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The *Other* Women's Preventive Health Services Benefits

By Dana Thomas

This is the first of two articles highlighting several of the Affordable Care Act's (ACA) preventive health services now available to women with commercial insurance at no additional cost-sharing – and their importance to family planning providers and the women they serve.

On August 1, 2012, NFPRHA celebrated women gaining guaranteed insurance coverage of comprehensive family planning, including all FDA-approved contraceptive methods, contraceptive counseling, and at least one annual well-woman visit. As the benefit becomes part of health plans across the country, there are several other preventive health benefits made available as a result of the ACA that are important to the provision of family planning services. In addition to the eight services recommended for women by the Institute of Medicine's (IOM) Committee on Preventive Services for Women ("the committee"), there are several recommended by the United States Preventive Services Task Force (USPSTF) that have a direct impact on sexual and reproductive health. This article will discuss a few of the preventive health services recommended by the committee.

Intimate Partner Violence Screening and Counseling

Breaking with many health care reviewing bodies and most current insurance plans, the US Department of Health and Human Services (HHS) adopted the committee's recommendation that women should have coverage of annual screening and counseling for interpersonal and domestic violence (IPV).[1] The recommendation was a result of gaps the committee identified in the ACA-related benefit categories and in existing guidelines and recommendations. The committee did point out that USPSTF's 2004 review of IPV screening found little evidence to recommend for or against screening of women because of a "lack of evidence that screening for intimate partner violence in primary care settings reduces adverse health outcomes, including premature death."[2] Despite the USPSTF, the committee noted that IPV interventions typically exist outside of the health care delivery system and therefore there is little research or evidence to evaluate the effectiveness of screening for violence in mainstream health care delivery. The committee also noted in its review that more recent evidence suggests that screening does correlate with lower rates of abuse and improved health outcomes.

IPV Recommendation: *The committee recommends for consideration as a preventive service for women: screening and counseling for interpersonal and domestic violence. Screening and counseling involve elicitation of information about current and past vio-*

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[1] Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*, (Washington, DC: Institute of Medicine, July 2011).

[2] Ibid. At the time of this writing, USPSTF was in the process of updating its IPV recommendation.

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lence and abuse from women and adolescent girls in a culturally sensitive and supportive manner to address current health concerns, prevent future health problems, and provide for the woman or girl's safety.[3]

Unlike the seven other services recommended by the IOM committee, the IPV screening and counseling recommendation is primarily directed at providers. IPV screening is not a service that women routinely seek, thus clinicians and other health care workers will largely bear the responsibility of ensuring that women access the benefit – a recognition that resonates strongly with women's health providers. According to the American Congress of Obstetricians and Gynecologists, "[women's health providers] are in the unique position to provide assistance for women who experience IPV because of the nature of the patient-physician relationship and the many opportunities for intervention that occur during the course of an annual examination, family planning, pregnancy and follow-up visits for ongoing care."[4] Moreover, while women of every socioeconomic and demographic experience IPV, it is most prevalent in women of reproductive age and has a direct impact on the family planning needs of that population. Women experiencing IPV tend to have higher rates of unintended pregnancy and report higher incidences of birth control sabotage. The link between unintended pregnancy and IPV emphasizes the role of family planning providers as the first and sometimes only health care intervention for women in violent relationships.

Although many family planning providers currently can and do screen for IPV, the coverage requirement presents some challenges, both structurally and culturally. The prevailing structural challenge of required IPV screening has been the uncompensated cost associated with the service. In the past, public and private insurance plans rarely covered IPV screening or the ancillary services women needed to transition away from their abusers, including mental health and substance abuse services. As a result, mission-driven agencies suffered the financial hit associated with the screening and struggled to link women with additional IPV resources. As a 2000 report published by Futures Without Violence noted, victims of violence "may need service[s] beyond the treatment of physical injuries, such as risk assessment, counseling, safety planning and referral outside of the health care system," which without adequate reimbursement proves expensive for providers required to do more with less.[5] The committee's coverage recommendation is intended to solve the reimbursement problem in private insurance but HHS has left it to insurers to develop the coverage details for the IPV benefit. Thus insurers could decide to cover the screening and counseling and no additional IPV-related services. To actually achieve fewer health problems and deaths related to IPV, HHS should require plans to cover both the IPV screenings and the breadth of services that women in violent relationships might need to transition away from their abusers.

Providers will also face the cultural challenge associated with engaging women in personal and often uncomfortable conversations about partner violence. Studies show that while women's health providers recognize the value of IPV screenings, they have anxieties about being able to provide culturally appropriate screening and feel ill-equipped to help women address problems with partner violence.[6] As HHS begins to educate the consumer and provider communities about the IPV screening coverage, it is imperative that women's health providers be given the support and the resources required to empower them to confidently and effectively deliver these services.

Sexually Transmitted Infections and Human Immunodeficiency Virus Infection Screening

Unlike IPV screening, which is relatively new to most insurance coverage, the committee's recommendation for services related to sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) strengthens and builds on current insurance coverage of disease management. The committee noted that current USPSTF screening guidelines applicable to both STIs and HIV are tied to certain high-risk populations and silent on women without risk factors. In the case of STI screening, USPSTF's recommendations link specific diseases to women in a certain age range with a defined sexual history. For example, USPSTF recommends syphilis counseling only for "commercial sex workers, people who exchange sex for drugs and incarcerated persons."[7] Similarly, USPSTF recommends HIV counseling and screening only for pregnant women and high-risk adolescents and adults.[8] The committee concluded that USPSTF's limitations in scope left coverage gaps for millions of women who could benefit from more frequent STI counseling and HIV screening.

STI Counseling Recommendation: *The committee recommends for consideration as a preventive service for women: annual counseling on sexually transmitted infections for all sexually active women.*

The STI counseling recommendation is a long-awaited change in insurance for family planning providers. Understanding the need to reduce incidences of disease, publicly funded fam-

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[3] Ibid.

[4] American College of Obstetricians and Gynecologists, Intimate Partner Violence. Committee Opinion No. 518, Obstet Gynecol 2-12: 119:412-2, http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co518.pdf?dmc=1&ts=20120806T2026248949.

[5] William Rudman Ph.D., *Coding and Documentation of Domestic Violence*, Futures Without Violence, formerly the Family Violence Prevention Fund, December 2000, accessed October 2012, http://www.futureswithoutviolence.org/userfiles/file/HealthCare/codingpaper.pdf.

[6] Alexis Marbach, "New Research Available on Barriers to Screening for Intimate Partner Violence," *Prevent Connect (blog)*, August 20, 2012, accessed October 2012, http://preventconnect.org/2012/08/new-research-available-on-barriers-to-screening-for-intimate-partner-violence/.

[7] Institute of Medicine, *Clinical Preventive Services for Women: Closing the Gaps*.

[8] Ibid.

ily planning providers have routinely counseled women and men on STIs and the importance of prevention, often without compensation or with a patchwork of federal family planning and STI program dollars. The committee's recommendation will strengthen the ability of family planning providers to meet the outsized demand for STI prevention services. The growth in access should eventually translate into better public health outcomes, lower incidence of disease, and reduced health disparities.

The level of STI coverage in commercial plans is not yet clear and is most likely to vary across plans. Most health plans typically cover STI treatment and will continue to do so under the ACA. However, many states are negotiating the composition of their essential health benefits packages and the integration of health plans with provider networks. A plan could impose medical management techniques on STI treatments akin to restrictions imposed on other prescription services, which may be inappropriate for women needing multiple treatments. Plans could also limit patient access to sexual and reproductive health providers that have experience with screening and treating STIs. To guarantee access to comprehensive STI services, HHS and states should incentivize health plans to offer a comprehensive scope of STI services to adequately ensure that the coverage changes achieve their intended public health goals.

