Use of Health Insurance Among Clients Seeking Contraceptive Services at Title X–Funded Facilities in 2016

CONTEXT: *As federal initiatives aim to fundamentally alter or dismantle the Affordable Care Act (ACA), evidence regarding the use of insurance among clients obtaining contraceptive care at Title X–funded facilities under ACA guidelines is essential to understanding what is at stake.*

METHODS: *A nationally representative sample of 2,911 clients seeking contraceptive care at 43 Title X–funded sites in 2016 completed a survey assessing their characteristics and insurance coverage and use. Chi-square tests for independence with adjustments for the sampling design were conducted to determine differences in insurance coverage and use across demographic characteristics and facility types.*

RESULTS: *Most clients (71%) had some form of public or private health insurance, and most of these (83%) planned to use it to pay for their services. Foreign-born clients were less likely than U.S.-born clients to have coverage (46% vs. 75%) and to use it (78% vs. 85%). Clients with private insurance were less likely than those with public insurance to plan to use their insurance (75% vs. 91%). More than one-quarter of clients not planning to use existing insurance for services indicated that the reason was that someone might find out.*

CONCLUSION: *Coverage gaps persist among individuals seeking contraceptive care within the Title X network, despite evidence indicating increases in health insurance coverage among this population since implementation of the ACA. Future research should explore the impact of altering or eliminating the ACA both on the Title X provider network and on the individuals who rely on it.*

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The national network of nearly 4,000 health care centers supported by Title X funding provides access to family planning and related preventive health care to about four million clients annually.[1] The Title X program was created in 1970 to help ensure that regardless of income, women and couples can obtain high-quality contraceptive services and related care, and remains the sole federal grant program dedicated to family planning in the United States. Title X funds are critical to providers' ability to offer free or reduced-cost care to family planning clients who do not have health insurance coverage, or who are unable to use their coverage.

Sites supported by Title X funds represent a diverse set of providers, ranging from affiliates of the Planned Parenthood Federation of America, and others that focus on sexual and reproductive health, to health departments and federally qualified health care centers (FQHCs), which provide family planning care as part of a broader range of primary health care services. These sites must meet high standards in the delivery of family planning care, ensuring that services are affordable, comprehensive, nonjudgmental, confidential, voluntary, evidence-based and respectful.[2] The contraceptive services provided by Title X–funded clinics in 2015 helped women avert nearly two million unintended pregnancies.[3]

Broad implementation of most of the health insurance reforms of the Affordable Care Act (ACA) in 2014 changed the landscape of health care nationally, increasing the proportion of individuals covered by some type of health insurance. Notably, the ACA's contraceptive mandate guarantees coverage of the full range of contraceptive methods and services without cost sharing for the individual. Between 2013 and 2015, the overall proportion of reproductive-aged women who were uninsured declined by 36%; the change has been attributed to increases in both Medicaid and private insurance coverage.[4] During this same period, a similar decrease in the proportion of clients who were uninsured was documented in a small sample of family planning providers across the United States.[5]

However, limited evidence exists to describe detailed patterns of insurance coverage among clients seeking reproductive health care since implementation of the ACA. The Family Planning Annual Report, released by the federal Office of Population Affairs, shows that in 2016, some 55% of clients seeking care at Title X–funded facilities were covered by either public or private insurance, but it does not document the extent to which these individuals used their coverage to pay for services.[1]

Prior to implementation of the ACA, a key reason for adolescents' not using existing health insurance to cover their services was confidentiality concerns,[6] and these concerns may have become relevant to other age-groups following the ACA, which expanded coverage for young people on their parents' insurance plans up to age 26. A

study using data from 2013–2015 indicated that one in 10 young women aged 18–25 and one in five aged 15–17 would not seek sexual and reproductive health care because of concerns that their parents might find out,[7] but we are aware of no comparable data on whether these concerns extend to patients seeking care at Title X–funded sites. Finally, although fluctuations in health insurance coverage, or "churn," can disrupt and inhibit access to health care broadly,[8,9] it is unclear how extensive this churn is among clients seeking care at Title X–funded sites.

