headstart. She began her health care career as an administrator/family planning counselor in a free clinic for women and children.

Ms. Edlund holds a Bachelor of Arts in Sociology from Boston University and a Bachelor in Science in Nursing from Boston College. She also received a certificate for Epidemiological Research in Women's Health from the New England Epidemiology Institute. In 1991, she was awarded the Commonwealth Citation for Outstanding Performance in the Massachusetts Performance Recognition Program.

Jennifer McIntosh is an Assistant Clinical Professor at Northeastern University in the Bouvé College of Health Science School of Pharmacy where she teaches on the U.S. health care system, health policy and advocacy, and the role of pharmacists in public health. She is also a pharmacy consultant to the Massachusetts Department of Public Health Family Planning Program. Previously Dr. McIntosh was a research assistant at the Women's and Children's Health Policy Center in Baltimore, Maryland. Dr. McIntosh received her Doctor of Pharmacy from the University of California, San Francisco, where she was awarded the Chancellor's Award for the Advancement of Women. She completed a pharmacy practice residency at the University of North Carolina Hospitals, Chapel Hill, and her Master of Health Science at the Johns Hopkins Bloomberg School of Public Health.

Lenore Tsikitas is a reproductive health educator, trainer, and program coordinator with over ten years of professional teaching experience. While pursuing a Master of Public Health degree at Columbia University, she worked on diverse initiatives including male involvement projects at the Young Men's Clinic in New York City and Instituto Promundo in Rio de Janeiro; and was awarded the 2005 Bernard Challenor Spirit Prize for Outstanding Community Building. As the Education and Clinical Operations Specialist at the Massachusetts Department of Public Health, she oversees state family planning contracts for clinical and educational services, works on statewide initiatives to promote healthy relationships and sexuality, develops health education materials and trainings, and monitors the impact of health care reform and other legislation intended to improve access to birth control and reduce health disparities in MA. She currently teaches a popular course entitled "Biology of Human Sexuality" at the Urban College of Boston.

Britt Wahlin is the Director of Development and Communications at Ibis Reproductive Health. Before joining Ibis in 2007, she was a consultant specializing in philanthropy and social-issue media. She spearheaded film-based public awareness campaigns for the nonprofit media organization, Active Voice, as well as helped secure foundation funding and new business for Active Voice campaigns on topics ranging from immigration and political asylum to gender equity in science. For Greater Boston Funders for Women and Girls, she planned events and led outreach and communications efforts to educate private foundations about the benefits of funding women- and girl-serving organizations. Previously, she was a program officer at the Women's Foundation of California, where she made grants to women's and girls' advocacy organizations, ran a program that taught leadership and philanthropy skills to young women, and directed a mentorship program for welfare recipients transitioning into the workforce. She has served on the boards of the Girls After School Academy in San Francisco, Sojourner Feminist Institute, and Women in Film & Video/New England, and has published articles in film, nonprofit, and feminist publications. She holds a Bachelor's degree in Modern Thought and Literature and a Master's degree in Humanities from Stanford University.