Moreover, without extending the coverage requirement to Medicaid plans, the impact on patients being seen in the family planning setting could be minimal. More women will have access to the counseling available in commercial insurance while the Medicaid coverage of STI counseling, testing, and treatment is falling behind. In 2009, 11 states covered STI testing in their Medicaid programs, nine covered the treatment, and counseling was even less accessible.[9] Since a number of women seen in the family planning setting will be Medicaid beneficiaries or uninsured, commercial coverage of STI counseling may have little impact on the network's health outcomes or STI rates. Without parity of the counseling coverage in Medicaid, many women in need of STI counseling will go without. If the goal is to reduce transmission across patient populations, HHS should advance policies that ensure publicly insured women have the same access to the STI screening afforded to privately insured women.

HIV Counseling and Screening Recommendation: *The committee recommends for consideration as a preventive service for women: counseling and screening for HIV infection on an annual basis for sexually active women.*

Like coverage of STI counseling, the HIV counseling and screening coverage requirement is an important advancement in HIV prevention. It is no secret that health plans have been deficient in their coverage of HIV care – often limiting prescriptions, capping benefits at certain levels or, in the most egregious of circumstances, refusing to cover individuals living with HIV or the services needed to treat the disease. Although insurers may have covered HIV counseling in the past, barriers to HIV counseling and the general discriminatory treatment of the disease by the health care system have undoubtedly impacted the number of women counseled and tested. The coverage change could make significant strides towards reducing stigma associated with HIV and enable all sexually active women to get routine counseling and screening for HIV.

Like IPV screening, realizing the benefits of HIV counseling and screening will depend in large part on family planning systems and other providers delivering the care. Patients regularly report not seeking out HIV services because of fear of discrimination and the stigma associated with the disease.[10] Many providers similarly report concerns with being able to adequately treat and support people living with HIV. In a recent study, researchers found some physician resistance to the Centers for Disease Control and Prevention's recommendation to screen all patients between the ages of 13 and 64 for HIV. In addition to a perceived lack of risk for some patients, the barriers reported included lack of knowledge and training, concerns about cultural competency and offending patients, resistance to the pretest counseling requirements, and concerns with treating HIV-positive patients.[11]

Patients' reluctance to seek out HIV services necessitates a greater role for family planning providers. The change in coverage means that if given the right tools, family planning providers could take the lead in ensuring that more women are informed about the coverage and receive annual HIV counseling and screening.

Opportunities in the Future

The ACA is significant for many reasons, not least of which for the required insurance coverage of many services critical to women's sexual and reproductive health. Research has shown that unrestricted access to women's preventive health services leads to better health outcomes, less disease incidence, and stronger communities free of violence. Realizing the actual benefits of preventive coverage, however, will require a stronger partnership between health plans, family planning providers, and the women they serve.

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[9] Henry J. Kaiser Family Foundation, *STD Testing and Treatment Coverage Under Medicaid, 2009*, accessed October 2012, http://www.statehealthfacts.org/comparemaptable.jsp?ind=808&cat=10.

[10] Frey Speilberg et al., "Moving from Apprehension to Action: HIV Counseling and Testing Preferences in Three At-Risk Populations," *AIDS Education and Prevention*, 13(6), (2001): 524-540.

[11] William Valenti, MD, "Expanding HIV Testing: Overcoming Physician Barriers," *AIDS Reader*, 19 (2009):201-203, http://www.theaidsreader.com/display/article/1145619/1411200.

Life After the ACA: Breaking Down the Barriers Facing Lesbian, Gay, Bisexual, and Transgender Patients

By Annie Walden-Newman

It is estimated that approximately 3.5% of adults, or 9 million, in the US identify themselves as lesbian, gay, or bisexual, and 0.3% identify as transgender.[1] As a group, lesbian, gay, bisexual, and transgender (LGBT) people have unique health needs that impact their ability to access comprehensive health care. Unfortunately, the US health care system lags behind in the research, data collection, training, and teaching tools necessary to meet the health needs of this population. The public health community has slowly come to recognize the disparities in information and clinical training related to LGBT health, prompting greater investments in reducing them. Additionally, the Affordable Care Act (ACA) contains small policy investments in LGBT health that could help change the public health landscape.

The strides being made in LGBT health will be important for the public health safety net, including publicly funded family planning health centers. As more individuals gain access to health insurance, family planning providers will look for ways to modify their current structures in order to accommodate marginalized communities. This article provides an overview of the health care barriers experienced by LGBT people and the policies that may help break them down.

LGBT Health Disparities

Like many marginalized groups, LGBT individuals experience routine health disparities. According to *Healthy People 2020*, health disparities particularly impact groups of people who have "systematically experienced greater obstacles to health" based on a number of factors, including their perceived or actual sexual orientation and/or gender identity.[2] Health disparities in the LGBT community are likely exacerbated by the economic challenges often experienced in this community. LGBT people collectively face as high, if not higher instances of poverty than their heterosexual counterparts. In the first study

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[1] Gates, Gary J., *How Many People are Lesbian, Gay, Bisexual, and Transgender?*, April 2011, accessed November 2012, http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf.

[2] "Disparities," HealthyPeople.gov website, December 2010, accessed November 2012, http://healthypeople.gov/2020/about/DisparitiesAbout.aspx.

Helpful Glossary of Terms

(From the Human Rights Campaign www.hrc.org – the largest civil rights organization dedicated to achieving LGBT equality)

Sexual Orientation: an individual's physical and/or emotional attraction to the same and/or opposite gender. For example, "Heterosexual," "bisexual," and "homosexual" are all sexual orientations.

Gay: a person who is emotionally, romantically, sexually, and relationally attracted to members of the same sex.

Lesbian: a woman who is emotionally, romantically, sexually, and relationally attracted to other women.

Bisexual: a person emotionally, romantically, sexually, and relationally attracted to both men and women.

Gender Identity: refers to a person's innate, deeply felt psychological identification as male or female, which may or may not correspond to the person's body or designated sex at birth (meaning what sex was originally listed on a person's birth certificate).

Gender Expression: refers to all of the external characteristics and behaviors that are socially defined as either masculine or feminine, such as dress, grooming, mannerisms, speech patterns, and social interactions. Social or cultural norms can vary widely and some characteristics that may be accepted as masculine, feminine, or neutral in one culture may not be assessed similarly in another.

Transgender: a broad range of people who experience and/or express their gender differently from what most people expect — either in terms of expressing a gender that does not match the sex listed on their original birth certificate (i.e., designated sex at birth), or physically changing their sex. It can also serve as an umbrella term that includes people who are transsexual, cross-dressers or otherwise gender non-conforming. Not all people who consider themselves (or who may be considered by others as) transgender will undergo a gender transition.

Transsexual: a person who either has changed, or is in the process of changing, his or her physical and/or legal sex to conform to his or her internal sense of gender identity. The term can also be used to describe people who, without undergoing medical treatment, identify and live their lives full-time as a member of the gender opposite their birth sex. For example, transsexuals transitioning from male-to-female are often referred to as "MTFs." Similarly, female-to-male transsexuals are frequently called "FTMs."

