Next Steps for America's Family Planning Program

LEVERAGING THE POTENTIAL OF MEDICAID AND TITLE X IN AN EVOLVING HEALTH CARE SYSTEM

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Rachel Benson Gold
Adam Sonfield
Cory L. Richards
Jennifer J. Frost

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Table of Contents

Executive Summary 4

Chapter 1: The Essential Role of Family Planning 6

Chapter 2: Publicly Funded Family Planning: Past and Present 12

Chapter 3: Leveraging Medicaid and Title X 18

Chapter 4: Challenges Facing Family Planning Centers 23

Chapter 5: Next Steps 29

Appendix Tables 32

References 36

Executive Summary

The advent of modern contraception has been hailed for its public health achievements and for advancing women's self-sufficiency and their educational, social and economic opportunities. Yet, although contraceptive use is nearly universal today, ensuring that every pregnancy is wanted and planned is difficult. Women and couples need assistance in the form of meaningful access to family planning options.

- About half of U.S. pregnancies—more than three million each year—are unintended, and by age 45, more than half of all American women will have experienced an unintended pregnancy.
- Barriers to access are particularly salient for those without stable and sufficient personal resources. Four in 10 poor women of reproductive age are uninsured, and 17.5 million American women need publicly supported contraceptive services.
- After years of progress in reducing income and racial disparities in contraceptive use, some of these gaps have widened again. Disparities in unintended pregnancy rates are also pronounced and growing worse.

Publicly Funded Family Planning: Past and Present

Growing recognition of the social, economic and health benefits of enabling women and couples to better control the number and timing of their pregnancies led to the establishment in 1970 of the Title X family planning program. Two years later, Congress required states to cover family planning under Medicaid. These programs remain the foundation of publicly funded family planning.

- In 2006, more than nine million clients received publicly funded contraceptive services. Some 8,200 family planning centers provided services to 7.2 million contraceptive clients; Title X–supported centers served 66%. One in four women who obtain contraceptive services—including half of poor women—do so at a publicly funded center.
- One in six women who obtain a Pap test or a pelvic exam do so at a family planning center, as do one-third of women who have an HIV test or who receive counseling, testing or treatment for an STI other than HIV. Because the package of services a center provides includes the same services provided in a woman's annual gynecologic exam and because centers often serve as a woman's entry point into the health care system, more than six in 10 women who obtain care at a center consider it their usual source of medical care.
- By providing millions of women with access to contraceptive services they want and need, publicly funded family planning helps women each year avoid 1.94 million unintended pregnancies. Without these services, the numbers of unintended pregnancies and abortions would be nearly two-thirds higher than they currently are among women overall and among teens.
- Every dollar invested in helping women avoid pregnancies they did not want to have saves $4.02 in Medicaid expenditures that otherwise would have been needed for pregnancy-related care.

Leveraging Medicaid and Title X

Over the last decade and a half, funding for family planning services has undergone a realignment that has revealed a synergy between Title X and Medicaid: Increasingly, Medicaid pays for core clinical care, and Title X wraps around that core to buttress the system of family planning centers and fill gaps in services and coverage.

- Seventy-one percent of the $1.85 billion spent by the federal and state governments to provide family planning services in 2006 came from Medicaid. Recent increases in Medicaid spending have been driven by state-initiated family planning expansions; two-thirds of the growth from 1994 to 2006 occurred in expansion states. These expansions have improved access to care, helped women avert unintended pregnancies and births, and generated significant cost savings in the process.

- Title X can pay for the services and activities not covered under Medicaid, such as expanded counseling and outreach; it can fill the gap left by inadequate Medicaid reimbursement; and it can pay for individuals ineligible for Medicaid coverage, including many immigrants. Critically, Title X can support the provider infrastructure in ways that Medicaid simply cannot.

- The availability of Medicaid, or any form of insurance, would quickly become meaningless absent a healthy network of providers to care for low-income clients. Although private providers have a critical role to play, they are increasingly unlikely to accept Medicaid clients. Instead, low-income women turn to family planning centers—supported by grants such as Title X—because of the low-cost, high-quality, confidential and accessible care offered.

Challenges Facing Family Planning Centers

Despite their myriad accomplishments, publicly funded family planning centers face significant challenges, including a growing and increasingly diverse clientele, new demands for counseling and clinical care, and sharply rising costs.

- Family planning centers are having to tailor their outreach efforts to address clients' widening array of languages and cultures; differing attitudes, values and beliefs about topics like sex, pregnancy, contraception and privacy; and fears about jeopardizing their immigration status. Centers are also struggling to reach potential clients with extremely complicated life situations, such as those who are homeless, incarcerated or impacted by domestic violence, substance abuse or mental health issues.

- To provide the multilingual, culturally sensitive and client-centered counseling and education that clients need, centers are placing a renewed emphasis on the human resources central to the effort, and are finding that having a sufficient number and mix of personnel is critical.

- Family planning centers are working to tailor clinical care to clients' needs. An increasing number of individuals are turning to centers for STI services, in part because routine screening for HIV and other STIs is becoming the standard of care for the population groups these centers serve.

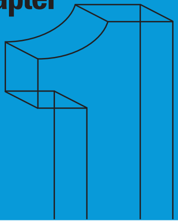
- Expanded screening and newer diagnostic technologies for STIs and cervical cancer have added to the expense of a family planning visit. Newer methods of contraception are often more expensive, and even the cost of oral contraceptives has escalated rapidly in recent years. Finally, staffing costs have risen sharply, and centers are struggling to compete with higher private-sector salaries.

Next Steps

Moving forward, policymakers need to establish a new framework for the publicly subsidized family planning effort that purposefully builds on the emerging relationship between Title X and Medicaid in a way that leverages their unique strengths. That framework should be premised on Medicaid's being the funding source of the clinical component of care for most individuals served. Congress should require states to provide family planning coverage at least up to the same income level they use to determine eligibility for Medicaid-covered pregnancy-related care. It should address other enrollment barriers in these family planning expansions and in the broader Medicaid program: The current ban on covering legal immigrants in their first five years should be eliminated, the burdensome citizenship documentation requirement should be eased and policymakers should consider allowing even immigrants who are in the country illegally to obtain reproductive health care—including family planning services—under Medicaid. In addition, reimbursement should be simplified and should be adjusted annually to adequately cover the costs of providing care.

Title X has not been reexamined in a quarter century, so providers have been left to confront today's challenges with an antiquated structure. Title X dollars will continue to be needed to cover individuals, services and activities that Medicaid does not or cannot cover. Mechanisms to assess the impact of Title X, which currently count merely the aggregate number of clients served, must be adjusted to reflect the myriad ways program funds are used to fill these gaps in services. Primarily, however, the new framework should recognize and value Title X's central role in sustaining the provider infrastructure, including basic operating needs, investments in new technology, expanded clinic hours and locations, and training and pay for clinicians, counselors and frontline staff. New leadership from the Office of Population Affairs and cooperation among federal and state agencies will be critical to making this framework work.

Reinvigorating the national family planning program—in terms of financing, infrastructure and leadership—would be an important contribution to the broader health care reform effort. These steps would also help consolidate family planning in the public mind as the basic health care that women have long known it to be. By acknowledging its importance alongside that of other essential preventive care, the authors and advocates of reform can help end an era in which family planning has too often been disparaged as a source of political controversy, rather than valued as a health care necessity.



The Essential Role of Family Planning

It is not hyperbole to say that the advent of modern contraception changed American life. The federal Centers for Disease Control and Prevention (CDC) included the development of and improved access to effective contraception among the 10 great public health achievements of the 20th century, along with such breakthroughs as the smallpox and polio vaccines, and the public health campaigns that have greatly reduced tobacco use.[1] According to the CDC, access to family planning services has led to smaller families and improved birth spacing; reduced infant, child and maternal deaths; and prevented the transmission of HIV and other STIs.

Widespread contraceptive use has had a decisive impact on women's self-sufficiency and educational, social and economic opportunities. *The Economist* magazine's special issue on "what has mattered most during this millennium"[2] included an article on oral contraceptives entitled simply "The liberator."[3] The piece concludes, "There is, perhaps, one invention that historians a thousand years in the future will look back on and say, 'That defined the 20th century.'…That invention is the contraceptive pill." With that, the article continues, "Women have taken a giant step towards their rightful position of equal partnership with men."

Economists who have assessed the impact of oral contraceptives in late 20th century America have concluded that oral contraceptives have increased women's age at marriage, which in turn has led to a significant increase in women's participation in the labor force, resulting in their greater financial independence.[4] Moreover, the increase in the age of marriage essentially made the investment in higher education worthwhile for women who otherwise would have left the workforce in their early 20s, or perhaps never have entered it at all. This investment opened new doors for women and brought a marked increase in women's entrance into professions that historically had been dominated by men, such as law and medicine.

Today, use of contraceptives—from the pill to the injectable to the IUD—is nearly universal in the United States and has found its place at the heart of health care for women. Indeed, 98% of sexually experienced American women have used a contraceptive method at some point in their lives.[5] The desire to time and space pregnancy is a powerful incentive that pulls women into the health care system. For many of these women, their family planning visit constitutes their basic health care for the year. During such a visit, a physician or advance-practice nurse not only dispenses a method of contraception, but also typically takes or updates a woman's medical history; provides her with counseling and education; conducts pelvic and breast exams; tests for STIs, reproductive cancers, heart disease, diabetes and a range of other health problems; and provides or refers for further diagnosis or treatment for problems discovered.

A Persistent Problem

Despite the demonstrable importance and ubiquity of contraception, the truth is that ensuring that every pregnancy is wanted and planned is difficult, at both the individual and the societal levels. For the typical American woman to have two children, she will spend about five years pregnant, postpartum or attempting to become pregnant, and three decades—more than three-quarters of her reproductive life—trying to avoid pregnancy (Figure 1.1).[6] Not all women, however, are successful: About half of all pregnancies in the United States each year—more than three million of them—are unintended.[7] By age 45, more than half of all American women will have experi-

enced an unintended pregnancy, and about one-third will have had an abortion.[8]

Nonetheless, contraceptive use can and does dramatically reduce women's odds of having an unintended pregnancy. Among all U.S. women at risk of an unintended pregnancy, the two-thirds who consistently and correctly practice contraception all year account for only 5% of unintended pregnancies (Figure 1.2, page 8).[7,9–12] The remaining 95% of unintended pregnancies occur among the one-third of women at risk who did not use contraceptives at all during the month of conception or who used a method inconsistently or improperly.

For women and couples to improve their odds of effectively practicing contraception over the course of so many years, they need assistance in the form of meaningful access to their family planning options. Women and couples need a broad range of high-quality contraceptive options, enabling them to select one that—according to their specific life circumstances, sexual behavior and health needs—maximizes their potential for effective use and minimizes the medical side-effects and other drawbacks that can lead to inconsistent use or nonuse. Women typically use different methods at different stages of their lives; in fact, the average woman uses four methods over the course of her life.[13] Moreover, women and couples need accurate information about the benefits and drawbacks of each option. They require access to health care providers who are willing and available to serve them, who can speak their language and understand their values and perspectives, who can discuss sexuality comfortably and without judgment, and who are trained to know about and be able to offer the full range of family planning options. Finally, women and couples require some way to pay for the services they need, year in and year out, be it through private health insurance, personal income or publicly supported coverage or care.

A Helping Hand

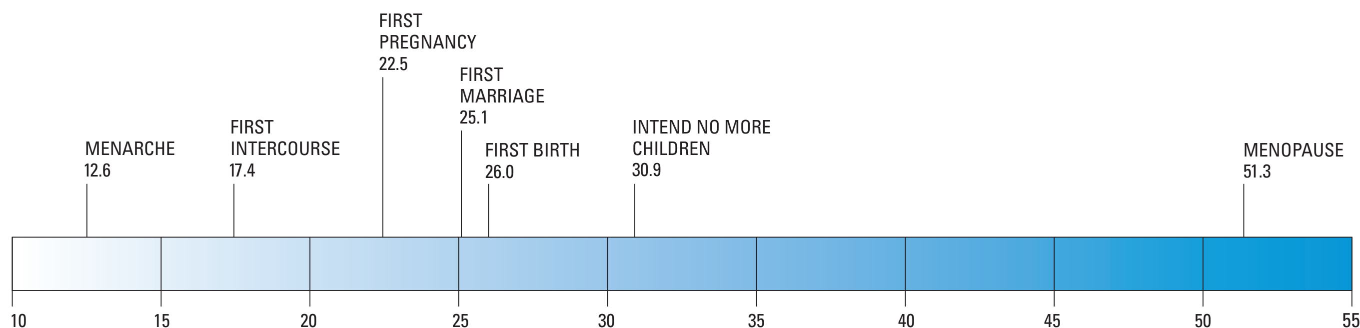
Four decades ago, the U.S. government—acknowledging the health, social and economic benefits of helping women and couples to overcome their difficulties practicing contraception—began working toward a solution. The goal then and now is to ensure access to family planning services and supplies for every person who wants and needs them. The federal government recognized that barriers to access are particularly salient for those without stable and sufficient personal resources, and has focused its efforts on expanding access for low-income and young women and men, in large part by supporting a nationwide network of family planning centers and by setting standards and guidelines to ensure that publicly funded patients receive the same quality counseling, care and technologies as privately insured patients.

Fully four in 10 poor women of reproductive age have no insurance coverage whatsoever (Figure 1.3, page 10).[14] Publicly supported family planning centers provide contraceptive services and closely related preventive care to a large proportion of the 17.5 million American women in need of publicly supported contraceptive services.[15] With the help of these services, clients are able to avoid millions of unintended pregnancies and the unintended births, abortions or miscarriages that would otherwise follow. This has led to considerable reductions in the U.S. rates of abortion and teen pregnancy, as well as infant and maternal mortality—goals that are shared broadly across the political spectrum. And by helping millions of women avoid pregnancies they do not want, these services yield billions of dollars in cost-savings to the federal and state governments.

Moreover, this national network of community-based, safety-net centers provides an array of important health promotion and disease prevention services well beyond birth control. Family planning centers have become a

FIGURE 1.1

The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years trying to avoid pregnancy.

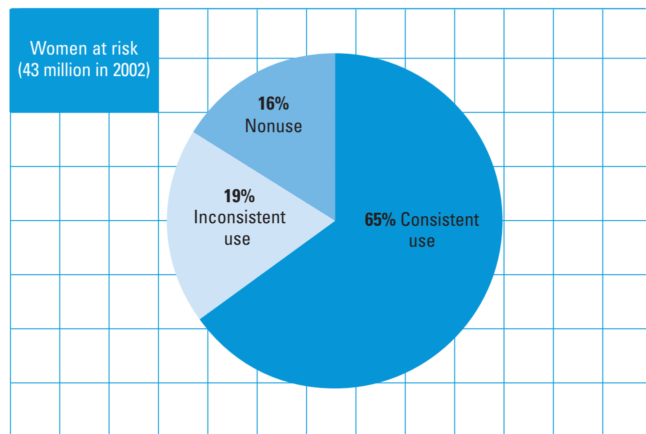


Median age at which event occurs*

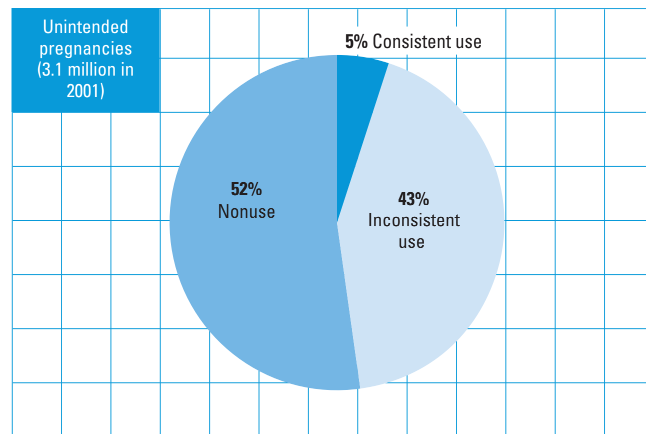
Note *Age by which half of women have experienced event.
Source Reference 6.