As federal initiatives to fundamentally alter health insurance eligibility and service coverage are considered, evidence regarding how insurance has or has not been used for contraceptive care under the ACA, as well as information on potential gaps in coverage, is necessary to help inform future policy. Given the role that Title X–funded facilities play in providing low-cost or free services to individuals with limited resources, the objective of this study was to document insurance-related characteristics of clients seeking contraceptive care at these facilities across the country following implementation of the ACA. Specifically, we sought to identify characteristics associated with using, and with not using, existing health insurance to cover contraceptive-related care, and characteristics associated with, and reasons for, not having coverage for such care.

METHODS

Sample and Fieldwork

We began by selecting a sample of sites, drawn from a list of U.S. facilities that had participated in a 2015 nationally representative study of service availability. (We started with this sample because our experience with conducting client-level surveys highlighted the importance of working with highly responsive facilities to administer surveys.) The earlier study had sampled facilities from a database of all known publicly funded family planning centers,[10] which is regularly updated on the basis of the directories of Title X–funded clinics, Planned Parenthood affiliates, FQHCs and Indian Health Service units, as well as personal communications with Title X grantees, agency administrators and others. Facilities were eligible to be included in our sample if they were receiving Title X funding at the time of our study and served more than 20 contraceptive clients per week. To achieve a nationally representative sample of the network of Title X–funded facilities, we stratified the universe of eligible clinics by type (health department, Planned Parenthood, FQHC or other) and by whether facilities were in a state that had expanded its Medicaid program under the ACA by early 2015. Within each of the eight resulting categories, the facilities were sorted by state and randomly selected to reflect the most recent national proportions specific to type.

Sixty sites were initially selected from among the eligible clinics. We contacted facility managers at these sites first by mail or e-mail, and then by phone, to request their participation in the study. Facilities were replaced in the sample (by the next facility on the list within the same stratum) if an administrator refused to participate, or if they had closed or had lost Title X funding. Survey materials were sent to managers at facilities that met the inclusion criteria and agreed to participate.

Facility staff distributed the survey to all female family planning clients aged 15 or older, including women seeking STD or HIV testing, and excluding any patients receiving only prenatal care, infertility services or abortion services, as these services are not covered by Title X funding.* Fielding lasted for 1–3 weeks at each facility, depending on patient volume. Eligible clients were asked to complete the questionnaire and return it to the front desk staff in a sealed envelope to ensure privacy. Facility staff were asked to collect all completed questionnaires at the end of each week of fielding and to mail them, in their sealed envelopes, back to the study team in a prepaid envelope; they were also asked to include information about the total number of female family planning patients seen during that week, which we used to calculate response rates. As incentive for participation, sites were offered a $100 honorarium, and clients who completed the questionnaires were eligible to enter a facility-specific random drawing to receive a $50 gift card.

The final sample consisted of facilities that achieved the following thresholds at the end of the fielding period: at least 40 surveys, with at least 50% of the female family planning clients seen each week completing more than half of the items. Fielding periods were extended for sites that were unable to meet these criteria in their initial fielding period, but were interested in continuing and were likely to meet the criteria with additional time. We followed up with facility staff on a regular basis to guide them through the fielding process, to answer any questions and to facilitate provision of extra materials if necessary.

Between March and October 2016, some 2,911 women were surveyed at 43 facilities. Participating sites reported having served 4,104 family planning patients during the survey period; the overall client response rate was 71%. Of the 43 participating clinics, 24 were from our original sample of 60, and 19 were replacement clinics. The remaining 17 sites from the original 60, as well as their replacements, either attempted participation but failed to meet the threshold, were deemed ineligible, had an administrator who refused participation, or yielded no contact or response after seven or more phone calls or e-mails. The final clinic response rate was 72%.

Survey Instrument

The survey was developed on the basis of previous surveys, adapted on the basis of current literature, then pilot-tested at a busy urban Title X–funded family planning clinic and adjusted in response to clients' feedback. Clinic staff distributed the pilot survey to eligible clients

*In the initial protocol, clinic staff distributed the survey to all female clients. After a month, we discovered that most respondents were not eligible for the study because they were not seeking family planning services; thereafter, only family planning female clients were surveyed. Six sites fielded the survey under the original protocol; however, we used data only from respondents who were seeking family planning care.