Gender Identity Disorder (GID) / Gender Dysphoria: a psychological diagnosis recognized by the American Psychiatric Association. This disorder is marked by severe distress and discomfort caused by the conflict between one's gender identity and one's designated sex at birth. Not all transgender people experience gender dysphoria or are diagnosed with GID.

of its kind, the Williams Institute found that 24% of lesbians and bisexual women were living below the federal poverty level (FPL) as compared to only 19% of heterosexual women; that same study found poverty rates for gay and bisexual men roughly equivalent to their heterosexual counterparts.[3]

Insurance Coverage

While the ACA is estimated to extend insurance coverage to millions of those previously uninsured, LGBT individuals may continue to face challenges in obtaining health coverage. It has been estimated that the current ratio of uninsured gay and lesbian adults to heterosexuals in America is two to one.[4] The National Coalition for LGBT Health provides a number of reasons for the disparity in insurance coverage.[5] Since a majority of Americans obtain health insurance through employment, LGBT persons who experience workplace discrimination may be more likely to see unpredictable levels of employment and thus coverage.[6] This is especially true for transgender individuals, 97% of whom report being mistreated at work because of their gender identity or expression.[7] Additionally, many employers do not extend benefits to the same-sex domestic partners of their employees, forcing those partners to either go without coverage or enter the individual health insurance market which can be prohibitively expensive.[8] Even for those LGBT individuals who do receive work-sponsored coverage, they may have plans that lack specific coverage for the kinds of care that LGBT people need such as hormone replacement therapy.[9]

Cultural Competency

The lack of culturally competent care for LGBT patient populations is a challenge facing LGBT patients' ability to access high quality care, especially sexual and reproductive health care. At the same time, it is difficult for providers to adopt culturally competent practices in a sensitive and comprehensive way. The lack of culturally competent care is a more complex and difficult problem to tackle as evidence suggests that many LGBT people fear the social stigma attached with being public about their sexual orientation or gender identity and therefore withhold critical information about their sexual practices from their health care professionals. These omissions in turn leave doctors and other providers unable to provide a full range of comprehensive services that fit these patients' specific needs.[10]

In a March 2011 report entitled, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, the Institute of Medicine (IOM) found that because of the historical stigma surrounding human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) and homosexuality, many gay and bisexual men, as well as those men who have sex with men (MSM) but may not identify as homosexual, avoid HIV testing and treatment and refuse participation in scientific research on the subject.[11] Additionally, many lesbian and bisexual women avoid or delay critical health care in large part because they fear their provider will lack understanding.[12] For example, some clinicians assume lesbians are not as at risk for sexually transmitted infections (STIs) and reproductive cancers and therefore fail to deliver similar testing and treatment provided to heterosexual women. This barrier is especially burdensome on the transgender population. According to the National Center for Transgender Equality, one in three transgender people and 48% of transgender men have delayed or avoided preventive health care such as "pelvic exams or STI [sexually transmitted infection] screening(s) out of fear of discrimination or disrespect."[13] The Center also found that providers often lack clinical knowledge about the unique health needs of their transgender patients. Fifty percent of transgender people reported having to teach a health care provider about providing appropriate care in one nationwide survey.[14]

Providers do not always draw a clear distinction between identity and sexual behavior. Narrowly defining patients' identities can cause providers to leave out entire groups that may not identify as LGBT but who engage in behaviors that place them at similar risk.[15] For example, the terms MSM and WSW (women who have sex with women) identify one's sexual practice, not one's sexual orientation. Meaning, a man can engage in sexual acts with other men but continue to identify as heterosexual.[16] The National Association of Community Health Centers (NACHC) points out that when thinking about how to

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[3] Randy Albelda et al., *Poverty in the Lesbian, Gay, and Bisexual Community*, March 2009, accessed November 2012, http://williamsinstitute.law.ucla.edu/wp-content/uploads/Albelda-Badgett-Schneebaum-Gates-LGB-Poverty-Report-March-2009.pdf.

[4] National Coalition for LGBT Health, *All of the Above: LGBT People of Color*, accessed November 2012, http://lgbthealth.webolutionary.com/sites/default/files/LGBT%20POC.pdf.

[5] Jeff Krehely, *How to Close the LGBT Health Disparities Gap*, December 21, 2009, http://lgbthealth.webolutionary.com/sites/default/files/CAP%20LGBT%20Health%20Disparities%20ultimate.pdf.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] Ibid.

[11] Institute of Medicine of the National Academies, *The Health of Lesbian, Gay, Bisexual, and Transgender People*: Building a Foundation for Better Understanding, March 2011, http://www.nap.edu/openbook.php?record_id=13128&page=69.

[12] U.S. Department of Health and Human Services, Lesbian and Bisexual Health Fact Sheet, February 2011, accessed November 2012, http://womenshealth.gov/publications/our-publications/fact-sheet/lesbian-bisexual-health.cfm#f.

[13] National Center for Transgender Equality, *Transgender Sexual and Reproductive Health: Unmet Needs and Barriers to Care*, April 2012, accessed November 2012, http://transequality.org/Resources/Factsheet_TransSexualandReproHealth_April2012.pdf.

[14] Ibid.

[15] National Association of Community Health Centers Inc., *Reaching Out to "Other" Special Populations: Providing Services to Lesbian, Gay, Bisexual and Transgender Patients*, August 2007, http://www.nachc.com/client/LGBTInformationBulletinAugust20072.pdf.

[16] Ibid.

best serve patients' needs, providers should focus on the fact that "sexual behavior – as opposed to sexual or gender identity – is what places patients' health at risk."[17]

Providers can also fail to recognize the elevated levels of violence experienced by LGBT individuals and therefore fail to offer interventions or other services such as counseling. LGBT patients face an increased level of violence and harassment due to their actual or perceived orientation. For example, it has been estimated that approximately 4 in 10 lesbians and bisexual individuals, and 4 in 10 gay men in the United States, have been victims of anti-gay victimization.[18] Additionally, according to NACHC, each year between 50,000 to 100,000 women are victims of intimate partner violence by a same-sex partner and 42% of homeless youth identify as lesbian, gay, or bisexual.[19] Like heterosexuals, these realities impact LGBT patients' decisions on seeking health care, and they may avoid the health system for fear of retaliation or additional violence and/or harassment by their perpetrators.

Data Collection Barriers

The limited amount of data collection for LGBT populations hinders advancement for LGBT health. Without data, the medical community and policymakers may ignore health challenges unique to the LGBT community. There are few federally supported surveys that include any questions on sexual orientation and there are currently no nationwide surveys asking about both sexual orientation and gender identity.[20] Nationally recognized studies such as the National Health Interview Survey (NHIS), the Behavior Risk Factor Surveillance System (BRFSS), and the National Health and Nutrition Examination Survey (NHANES) collect data on a range of demographic information which is then used with other data in determining funding and priorities for local, state, and federal programs.[21] Yet, none of them include LGBT populations in their studies. By not collecting this information, government program officers and service providers, as well as researchers, lack the knowledge needed "to identify, track, and address health disparities affecting the LGBT community."[22] Moreover, greater investments in promoting LGBT health will stall without additional research support. Health care is undergoing dramatic changes which present a unique opportunity for public and private institutions to prioritize the research and data collection needed to promote better health care for LGBT populations.