FIGURE 1.2

The two-thirds of U.S. women at risk of unintended pregnancy who practice contraception consistently and correctly account for only 5% of unintended pregnancies.



By consistency of method use all year



By consistency of method use during month of conception

Notes Top—Data on one-year contraceptive use and consistency patterns for nonsterilized adult women (aged 18–44) at risk (28.3 million) have been supplemented with data on the number of women using contraceptive sterilization (13.2 million) and estimated contraceptive use patterns for sexually active minors (1.4 million). **Consistent use** includes pill users who missed no pills, condom and other barrier method users who correctly used their method every time and women who used a long-acting method or were sterilized, as well as 3% of women with no information on consistency of use. **Inconsistent use** includes pill users who skipped one or more pills, and condom and other barrier method users who did not use their method correctly at every act of intercourse. **Nonuse** includes women not using a method all year (6%) and those with an at-risk gap in use of at least one month (10%).

Bottom—The proportion of unintended pregnancies attributed to women with consistent use (i.e., those whose method failed) was calculated by dividing the weighted average of perfect-use failure rates for all reversible method users by the weighted typical-use failure rate for all reversible method users. The result was multiplied by the proportion of pregnancies that occurred among women who were using a method.

Sources Top—References 11 and 12. Bottom—References 7, 9 and 10.

vital, albeit largely unheralded, component of the nation's health care infrastructure, which function despite tremendous financial pressures and, at least in some quarters, no small amount of political opposition.

A New Opportunity

Title X of the Public Health Service Act is the sole federal program devoted entirely to family planning. Through Title X, the federal government sets family planning policy, and its flexible grant funds not only subsidize direct client services, but are critical to putting family planning centers in communities and to supporting their ongoing infrastructure needs.

Medicaid—the nation's insurance program for the poor—has become an increasingly important source of family planning center revenue and of support for family planning service delivery to Medicaid enrollees by private physicians.[16] Medicaid's centrality to the family planning effort has been consolidated since the mid-1990s, as more than half the states have initiated programs expanding eligibility for family planning services to income levels far above the ceilings set for Medicaid more broadly.[17]

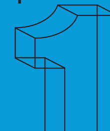
Particularly in states with these Medicaid expansions, family planning providers have found ways to weave Medicaid and Title X together, maximizing their relative advantages as funding sources to serve more women and better meet their needs. Looking forward, policymakers must address and evaluate the roles of these two programs together, to most effectively retool publicly supported family planning for the future.

The timing for such a review is fortuitous. A new president and a new Congress are charged with the formidable task of fixing America's broken system of health care financing, one beset by falling rates of employer-sponsored insurance coverage and rising health care costs. This was a critical issue during the 2008 presidential election, as the Democratic and Republican candidates, along with scores of candidates for House and Senate seats, contrasted their markedly different visions for reforming the system. To be sure, there have long been and remain numerous obstacles to reform: partisan conflict, the woeful state of the economy and government budgets, and sharply different visions for the role of government versus the private sector. Nevertheless, for the first time since the early 1990s, there seems to be legitimate hope for making meaningful progress toward ensuring that no one is denied what in most developed nations is acknowledged as the human right to basic health care.

For low-income women and men, health care reform will most likely focus on enhancing Medicaid and related public insurance programs to fill in the many gaps in eligibility that leave some of the poorest people in this country dependent entirely on understaffed and underfunded community health centers and emergency rooms. For family planning, that means that Medicaid's role as the

primary public funder of client medical services will need to be further solidified. At the same time, the critical complementary role of Title X needs to be fully acknowledged, legislatively facilitated and adequately funded. Congress has not embarked on a formal Title X reauthorization process since 1985, because of the political controversy that has dogged the program, fueled by a small but vocal faction of social conservatives who equate contraception with abortion and who oppose confidential family planning services for teens. Such a process is long overdue.

If both Title X and Medicaid are thoughtfully reviewed and updated, family planning service providers will be better equipped to effectively reach out to an increasingly hard-to-reach clientele, such as women with limited English proficiency and those who are facing domestic violence, homelessness or substance abuse. Also, providers will be better able to help those Americans who struggle to use a birth control method effectively to find ways to overcome their individual hurdles. Addressing family planning services under the aegis of health care reform, as an integral aspect of health care for women and men, is appropriate and long overdue. It is also a step toward transforming the way in which these services are regarded by health policy experts, government officials and the American people in general, so that this care is rightfully provided the secure base of funding it requires.



A Need for Change

Taking bold action now is imperative, because publicly funded family planning faces a host of challenges, including a growing and increasingly diverse client base, evolving standards of care and unique cost pressures above and beyond those facing the overall health care system.

Terms Used in this Report

INCOME

Unless otherwise specified in the relevant figures and tables, poor is defined as having a family income below 100% of the federal poverty level ($17,600 for a family of three in 2008);[1] low-income is defined as having a family income at least 100% but less than 200% of the poverty level.

RACE AND ETHNICITY

Three mutually exclusive racial and ethnic categories are used in this report: white, black and Latina. Although Latinas may be of any race, the research cited here treats them as a distinct group. Other racial and ethnic categories such as Asians are not discussed, because the national surveys upon which most of this report is based are not large enough to provide reliable estimates for these smaller groups of Americans.

FAMILY PLANNING SERVICES AND SUPPLIES

Usually refers to the package of direct patient care services provided through family planning programs to reversible-contraceptive clients. These include client counseling and education, contraceptive drugs and devices, related diagnostic tests (e.g., for pregnancy, cervical cancer, HIV, other STIs and chronic medical conditions) and procedures (e.g., breast and pelvic exams), and treatment after diagnosis (e.g., for urinary tract infections and STIs other than HIV). In some contexts, it also includes sterilization services and community-based outreach and education services.

PUBLICLY FUNDED FAMILY PLANNING CENTER

A site that offers contraceptive services to the general public and uses public funds, including Medicaid, to provide free or reduced-fee services to at least some clients. These sites may be operated by a diverse range of provider agencies, including public health departments, Planned Parenthood affiliates, hospitals, community health centers and other, independent organizations. In this report, “center” is used instead of the synonymous term “clinic.”

TITLE X–SUPPORTED FAMILY PLANNING CENTER

A center that receives any Title X funds. All clients served at a Title X–supported center are considered Title X clients and served in accordance with Title X policies, even if their care is paid partially through another funding source, such as Medicaid.

UNINTENDED PREGNANCY

A pregnancy that, at the time of conception, was either mistimed (i.e., the woman wanted additional children, but not yet) or unwanted (i.e., the woman did not want any additional children).

WOMEN OF REPRODUCTIVE AGE

Usually refers to women aged 13–44, the years during which most women are able to become pregnant. In some specified cases, the term refers to women aged 15–44.

WOMEN AT RISK OF UNINTENDED PREGNANCY

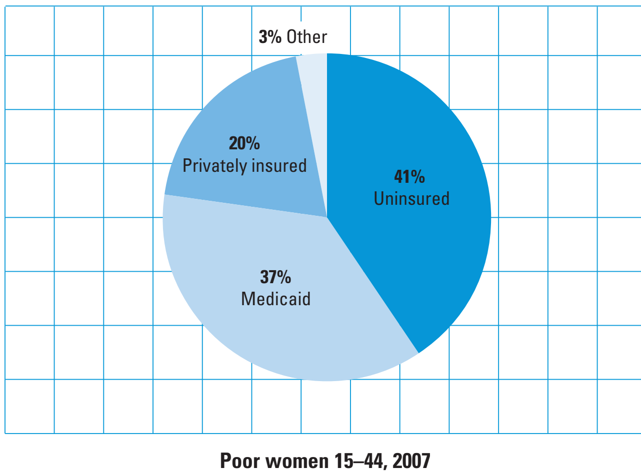
Women aged 13–44 who are sexually active and able to become pregnant, but do not wish to become pregnant. (Women who rely on contraceptive sterilization are considered “at risk of unintended pregnancy” and using sterilization as their contraceptive method.)

WOMEN IN NEED OF PUBLICLY SUBSIDIZED CONTRACEPTIVE SERVICES

Women aged 13–44 who are sexually active, able to become pregnant but do not wish to become pregnant, and either have a family income below 250% of the federal poverty level or are younger than age 20 and are therefore assumed to have a low personal income. The term is sometimes abbreviated as “women in need.” (Women who rely on contraceptive sterilization are not considered in need of publicly subsidized contraceptive services.)

FIGURE 1.3

Four in 10 poor women of reproductive age have no insurance coverage, and nearly that many rely on Medicaid.



Poor women 15–44, 2007

Source Reference 14.

None of these challenges is more pressing than the distressing fact that the national effort has begun to lose ground in meeting its core mission: ensuring that no one is disadvantaged by a lack of the information and services they need to plan if and when to have children.

One of the most notable successes of the national family planning effort during its first quarter-century was the near elimination of the income and racial disparities in contraceptive use that spurred the government's initial involvement in family planning. In 1982, 20% of poor women at risk of unintended pregnancy were not using a contraceptive method, compared with 9% of their more affluent counterparts (Figure 1.4).[18] Contraceptive nonuse among black and Latina women, too, was substantially higher than among white women. By 1995, nonuse had decreased significantly, and the disparities had largely disappeared. Yet, by 2002, some hard-fought ground had been lost. The proportion of at-risk women not using contraceptives rose precipitously among poor and black women.

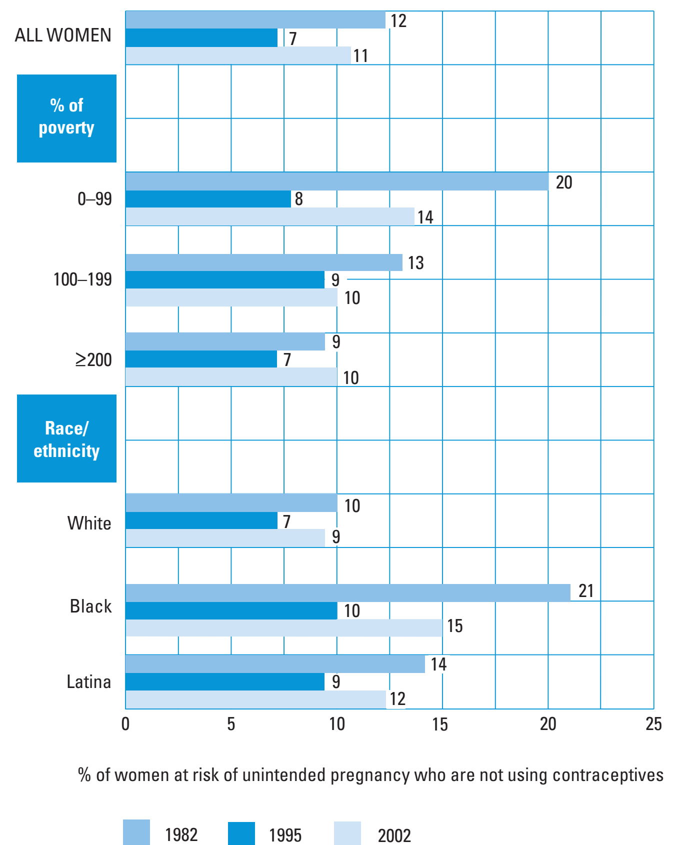
These reemerging racial, ethnic and income disparities are compounded by differences in the continuous use of contraceptives. Over the course of a year, 28% of poor women at risk of unintended pregnancy experience one or more gaps of at least one month in their contraceptive use, compared with 19% of more affluent women; 30% of black women and Latinas at risk experience such a gap in contraceptive use, compared with 19% of white women.[19]

The trends in contraceptive use—the positive and the negative—have been reflected in U.S. rates of unintended pregnancy. Between 1981 and 1994, the national rate of unintended pregnancy fell 14%, from 60 to 51 unintended pregnancies per 1,000 women aged 15–44 (Figure 1.5).[7,20] But between 1994 and 2001, that overall national rate stagnated. Worse yet, rates among poor and low-income women rose considerably over the latter period, even as they continued to fall among more affluent women, thereby exacerbating already substantial disparities. Unintended pregnancy did fall modestly among black women, but their rates, and those of Latinas, continue to dwarf those of their white peers.

The differences in contraceptive use and unintended pregnancy are by no means the only sexual and reproductive health disparities plaguing low-income Americans and communities of color. For example, maternal mortality is heavily concentrated among black women, who have rates more than triple their white and Latina peers.[21] HIV and other STIs, too, disproportionately affect black women and men. And beyond the field of reproductive health, there are even more disparities. Whether measured in rates of heart disease, cancer and diabetes or the use of numerous types of diagnostic, preventive and treatment services, gaps tied to poverty or race are too frequent and too pronounced.[22,23] A renewed commitment to closing all these

FIGURE 1.4

Disparities in contraceptive use narrowed in the 1980s and 1990s, but have begun to widen again.



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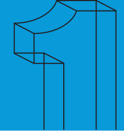
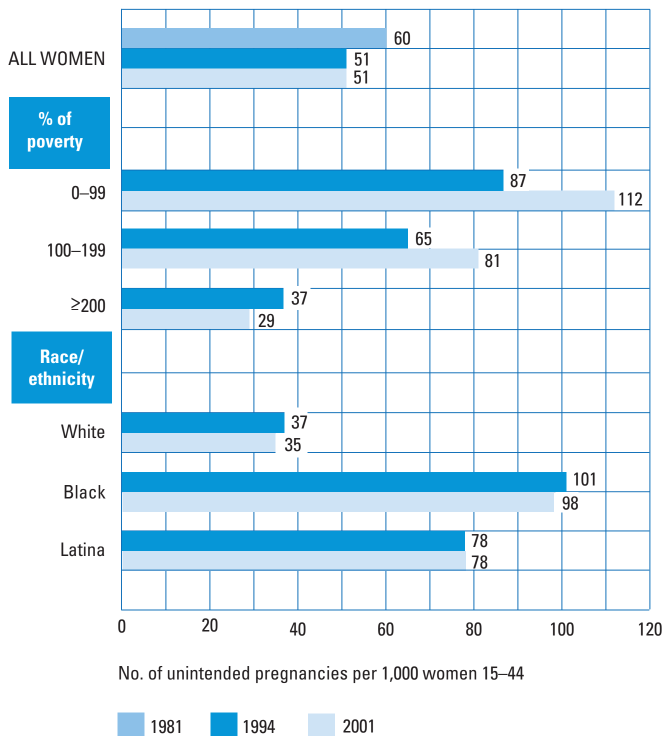


FIGURE 1.5

Between 1994 and 2001, overall rates of unintended pregnancy stagnated, but rates among poor and low-income women rose considerably.



Sources References 7 and 20.

gaps has been set as one of the nation's public health priorities,[24] and the national family planning effort has a critical role to play.

This report seeks to illuminate the challenges and opportunities ahead and to lay out a way forward. In Chapter 2, we review the origins of public efforts to improve access to family planning services for disadvantaged Americans and describe how these programs have helped women plan their reproductive lives and have otherwise improved the well-being of women and their families. Chapter 3 details the ways in which public financing for family planning is changing and the opportunities these changes provide. In Chapter 4, we explore a broad set of challenges to the system, including the difficulty of reaching the most disadvantaged groups of women; of meeting the counseling, education and clinical needs of the clients who do come in; and of meeting the ever-rising costs of providing services. Finally, in Chapter 5, we make recommendations on how the system can be reshaped to attain in the near future a stable, cohesive set of programs that provides subsidized contraceptive and related care for everyone who wants and needs it, and in which family planning is viewed not as a source of controversy, but rather as basic health care to which all women and men are entitled.