TABLE 1. Percentage distribution of female contraceptive clients surveyed at Title X–funded facilities, by selected background characteristics, 2016

Characteristic	% (N=2,911)
Age	
<18	7
18–19	11
20–24	31
25–29	21
≥30	29
Parity	
0	54
≥1	46
Relationship status	
Married	16
Living with a partner	20
Not married or living with a partner	64
Income (as % of federal poverty level)	
<100	46
100–249	48
≥250	6
Insurance type†	
Public	40
Private	26
Other	5
Uninsured	30
Race/ethnicity	
White	44
Black	14
Hispanic	36
Asian	6
Other/unknown	1
Educational attainment	
<high school	19
High school graduate/GED	36
Some college/associate's degree	30
College graduate	16
Primary language spoken at home	
English	78
Spanish	15
Both English and Spanish	6
Other	1
Nativity	
U.S.-born	83
Foreign-born	17
Clinic type	
Health department	28
FQHC	19
Planned Parenthood	41
Other	12
Total	100

†Based on the 2,474 respondents who correctly followed the skip pattern on relevant survey questions. Public insurance comprises Medicaid, Medicare, TRICARE (military-related health care) and Indian Health Service coverage. Private insurance comprises employer-based plans and plans purchased on the marketplace or exchange. "Other" denotes that clients were unsure of or did not know their coverage type. *Notes*: The proportion of clients on whom data were missing was 10% for income and 0–3% for all other characteristics. Percentages may not sum to 100 because of rounding. FQHC=federally qualified health center.

at check-in; clients were offered a $5 voucher for public transportation in return for completing the survey and providing face-to-face feedback to research staff on the ease or difficulty of filling out the survey.

The final survey instrument, a four-page questionnaire, included primarily closed-ended questions regarding current contraceptive use, desired method, health care–seeking behaviors, insurance status over the past year and current insurance use. Insurance was categorized as private, public or none; private insurance included all employer-based plans and plans purchased on the marketplace or exchange, while public insurance included Medicaid, Medicare, TRICARE (military-related health care) and Indian Health Service coverage. Questions related to clients' social and demographic characteristics were also included. The questionnaire was available in English and Spanish at each site. Eligible clients received it at check-in when they arrived at the facility for their appointment; most commonly, they completed it in the waiting room prior to their appointment.

The final survey instrument and fielding protocols were approved by the federally registered institutional review board at the authors' institution.

Analysis

We followed a two-stage weighting approach to reflect the universe of female contraceptive clients served at Title X–funded family planning facilities in 2015.[3] First, we weighted respondents from each facility up to the site's total female caseload; then we weighted respondents up to the total female client caseload served at all sites within the facility's stratum (type and state Medicaid family planning expansion status). Chi-square tests for independence were performed to assess differences between the study sample and the national population of clients seeking care at Title X–funded facilities,[11] and differences in outcomes across demographic characteristics and facility types; results were deemed statistically significant at the $p<.05$ level. Proportions and p values based on fewer than five responses were suppressed.

Some 437 respondents (15%) failed to correctly follow the skip pattern associated with a series of questions on current insurance coverage; we excluded them from our analysis of insurance-related outcomes, because we could not adequately interpret their insurance status.* For outcome variables that were particularly relevant to clients younger than 20, such as reasons related to confidentiality, cell sizes for older clients were small; in these cases, we limited the sample to clients younger than 30 in the two age-groups for which we had sufficient data (younger than 20 and 20–29). All analyses were executed in Stata version 14.2.

RESULTS

Sample

Half of the 2,911 survey respondents were younger than 25, and one-third were married or living with a partner (Table 1). Forty percent of those with valid insurance data reported being covered by public insurance; 26% reported

*Compared with those who were included in the insurance analyses, respondents omitted from the analyses had lower income and less education and were more likely to be nonwhite, foreign-born, non–English-speaking and uninsured.

having private insurance, 5% had other insurance and 30% had no health insurance at all. Some 44% of women were white; 36% were Hispanic, 14% were black, 6% were Asian and 1% were of some other race. The majority had at least a high school education (82%), spoke English at home (78%) and were U.S.-born (83%). Twenty-eight percent of women sought contraceptive services at a health department, 19% at an FQHC, 41% at a Planned Parenthood clinic and 12% at some other type of clinic. The sample was broadly similar to the population of female contraceptive clients who received care at Title X–funded clinics according to the 2015 Family Planning Annual Report;[11] the exception was that in our sample, a higher proportion of women were aged 20–24 and a lower proportion were black.