Emerging Policies Addressing LGBT Health

The ACA contains only one provision explicitly addressing gender and sexual orientation related to mental and behavioral health education and training programs. However, the law does contain several provisions which make great strides in improving access to quality health care for the LGBT population.[23] These important policies range from fighting health disparities, including funding for cultural competence in the workforce, as well as increased data collection on health disparities specifically facing LGBT Americans.[24]

In *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding,* the IOM recommended that HHS begin collecting data on sexual orientation and gender identity similar to the way race and ethnicity data is currently being collected.[25] As a result of the ACA, as well as the recommendations by the IOM, HHS is currently developing a system to fully incorporate LGBT demographic data into their national surveys by 2013.[26]

The ACA investments in insurance coverage could have a positive impact on the number of LGBT people who gain access to more routine health care. This is important for LGBT youth who often struggle with mental health and substance abuse problems resulting from marginalization or fear of discrimination. LGBT young adults also have the option to stay on their parents' insurance plans until the age of 26. Insurance companies can no longer discriminate against LGBT people with pre-existing conditions and those insurance plans that participate in insurance exchanges will be prohibited from discriminating against patients based on their sexual orientation or gender identity. Poor and low-income LGBT individuals living in states that choose to expand their Medicaid eligibility could gain more access to care and the creation of insurance exchanges will allow LGBT individuals and business owners the option of coverage at a competitive price.[27]

The increase in access to preventive health services could help address some of the disease disparities experienced by LGBT individuals. Under the ACA, insurance companies are prohibited from denying coverage based on a patient's pre-existing

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[17] Ibid.

[18] American Psychological Association, Practice Guidelines for LGB Clients: Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients, accessed November 2012, http://www.apa.org/pi/lgbt/resources/guidelines.aspx?item=2.

[19] National Association of Community Health Centers Inc., *Reaching Out to "Other" Special Populations: Providing Services to Lesbian, Gay, Bisexual and Transgender Patients*.

[20] National Coalition for LGBT Health, *LGBT Inclusion in Federal Health Surveys*, November 2010, accessed November 2012, http://lgbthealth.webolutionary.com/sites/default/files/LGBT%20Inclusion%20in%20Surveys_0.pdf.

[21] Ibid.

[22] Ibid.

[23] Kellan Baker and Jeff Krehely, *Changing the Game: What Health Care Reform Means for Gay, Lesbian, Bisexual and Transgender Americans*, March 2011, http://lgbthealth.webolutionary.com/sites/default/files/aca_lgbt.pdf.

[24] "The Affordable Care Act and LGBT Americans," US Department of Health and Human Services website, last modified February 17, 2012, accessed November 2012, http://www.healthcare.gov/news/factsheets/2011/01/new-options-for-lgbt-americans.html.

[25] Institute of Medicine of the National Academies, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

[26] "Improving Data Collection for the LGBT Community," US Department of Health and Human Services website, last modified June 29, 2011, accessed November 2012, http://www.healthcare.gov/news/factsheets/2011/06/lgbt06292011a.html.

[27] US Department of Health and Human Services, *HHS LGBT Issues Coordinating Committee 2012 Report*, February 16, 2012, accessed November 2012, http://www.hhs.gov/secretary/about/lgbthealth_objectives_2012.html#intro.

condition, including STIs and HIV. Insurance companies are also prohibited from instituting lifetime limits on coverage - important for LGBT individuals who as a group are affected by chronic diseases at a higher rate than their heterosexual counterparts.[28] In what can be considered a monumental change in health care delivery, LGBT couples will be able to search for health insurance plans that allow coverage for their same-sex partners through a user-friendly website. This website will include a similar same-sex partner filter which small business employers can use to choose an insurance plan for their employees.[29] The ACA also instituted funding for prevention efforts across the country that will allow organizations serving LGBT patients to help address "tobacco control, obesity prevention, HIV-related health disparities, better nutrition, and physical activity."[30]

Conclusion

Over the past few years, HHS has taken a number of successful steps towards decreasing the hurdles facing LGBT patients in accessing quality health care and coverage. In April 2010, President Obama directed HHS Secretary Kathleen Sebelius to identify ways to improve the "health and well-being of LGBT individuals and families."[31] Additionally, programs like *Healthy People 2020* will begin including sexual identity and orientation as part of the data included in tracking rates of illness and other critical health information. And ACA implementation will continue to introduce critical provisions that improve the health and well-being of LGBT persons.[32] While it remains to be seen whether these changes will entirely eliminate the health disparities facing LGBT patients, it is impressive that in a short time the federal government and health care providers have taken positive steps toward breaking down the barriers facing sexual minorities. Overall, it is imperative that the health care system and its providers — particularly those who serve low-income populations — continue devoting time and resources to LGBT patients to both improve health outcomes and save lives.

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[28] "The Affordable Care Act and LGBT Americans," US Department of Health and Human Services website.

[29] Ibid.

[30] Ibid.

[31] US Department of Health and Human Services, *HHS LGBT Issues Coordinating Committee 2012 Report.*

[32] Ibid.

Essential Community Provider Policy: Challenges and Opportunities

By Julie Lewis

Background

Policies to promote network adequacy and provider diversity are necessary to guarantee patient access to health care services. One strategy written into the Affordable Care Act (ACA) to assure adequate access to providers for the potentially newly insured was a requirement that qualified health plans participating in the health insurance exchanges contract with essential community providers (ECPs).[1] The ECP designation and the contracting requirement stem from the need to protect access to care for all individuals, including poor and low-income patients who traditionally face challenges in accessing health care. As a result of the ECP designation, many of the newly insured are expected to be able to continue seeing providers who are familiar with their health conditions and have traditionally delivered their care.

Language specifying the inclusion of ECPs was initially conceived in President Clinton's 1992 health reform bill and later adopted by some states with Medicaid managed care (MMC) to support and protect entities and individual providers that offer services for those at higher risk for inadequate health access. According to an article by Sara Rosenbaum, after its use in Clinton's health reform effort, the term has been increasingly used by policymakers and researchers to categorize providers "that through legal obligation or mission, organizational and service structure, and patient population characteristics, play a significant role in health care for patients and populations at disparate risk for inadequate access."[2]

Forging New Relationships

Most commercial health insurers (outside of those who have MMC contracts) have had limited contact with the safety net. Providers in the safety net have not been attractive business partners because their patients are unlikely to be insured through an employer or self-insured. Moreover, when extending a contract to a safety-net provider, the commercial plans sometimes paid inadequate reimbursement rates because these providers lacked the leverage needed to negotiate. These two factors have led to few relationships between ECPs and commercial insurance.

Safety-net advocates and providers had hoped that the US Department of Health and Human Services' (HHS) regulations

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[1] Patient Protection and Affordable Care Act of 2010. §1311(c)(1)(B) and §1311(c)(1)(C).

[2] Sara Rosenbaum, *Essential Community Providers*, March 11, 2011, accessed November 2012, http://healthreformgps.org/resources/essential-community-providers/.

implementing the ACA would require all qualified health plans (QHPs) to contract with "any willing provider." Unfortunately, final regulations stopped short of this standard. However, QHPs will still be required to show they have a robust network of community-based or safety-net providers. The criteria can be based either on geography or certain populations that may need special attention. For example, in Washington state, tribal health authorities and organizations have been included as stakeholders for the exchange in state statute as well as ECPs as required by the ACA.[3]

Historical Reliance on Safety-Net Providers

Individuals without health insurance either forego health services or rely on a patchwork system of ECPs and visits to the emergency room for their care. Those with public insurance are often seen in these settings as well. For example, 67% of Title X patients are uninsured; family planning health centers and community health centers currently provide a disproportionate amount of care to Medicaid recipients.[4] Clinicians already serving Medicaid patients are more likely to be able and willing to take on additional Medicaid patients and are more likely to already be working at safety-net health centers, making them a natural fit to serve the newly insured.[5]

As patients previously uninsured or underinsured become insured, especially those at the lowest income levels, they are likely to 1) be familiar with seeking care from the safety net; 2) be more liable to "churn," meaning cycle between public, private, and no health insurance; and 3) in some cases have easier access to their most recently visited health center because of established relationships and proximity. The ECP policy is an attempt to recognize those realities and promote health care access for uninsured and underinsured patients because they are the populations most likely to experience barriers to access despite being insured.