Chapter 2

Publicly Funded Family Planning: Past and Present

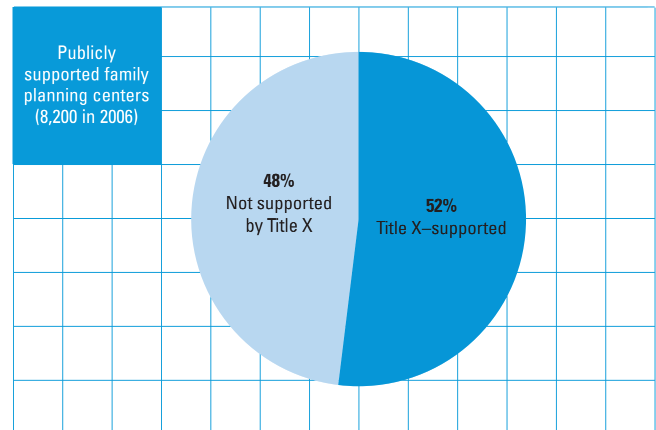
Fifty years ago, a rare confluence of medical, legal and social developments ushered in a new era. The 1960s was a period of rapid social change, marked by the civil rights and women's rights movements—both of which were focused on reducing inequality and expanding human freedoms and opportunities. Many leaders of these movements recognized family planning as being fundamental to the drive for equality and social justice. Martin Luther King, Jr., for one, lauded family planning for improving the lives of African Americans and for offering them "a fair opportunity to develop and advance as all other people in our society."[25]

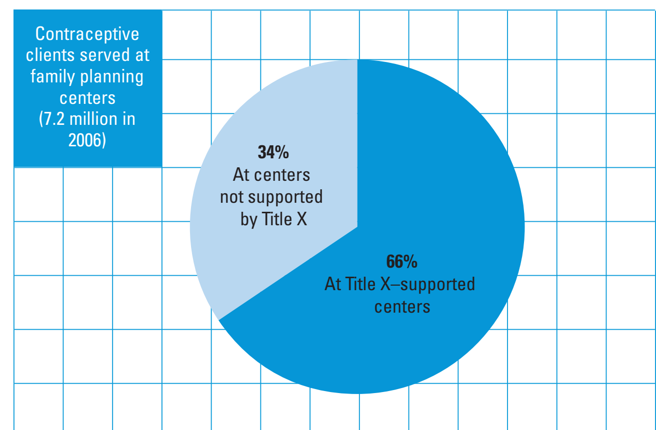
The impetus for government involvement in subsidized family planning services in the 1960s clearly reflected these social movements, as well as new developments specific to the field of sexual and reproductive health. Beginning with the U.S. Food and Drug Administration's approval of the first oral contraceptives in 1960, the development of increasingly effective and convenient methods of contraception made the prospect of controlling childbearing a reality. Furthermore, over the course of the 1960s, there was increasing recognition among researchers, advocates and policymakers that enabling women and couples to better control the number and timing of their pregnancies could play an important role in reducing disparities in three key areas: poverty and government dependency, public health and human aspirations.

In terms of poverty and government dependency, numerous studies at the time documented the substantial and far-reaching economic consequences that unintended pregnancy could have—particularly among teenagers—by increasing a woman's risk of living in poverty and reducing her ability to participate in the workforce or complete an education.[26–28] (Notably, the first federal family plan-

FIGURE 2.1

Title X–supported family planning centers make up half of the national network and serve two-thirds of all clients.





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ning grants were made by the Office of Economic Opportunity, as part of the Johnson administration's signature War on Poverty.) In regard to public health, researchers found that closely spaced births and childbearing very early or late in a woman's reproductive years could lead to adverse health outcomes for both mothers and their children—findings that have been corroborated more recently.[29] And in terms of human aspirations, groundbreaking research showed that although women at all income levels wanted about the same number of children, lower-income women continued to have more children than they desired because they lacked access to affordable and effective contraceptives.[30,31]

A National Effort

These concerns about disparities and social justice fed into the establishment, in 1970, of the Title X national family planning program.[32] The legislation establishing the program garnered wide, bipartisan support. The Senate approved the measure unanimously,[33] and the House soon followed, passing the measure by an overwhelming vote of 298 to 32.[34]

Two years later, Congress took another dramatic step, by requiring that each state's Medicaid program include coverage of voluntary family planning services and supplies for all beneficiaries of childbearing age.[35] Moreover, a second critical provision of the legislation committed the federal government to reimburse states for 90% of the cost of providing family planning services to program enrollees.

With the creation of Title X and the mandate that family planning services be covered nationwide under Medicaid, Congress had established the groundwork for a national effort to provide contraceptive services and closely related medical care to individuals in need. Government efforts, however, did not stop there. In 1975, Congress authorized the creation of a nationwide network of community health centers, requiring them to provide a broad range of primary and preventive health services, specifically including family planning.[36] Over the subsequent decades, states have allocated funding from several other federal programs—notably the maternal and child health, social services and Temporary Assistance for Needy Families block grants—for family planning, and most have contributed revenues of their own.[16]

Nevertheless, Title X and Medicaid are the foundation on which the family planning effort continues to rest today. Title X remains the locus of the federal government's policymaking on family planning issues and sets the standards for publicly funded services, while Medicaid has become increasingly important as a source of funding for clinical services.

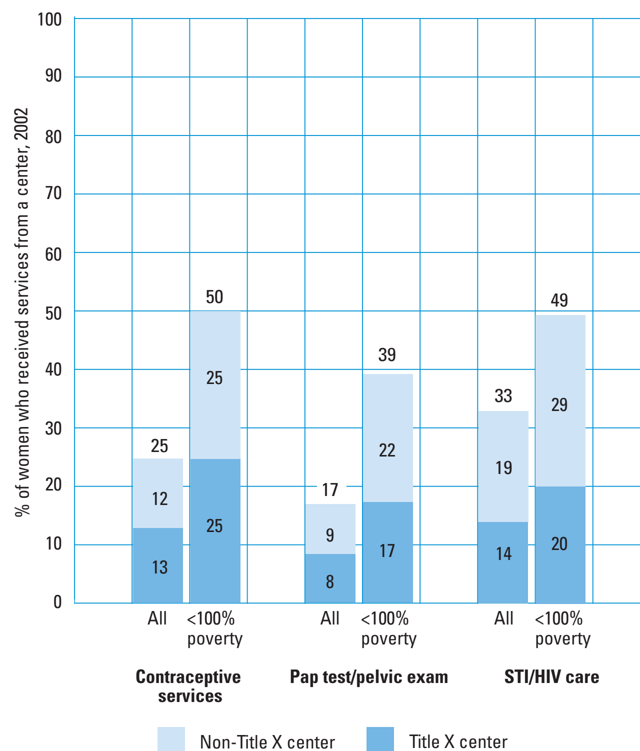
Title X and Medicaid are fundamentally different programs. Under Title X, funds are allocated to entities that submit applications for grants to support the provision of contraceptive services and related preventive health care, with a priority on meeting the needs of low-income and young women and men. Such entities include state and local health departments, as well as nongovernmental organizations such as community health centers, Planned Parenthood affiliates and other, independent agencies. Because it is a grant program, Title X not only funds direct client services, but provides critical support to centers' infrastructure in ways that other funding sources do not.

Unlike Title X, Medicaid is essentially an insurance program, which reimburses providers for care to individuals meeting the program's strict eligibility criteria. In general, Medicaid reimbursement is available only for the cost of providing direct medical care and—because payment rates are typically low—only for a portion of the cost. On the other hand, Medicaid is a means-tested entitlement program, under which overall spending is not subject to annual appropriations, but instead expands as the number of enrollees expands. (Nonetheless, states can limit spending by restricting the specific services covered, adjusting eligibility levels or imposing other administrative restrictions.)

Family planning centers, as well as private physicians, may claim reimbursement under Medicaid for serving program enrollees. Medicaid has become a critical source of funding for family planning centers: Eight in 10 family planning agencies—the administrative entities that oper-

FIGURE 2.2

One-quarter of U.S. women obtaining contraceptive services, and nearly one-half of poor women, do so at a publicly funded family planning center.



Sources References 45 and 47.

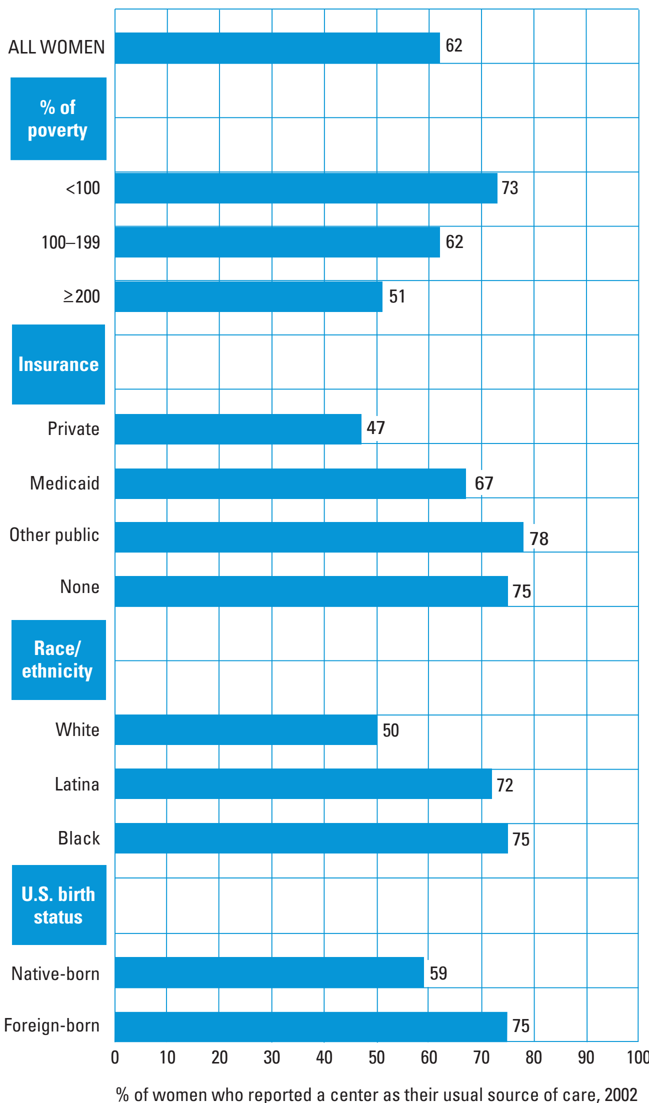
ate individual centers—receive some reimbursement through Medicaid.[37] Although its contribution varies by state, nationally, Medicaid is the single largest source of financial support for Title X–supported centers. Medicaid contributes 30% of all revenue reported by these centers, and Title X provides 24%.[38] (The remaining 46% comes from state and local governments, other federal programs, private insurance and fees paid by clients.)

Defining the Effort

Along with supporting the family planning center network, Title X essentially sets the standard for the provision of publicly supported family planning services. From its inception, the Title X statute, as well as regulations promulgated under the statute and a detailed set of program guidelines, have applied to all women and men seen at centers supported to any extent with Title X dollars, even if an individual's care is paid partially or entirely through another public program such as Medicaid, through private insurance or by the client.

FIGURE 2.3

The large majority of women who obtain care at a family planning center consider it their usual source of care.



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The policymakers who crafted Title X recognized that publicly subsidized contraceptive initiatives can be a double-edged sword. The ability to decide if and when to have a child can be a central source of empowerment for individual women and couples. But history—including U.S. history—is replete with examples of using fertility control as a tool of social control, through deliberate campaigns to limit the fertility of women of color, low-income women and women with disabilities. Recognizing that there needed to be a standard of care for the ethical delivery of services, the authors of Title X ensured that participation would be truly voluntary, by including key patient protections from the beginning. Notably, it contains a requirement that clients must be offered a broad range of contraceptive methods from which they can make a choice, a guarantee that clients would not be coerced into accepting a particular method and an express prohibition against conditioning the receipt of government assistance on the acceptance of any contraceptive method. Moreover, program regulations require that centers that receive any funding through Title X must ensure confidentiality for all their clients.[39]

The current Title X program guidelines—developed in 2001 in conjunction with the American College of Obstetricians and Gynecologists—provide that all clients seeking services at a Title X–supported center are to be offered a package of contraceptive services and closely related preventive services, including a pelvic exam, Pap test to screen for cervical cancer, physical exam, blood pressure check and breast exam.[40] Women at high risk for STIs who are served at family planning centers that receive any Title X funding are expected to be tested and to receive appropriate counseling, treatment and medical referral. Title X–supported centers are required to establish arrangements with health and social services providers, so that clients needing additional services or follow-up care can easily and quickly be referred for such services or care.[41]

By regulation, services provided in centers that receive Title X funds are free of charge to clients with an income below the federal poverty level.[42] Other clients are assessed a fee according to a sliding scale on the basis of their income. Clients with an income above 250% of the federal poverty level are charged the full fee.

The Title X statute has always expressly prohibited using grant dollars to fund abortion. Pregnancy testing, however, is a core service,[43] and a client who is found to be pregnant is entitled to receive nondirective counseling on, and referral for, all of her legal options, including prenatal care, adoption and abortion.[44]

Finally, the program sets the standard for accountability for publicly funded family planning in the United States.

Title X grantees collect data on a range of indicators related to clients served, revenues and the services provided. These data clearly document the program's effectiveness and cost-effectiveness since its inception and paint a clear picture of the public's return on its investment.

A Critical Safety Net

In 2006, more than nine million clients received publicly funded contraceptive services, amounting to 54% of women in need of publicly subsidized contraception.[15] Roughly two million of them were Medicaid enrollees served by private physicians and, indeed, in large part because of Medicaid, 45% of poor women in the United States who receive a contraceptive service do so in a physician's office.[45]

Yet, in large measure, family planning centers are the backbone of the provider network. Nationwide, in 2006, a total of 8,200 sites provided services to 7.2 million contraceptive clients, who represented 41% of women in need.[15] More than half of these centers (4,300) received some Title X funding (Figure 2.1, page 12). Title X–supported centers are located in three-fourths of U.S. counties,[46] and provide services to 66% of all clients served at family planning centers nationwide and to 27% of women in need.[15] One in four women who obtain contraceptive services in the United States—including 50% of poor women—do so at publicly funded family planning centers (Figure 2.2, page 13).[45,47]

Access to publicly funded contraceptive services allows millions of women to obtain and use contraceptive methods that they would otherwise not be able to afford. Among women who practice contraception and rely on publicly funded family planning centers, three-quarters use highly effective prescription methods, such as the pill, injectable and IUD, and one-quarter rely on male condoms or other nonprescription methods.[48] By facilitating access to a more effective mix of contraceptive methods, publicly funded family planning centers enable the clients they serve to have 78% fewer unintended pregnancies than are expected among similar women who do not use or do not have access to these services.

At the same time, the package of services provided at family planning centers is much broader than contraception. Women who make an initial or annual visit to a family planning center typically receive a breast exam, a simple procedure that can lead to detecting breast cancer early, when it is most successfully treated. Family planning centers also provide Pap tests, which can detect cervical cancer early, when it is most treatable, or even prevent it entirely by detecting treatable precancerous cells. Each

FIGURE 2.4

The national publicly funded family planning effort helps women avoid 1.94 million unintended pregnancies annually, 1.48 million of which would have been among clients of family planning centers.