Health Care–Related Services

Most respondents were returning clients (82%—Table 2); respondents were more likely to be insured than uninsured (85% vs. 77%), and were more likely to be seeking care at health departments than at other clinic types (92% vs. 77–84%). Most women sought contraceptive care (63%), and this was the case regardless of insurance status or facility type.

Reported reasons for visiting the interview site most commonly related to its familiarity (70%) and quality and convenience (59%); sizable proportions of clients also identified reasons related to affordability (50%) and availability of services (45%). Compared with clients who had health insurance coverage, those without coverage more commonly identified facility recommendations (22% vs. 16%) and reasons related to affordability (59% vs. 51%) and service availability (53% vs. 41%), and less commonly cited previous experience at the site (57% vs. 66%). Younger women more commonly cited confidential services as a driver for visiting than did their older counterparts—37% of clients younger than 20 reported this reason, compared with 28% of 20–29-year-olds and 21% of clients aged 30 and older (p=.01; not shown).

Reasons for visiting the facility also differed by where clients were seeking care. Compared with clients at other types of facilities, those at FQHCs less commonly identified confidentiality of services (19% vs. 24–34%), free or low-cost services (26% vs. 34–44%) and reasons related to availability

TABLE 2. Percentage of female contraceptive clients surveyed at Title X–funded facilities, by selected health care–related characteristics, according to insurance status and facility type

Characteristic	Total	Insurance status		Facility type			
		Insured	Uninsured	Health department	FQHC	Planned Parenthood	Other
Returning client	82	85	77***	92	84	77	79***
Primary purpose of this visit							
Contraception	63	63	64	71	60	58	60*
Annual gynecologic exam	15	14	14	13	18	13	21*
STD service only	14	14	15	10	12	19	11*
Other	9	9	7	6	11	9	8*
Reasons for visiting this site†							
Familiarity	70	75	70	69	71	70	70
Have been here before	60	66	57***	64	61	58	56
Facility was recommended	17	16	22**	11	14	20	25*
Quality/convenience of care	59	64	60	55	55	62	61
Location is convenient	41	44	39	37	43	42	40
Services are confidential	28	30	31	24	19	34	29***
Staff are respectful	42	46	45	40	38	44	48
Facility offers referrals	14	15	16	14	14	13	19
Affordability	50	51	59**	44	49	53	55
Can get free/low-cost services	37	31	58***	34	26	44	38*
Can use insurance	26	39	4***	19	37	23	33*
Available services	45	41	53*	50	33	47	45***
Only place that offers needed services	24	18	34***	28	15	26	22***
Offers desired contraceptive method	28	28	32	31	21	29	30*
Offers adolescent/young adult services	10	9	13	8	3	13	12**
Health care–seeking in past 12 months							
Got broad health care at this facility only	60	54	65***	62	64	58	62
Did not seek any family planning care	55	51	57*	46	63	57	57***
Reasons for not seeking family planning care†							
No need for these services	55	58	60	50	52	62	46
Had annual gynecologic exam	18	20	12	23	16	15	22
Could not afford to	12	8	17*	14	13	9	20
Did not want partner/family to find out	5	4	5	5	u	7	2
Not comfortable seeing a provider for these services	4	4	4	5	u	4	4
Too inconvenient	4	4	3	5	u	4	5
Other	7	8	5	5	13	5	10

*Percentages by insurance status or facility type differ at p≤.05. **Percentages by insurance status or facility type differ at p≤.01. ***Percentages by insurance status or facility type differ at p≤.001. †Among clients who had not received family planning care at any facility in the past 12 months; respondents could select more than one option. *Notes*: The proportion of clients on whom data were missing was 7% for receipt of family planning health care from any facility and 0–3% for all other characteristics. FQHC=federally qualified health center. u=unavailable.