The ACA language is particularly important because of the historical reliance by Medicaid patients on community providers. Protecting ECPs offers the opportunity for safety-net providers to continue as the providers of choice in the new health care market. It also places them on the same playing field as providers already accustomed to participating in the health care marketplace.

Essential Community Providers are in a Position of Strength

As a result of the federal regulatory framework, family planning providers are in a place of strength to negotiate with health plans for fair reimbursement rates and for inclusion in their networks because health plans are now legally required to do both. While federal regulations are not stringent, they do allow states to have stricter enforcement provisions. Some states have language in place requiring MMC to maintain certain levels of network adequacy. For example, Colorado[6] and Minnesota both have pre-ACA ECP network adequacy provisions in place.[7] In both states, officials are charged with certifying that managed care networks are adequate to meet the health needs of their citizens. States in the process of determining how qualified health plans will be certified in the exchanges have in some cases defaulted to current state standards. In Colorado, this application and subsequent designation will also apply to the Colorado Health Benefit Exchange. The application specifically describes Title X health centers as state-defined ECPs, but state statute does not.[8]

Greater Access to Family Planning Service Delivery Professionals

Providers at family planning and other safety-net clinics are experts in treating STIs, other communicable diseases, and providing family planning services. This expertise allows these providers to offer more thorough counseling and support to their patients. The ECP designation maintains the ability of these providers to be the experts in their communities. In contrast, providers in other settings may be less familiar with STIs, other communicable diseases, and family planning and may not be able to provide as accurate and robust services as safety-net providers. For example, analysis by the Guttmacher Institute shows the importance of Title X in shaping family planning services delivery. Two out of three women receiving publicly funded family planning services are served at a health center receiving Title X funding, which is evidence of the program's outsized impact on the services the majority of women accessing care in the safety net receive.[9] Inclusion of health centers participating in Title X in health insurance networks allows for greater access to high-quality care for those enrolled in commercial and public health insurance, as well as those who may remain uninsured.

Challenges for Essential Community Providers

Contracting with commercial health plans will create a new challenge for health centers that may have greater familiarity working with public insurance. While federal and state guidance may exist, it is unlikely to be directive enough to ensure

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[3] American Indian Health Commission for Washington State, *Tribal Analysis for Washington State Health Benefit Exchange and Health Care Authority*, April 2012, accessed November 2012, http://www.edfoxphd.com/AIHC_Tribal_Analysis_for_WHBEB_-_FINAL__R-04-03-12_.pdf

[4] Kaiser Commission on Medicaid and the Uninsured, *Physician Willingness and Resources to Serve More Medicaid Patients: Perspectives from Primary Care Physicians*, April 2011, accessed November 2012, http://www.kff.org/medicaid/upload/8178.pdf.

[5] Ibid.

[6] Colorado Statutes. Health Care Policy and Financing. § 25.5-5-403.

[7] Minnesota Exchange Staff, *Background Paper on Network Adequacy and Essential Community Providers*, June 25, 2012, accessed November 2012, http://mn.gov/commerce/insurance/images/ExchPlanBkgndPaper6-27-12.

[8] Colorado Department of Health Care Policy & Financing, *Department of Health Care Policy and Financing Essential Community Provider (ECP) Application*, accessed November 13, 2012, http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251825626943&ssbinary=true.

[9] Rachel Benson Gold, *Going the Extra Mile: The Difference Title X Makes*, Spring 2012, accessed November 2012, http://www.guttmacher.org/pubs/gpr/15/2/gpr150213.html.

inclusion of ECPs. Accordingly, health centers may need to pursue these contracts and simultaneously strengthen their negotiating skills to ensure they not only participate but are appropriately valued as part of the delivery system.

Most health centers will need to significantly rethink their approach to revenue cycle, insurance billing, and client services. In many health care settings, this may result in a reorganization of service delivery, changes to staff training, and changes to staff interactions with patients. Some health centers will be able to make a smooth transition, while others will have difficulty. Fortunately, some states, like New York, will not be fully certifying health plans until 2020, partially to see how the market develops. This gives health centers in many states the opportunity to become health plan members and address some initial challenges that will be experienced early in the coverage expansions.

Looking Forward

As states slowly move toward full implementation of the ACA, there are opportunities now and into the future for Title X and other safety-net providers to be included in the changing health care delivery system. Of the 18 states that have declared they are creating a state-based exchange, most have not yet fully detailed ECP requirements and some states seem to be depending on existing infrastructure through insurance or commerce departments.[10] The results of the 2012 presidential election have encouraged health reform implementation because state officials now know that the ACA will be implemented by the federal government. Because of their unique position as experts in the community, federal requirements to contract with them, and ability to offer access to a range of services, ECPs are in a position of strength – the challenge will be leveraging these opportunities to become fully engaged in the new health care market.

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[10] At the time of publication.

The Life After 40 Case Studies in 2013: A Look Ahead

By Melissa Kleder

In 2013, NFPRHA's *Life After 40: The Family Planning Network and the ACA* project team will produce additional case studies to assist publicly funded family planning providers as they adapt to change driven by the Affordable Care Act (ACA). The case studies will highlight strategies that family planning providers have used or explored to increase their efficiency and sustainability in the face of health care reform.

The project's first case study, *A Look to Massachusetts for Lessons Learned*, shares strategies utilized by the Massachusetts network of family planning providers to adapt to state-level health care reform legislation enacted in 2006. The next case study, *Innovative Practices and Projects at Publicly Operated Family Planning Centers*, examines various approaches used to address the unique challenges experienced by health centers operated by a health department. At time of publication, two additional case study topics have been determined.

Case Study 3: Billing and Coding

Life After 40's third case study will tackle the popular and anxiety-producing topic of billing and coding. Under the ACA, it is estimated that 10 million people will gain Medicaid coverage and 19 million people are expected to enter health insurance exchanges beginning in 2014.[1] As a result, exploring options to maximize revenue is a key factor in maintaining sustainability for health care providers. For some family planning providers, this anticipated influx of newly covered patients means engaging in insurance billing for the first time. Other providers will be looking to fine tune their revenue cycle to ensure top payment for services. The case study will focus on family planning organizations' experiences with contract negotiation and cultural changes created by a shift in business model and/or the implementation of health information technology. The companion workbook will offer examples of tools and resources participants used to implement change.

After reaching out to 13 members, three were selected to participate in the case study: Planned Parenthood Arizona, Community Action Partnership of San Luis Obispo, and Bridgercare (Bozeman, MT). Initial phone surveys have been conducted and site visits are scheduled.

Case Study 4: Family Planning and FQHCs

In order to remain sustainable in a post-ACA health care economy, it is important that family planning providers identify and build new partnerships with other agencies. The *Life After 40* project's fourth case study will focus on possible collaborations between family planning providers and federally qualified health centers (FQHCs). The objective of the case study is to highlight three family planning providers that are in various stages of a partnership with an FQHC.

The project team is currently researching potential participants for the fourth case study. If you are interested in sharing your organization's experience partnering with or becoming an FQHC/lookalike, please contact *Life After 40* Project Manager, Melissa Kleder at mkleder@nfprha.org or 202-293-3114 ext. 209.