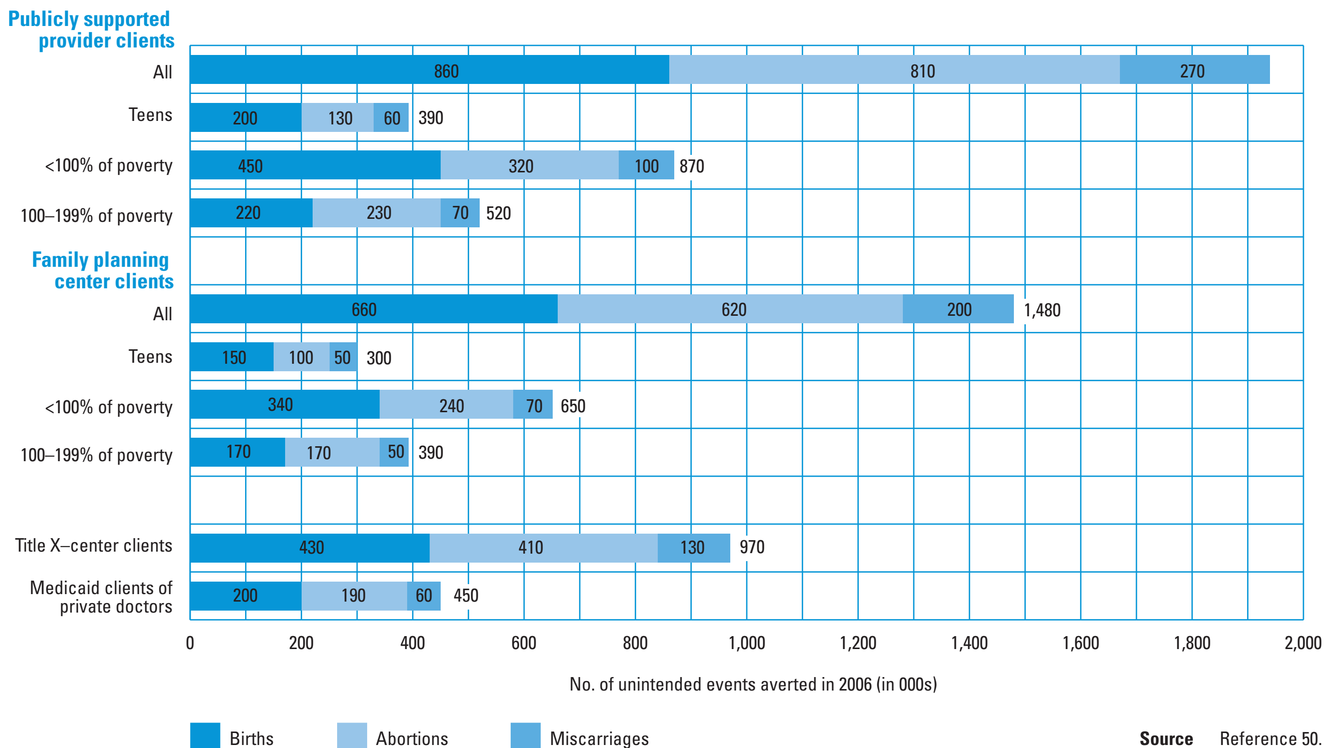

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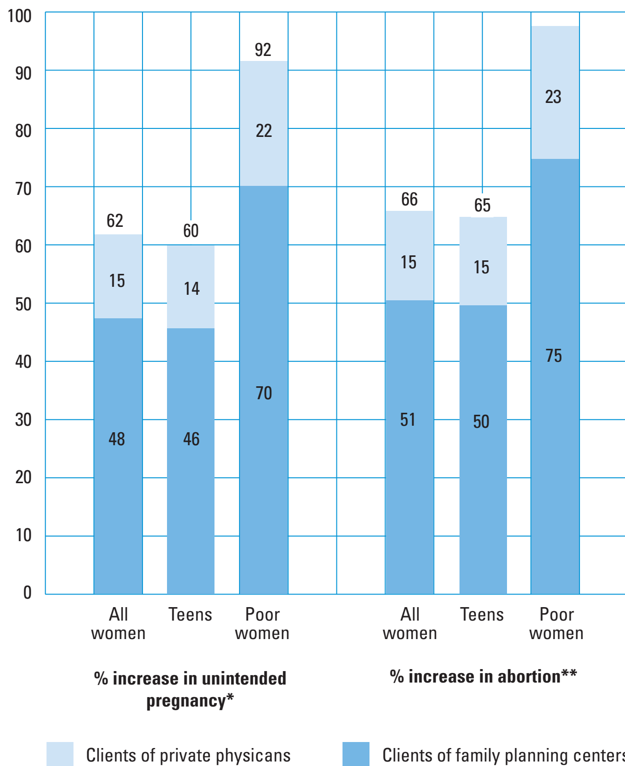
FIGURE 2.5

In the absence of publicly funded family planning, levels of unintended pregnancy and abortion would be nearly two-thirds higher among women overall and teens, and close to twice as high among poor women.



Notes *Compared with national unintended pregnancy levels in 2001. **Compared with national abortion levels for 2004. Most recent data available for each type of event.

Source Reference 50.

year, one in six women who obtain a Pap test or a pelvic exam do so at a publicly supported family planning center.[45,47] Furthermore, Title X–supported centers alone reported providing 2.5 million Pap tests to their clients in 2006.[38] One percent of these tests, representing nearly 25,000 women, detected potentially precancerous cells that required follow-up.

Family planning centers are also critical in providing STI services to women and men (see box). One in three women tested for HIV nationally do so at a family planning center.[45,47] In addition, a similar proportion of women who receive counseling, testing or treatment for an STI other than HIV receive that care from a family planning center. In 2006, Title X–supported centers reported that 2.3 million clients were tested for chlamydia, 2.1 million for gonorrhea, 700,000 for syphilis and more than 650,000 for HIV.[38] Early diagnosis and treatment is a critical prevention strategy for all STIs, and some of the STI treatment provided to young women in family planning centers is fundamental to preventing infertility later in life.

In short, the package of basic, preventive sexual and reproductive health services routinely provided in family planning centers—along with contraceptive services and supplies—is essentially the same package of care a private physician offers a woman during her annual gynecologic exam. In many cases, family planning centers are able to treat conditions that are diagnosed in the course of a routine family planning center visit, such as STIs or urinary tract infections. In other cases, such as when a breast exam reveals a suspicious lump or an HIV test yields a positive result, family planning centers will refer the client to another provider for follow-up care.

It is therefore not at all surprising that many young and low-income women look to family planning centers as their usual source of medical care, their entry point into the health care system and, in many cases, effectively a so-called medical home that helps them manage all their health care needs. More than six in 10 women who obtain care at a family planning center consider the center to be their usual source of medical care (Figure 2.3, page 14).[49] For some women, the numbers are much higher: About three-quarters of poor women who obtain care at a family planning center consider the center to be their usual source of care. These numbers are similar for women who are uninsured, who are black or Latina, or who were born outside the United States.

Preventing Unintended Pregnancy

By providing millions of women with access to the contraceptive services they want and need, public funding for family planning helps women avoid 1.94 million unintended pregnancies each year (Figure 2.4, page 15).[50] An estimated 450,000 of these unintended pregnancies are prevented as a result of services provided by private doctors under Medicaid. Yet, publicly supported family planning centers are the dominant source of services—helping women avoid 1.48 million unintended pregnancies. Fully 300,000 of these pregnancies averted with the help of family planning centers would have occurred among teens, and just over one million would have occurred among poor and low-income women. Centers that receive some Title X funds provide services that enable women to avoid nearly one million unintended pregnancies each year.

Enabling these women to avoid an unintended pregnancy reduces the number of women and couples confronting the choice between turning to abortion and having a birth they did not intend to have. Without publicly supported family planning services, the number of unintended pregnancies and abortions occurring in the United States each year would be nearly two-thirds higher among women overall and among teens (Figure 2.5);[50] the number of unintended pregnancies among poor women would nearly double. Without the services provided just in centers receiving Title X funds, unintended pregnancy in the United States would be 31% higher. And absent publicly supported services, the U.S. abortion rate today would be higher than it ever has been.[50,51]

Nine in 10 women who would have become pregnant unintentionally in the absence of the services received at family planning centers would be eligible for a Medicaid-covered birth if they were to become pregnant.[48] In 2004, the cost of pregnancy-related services (prenatal, labor, delivery and postpartum care) for these women, as well as one year of medical care for their infants, would have totaled $5.7 billion. Subtracting what was spent to provide contraceptive and related health services to family planning center clients that year, the services provided at publicly funded centers saved the federal and state governments an estimated $4.3 billion, including nearly $3 billion just from services provided at Title X–supported centers. In other words, every dollar invested in helping women avoid pregnancies they did not want to have saved $4.02 in Medicaid expenditures that otherwise would have been needed.

Significantly, these savings account only for the medical care that would be provided to women during pregnancy and to infants during their first year. They do not include savings from any of the other benefits to women and families, such as preventing and treating STIs, or avoiding and detecting reproductive cancers—all benefits that accrue as part of the package of care provided by family planning centers.

Similarly, this cost-benefit analysis does not attempt to measure any of the broader health, social or economic benefits of enabling women to time or prepare for their pregnancies. One important unmeasured benefit of using contraceptives is that increasing women's ability to plan pregnancy opens the door for preconception care—a set of interventions recommended by the Centers for Disease Control and Prevention aimed at reducing biomedical, behavioral and social risks and at improving birth outcomes for mother and infant.[52] Also unmeasured is the impact of contraceptive availability on women's educational attainment and workforce participation.

Meeting Men's Reproductive Health Needs

Although reproductive health research on men is considerably less developed than comparable research on women, one thing is clear: Men receive considerably fewer services than women. In 2002, only 30% of men aged 20–44 received a reproductive health service—defined as birth control (including condom) advice or services; STI advice, counseling, testing or treatment; HIV advice, counseling or testing; or advice about sterilization.[1] The comparable figure for reproductive-aged women was almost 75%.[2]

The men who do receive services often do so at publicly funded family planning centers—at least nine in 10 of which offered STI counseling, testing and treatment, condom provision and contraceptive counseling to men as long ago as the late 1990s, when the subject was last studied in depth.[3] About half of the time, a family planning center's male clients are partners of a female client, reflecting long-standing attempts to increase male partners' involvement in contraceptive use, and STI prevention and treatment. In other cases, it appears to be the availability of STI services that primarily draws in men.

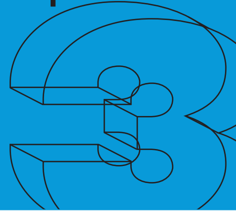
Family planning policymakers and providers have made a number of efforts to expand the provision of men's care. For example, for over a decade, Title X has funded a series of small grant programs to expand services for men, with the goal of integrating family planning services and education into projects providing other health, education or social services to young men.[4] More than one-third of publicly funded family planning centers in 2003 had recruitment efforts targeting the partners of their female clients, and 18% recruited men in general.[5] And of the 27 approved state programs to expand Medicaid eligibility for family planning, eight include men[6]—a marked development for Medicaid, which has traditionally ignored men, especially those who are not yet fathers.

Yet, efforts to expand family planning center services for men face an array of problems. For one, there is no commonly agreed upon set of sexual and reproductive health services that should be provided to men, in general, or by family planning providers, specifically.[7] Even assuming some degree of consensus—that men, at a minimum, need information and counseling to help them avoid unplanned pregnancy and STIs, for example—few health professionals are specifically trained to provide these services to men. In fact, most family planning providers are specifically trained to serve women.

Moreover, young men are considerably less likely than their female peers to have private health insurance or to be eligible for public coverage through Medicaid or the State Children's Health Insurance Program. Without such sources of financing for men's care, there is a danger that expanding services for men would require providers to draw on Title X and other sources, which are limited due to stagnant funding.

Title X—with its traditional focus, first and foremost, on clinical contraceptive services—may not be currently constructed as the optimal program to provide the reproductive health services men want and need most. Indeed, Title X–supported centers are required by the federal government to keep track only of their male contraceptive clients (272,000 in 2006, amounting to 5% of all contraceptive clients[8]); clients visiting the same center only for STI-related services would not be counted at all, and their care would typically be paid for through other public programs.

Finally, the fact remains that for most men, contraception (apart from vasectomy and in the absence of new male contraceptives) is not primarily a clinical matter. In addition, men—especially young men—are considerably less likely than women to seek out health care in general. For those reasons, the challenges to providing the information, counseling and relationship skills training, and clinical care men need to protect their and their partners' reproductive health are unlikely to be fully met anytime soon.



Leveraging Medicaid And Title X

Over the last decade and a half, funding for family planning services has undergone a historic shift, with Medicaid emerging as the central funder, particularly in states that have received federal approval to expand eligibility for family planning under the program. This realignment has revealed the different but highly complementary strengths of Title X and Medicaid. A synergy between the two is becoming evident: Medicaid pays for the core of the clinical care, and Title X wraps around that core—buttressing the family planning center system and filling gaps in services and coverage. And although the expansion of Medicaid has increased private physicians' role in the provision of publicly subsidized family planning, it has also made clear that centers will likely remain the mainstay of the effort going forward.

Rise of Medicaid

Together, the federal and state governments spent $1.85 billion on family planning services in 2006.[16] Although funding for the effort came from a variety of sources, Medicaid was overwhelmingly the dominant one (Figure 3.1). Once a small portion of total expenditures—contributing 20% of funding in 1980—Medicaid now accounts for 71% of all family planning dollars spent (Figure 3.2, page 20).[16] In contrast, the share that Title X accounts for has fallen from 44% in 1980 to only 12% in 2006. Nonetheless, by providing support to 4,300 of the country's 8,200 family planning centers—at which 66% of all family planning center clients are served—the Title X program's reach, in terms of its defining principles, standards and support for infrastructure, remains critical.[15]

The increase in Medicaid spending has not been consistent across states. In large measure, the growth has been driven by state-initiated expansions specifically for family planning. To date, 27 states have successfully navigated the cumbersome and time-consuming process of obtaining permission from the Centers for Medicare and Medicaid Services (CMS)—the federal agency that administers Medicaid—to expand eligibility under the program specifically for family planning.[17]

The expansions in six states are limited and only extend coverage to some or all individuals who are otherwise losing Medicaid coverage. The expansions in the remaining 21 states, however, extend coverage for family planning solely on the basis of income, regardless of whether the individual has ever been enrolled in Medicaid (Figure 3.3, page 20).[17] (Eight of these 21 states include men, as well as women, in their program.) Most of these states set the income-eligibility ceiling for Medicaid-covered family planning at the same level used to determine eligibility for pregnancy-related care: generally at or near 200% of poverty.[53] These levels are well above the regular income cut-off for Medicaid coverage in those states, which across the states averages 63% of poverty for working parents.[54] Childless adults are generally excluded from eligibility at any income level. Sixty-four percent of women in need of publicly funded family planning live in one of these 21 states.[55]

State efforts to expand eligibility for family planning under Medicaid are infusing much-needed new funding into the system. Two-thirds of the growth in family planning spending nationwide between 1994 and 2006 occurred in states with an income-based expansion in place.[16] And because the increase in Medicaid spending in states with income-based expansions has not, in general, been accompanied by a decline in spending from other sources, family planning efforts in these states have more resources than do programs in other states (Figure 3.4,

page 21).[56] In fact, from 1994 to 2006, inflation-adjusted expenditures per woman in need grew by 81% in expansion states, but only by 32% in other states. As a result, the number of Medicaid family planning clients served in states with expansions grew by 60% over the first half of this decade.[16] Even in states without expansions, the number of clients grew by 18% over that same time, reflecting Medicaid's success in keeping up with increasing levels of poverty and uninsurance.

Impact of Expansions

These new resources are giving programs and providers a historic opportunity to address long-standing issues they have lacked the means to confront. These resources are enabling providers to help women who are already practicing contraception to either switch to a more effective—but potentially more costly—method, or to obtain the additional assistance or ongoing support they might need to use their current method more effectively. In addition, they allow many women who have been unable to access services at all to now obtain them.