(33% vs. 45–50%) as driving their visit. Clients at FQHCs and "other" types of facilities more commonly reported being able to use insurance at these sites as a reason for visiting (37% and 33%) than did clients at health department and Planned Parenthood clinics (19% and 23%). Clients at health departments and FQHCs cited recommendations about the facility as a reason for visiting less commonly than clients at Planned Parenthood and other facilities (11–14% vs. 20–25%).

For most clients in the sample (60%), the site where they were currently seeking care had been the only source of broader health care over the past year; this was more likely to be true for uninsured clients than for insured ones (65% vs. 54%). This outcome did not differ by clinic type. Some 55% of clients had not received any family planning care in the past year; lack of care was more commonly reported by uninsured clients than by insured clients (57% vs. 51%), and by those at an FQHC than by those at other types of clinics (63% vs. 46–57%). Among clients who had not sought family planning care, the most commonly reported reason was lack of need (55%). One in 10 had not been able to afford to seek care, and this reason was more prevalent among clients with no health insurance coverage than among those with coverage (17% vs. 8%). Also, among those who had not received family planning care in the past year, clients younger than 20 were more likely than those aged 20–29 to cite not wanting a partner or family member to find out as a reason for not seeking family planning care (23% vs. 2%, p<.001; not shown).

Health Insurance Status and Use

The majority of clients surveyed, 71%, were insured at the time of their visit (Table 3). Coverage was more commonly reported among women with the highest incomes than among those in other income groups (86% vs. 68–72%), among white and black women than among Hispanic women and those of other races (81% for each vs. 55–63%), and among U.S.-born than among foreign-born women (75% vs. 46%). Most insured women (83%) planned to use their insurance to pay for the clinic visit. Hispanic clients and those of other races were less likely than whites or blacks to plan to use their insurance for the visit (65–78% vs. 84–88%). Foreign-born women were less likely than U.S.-born women, and women with private insurance were less likely than those with public insurance, to report that they planned to use their insurance (78% vs. 85% and 75% vs. 91%, respectively). The most common reasons given by insured clients for not using their coverage were that the services they were going to receive were not covered under their plan (31%) and that someone might find out about their visit (28%). Concern over someone's finding out about the visit was more commonly reported by insured clients younger than 20 than by those aged 20–29 (53% vs. 20%);* it was also more prevalent among privately insured clients than among publicly insured ones (31% vs. 17%). Compared with their younger counterparts, clients aged 30 and older more commonly said that they did not use their existing insurance because it "can't be used here" (38% vs. 8–14%) or the "deductible or copay is too high" (29% vs. 2–19%).

Seventy-one percent of surveyed clients said their insurance status had remained stable throughout the previous year—that is, they had had either steady coverage (58%) or a complete lack of coverage (13%). Steady coverage was more commonly reported by white and black clients than by Hispanic clients and those of other races (66–67% vs. 44–46%), and by U.S.-born than by foreign-born clients (60% vs. 41%). A complete lack of coverage was more common among clients in the lower income categories than among those with the highest incomes (12–16% vs. 4%), among Hispanic clients than among those of any other race (21% vs. 8–17%) and among foreign-born clients than among U.S.-born ones (34% vs. 10%).

Among those who were uninsured at the time of the survey, half had attempted to get insurance at some point during the previous 12 months; the reason these clients most commonly reported for not being able to get insurance was lack of affordability (42%). Younger, low-income, Hispanic and foreign-born clients were more likely than others to report not having tried to get insurance. The most common reasons women gave for not having tried to get insurance were that they had thought it was too expensive (26%) and they had not known how to obtain it (26%). Clients younger than 20 cited the need for parental involvement more commonly than did clients aged 20–29 (37% vs. 7%). Some 35% of uninsured clients wrote in other reasons for having been unable to obtain coverage, and 23% wrote in other reasons for not having tried to get it. These reasons often included timing (not shown); for instance, clients had recently lost their insurance, had not yet had a chance to try to become insured, or had recently tried to get insurance but could not yet confirm that they were insured.