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[1] Congressional Budget Office and staff of the Joint Committee on Taxation (JCT), *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012, accessed August 27, 2012, http://www.cbo.gov/publication/43472.

Financial Statements

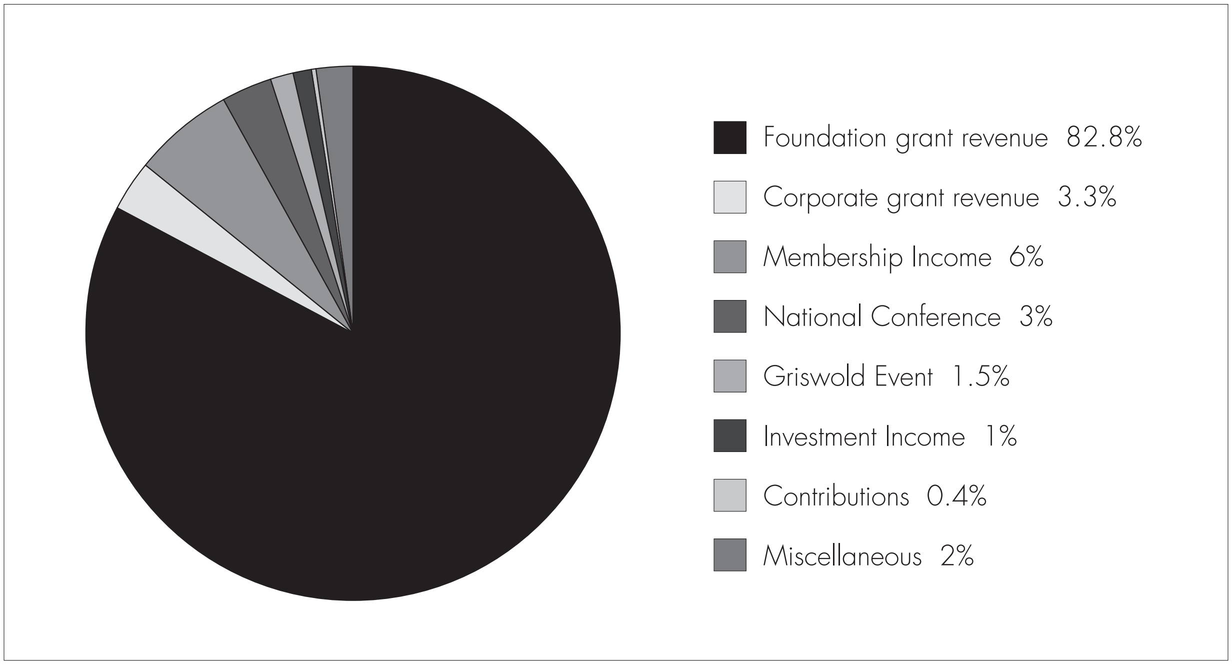
NFPRHA is pleased to announce that for the third year in a row the organization's fiscal year ended in a surplus. A significant portion of the fiscal year (FY) 2012 surplus can be attributed to the grant supporting the *Life After 40: The Family Planning Network and the ACA* project preparing NFPRHA members for health care reform implementation. NFPRHA is very grateful to the foundations, members and individuals that supported its efforts to advocate on behalf of family planning providers. As a small organization, every grant and contribution is essential. On behalf of the millions of women and men served by our members, NFPRHA thanks all of its supporters for their generosity.

NFPRHA would like to offer a special acknowledgement to the following foundations for their generosity. Their support provided 82.8% of NFPRHA's total revenue in FY 2012:

Anonymous
The Brush Foundation
Edna Wardlaw Charitable Trust
Ford Foundation
The Moriah Fund
Robert Sterling Clark Foundation
The Seth & Sarah Glickenhaus Foundation
The William and Flora Hewlett Foundation
Weeden Foundation

Support and Revenue

In FY 2012, Support and Revenue totaled $3,863,112. The following chart shows the sources of this revenue.



Statement of Financial Position of NFPRHA for Fiscal Years 2011 and 2012

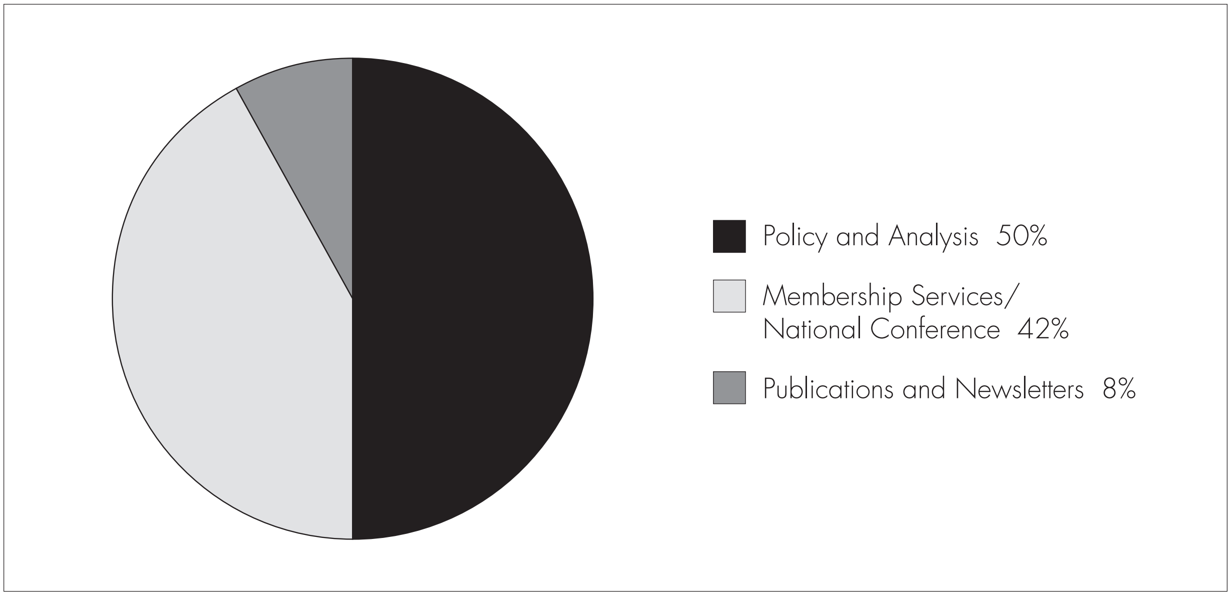
	2012	2011
ASSETS (CURRENT ASSETS)		
Cash and cash Equivalents	$983,492	$967,858
Investments	$1,885,397	$1,283,732
Grants receivable	$1,538,000	$190,000
Prepaid expenses	$29,440	$26,471
Furniture and equipment, net	$45,557	$40,833
Deposit	$9,774	$9,774
Total Assets	$4,491,660	$2,518,668
LIABILITIES AND NET ASSETS		
Accounts payable and accrued liabilities	$103,129	$73,263
Deferred revenue	$120,063	$128,194
Total Liabilities	$223,192	$201,457
NET ASSETS		
Unrestricted	$1,146,477	$1,441,378
Temporarily restricted	$3,121,991	$875,833
Total Net Assets	$4,268,468	$2,317,211
TOTAL LIABILITIES NET ASSETS	$4,491,660	$2,518,668

Summary Statement of Activities and Changes in Net Assets

	2012	2011
Revenue and Other Support	$3,863,112	$2,115,044
Expenses	$1,911,855	$1,591,820
Change in Net Assets	$1,951,257	$523,224
Beginning Net Assets	$2,317,211	$1,793,987
Ending Net Assets	$4,268,468	$2,317,211