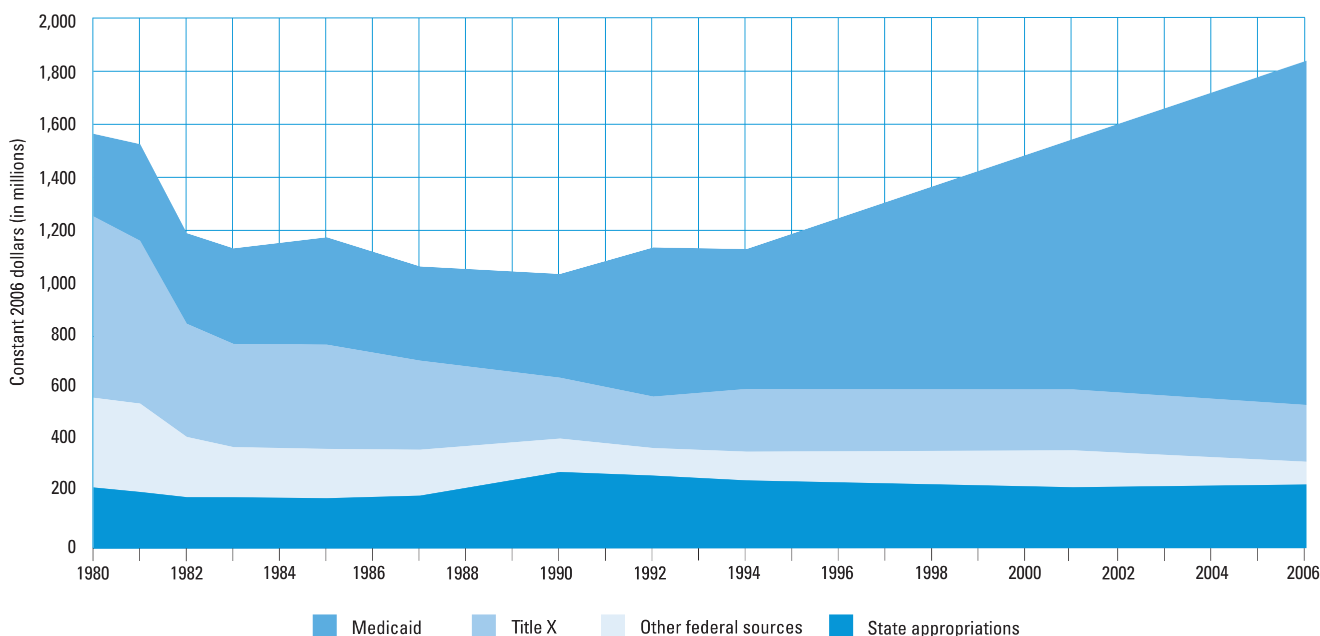
Indeed, across the nation, these efforts improve women's ability to avoid unintended pregnancy and birth, as well as abortion. In 2002 alone, the Medicaid expansion program in California—the nation's largest—enabled 205,000 women to avoid an unintended pregnancy; by doing so, the program averted 79,000 abortions and 94,000 births.[57] (Of these, 44,000 unintended pregnancies, 16,000 abortions and 21,000 births would have been to teens.) In 2005–2006, the effort helped women to avoid 248,000 unintended pregnancies.[58] Similarly, in 2006, the considerably smaller Wisconsin program aided women in averting 12,000 unintended births.[59]

Another measure of the success of expanding Medicaid eligibility is that family planning centers in states with income-based expansions are able to meet more of the need for subsidized family planning services than are centers in other states: Centers in states with income-based expansions serve 48% of women in need, whereas centers in other states serve just 36% (Figure 3.5, page 22).[60] In addition, only the expansion states showed improvement in their ability to meet the need for services between 1994 and 2006: The proportion of women in need served by centers in expansion states rose by one-fifth over that period, from 40% to 48%, whereas the proportion in other states remained relatively stable.

Moreover, by helping low-income women who would be eligible for Medicaid-funded pregnancy-related care to avoid unintended pregnancies, state after state has shown that these programs generate significant cost-savings. According to a CMS-funded evaluation of six state programs, all six yielded significant savings to both the federal government and the states, including a combined $19 million in a single year in Alabama and $30 million in

FIGURE 3.1

Medicaid accounts for all of the inflation-adjusted growth in publicly funded family planning since the early 1990s.



Notes Inflation-adjusted data are reported in constant 2006 dollars using the Medical Care Consumer Price Index–All Urban Consumers, with $1.00 in 2006 equal to $4.49 in 1980. Data available only for 1980, 1981, 1982, 1983, 1985, 1987, 1990, 1992, 1994, 2001 and 2006. Other federal sources include the maternal and child health, social services and Temporary Assistance for Needy Families block grants.
Source Reference 16.

Arkansas.[61] Similarly, according to individual state evaluations, the savings generated by helping women avoid unintended pregnancies far surpass the costs of providing family planning services to program enrollees.[62–64]

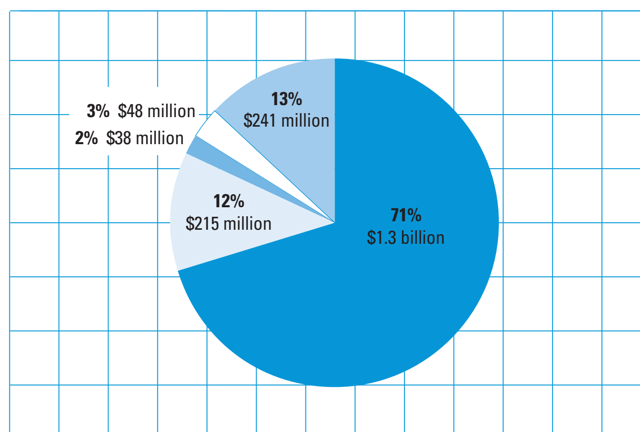
Complementary Programs

The Medicaid expansions have not only brought in critical new resources, but also have the potential to fundamentally alter the relationship and create a new synergy between Medicaid and Title X. In effect, they are setting the national family planning effort on a road that maternal and child health (MCH) programs have been traveling for nearly two decades.[65] When it comes to pregnancy-related care, the MCH program, like Title X, supports a diverse network of providers, including local health departments, community health centers and others. And like Title X–supported providers, those supported by the MCH program often cobble together funding from multiple sources to serve low-income clients in need.

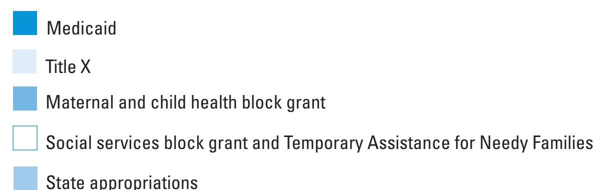
Although the MCH program supports a range of efforts aimed at improving children's health, the program was historically a critical funder of direct prenatal care to women. Through a series of incremental steps in the 1980s, however, Congress dramatically changed how publicly supported pregnancy-related care is financed, by greatly expanding Medicaid eligibility for pregnant women.[66] As a direct result, the proportion of all births funded by Medicaid has grown from 17% in 1985[67] to 41% today.[68]

FIGURE 3.2

Medicaid accounts for seven in 10 public dollars spent for family planning in the United States.



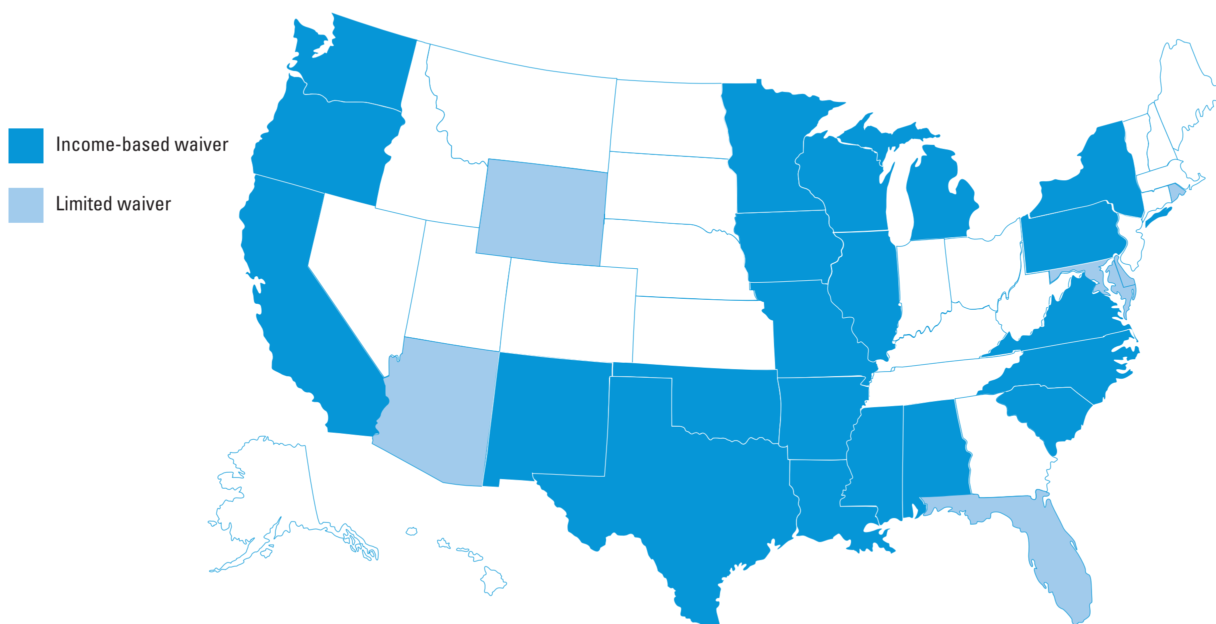
Public expenditures on family planning client services, FY 2006



Source Reference 16.

FIGURE 3.3

Twenty-seven states have expanded Medicaid eligibility for family planning, with most basing eligibility solely on income.



Source Reference 17.

The expansion of Medicaid as a way to pay for pregnancy-related services freed up MCH funds previously used to pay for that same care. Although prenatal care will always be an important part of the effort, program officials consider the direct health care provided by the program as "gap filling," and view the MCH program as the "last-stop safety net," rather than as the funder of first resort.

Instead, the MCH program now focuses more on providing a set of services and activities that are closely related to core clinical services, including enabling services such as transportation, translation, care coordination and follow-up. In addition, MCH funding buttresses program infrastructure by providing critical support for staff, including training and ongoing technical assistance.

A similar transition is occurring within family planning programs in at least some states with Medicaid eligibility expansions, albeit with little federal guidance. Instead, the trail is being blazed by state policymakers and frontline family planning providers.[69] With that transition, a new role for Title X is emerging, as well as a new relationship between Medicaid and Title X that leverages their very different strengths.

In many of these states, Medicaid is shouldering an increasing share of the cost of providing the clinical component of family planning services. But like any insurance program, Medicaid will only fund care for those individuals who meet the program's eligibility requirements—and even then, it will pay only for a clearly defined package of medical care, which includes contraceptive services and counseling, and other services directly tied to a family planning visit. On the other hand, spending under Medicaid is not subject to annual congressional appropriations. As an entitlement program, Medicaid expenditures can and, in fact, are specifically designed to grow as the number of eligible enrollees or the cost of care provided to them increases—a critical feature during periods of economic distress. Although this is clearly among the program's central strengths, it also makes it a perennial target for legislators seeking to rein in public spending.

Title X brings different, but no less critical, strengths to the table. Title X can essentially wrap around the core of services provided by Medicaid, to help provide the full range of services and activities necessary to optimize outcomes for clients and maintain the very existence of the network of family planning centers. Moreover, Title X is a program under which funds are distributed to grantees who design and operate their own programs, and target funds to address specific local needs and challenges.

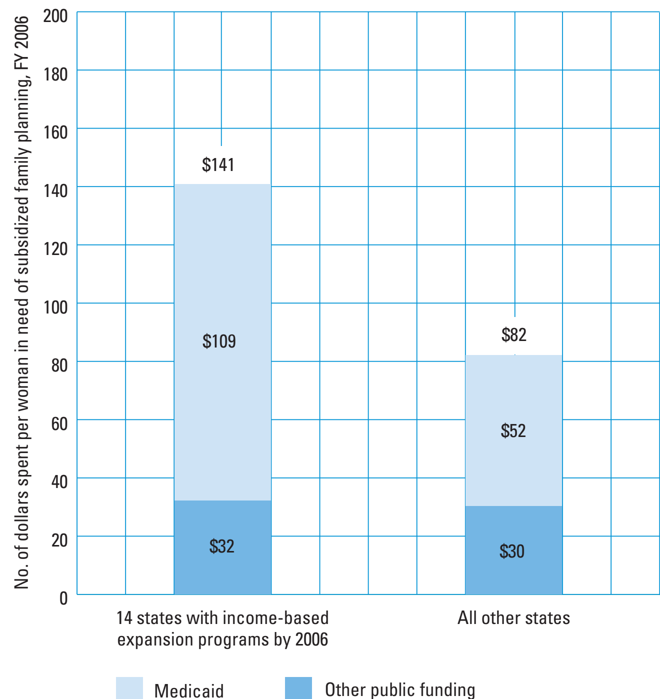
For example, Title X can pay for the services and activities that may not be covered under a state's Medicaid program, such as treatment of STIs or urinary tract infections, or the expanded counseling needed by some clients, such as teenagers, homeless and incarcerated women, and women with substance abuse or domestic violence issues. In addition, Title X can cover the cost of the expanded outreach needed to encourage some of these hard-to-reach women to visit a center for care. And even for those services that are covered by Medicaid, the amount providers are reimbursed is often below their actual costs: For example, Medicaid covered an average of only 54% of the cost of an initial family planning visit in 2004. Again, this leaves Title X and other funding sources to fill in the gap.[70]

Title X can also support the provider infrastructure in ways that Medicaid, as an insurance mechanism, simply cannot. In some cases, this may involve enabling family planning centers to operate outside a regular 40-hour workweek. Or it may involve any number of approaches to addressing staff-related issues, including tailoring staffing to meet a community's need for linguistic or culturally appropriate care; providing clinical training, so staff can be current with the latest medical techniques; and paying sufficient wages to staff at all levels—from the frontline staff to clinicians—to reduce the high level of staff turnover that has long plagued safety-net providers nationwide.[69,71,72]

Finally, a basic role for Title X, like the MCH program, has always been—and will continue to be, regardless of changes to Medicaid eligibility—the direct provision of family plan-

FIGURE 3.4

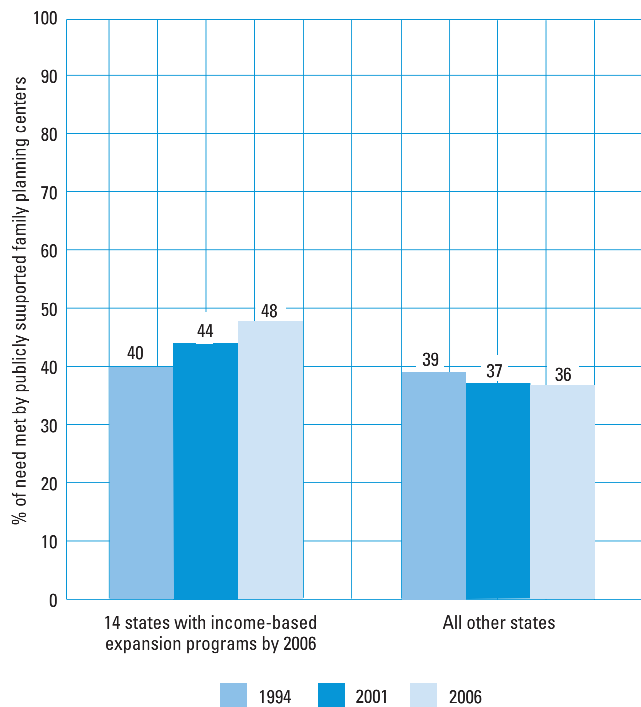
Family planning efforts in states with Medicaid expansions have more resources than do those in other states.



Source Reference 56.

FIGURE 3.5

Family planning centers in states with Medicaid expansions meet more of the need for publicly supported contraceptive care.



Source Reference 60.

ning services and supplies to those in need who are unable to pay. Although some states have dramatically expanded Medicaid eligibility for family planning, none covers individuals with an income up to 250% of poverty, the ceiling for receiving subsidized services under Title X.[41] Increasingly, those ineligible for Medicaid are immigrants—either recent legal immigrants, who are barred from coverage for their first five years of residency, or those who are undocumented and therefore ineligible for anything other than emergency care. Also effectively ineligible are citizens unable to meet stringent new requirements enacted in 2006 that mandate that those applying for Medicaid provide written evidence of their identity and American citizenship. For these individuals, and the providers who serve them, Title X is indispensable.

A Continuing Role

Even as the role of Medicaid continues to expand, the need for Title X to undergird the system of family planning centers will remain as important as it has always been.[73] The availability of Medicaid or any form of insurance reimbursement would be meaningless without a healthy provider network to provide the care poor and low-income clients need and to which they are entitled. Moreover, it is these frontline providers that knit the disparate funding streams together into a coherent program that can meet the needs of their unique clientele.

The critical role of the organized provider network is clearly recognized by state Medicaid programs, which are turning to family planning centers as essential partners in designing and implementing their expansion programs in ways unlikely to happen in private physician practices.[74] Most notably, several states have developed systems where the entire eligibility and enrollment process happens right in the center during the woman's family planning visit. Other states permit family planning center staff to at least screen for eligibility and then assure payment for the woman's initial visit, even if her application is ultimately not approved.