One in four clients surveyed had lost insurance coverage at some point in the previous year. Compared with clients younger than 20 and those aged 30 and older, clients aged 20–29 more commonly reported losing insurance (30% vs. 16–22%). Those identifying as Hispanic or some other race reported losing insurance in the past year more commonly than whites and blacks (31–34% vs. 20–23%). A higher proportion of clients with no insurance than of those with private or public insurance reported having lost coverage (50% vs. 14–19%). The two most common reasons for having lost insurance were that a big life change had occurred (cited by 40% of those who had lost coverage) and that the plan had been canceled (22%). Black clients identified a big life change as a reason for losing insurance less commonly than clients who were white, Hispanic or of some other race did (25% vs. 33–49%), and clients who were black, Hispanic or of some other race more commonly identified plan cancellation as a reason for insurance loss than did white clients (17–34% vs. 10%). Clients with private insur-

*Because the ACA allows parents to include dependents up to age 26 in their coverage, we also examined the proportion of insured respondents aged 20–26 who reported confidentiality concerns as a reason for not using existing coverage to pay for services; 25% reported this as a reason.

TABLE 3. Percentage of female contraceptive clients surveyed at Title X–funded facilities, by selected health insurance–related characteristics, according to selected background characteristics

Insurance-related characteristic	Total	Age			Income (as % of federal poverty level)		
		<20	20–29	≥30	<100	100–249	≥250
Current status and use							
Insured	71	79	70	67	68	72	86*
Insured, plan to use insurance at visit	83	75	84	90	86	81	88
If insured, reasons for not using†							
Service not covered	31	27	38	18	25	31	25
Someone might find out	28	53	20**	na	32	27	u
Cannot use my insurance here	16	8	14	38**	20	13	37
Deductible or copay too high	14	2	19	29***	9	20	15
Other	27	17	32	16	25	28	u
Status within past 12 months							
Insured throughout	58	66	54	60	56	59	76
Uninsured throughout	13	13	12	15	16	12	4***
If uninsured, tried to get insurance	49	33	55	48**	43	59	63**
If uninsured, reasons unable to get†							
Could not afford it	42	49	38	50	36	53	19*
Too complicated	12	35	11	7**	7	16	u
Lacked paperwork	9	u	12	6	15	7	u
Made too much money	9	9	11	7	3	15	u
Other	35	29	38	34	38	35	56
If uninsured, did not try to get insurance	51	67	45	52**	57	41	37**
If uninsured, reasons for not trying to get†							
Seemed too expensive	26	16	32	22	16	38	50***
Did not know how	26	35	26	20	28	18	u
Immigration status	17	u	19	24	20	13	u
Parents would have had to sign up‡	10	37	7***	na	9	11	u
Did not want or need	7	9	7	8	5	9	u
Lacked paperwork	6	u	4	9	9	4	u
Made too much money	6	u	6	8	8	4	u
Other	23	21	30	11**	17	26	u
Lost insurance	25	16	30	22**	25	26	19
If lost insurance, reasons†							
Had a big life change	40	32	36	55	39	39	75
Plan was canceled	22	28	22	17	25	20	u
Could no longer afford	14	10	13	18	13	11	23
Aged out of parents' plan‡	10	22	11	na	8	10	17
Made too much money	9	5	10	9	5	12	u
Lacked paperwork	4	u	4	4	3	5	u
Other	16	25	15	12	20	13	26
If lost insurance, months insured							
<1	11	16	10	10	8	14	u
1–3	21	14	22	22	22	22	16
4–6	35	39	35	34	43	29	39
7–12	33	32	32	34	28	35	39

Table continues

ance more commonly cited affordability as a reason for losing it than did clients with public or no insurance (30% vs. 5–14%). Among clients who had lost insurance within the previous year, one-third had been covered for the majority of the year, and the same proportion had been covered for three or fewer months.

DISCUSSION

In 2016, the majority of U.S. women obtaining contraceptive care at Title X–funded facilities reported having some form of health insurance coverage; most insured clients used their coverage for these services. However, our findings help to shed light on fluctuations and gaps that occurred in this coverage over the previous year and that would be missed by single point-in-time measures of coverage. Although much of the focus in discussions of the ACA has been on how best to improve private health insurance coverage, our findings regarding clients' reasons for not using their existing coverage highlight that improvements to public health insurance coverage through Medicaid are just as critical to ensuring affordable, high-quality, comprehensive coverage.