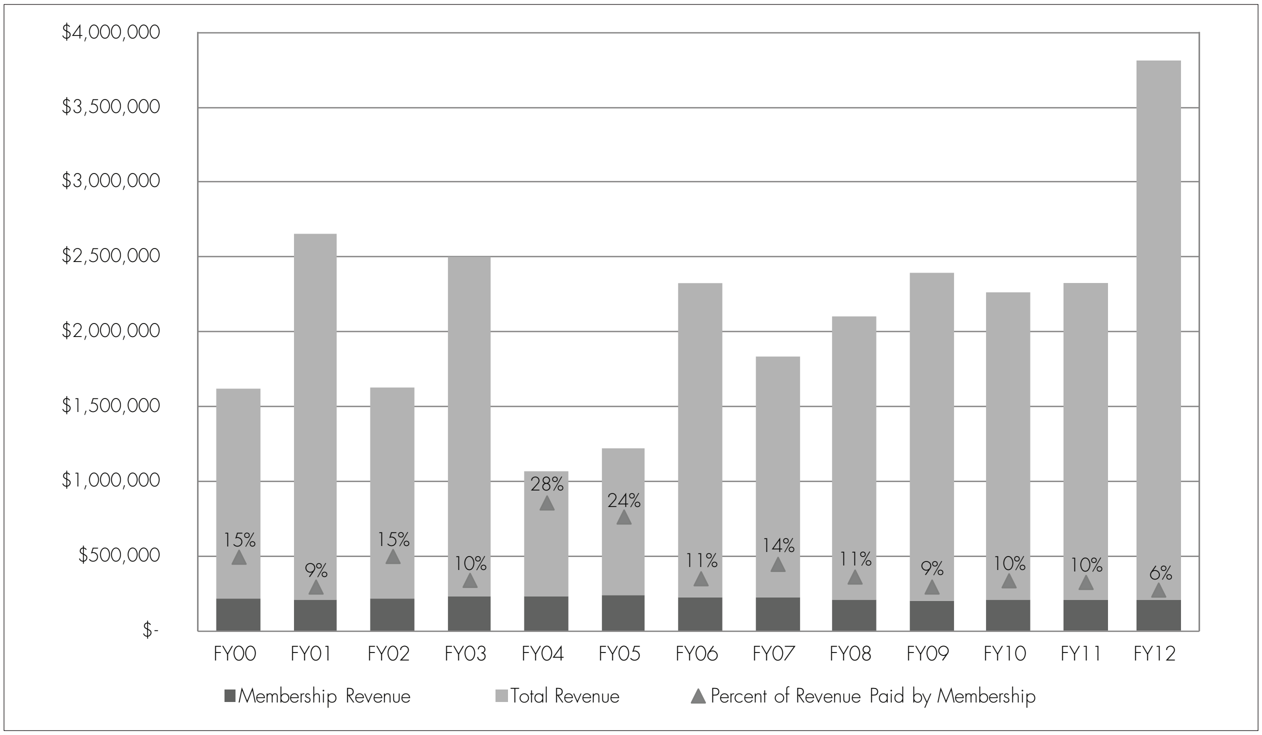
Program Activities

This chart reflects program activities for FY 2012.



Membership Revenue

This chart reflects membership revenue as a percentage of total revenue from FY 2000 to FY 2012.



Member Spotlight: Innovations in Marketing to Teens and Advocating for Change

venus/*Family Planning Services*, Des Moines, IA and Family Planning Health Services, Wausau, WI

By Lauren Levenstein and Illysa Schrager

In an age of new technologies, internet capabilities, and the prevalence of social media, family planning health centers and systems are developing new ways through which they communicate and market to different populations. This *Member Spotlight* provides examples of how health centers have effectively honed their communications and marketing to teens and for the purpose of advocacy and education. These changes are intended to generate new revenue, spread public awareness about sexual and reproductive health, and preserve the policies that enable them to serve their communities.

Marketing to Teens: venus/*Family Planning Services,*[1] Des Moines, IA

[teen talk]

guys&gals:
join us
april 24

Win Prizes
Enjoy Free Pizza
Get Autographs
from The Iowa Crush

learn about
taking control...
Binge Drinking • Bullying
Synthetic Drugs • Sexting
STD/HIV • Dating Violence

[prizes • pizza • fun • learning • sharing • autographs]

april 24 • 12:30–4 p.m.

location: 1200 University Ave, Ste 100
(Corner of University Ave & 13th St)
Des Moines, Iowa

venus / Family Planning Services
A PROGRAM OF Visiting Nurse Services of Iowa
www.venusfamilyplanning.com • 558-9609

venus/*Family Planning Services*, a Title X sub-recipient agency in Des Moines, IA, has been developing its marketing to teens. In 2012, **venus** planned and hosted its first teen-centered event called "Teen Talk" to educate local teens about pressing social issues and spread the word about the health center's services. In an effort to reach adolescents and combat negative stereotyping, the event included discussions about binge drinking, bullying, synthetic drugs, sexting, STIs/HIV, oral sex and oral cancer, and dating violence. To incentivize teens to attend the event, **venus** served free pizza and offered prizes, including an Xbox 360, a summer pass to a local theme park, and a flat screen television. A local women's football team was also on hand to sign autographs. **venus**' outreach team secured many of the prizes at little or no cost through donations by local businesses. The **venus** staff found that it was a good opportunity to make local connections, spread awareness about the center, and help dispel myths about family planning services.**venus** advertised the prizes, pizza, and autographs on its event fliers, also plugging its Facebook presence with the logo and an invitation for the public to "like" them. The fliers also featured a "QR" code which allows anyone with a smartphone to scan the code and be automatically linked to the health center's website. QR codes are available for free online and many of **venus**' marketing materials, especially the ones targeting teens, include a QR code for easy access to its site. Including the logo and QR codes in its marketing materials also signals that **venus** is technologically savvy and in touch with a younger population. **venus**' outreach team distributed these fliers to local entities that cater to the teen and young adult populations including area schools, skating rinks, and bowling alleys. Thirty-eight teens attended the event which was held in **venus**' health center, with nearly equal number of males and females attending.

venus is currently planning its 2013 "Teen Talk" and will expand its capacity and reach from the inaugural event. The next "Teen Talk" will be held at a nearby university and include a keynote speaker, secured in part through a grant from **venus**' parent agency. In addition to relevant discussion topics, teens will have the option to tour the university and visit with representatives from different local agencies and organizations that were offered the opportunity to table at the event for a nominal fee of $50. While **venus** is already offsetting much of the event's expenses through donated prizes, volunteers, and discounted space rental, the $50 vendor fee will help cover costs. Partnering with other agencies to host an event is a smart way to help cut costs, especially for small or cash-strapped health centers.

Program Manger Julie Baker believes an expansion in the number of presentations health center educators have given at middle and high schools is an important strategy for **venus**. The organization's outreach team has built a rapport with school professionals in the area who trust them to provide factually accurate information about sexual and reproductive health to teens. **venus** has also tried to make its health center teen-friendly, displaying posters and handing out cards and materials that talk about healthy relationships. When you walk into **venus**' main health center, a series of colorful t-shirts are on display and available for purchase for a $10 donation. The fun shirts include one that states "Fight like a girl" and honors cervical and breast cancer awareness. Another one, supporting the LGBT community, is tie-dyed and promotes STI testing.

venus also markets its "Teen Talk" event and health center services to teens and twentysomethings through ads on a local radio station that attracts the targeted demographic. While **venus** is able to pay for these ad on a regular basis, many radio stations will donate advertising slots for special non-profit events and public

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[1] The font used throughout represents Venus' branding and logo.

service announcements. A local radio station, for example, may allow air time for a family planning health center to promote HIV testing on World AIDS Day in December or Pap smears during Cervical Cancer Awareness Month in January. These special advertising slots can provide health centers the opportunity to reach teens and promote their services at little to no cost.