The Medicaid expansions also have the potential to bring more private physicians into the provider network and to make them more significant players. Nonetheless, although private providers have a critical role to play, that role has important limitations. In California, a state that has made a significant effort to enroll private physicians, 63% of the providers are private physicians, each of whom serves a relatively small number of clients. Consequently, the 37% of providers that are family planning centers serve about two-thirds of clients.[75]

Nationwide, private physicians are increasingly unlikely to have any Medicaid patients or to accept new Medicaid clients.[76] As a result, the care of Medicaid patients is becoming ever more concentrated among a relatively small number of physicians who practice in large groups, hospitals, academic medical centers and community health centers.

Part of the difficulty in attracting private physicians is specific to Medicaid: More than eight in 10 physicians who are not accepting new Medicaid patients cite inadequate reimbursement as an important reason; two in three name other administrative issues with the program, such as reimbursement delays and billing requirements. But even addressing just these administrative and financial issues would not be sufficient. Half of physicians not accepting new Medicaid clients cite the high clinical burden of these patients, who often have complicated needs and require time-intensive counseling. Having the time and trained personnel to meet these needs is especially problematic for private practices, which are under increasing pressure from managed care plans and other payers to limit the time and resources devoted to each client.

In contrast, it is exactly this counseling and support that is the hallmark of the family planning center system. Even women who have a regular source of medical care aside from the family planning center often turn to that center for their contraceptive care.[77] Tellingly, these women cite cost of care, confidentiality, quality and accessibility as reasons for turning to centers. Although other providers, such as more broad-based primary care centers or private physicians, can and sometimes do provide this level of family planning services and counseling, family planning centers, as a group, have this as their core mission.

Challenges Facing Family Planning Centers

Despite its myriad accomplishments, publicly funded family planning faces significant challenges going forward. The population in need of publicly funded family planning services is growing, even as it is becoming ever more difficult to reach and serve. Private doctors clearly have an important role to play, but family planning centers will remain at the heart of the effort. Centers must expand and retool their outreach efforts and be prepared to offer care—including counseling and education, as well as clinical services—appropriate to the knowledge, culture, values and life circumstances of an increasingly diverse clientele. And centers must do all this facing continually rising costs, which make even maintaining their current efforts a daunting task.

Reaching Out

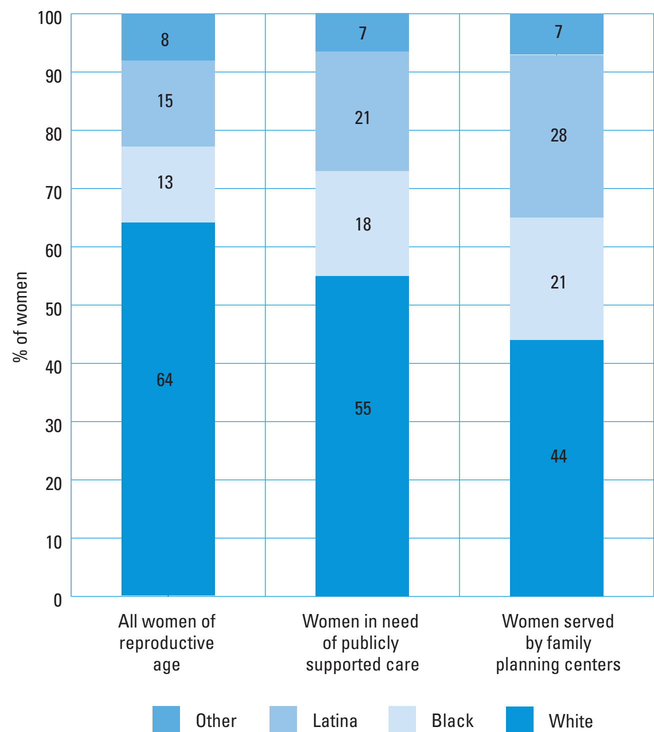
According to the most recent national data (from 2006), 17.5 million women are in need of publicly subsidized family planning.[15] Between 2000 and 2006, the total number of women in need increased by one million, in part because of an increase in poverty.

The clients served by family planning centers in 2006 represent 41% of these women. (Private physicians served an additional 13%.) Clearly, this level of effort must be maintained; however, even with providers' efforts, there are still millions of women whose needs are not yet being fully met. Although many women already know to look to family planning centers for care, many others do not. To reach women who have not yet been reached, centers are having to further refine their outreach strategies and efforts based on their individual communities.

Family planning center clients come from a range of backgrounds and cultures, and speak a widening array of lan-

FIGURE 4.1

Latinas and African American women make up a disproportionate share of women in need of subsidized care and of family planning center clients.



Sources All women of reproductive age and women served by family planning centers, 2002—Reference 45.
Women in need of publicly supported care, 2006—Reference 15.

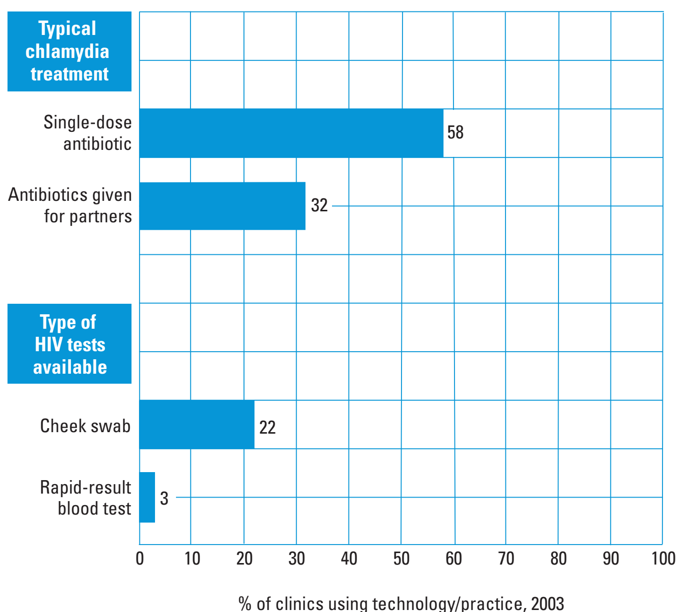
guages. Twenty-one percent of women in need of publicly subsidized family planning services, and 28% of clients served by family planning centers, are Latina (Figure 4.1, page 23).[15,45] And even Latinas are a decidedly heterogeneous group, coming from numerous countries and cultures. Moreover, an increasing portion of the client base was born outside of the United States: Between 1988 and 2002, the proportion of poor reproductive-age women who were foreign-born doubled, from 11% to 23%.[78]

Not only are family planning centers having to tailor their outreach efforts to an array of languages, but they are finding that they need to be sensitive to differing attitudes, values and beliefs about topics like sex, pregnancy, contraception and privacy. In addition, they must confront widespread fears within some communities that clients jeopardize their immigration status by coming in for care. The Texas Health and Human Services Commission, for example, has provided training within the Latina community to "promotoras"—advocates who raise awareness of health and educational issues—to talk to women one-on-one, in small groups or at community meetings.[74] Similarly, to provide Latino parents with information about parent-child communication, STIs, contraceptive methods and the services available at clinics, Planned Parenthood of Wisconsin has conducted home health parties, which allow outreach staff to discuss these sensitive topics in a comfortable setting, such as around a kitchen table.[69]

Centers must also do more to reach other potential clients who have extremely complicated life situations, such as those who are homeless, incarcerated or recently incarcerated; those impacted by domestic violence, substance abuse or mental health issues; and adolescents living in foster care. For example, the Venice Family Clinic in Los Angeles sends outreach teams to street corners and homeless shelters with backpacks of condoms and basic educational materials.[69] Through these efforts, the staff has found that outreach workers may need to make several visits to a homeless shelter or have multiple street-corner conversations before potential clients feel safe and comfortable enough to visit a family planning center.

FIGURE 4.2

Family planning centers have adopted some new testing and treatment technologies more than others.



Source Reference 91.

TABLE 4.1

Approximately nine million new STI cases occur among 15–24-year-olds each year.

STI	No. of new cases
HPV	4.6 million
Trichomoniasis	1.9 million
Chlamydia	1.5 million
Genital herpes	640,000
Gonorrhea	431,000
HIV	15,000
Syphilis	8,200
Hepatitis B	7,500
Total	**9.1 million**

Source Reference 87.

Another way centers encourage those in need to come in for care is by improving the accessibility and availability of services in both urban and rural areas. In many cases, that means locating centers where clients live, work and attend school, and in places easily accessible by public transportation. Increasingly, providers are opening their doors during nontraditional hours—weeknights, weekends, even holidays—as a way to reach people who are too often invisible, such as those who work as domestics, as day laborers or in sweatshops. These women and men work long hours, often in inflexible employment situations that make it impossible to visit a family planning center during traditional hours.[69] A newly renovated clinic in Milwaukee serves clients for 12 hours a day on weekdays and nine hours on Saturday; the Eisner Pediatric and Family Medical Center in Los Angeles not only provides extended hours on a regular basis, but stays open on all holidays, except Christmas.

Meeting Clients' Needs

Once a client comes in to a family planning center for care, it is critical that the center be able to provide the types of multilingual, culturally sensitive and client-centered care best suited to that client's knowledge, beliefs and circumstances.

Counseling and Education

Patient education and counseling have long been at the heart of what family planning centers do. A woman making her first visit to a center may require an extended visit to allow her provider to obtain a complete medical history; perform a range of diagnostic tests; and provide counseling and information on numerous contraceptive options, the risks of STIs, and other sexual and reproductive health matters. Some new clients may even need education on the basics of sex and reproduction. Young clients, too, often need additional counseling to counterbalance misinformation they may have received online or from their friends. And other new clients may need care tailored to the often-complicated circumstances of their lives.

There is increasing recognition, however, that experienced contraceptive users and returning clients need careful attention as well.[79,80] Year after year, these clients need to be asked about life changes that may affect their reproductive health needs; kept abreast of new information, standards and technologies; and provided with general support for the ongoing challenges they face in avoiding unintended pregnancy and STIs.

In fact, recent evidence suggests that building a relationship between center personnel and family planning clients is critical. In one study, women who reported receiving "personalized" counseling in the past two years were more likely than others to be satisfied with those services and to be currently using a contraceptive method.[81] And according to a recent Guttmacher Institute study, women who reported feeling that they cannot contact their contraceptive provider with a follow-up question were more likely than others to experience a gap in their contraceptive use over the course of a year.[19]

To provide the counseling and education clients need, family planning centers are placing a renewed emphasis on the human resources that are central to the effort. They are exploring the ways in which case managers and peer educators, for example, can augment the counseling provided to patients during a routine family planning visit. For instance, teenagers calling the Venice Health Center in Los Angeles are told about a special teen clinic, one of several across the state supported in part with Title X funds.[69] At these sites, peer educators start conversations in the waiting room in hopes of both providing basic

Models for Expediting Clients' Contraceptive Care

Family planning providers across the country, wanting to simplify access to contraceptives and better integrate contraceptive use into women's everyday lives, are taking bold steps to attempt to make contraceptive use more convenient and sustainable.[1] Although some strategies—such as making hormonal contraceptives available without a prescription—remain a long way off, others are already being explored at some family planning centers.

At the heart of these efforts are attempts to ease the process of initially obtaining contraceptives. Many family planning centers, for example, offer the so-called quick-start option for hormonal contraceptives, which allows women to begin using hormonal contraceptives on the day that they visit their provider's office, instead of waiting until a certain point in their menstrual cycle. This option is available in three-fourths of the health centers operated by Planned Parenthood affiliates, nearly half of the centers operated by health departments and one-fourth of the family planning centers operated by other agencies.[2]

Traditionally, a woman's initial visit to a family planning center involves a comprehensive physical examination, including a pelvic exam and a Pap test. Because those procedures may deter some women—especially young women—from even coming to the clinic, Title X permits clients to delay the physical examination for up to six months, but still obtain a contraceptive method in the meantime.[3] In 2003, 70% of the agencies that operate publicly funded family planning centers permitted clients to delay a pelvic exam when beginning oral contraceptive use, an increase from 45% in 1995.[4]

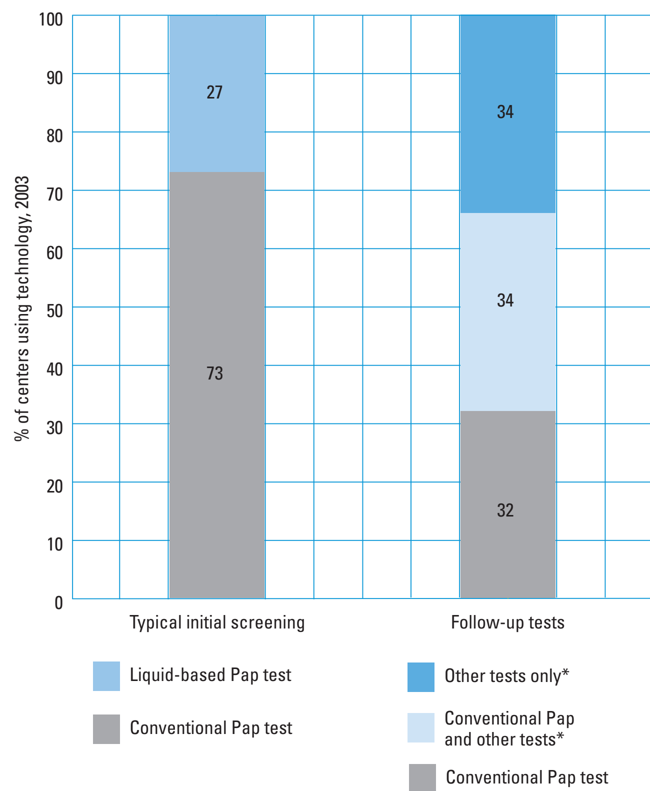
Some Planned Parenthood affiliates have adopted a range of strategies that go further than what is permitted under Title X. For example, Planned Parenthood Federation of America's Hormonal Options without Pelvic Exam (HOPE) program, begun in 1998, allows participating centers to dispense oral contraceptives without requiring a physical or pelvic exam.

Under the Title X model, clients choosing a method such as oral contraceptives or the contraceptive patch generally receive a several-months' supply of their chosen method at their health center visit. In contrast, centers participating in Planned Parenthood's Easy Scripts program will mail oral contraceptives or the patch directly to a client's home on a regular basis. This strategy has been especially beneficial for women in rural areas, who may find it difficult to get to a distant family planning center to obtain refills.

Some Planned Parenthood affiliates have taken steps to separate the process of obtaining contraceptives from a health center visit entirely. For example, the Online Health Center operated by Planned Parenthood of the Great Northwest allows clients to order or obtain a refill of certain contraceptive methods via the Internet.[5] A client seeking to obtain a method for the first time fills out a health history form and chooses a method. A nurse will telephone the client to answer questions and review her health history. The contraceptive methods themselves can be delivered directly to the client's home, called into a pharmacy or picked up by the client at a health center.

FIGURE 4.3

Family planning centers frequently use new technologies to test for cervical cancer, especially for a follow-up after an abnormal or inconclusive initial result.



Note *Other tests include liquid-based Pap test, DNA test for HPV, combined Pap and DNA tests, and colposcopy.

Source Reference 91.

patient education and putting clients at ease. They can stay with a client, if requested, throughout the visit.

Indeed, center staff say that taking the time to connect with a client, listen to her and respond to her individual needs is a basic sign of respect—something that low-income and non-English speaking clients frequently cite as lacking in their interactions with health care providers.[73,82] Finally, a staffing model that allows staff members to provide care to the same clients at successive visits enables them to develop a rapport.