The importance of improving both private and public health insurance to ensure full contraceptive coverage is underscored by the findings that some clients did not use their insurance because their services were not covered or the out-of-pocket cost was too high. Although some of these clients may have been enrolled in "grandfathered" insurance plans, and thus not guaranteed full coverage of contraceptive care without cost sharing, others may have been subject

TABLE 3 (continued)

Insurance-related characteristic	Race/ethnicity				Nativity		Insurance type§		
	White	Black	Hispanic	Other	U.S.- born	Foreign-born	Public	Private	None
Current status and use									
Insured	81	81	55	63***	75	46***	na	na	na
Insured, plan to use insurance at visit	88	84	78	65***	85	78*	91	75***	na
If insured, reasons for not using†									
Service not covered	32	u	38	40	28	40	42	24	na
Someone might find out	35	u	22	41	29	u	17	31*	na
Cannot use my insurance here	11	25	21	u	15	u	21	14	na
Deductible or copay too high	18	u	12	u	17	u	u	22	na
Other	18	45	25	19	26	u	25	27	na
Status within past 12 months									
Insured throughout	67	66	44	46***	60	41***	76	81	na
Uninsured throughout	9	8	21	17***	10	34***	na	na	na
If uninsured, tried to get insurance	56	79	40	57***	56	32***	na	na	na
If uninsured, reasons unable to get†									
Could not afford it	49	45	36	43	46	26	na	na	na
Too complicated	14	u	12	u	13	9	na	na	na
Lacked paperwork	8	u	14	u	8	14	na	na	na
Made too much money	13	18	5	u	12	u	na	na	na
Other	36	31	32	61	36	26	na	na	na
If uninsured, did not try to get insurance	44	21	60	43***	44	68***	na	na	na
If uninsured, reasons for not trying to get†									
Seemed too expensive	43	41	17	30	36	10***	na	na	na
Did not know how	13	29	29	36	23	28	na	na	na
Immigration status	u	u	29	u	u	49	na	na	na
Parents would have had to sign up	13	u	10	u	15	u	na	na	na
Did not want or need	3	u	8	u	9	u	na	na	na
Lacked paperwork	u	u	8	u	4	8	na	na	na
Made too much money	4	u	7	u	5	7	na	na	na
Other	28	26	19	u	25	18	na	na	na
Lost insurance	20	23	31	34*	25	23	19	14	50***
If lost insurance, reasons†									
Had a big life change	49	25	33	48*	40	35	34	40	43
Plan was canceled	10	21	34	17***	22	16	21	24	22
Could no longer afford	14	20	12	u	14	15	5	30	14***
Aged out of parents' plan	12	6	7	21	10	u	8	8	12
Made too much money	7	21	7	u	8	14	15	6	6
Lacked paperwork	2	u	6	u	3	u	6	u	3
Other	19	15	14	10	17	u	16	12	15
If lost insurance, months insured									
<1	7	14	15	u	11	15	12	8	12
1–3	19	19	25	13	21	18	15	39	19
4–6	41	43	26	40	37	20	45	27	30
7–12	33	24	34	38	31	47	29	26	39

*Percentages by age, income, race or ethnicity, nativity or insurance type differ at p≤.05. **Percentages by age, income, race or ethnicity, nativity or insurance type differ at p≤.01. ***Percentages by age, income, race or ethnicity, nativity or insurance type differ at p≤.001. †Respondents could select more than one option. ‡Analysis was limited to clients younger than 30 in chi-square test for independence between survey item and age. §Excludes 113 respondents who indicated that they had another type of insurance. *Notes:* Analysis of insurance data is based on the 2,474 respondents who correctly followed the skip pattern on relevant survey questions. The proportion of clients on whom data were missing was 22% for intended insurance use, 18% for insurance status over past year and 0–3% for all other characteristics. u=unavailable. na=not applicable.

to some lag in the full adoption and implementation of the guarantee on the part of their provider or health plan issuer. Still others may have had misconceptions about their coverage, perhaps because of misunderstandings or inaccurate or unclear communications among patient, provider and health plan. That a higher proportion of publicly insured clients than of privately insured ones planned to use their coverage to pay for services may point to greater concerns among the latter group regarding cost sharing.