Example of Teen-Targeted venus Radio Ad: "HITs [radio station] is 99.9% commercial free thanks to **venus** family planning where you can get everything from birth control to free condoms, on your schedule. **venus** family planning, where walk-ins are always welcome."

venus has seen an increase in its teen patient population, which administrators attribute to its connection with local schools, word-of-mouth referrals, radio advertising geared to teens, and its "Teen Talk" event. The health center has especially seen an increase in male patients ages 16 to 25. **venus**' approach to connecting with young adults is drawing more Title X and insured patients alike, while providing public education and dispelling stigmas around family planning. By using social media, creating a teen-friendly health center, and hosting an annual teen-centered event that involves the community, **venus** administrators are meeting teens where they live, generating new opportunities for income, and advancing access to family planning.

Advocacy and Education: Family Planning Health Services, Wausau, WI

Family Planning Health Services, Inc. (FPHS), a private, non-profit based in central Wisconsin, not only provides sexual and reproductive health care services, but places great emphasis on big-picture advocacy efforts to communicate the family planning message within and well beyond its community. FPHS is unique from many family planning agencies in that it has a public affairs/public relations team within its network of 10 health centers. Its administrators advocate for reproductive justice, and also ensure that people in communities across the country have the resources they need to plan and provide for families.

Currently, FPHS' advocacy efforts focus extensively on the implementation of the Affordable Care Act (ACA) and the new opportunities now available under the law, such as collaborating to become a partner in an Accountable Care Organization (ACO) and using telehealth and video technology to enable, extend, and empower a multi-agency network. The care coordination and information exchange requirements of meaningful use have led FPHS to think a lot about the interactions of different kinds of networks that define their business. Systems including social networks, care networks, information exchange, and payment networks can often collide rather than coordinate, which can harm patient care. To address colliding systems and to promote more care coordination, the organization formed the Women's Health Network of Wisconsin which is implementing a virtual medical "neighborhood" that is open, inclusive, collaborative, and centered on the patient. The network is using new technologies enabling telehealth communications and interagency personal health information exchange.

Through additional partnerships within Wisconsin, FPHS is able to reach broader audiences with its advocacy efforts. FPHS and other maternal and child health advocates worked with state legislators and the federal government to develop and implement Wisconsin's Medicaid Family Planning Waiver and then worked to make family planning expansions an optional part of states' federal Medicaid agreements. In November of 2010, Wisconsin was the first state to win federal approval of a Medicaid state plan amendment.

The organization is also engaged in a collaborative partnership called Subsequent Pregnancy and Contraceptive Education (SPACE) with WIC agencies and programs to provide low-income women with the supplies and education they need to plan and space their pregnancies more effectively immediately post-partum. In addition, FPHS is able to provide services to patients in need of emergency contraception (EC) through agreements with other women's advocacy agencies and community service providers. The program is called *EZ-EC* and includes a website and statewide EC hotline.When it comes to communicating with the media, FPHS staff produces news releases to announce events or celebrate accomplishments of their health centers. They promote the ACA through several avenues such as hosting local providers in panel discussions and then posting the audio online. If they are not able to have a speaker with a live audience, FPHS leaders and communications staff often conduct interviews and place the recording online via podcasts, using fairly simple recording and sound editing technology. They started recording and publishing podcasts because it is an easy way to get national leaders and speakers to reach their broad audiences. FPHS also hosts public events, such as a recent forum at a local university featuring Frances Kissling, former President of Catholics for a Free Choice, and an attorney at the Hercules Company, which sued the federal government to prevent implementation of women's health preventive benefits. The provision includes no co-pay or deductibles for birth control for women with private-pay insurance. The forum provided a public outlet for local live and even broader web-based discussion about a controversial and timely topic.

Some of FPHS' greatest advocacy efforts are executed through its website BelowtheWaist.org. The site was created in addition to the agency's primary website. It is an online community for individuals and organizations interested in protecting and promoting reproductive health care and reproductive justice. FPHS offers numerous opportunities for social networking, commenting, sharing ideas, and learning about others interested in these issues.

The website, which is supported within FPHS' 501(c)3 structure, provides users and visitors the opportunity to meet advocates, activists, leaders, practitioners, educators, and others throughout the nation who share interest and care about the future of reproductive freedom and health. To add to the conversation, BelowtheWaist.org produces bi-weekly podcasts that feature reproductive health news and opinion, as well as interviews and discussions with individuals around the nation on timely topics.

Below the Waist

FPHS believes that community health leaders have shared goals as well as shared challenges, and that the use of communications technology will better serve communities across the nation. With a constant effort to strengthen its networking and connections, FPHS continues to grow its advocacy efforts to ensure that women and men in Wisconsin and beyond have access to the family planning services and resources they need.

* * *

Visit **venus**/*Family Planning Services* on the web at:
http://www.venusfamilyplanning.org

Visit Family Planning Health Services, Inc. on the web at:
http://www.fphs.org/ and http://belowthewaist.org

Advertise Today!

Family Planning Matters is a reliable source of information on NFPRHA's public policy agenda and congressional and administration action on family planning and reproductive health. Each issue of *Family Planning Matters* is available year-round on our website,

www.nationalfamilyplanning.org, which receives an average of 55,000 visits per month.

Rates

Ad type	1x	2x	3x	4x	5x
Full page pull-out	$5,000	$4,500	$4,000	$3,500	$3,000
Full page	$2,000	$1,800	$1,600	$1,400	$1,200
½ page	$1,250	$1,125	$1,000	$875	$750
¼ page	$750	$675	$600	$525	$450

All ads are black and white. The deadline for ad submission is the 1st of the month of publication. Contact Lily Davidson at ldavidson@nfprha.org or (202) 293-3114 for additional information. Special rates are available for NFPRHA members.

National Conference
NFPRHA 2013

Register now!

NFPRHA's 2013 National Conference is a must-attend event for family planning providers who are intensifying their efforts to prepare for full Affordable Care Act (ACA) implementation in 2014.

Sessions at NFPRHA's 2013 National Conference will feature topics specifically designed to help you ensure your organization's readiness for the ACA including the future of Medicaid, outreach and enrollment, ACA and confidentiality, and understanding health insurance exchanges. The conference will also feature sessions on topics essential to your work like electronic health records implementation, attacks on contraceptive coverage, and quality measurement.

NFPRHA's National Conference offers unparalleled networking, education, training and advocacy opportunities for family planning administrators and clinicians.

Visit **www.nationalfamilyplanning.org/NC** to view the conference agenda and register. Conference sponsorship and exhibit opportunities are available now. NFPRHA has grant funding to facilitate member travel to the conference, but to take advantage of it you must register for the meeting and request assistance by March 29, 2013.

Highlights Include:

- Subsidized travel and lodging available for members
- Free pre- and post-conference training sessions on billing and coding
- Advocacy Day on Capitol Hill
- Family Planning Boot Camp: Orientation to the field for new employees
- CEUs for nurse practitioners, physicians, nurse midwives, and physician assistants
- NFPRHA Awards Luncheon
- *Griswold v. Connecticut* fundraising reception

National
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