Further complicating the situation, especially in large metropolitan areas, is the growing need for language assistance. In a given city, clients of family planning centers may speak dozens of different languages. Recipients of federal funding are required to offer and provide extensive, timely and cost-free language assistance services to all patients who need it.[83] Title X guidelines, specifically, say that client education "should be appropriate to the client's age, level of knowledge, language, and socio-cultural background."[84] In 2006, 12% of clients at Title X–supported centers received language assistance (either formally or through a friend or relative)—a rate that was as high as 24% in the program region that includes California.[38]

Family planning centers are finding that having a sufficient number and mix of personnel can be critical in addressing both language and cultural issues. At Westside Family Clinic, a small Title X–supported center in Los Angeles where 35 of the center's 45 staff members are bilingual community health workers, clients do not have to communicate through a translator; rather, they are able to speak and hear information directly.[69] According to clinic staff, this is critical to the clinic's ability to obtain meaningful informed consent, especially in a population leery that interaction with the health care system may result in questions about their immigration status. Moreover, hiring capable people directly from the community and providing quality training has the additional advantage of bringing family planning programs back to their antipoverty origins, by making jobs available and expanding economic opportunity in the local community.

Clinical Care

Just as family planning centers tailor outreach and counseling efforts to clients' needs, so do they tailor medical care. With a significant proportion of clients looking to centers as their usual source of health care, it is important that centers offer the range of closely related preventive care services that has long been the standard for Title X–supported centers: pelvic exams, Pap tests, physical exams, blood pressure checks, breast exams, and STI testing and treatment services. At the same time, some centers are incorporating other models that provide a fast track to contraceptive services for clients for whom a specific service such as a pelvic exam may be a deterrent (see box, page 25). Even under these models, however, staff in Title X–supported centers will offer the full package of services and discuss their importance with all of their clients.

An increasing number of women and men are turning to family planning providers for testing and treatment for STIs that can cause a range of problems, from pelvic inflammatory disease and infertility to blindness and, in the case of HIV, death. One reason clients are increasingly seeking STI services is that medical knowledge has improved: In the 1970s, at the beginning of the Title X family planning program, there were only a handful of recognized STIs, most notably syphilis and gonorrhea;[85] today, there are more than two dozen.[86] Moreover, it is increasingly possible to diagnose and treat STIs, and the incidence of some may be increasing. The result of these trends is that STIs like human papillomavirus (HPV), trichomoniasis and chlamydia are now known to affect millions of young Americans each year (Table 4.1, page 24).[87] Young and minority Americans—populations who heavily rely on publicly subsidized providers—are at greatest risk of infection.[86]

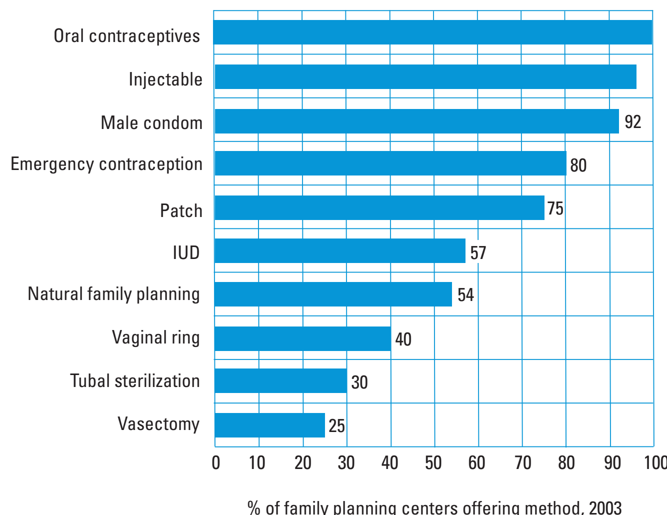
Furthermore, even though it has not yet been fully incorporated into the Title X program guidelines, routine screening for HIV and other STIs is becoming the standard of care for the population groups seeking care at family planning centers. Guidelines developed over the past decade by the Centers for Disease Control and Prevention (CDC) and the U.S. Preventive Services Task Force, for example, recommend annual chlamydia screening for women in their teens and early 20s.[88,89] Similarly, CDC guidelines issued in 2006 recommend routine HIV testing for all teens and for adults younger than 65, integrating it into all medical settings.[90]

It is difficult for providers to meet clients' needs and keep up with changing guidelines—particularly given static funding levels; however, they are clearly trying. The majority of family planning centers in 2003, for example, typically provided a recently developed, single-dose antibiotic treatment for chlamydia, and one-third gave or prescribed antibiotics for women to take home to their partners (where legal) to break the cycle of infection (Figure 4.2, page 24).[91] In addition, almost one-quarter of providers were using cheek swabs for HIV testing, rather than relying only on the slower traditional blood test; a small proportion were even using the very new rapid-result blood tests.

Actual treatment for HIV is beyond the capacity of most family planning centers; however, they refer clients to providers subsidized by other government programs for treatment such as antiretroviral therapy and the management of related conditions. But referring a client for HIV treatment, or for treatment of any of the range of conditions that may be diagnosed in the course of a family planning visit, raises important and sometimes troubling issues. For example, centers are mindful that clients may not have the resources or insurance coverage for the needed treatment.

FIGURE 4.4

Virtually all family planning centers offer oral contraceptives, the injectable and the male condom, and many offer a range of other methods, as well.



Sources References 91 and 94.

In 2006, an HPV vaccine that protects against the most serious strains of the virus was approved, bringing new opportunities and new imperatives. Providers can help women make informed decisions for their own health and for the health of their children, by educating clients about cervical cancer and its link with HPV, the benefits of the HPV vaccine and the continuing need for Pap smears. It is considerably more challenging, however, to provide the vaccine than it is to provide information, because of its high cost, the need for extensive staff training, logistical hurdles relating to client confidentiality, and difficulties storing the vaccine and delivering the required three-shot regimen.[92]

Rising Costs

All of these demands on family planning centers are occurring against a backdrop of rising costs for publicly subsidized providers. Meeting the needs of new populations is expensive. Many low-income clients, especially those in states without Medicaid family planning expansions, come to a family planning provider without a source of payment, and it is up to the provider to find a way to subsidize their care. Moreover, as centers succeed in bringing in the hardest-to-reach clients, they increase the demand on specially tailored—and thus more expensive—counseling, education and services.

New and expanded services come with higher costs. Expanded routine testing for HIV and other STIs, and newer diagnostic technologies for STIs and cervical cancer, for example, have added to the expense of a family planning visit. An increasing number of providers use advanced tests for the antecedents of cervical cancer (such as HPV tests and liquid-based Pap tests), either for the initial test or as part of follow-up after an abnormal or inconclusive test (Figure 4.3).[91] These tests, which have long been routine in private practice, are considerably more expensive than the conventional Pap test. Several small-scale investigations of Title X–supported centers' expenses found that centers are devoting an increasing proportion of their resources to diagnostic tests.[93] According to the most recent investigation (from 2005), Title X expenditures on diagnostic tests more than doubled over three years among 11 grantees who were able to document this category of expenses over this period.[70]

Similarly, contraceptive technology has made important advances over the past several decades. The hormones used in the pill have been adapted to numerous other

delivery mechanisms: a weekly patch, a monthly vaginal ring, a three-month injection, a three-year implant or a five-year IUD. By reducing the opportunities for women to miss or mistime a dose of hormones, these new mechanisms are designed to lower rates of contraceptive failure.

Yet, these newer methods of contraception are usually more expensive than the pill, at least up front. Injectable contraceptives have been available long enough that they have become roughly comparable in price to the pill, and virtually all family planning centers now offer the injectable alongside oral contraceptives and the male condom (Figure 4.4, page 27).[91,94] The patch and the ring, on the other hand, do not yet have generic alternatives and cost centers several times more per client than the pill. Long-acting methods, such as the implant and the IUD, although cost-effective in the long run, cost several hundred dollars per client up front, not including the costs of insertion and, ultimately, removal. Thus, in 2003, 57% of family planning agencies reported not stocking certain methods because of their high cost.[37]

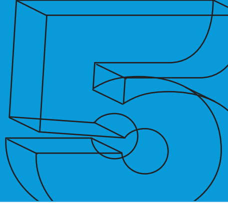
Even the cost of long-established services and supplies—most notably, oral contraceptives—has escalated rapidly, as drug manufacturers have backed away from the steep discounts long offered to family planning centers.[95] Comprehensive data on the prices centers pay are not available, in large part because manufacturers consider the prices to be proprietary; however, anecdotal reports and small-scale studies paint a bleak picture. According to data from the Oregon statewide family planning program, for example, the lowest cost oral contraceptives offered increased from $1.85 to $3.20 per monthly cycle between 2002 and 2007; their most expensive pills increased from $3.25 to $14.70 over that period.[96]

Increasing demand for newer contraceptive methods magnifies the impact of these rising prices. The average cost per client of contraceptive supplies under the Oregon program increased 71% between 2002 and 2006, from $41 to $70.[96] In addition, a 2002 small-scale investigation of selected Title X grantees found that the reported cost per client of providing contraceptive supplies had risen 58% from 1995 to 2001 (more than twice the rate of medical inflation).[93] And according to a 2005 follow-up study, grantees had increased their Title X spending on contraceptive supplies by an average of 26% over just three years, while their Title X grants rose only 11% over that period.[70]

In addition to the rising cost of contraceptive methods and diagnostic tests, other technological advances—although immensely helpful to providing services—are exacting a financial toll. Perhaps most notable is the nationwide drive toward adopting electronic medical records, online client services, electronic inventory systems and other health information technology that centers increasingly need to function in today's health care marketplace. Family planning providers are also seeking technological solutions for their language assistance needs—for example, language lines, which come at a substantial cost, but can provide telephone-based interpretation services in a far wider range of languages than could an individual family planning center.

Increases in wages and benefits have also been a reality for publicly funded family planning centers. The United States has long faced a shortage of nurses—one that is projected to surpass one million by 2020.[97] The market has been adjusting to this shortage: Wages for nurses increased nationally by 40% between 1997 and 2005, nearly twice as fast as wages overall.[98] Evolving professional standards that place greater emphasis on nurses with doctorates and other advanced degrees only add to the pressure. All of this is increasingly challenging for nonprofit and public-sector family planning centers, which may not be able to compete with the higher salaries offered by hospitals and private medical offices.

Similarly, family planning agencies frequently note difficulty retaining front desk and entry-level staff, because of the rising cost of salaries, benefits and training. Agencies spend tens of thousands of dollars to train new staff members to perform critical functions such as scheduling, client intake and translation; however, once trained, these staff are extremely marketable and, therefore, frequently lured by higher salaries offered in the for-profit sector.[93]


Chapter 5

Next Steps

For four decades, publicly subsidized family planning services have helped millions of low-income women and couples to achieve their childbearing goals by enabling them to determine the timing and spacing of their pregnancies. Today, free or low-cost contraceptive services and related preventive health care are provided to some nine million clients annually.[15] Absent these services, levels of unintended pregnancy, abortion and unintended childbearing in the United States would be nearly two-thirds higher than they currently are; the levels among poor women would be almost double.[50] The investment of federal and state dollars in family planning over the years has helped millions of disadvantaged Americans to improve health outcomes for themselves and their children, take advantage of educational and employment opportunities, and better manage their individual and family life.

Despite these accomplishments, much remains to be done. Publicly funded providers reach only half of U.S. women in need of subsidized family planning services. Just since 2000, a million additional women have joined the ranks of those needing subsidized services, in large part because so many women and families have fallen into poverty.[15] In addition, although gaps in contraceptive use by income and by race and ethnicity have narrowed significantly since the effort began, some of that hard-fought ground has been lost.[18] Furthermore, unintended pregnancy among poor and low-income women has begun to rise, even as it has continued to fall among more affluent women.[7,20] Meanwhile, community-based family planning centers have been struggling to meet the needs of an increasingly diverse and hard-to-serve clientele, and at the same time, they have confronted unrelenting cost pressures.

Financing for the national family planning effort has undergone a sea change in the last decade that has provided a prime opportunity to solve these problems. Title X, once the dominant funding source for family planning clinical services, now contributes only 12% of funding, while Medicaid funding has increased dramatically and accounts for $7 of every $10 spent. In large part, the phenomenal growth in Medicaid spending has come as the result of state efforts to expand eligibility for family planning under the program: Two-thirds of the growth in family planning spending nationwide has taken place in the states with the broadest of these expansions. Recognizing the opportunities inherent in this change in financing, many family planning centers have worked to knit together Medicaid and Title X, along with other public and private revenue, to make quality services available to those who need them. They have done so, however, largely in the absence of much coordination, planning or encouragement from federal or state policymakers to help them take advantage of the potential synergies among these disparate funding streams.

Maximizing these synergies, however, is key to the future viability and health of the national family planning effort, and it is time to recognize and embrace them as a matter of federal policy. Title X, which remains the foundation on which the entire endeavor rests, has not been re-examined in nearly a quarter century, and there has never been a systematic look at Medicaid's role in or potential for supporting family planning. As a result, providers are attempting to confront today's challenges with an antiquated policy framework.

What is required is a new framework for the national family planning effort that rationalizes the emerging relationship between these two fundamentally different programs in a way that leverages their unique strengths. That

framework should be premised on the primacy of Medicaid as the funding source of the clinical component of care for most of the individuals served. To be sure, Title X dollars will always remain necessary for clinical care. These dollars are indispensable to serving individuals Medicaid does not cover. They are also needed to cover the services and activities—including outreach, language assistance and extensive counseling—that are not Medicaid's strengths. Title X must continue to generate the research that documents the breadth and impact of the effort and provides the accountability the public deserves for the resources it contributes. Primarily, however, this framework should recognize and value Title X's central role in sustaining the provider infrastructure—including, significantly, not just the bricks and mortar, but the critical human resources—in a way that a reimbursement program like Medicaid is simply not designed to do.

Medicaid

Private-sector coverage of contraceptives has improved dramatically since the early 1990s,[99] particularly in large-group plans. As policymakers turn their attention to health care reform, they will need to ensure that this progress is extended to the small and individual markets. Yet there is widespread consensus that Medicaid is and will continue to be the primary insurer for low-income Americans well into the future. As such, it will be central to the delivery of family planning services for this population.

On their own initiative, more than half the states have taken steps to expand Medicaid's role, by extending coverage for family planning to women and men not otherwise covered by Medicaid. What is now needed is a national floor of family planning coverage, set at the same state-set levels used to determine eligibility for Medicaid-covered pregnancy-related care. This step would effectively give low-income women equal access to the services they need to achieve a healthy, wanted pregnancy or to avoid an unplanned one. In addition, the innovative strategies developed in the existing state-initiated expansions to facilitate eligibility and enrollment, including point-of-service application and enrollment, should become the norm.

Indeed, establishing a national floor would yield dramatic results. Such a national effort (accounting for states that have already expanded coverage and the remaining states that would do so) would enable women to avoid about 800,000 unintended pregnancies each year.[100] This, in turn, would prevent 320,000 abortions, while helping 380,000 women avoid an unplanned birth. Overall, establishing a nationwide eligibility floor would generate a net savings of $2.6 billion in Medicaid costs annually. Finally, it would eliminate the burden and uncertainty that states now face in seeking federal approval to expand and renew their programs.

With regard to both these expansions and the Medicaid program in general, the current federal policy denying coverage to legal immigrants in their first five years should be eliminated and other barriers to enrollment, such as the citizenship documentation requirement, eased. Moreover, policymakers should consider allowing even immigrants who are in the country illegally to obtain reproductive health care, including family planning services to prevent unintended pregnancy, under Medicaid.[101] Given that all children born in this country are U.S. citizens, it is short-sighted at best to deny their mothers prenatal and postpartum care to help them achieve the healthiest birth outcomes possible. And it is self-defeating to deny anyone services for communicable diseases, such as HIV or other STIs.

Beyond enrollment, policymakers must consider the adequacy of provider reimbursement to maximize access. Reimbursement levels should take into account the administrative and staffing costs of providing care, as well as the cost of contraceptive and other supplies to providers; once reasonable levels are established, they should be adjusted annually to reflect changes in the cost of providing care. Failing to do so could threaten the financial viability of family planning centers trying to provide care to enrollees, while also serving as a powerful disincentive to private physicians, whose participation is important in reaching all those in need. At the same time, reimbursement processes should be made as simple as possible, to reduce unnecessary red tape and ensure timely provider payment.