More broadly, our findings echo those of previous research that underscores the importance of Title X–funded facilities to women's reproductive health.[11] That the site where the women received family planning care was the sole source of broad health care for the majority highlights the role that Title X–funded centers can play as a gateway to care for a wide range of health issues.

In addition, our findings identify population groups among clients of Title X–funded facilities that are less likely than others to have health insurance coverage or to use existing coverage. Mirroring broader trends,[12] foreign-born clients reported lower levels of insurance coverage and, among those with no coverage, fewer attempts to obtain it

in the past year than U.S.-born women. Among those with coverage, foreign-born clients were less likely to use it to cover contraceptive services. Myriad legal and policy barriers prevent many immigrants from obtaining affordable health insurance coverage. Many immigrants who are otherwise eligible for Medicaid are barred from obtaining coverage for the first five years after becoming legal residents; individuals granted Deferred Action for Childhood Arrivals status and undocumented immigrants are ineligible for public coverage or coverage on the ACA's health insurance marketplaces.[13] Some immigrant women attending Title X–funded clinics who have coverage but choose not to use it may be experiencing real or perceived threats of action against themselves or their family members because of their immigration status, and others may be experiencing language and other logistical barriers.[14]

Confidential services are especially important to younger clients, given their increased desired for privacy and autonomy.[15] Most clients younger than 20 with no insurance coverage had not even tried to obtain coverage in the past year, primarily because they had not wanted their parents to be involved or because they simply had not known how to do it. Over half of younger clients with insurance indicated that they would not use it to cover the services because of confidentiality concerns. These concerns can have implications far beyond the client level, as Title X–funded facilities must step in to cover the costs of services for clients who do not have or do not use coverage for care.

The confidential nature of the services received at Title X–funded facilities is important not just to the youngest clients; more than one-quarter of clients of all ages flagged it as a reason for seeking care at a specific site. Of note, a far lower proportion of clients seeking care at an FQHC than of those seeking care at other types of Title X–funded facilities cited this as a reason. Although all sites receiving Title X funding are held to the same standards of care for providing confidential services, clients who are particularly concerned about confidentiality may seek services at sites that they perceive to be better equipped to protect their privacy in regard to reproductive health issues—sites that specialize in providing reproductive health care, such as Planned Parenthood facilities.

A few years after the implementation of the ACA, most clients reported having had continuous health insurance coverage over the previous year. For those who had been unable to obtain coverage, cost had been the primary barrier; only a small proportion indicated that the process had been too complicated. Enrollment assistance programs may be helping to ease the application process for those who try; however, our findings that half of clients without coverage in the past year had not even tried to obtain it and that one-quarter of these had not known how to obtain it indicates that more work needs to be done to reduce barriers to securing coverage. Our findings reveal that health insurance coverage can change over a relatively short period, highlighting the necessity for providers to regularly ask about patients' coverage status, a strategy that will also ensure that providers are reimbursed for services delivered to patients who may be newly covered.

Limitations

This study is subject to some limitations. Although the study design aimed to achieve a nationally representative sample of female clients seeking family planning services at Title X–funded facilities, we were unable to determine how closely our final sample aligned with the national profile on the measure of insurance status, given the inclusion of male clients in the Family Planning Annual Report's national data on income and insurance coverage.[11] In light of the focus of this study on insurance-related characteristics of clients and the difficulties many respondents had in correctly completing the insurance-related questions, our findings may underrepresent the impact of insurance coverage on some of our outcomes of interest and should therefore be interpreted with caution.

Conclusion

The progress that has been made in helping people to obtain affordable family planning care has been jeopardized by attempts by the current Congress and presidential administration to roll back major coverage provisions of the ACA, including the contraceptive coverage guarantee, and to undermine Title X.[16] These threats are especially acute for underserved populations, such as low-income, immigrant and young clients—groups who are particularly in need of the care provided through the family planning safety net.[17] If currently insured individuals seeking care in the Title X system lose health insurance coverage, demands on the system will increase substantially; this, taken in tandem with policy threats to eliminate or fundamentally alter the Title X program, suggests that people's access to contraceptive services may decrease substantially in the future. Efforts are needed to understand the impact of such restrictive policy changes both on the Title X provider network and on the women who rely on it for high-quality care nationwide.

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