Title X

Although Medicaid should be seen as the primary payer of clinical family planning care, Title X will be necessary to provide medical services to some clients. Program funds will be needed to serve those Medicaid is unlikely to reach, such as individuals who are above state-set income ceilings or those confronting issues related to homelessness, substance abuse or domestic violence. Moreover, many clients, especially those just starting a contraceptive method, need specialized and time-intensive counseling, but Medicaid generally covers only the basic counseling included in a typical visit. Medicaid should be expanded to include coverage of the more extensive counseling needed by some clients. But, even if this is accomplished, a flexible program such as Title X, with resources that can be selectively deployed, will remain indispensable to ensure that providers have the time and resources to meet clients' needs.

Mechanisms to assess the impact of Title X must reflect the ways in which program funds are used to fill these gaps in services. Measuring provider effort should no longer be a matter of simply counting the aggregate number of clients served. Instead, it must incorporate the reality that not all clients require the same level of program resources, and attempt to account for the extent to which providers reach out to and serve clients who have extensive needs and require intensive and expensive care. Similarly, the indicators used to measure the use and impact of Title X dollars should be expanded to account for counseling and education activities, and for the outcomes they yield.

Meanwhile, support for the provider infrastructure will be as critical going forward as it has been in the past, if not more so. Without a healthy and vibrant provider network, the promise of expanded coverage under Medicaid—by itself or as part of health care reform—would be a hollow one indeed. Although private physicians play a vital and potentially growing role, the nationwide network of family planning centers is the backbone of the effort. Indeed, supporting the infrastructure of these community-based centers is emerging as Title X's most important role. Its flexible dollars are essential to covering basic operating needs—from paying utility bills to purchasing examining tables, paper gowns and other medical supplies—that will exist as long as family planning centers exist. These funds can also make possible the investments in the electronic medical records and other health information technology that will allow centers to be active participants in the emerging health care marketplace of the 21st century.

Moreover, Title X funds can underwrite outreach to immigrants, the homeless and other hard-to-reach groups, to help them feel comfortable enough to come in for care. Such funds can be used to cover the steps that centers are taking to make services truly accessible, by delivering services where clients live, work or attend school. And they can pay for extending centers' schedules, to serve clients who work long hours in inflexible employment situations that make coming to a center during traditional hours impossible.

The Title X program should explicitly stress the importance of supporting the human resources that lie at the heart of the entire endeavor. From the legislation's initial passage in 1970, training has been recognized as an important component of Title X. That effort must be given the priority and support it needs to ensure that family planning center staff are employing the latest medical protocols and best-practice techniques, and that a sufficient supply of trained clinicians and other staff is available to provide culturally sensitive, multilingual, client-centered care appropriate for the community. To do so, federal policymakers should consider implementing a loan-repayment program, such as has long been in place through the National Health Service Corps, to attract and retain qualified health care professionals. Moreover, a focus on human resources would make funding available to pay staff at all levels—from the frontline staff who schedule appointments to counselors and clinicians—competitive wages and benefits sufficient to address the high staff turnover rates that plague safety-net providers nationwide.

Moving Ahead

Making this vision a reality will require real leadership to overcome the real hurdles that providers confront every day. For example, in recent years, the cost of contraceptive supplies and diagnostic tests has risen dramatically, because of new technologies, rising demand and changes in the marketplace. The Office of Population Affairs (OPA) should take a leadership role in facilitating clients' access to affordable contraceptives and other commodities by supporting purchasing cooperatives and bulk purchasing arrangements, serving as a clearinghouse of information on prices and purchasing options, or intervening directly with manufacturers, as appropriate. Similarly, OPA leadership is needed to ensure that family planning standards and guidelines provide flexibility to respond to local needs while being consistently aligned with up-to-date professional guidelines, such as those issued by the American College of Obstetricians and Gynecologists, CDC and the American Cancer Society.

Because so many federal and state agencies have a hand in family planning, this leadership should be rooted in cooperation. All too often today, these agencies work in isolation, or with only minimal, sporadic coordination. Several states have broken that mold in establishing and implementing their Medicaid family planning eligibility expansions—by having the relevant agencies work together to formulate a single plan for client and provider outreach, streamline enrollment and ensure adequate and timely reimbursement. These models should be examined for their potential applicability nationwide. To be sure, OPA, the Centers for Medicare and Medicaid Services, CDC and other federal agencies will need to coordinate their planning, service and research activities to ensure that scarce public dollars are spent effectively and that challenges—and solutions to those challenges—can be quickly identified. The state agencies responsible for family planning and Medicaid will need to coordinate as well, to ensure that their combined resources are channeled to the local communities that need them.

Reinvigorating the national family planning program—in terms of financing, infrastructure and leadership—will be an important contribution to the broader health care reform effort. The plans put forward by President Obama, congressional leaders and numerous advocacy groups representing patients, providers, insurers, business and labor have all made clear that Medicaid will remain the primary insurer for low-income Americans, and expanding it to fill current gaps in coverage will be a central component of health care reform. Maintaining a vital, healthy network of community-based, safety-net providers will also be central. Thus, the steps outlined above, if completed, would constitute a critical component of health care reform when it comes to the family planning needs of low-income women and men.

These same steps—along with others as part of health care reform to ensure coverage and access to family planning services among privately insured women—would accomplish something else as well: They would consolidate family planning in the public mind as the truly basic health care that women have long known it to be. By acknowledging its importance alongside other essential preventive care, the authors and advocates of reform can help end an era in which family planning has too often been disparaged as a source of political controversy, rather than valued as a health care necessity.

APPENDIX TABLE 1 State data on women in need and public expenditures

U.S./state	No. of women aged 13–44, 2006	% of women aged 15–44, 2006–2007			No. of women in need of publicly funded contraceptive services and supplies, 2006				
		<100% poverty	Uninsured	Medicaid	Aged 13–44	Aged 13–19	White	Black	Latina
U.S. total	66,380,710	15.0*	19.8*	12.2*	17,485,330	5,055,790	9,560,250	3,068,450	3,646,100
Alabama	1,007,370	18.5	19.3	11.7	276,580	82,930	155,950	106,050	8,100
Alaska	153,340	9.8	22.5	9.8	38,500	11,570	22,180	1,970	2,370
Arizona	1,342,480	17.9	25.9	15.9	404,060	97,250	181,050	17,230	164,720
Arkansas	605,520	15.3	25.6	12.6	178,280	47,980	120,640	40,080	12,040
California	8,361,000	14.5	22.4	13.2	2,385,940	609,980	724,970	190,990	1,158,700
Colorado	1,071,290	12.1	20.6	7.4	271,170	72,750	169,210	13,620	73,420
Connecticut	759,180	9.5	12.4	11.7	167,710	58,590	94,830	27,870	35,280
Delaware	189,640	11.6	15.6	11.7	43,180	15,620	24,440	13,210	3,810
D.C.	152,270	18.7	10.9	19.2	36,550	12,220	9,390	21,480	3,480
Florida	3,741,720	15.3	26.6	7.6	971,010	273,530	465,340	233,910	233,980
Georgia	2,187,740	16.3	22.1	9.3	553,980	167,630	255,520	224,570	51,830
Hawaii	272,670	9.0	10.3	11.7	67,820	19,040	17,300	2,510	7,300
Idaho	320,150	12.6	19.3	9.3	103,070	26,540	84,750	540	13,420
Illinois	2,883,850	12.4	16.7	11.9	684,630	219,900	352,110	158,330	138,650
Indiana	1,386,390	15.4	16.3	11.0	350,390	107,760	269,670	48,520	21,480
Iowa	627,610	13.5	14.2	12.8	161,790	52,000	139,500	6,940	9,090
Kansas	597,230	16.6	18.4	8.9	152,820	47,450	111,520	13,700	18,940
Kentucky	923,480	20.3	20.6	13.7	254,280	67,850	216,160	26,250	6,210
Louisiana	959,280	19.4	25.3	12.4	297,060	82,320	151,960	127,330	8,930
Maine	276,090	11.6	11.0	22.0	80,180	20,930	75,300	1,110	1,220
Maryland	1,285,390	10.5	18.2	7.0	258,560	99,100	116,570	104,630	20,660
Massachusetts	1,447,690	14.0	9.4	18.6	320,950	108,390	209,720	31,620	50,960
Michigan	2,209,110	14.4	15.9	13.7	560,020	180,160	380,340	123,890	28,450
Minnesota	1,141,250	11.4	11.8	11.4	253,130	87,560	195,450	21,490	14,810
Mississippi	651,430	24.7	26.8	13.7	197,050	57,600	90,190	99,440	3,570
Missouri	1,278,110	16.5	18.4	11.4	348,060	99,610	261,580	61,700	12,310
Montana	192,370	20.2	22.5	11.2	63,910	15,400	53,880	250	2,180
Nebraska	380,540	11.0	14.8	8.6	101,520	30,610	79,060	7,100	10,260
Nevada	548,200	10.4	22.2	5.6	149,670	36,820	68,730	16,090	51,140
New Hampshire	286,940	6.8	13.2	5.9	66,510	22,180	60,850	920	2,400
New Jersey	1,904,170	9.7	20.2	8.5	385,260	136,430	168,420	85,830	100,380
New Mexico	428,350	16.7	29.6	15.2	139,520	32,420	43,620	3,210	71,790
New York	4,352,810	17.4	17.0	18.9	1,183,540	328,000	551,040	246,270	277,590
North Carolina	1,971,160	18.9	23.0	10.9	504,160	151,470	282,400	151,090	48,190
North Dakota	133,670	14.2	14.0	10.2	38,450	11,690	33,060	470	920
Ohio	2,488,330	16.0	15.3	14.7	645,540	195,260	484,270	120,350	19,340
Oklahoma	771,940	16.8	26.9	10.8	221,210	59,850	142,590	23,820	20,730
Oregon	791,780	13.0	22.3	10.8	238,200	57,550	177,010	5,340	36,430
Pennsylvania	2,622,130	12.0	12.0	13.1	706,700	216,030	515,000	114,010	48,380
Rhode Island	240,400	11.0	12.9	18.4	65,030	20,260	42,570	5,290	12,640
South Carolina	952,210	14.8	20.3	11.9	259,820	81,060	136,770	105,450	11,120
South Dakota	162,620	13.0	15.3	8.4	43,830	13,360	35,380	470	1,130
Tennessee	1,331,250	17.6	16.7	14.4	352,700	99,220	243,610	85,790	13,970
Texas	5,418,860	18.5	31.7	8.7	1,469,560	397,400	519,510	212,300	679,970
Utah	608,570	12.2	18.4	7.8	182,510	51,500	144,000	2,010	25,230
Vermont	132,710	12.4	14.8	19.4	38,420	10,800	35,980	420	670
Virginia	1,726,080	9.7	18.6	6.0	388,030	128,270	225,120	107,020	31,210
Washington	1,417,800	12.4	14.6	11.8	391,760	102,380	270,900	18,610	52,410
West Virginia	374,280	20.4	22.0	16.0	111,760	28,450	104,120	4,390	1,190
Wisconsin	1,204,390	12.1	10.8	13.7	288,700	94,570	219,280	32,680	20,490
Wyoming	107,870	15.3	21.4	7.5	32,250	8,550	27,440	290	2,610
	1	2	3	4	5	6	7	8	9

*U.S. total is for 2007. †Includes the maternal and child health, social services and Temporary Assistance for Needy Families block grants. **Notes:** nr= no response or not available. u=unknown. **Sources: Column 1:** Reference 15. **Columns 2–4:** Reference 14. **Columns 5–9:** Reference 15. **Columns 10–14:** Reference 16. **Columns 15–16:** Reference 56.

Public expenditures for family planning client services, FY 2006 (in 000s of dollars)					Total expenditures per woman in need (in dollars), FY 2006	% change in expenditures per woman in need, 1994–2006	U.S./state
All	Medicaid	Title X	State	Other†			
1,846,960	1,304,010	215,300	241,150	86,510	106	54	U.S. total
32,080	22,900	5,110	3,520	550	116	36	Alabama
1,920	340	1,240	nr	340	50	51	Alaska
38,060	32,740	4,520	0	800	94	343	Arizona
20,040	17,080	2,770	190	0	112	135	Arkansas
387,710	320,920	13,630	53,160	0	162	157	California
9,220	4,780	3,260	1,190	0	34	0	Colorado
17,880	13,790	1,920	1,100	1,070	107	19	Connecticut
4,990	3,590	1,220	170	0	116	29	Delaware
1,300	70	1,210	nr	20	36	–38	D.C.
64,300	20,660	11,750	31,890	0	66	–25	Florida
18,100	2,520	8,330	1,210	6,050	33	–44	Georgia
1,370	280	1,000	100	0	20	–66	Hawaii
7,590	1,840	1,550	3,610	590	74	114	Idaho
49,680	30,700	7,330	7,620	4,040	73	66	Illinois
9,810	2,280	4,480	u	3,050	28	1	Indiana
13,480	9,340	3,640	70	430	83	64	Iowa
14,510	7,510	2,230	4,770	0	95	159	Kansas
66,850	52,940	5,260	7,650	1,000	263	234	Kentucky
20,380	11,720	3,400	4,700	550	69	319	Louisiana
7,930	5,120	1,570	220	1,020	99	–10	Maine
40,230	25,870	4,070	10,280	0	156	62	Maryland
30,300	21,950	3,810	4,500	40	94	46	Massachusetts
38,790	23,700	7,260	6,100	1,720	69	12	Michigan
10,640	2,360	2,970	4,560	750	42	–40	Minnesota
13,270	9,150	4,110	0	0	67	–12	Mississippi
30,100	25,370	4,700	20	0	86	6	Missouri
3,510	1,010	2,330	0	170	55	–23	Montana
5,180	3,680	1,500	0	0	51	40	Nebraska
6,260	3,700	2,270	0	290	42	–48	Nevada
2,860	1,190	940	260	470	43	–60	New Hampshire
55,430	37,170	8,970	6,980	2,310	144	157	New Jersey
11,940	7,640	3,270	450	570	86	29	New Mexico
149,610	111,550	11,130	23,930	3,000	126	–5	New York
56,100	26,580	6,770	17,720	5,030	111	48	North Carolina
2,140	960	830	240	110	56	–7	North Dakota
32,210	21,040	7,110	1,580	2,480	50	–2	Ohio
30,230	15,210	3,650	11,380	0	137	134	Oklahoma
66,440	59,630	1,940	3,960	910	279	300	Oregon
83,350	61,840	10,140	5,960	5,410	118	122	Pennsylvania
3,780	2,560	1,020	40	150	58	213	Rhode Island
31,490	27,240	3,370	870	0	121	30	South Carolina
1,850	560	990	0	300	42	60	South Dakota
56,790	43,780	6,120	3,820	3,070	161	254	Tennessee
87,210	40,810	14,950	360	31,080	59	–25	Texas
4,490	2,910	1,110	0	460	25	–39	Utah
3,590	3,040	290	190	70	93	–24	Vermont
51,110	42,350	4,190	4,560	0	132	23	Virginia
94,280	79,630	4,500	10,160	0	241	317	Washington
10,420	5,290	1,840	1,500	1,790	93	28	West Virginia
38,550	28,910	3,000	0	6,640	134	128	Wisconsin
7,630	6,190	700	580	160	236	170	Wyoming
10	11	12	13	14	15	16	

APPENDIX TABLE 2 State data on family planning centers and clients served

U.S./state	Publicly funded family planning centers and female contraceptive clients served, 2006								
	No.			No. of unintended events averted			% of need met by centers	% change in need met by centers, 1994–2006	Cost savings from center services, 2004 (in 000s of dollars)
	All centers	All clients	Clients aged <20	Pregnancies	Births	Abortions			
U.S. total	8,199	7,198,210	1,794,940	1,482,800	659,300	619,000	41.2	4.6	4,320,523
Alabama	166	85,110	22,410	17,500	7,800	7,300	30.8	–27.6	44,994
Alaska	109	37,470	6,770	7,700	3,400	3,200	97.3	55.2	31,072
Arizona	192	128,820	29,940	26,500	11,800	11,100	31.9	–31.1	59,005
Arkansas	144	116,300	34,340	24,000	10,700	10,000	65.2	23.6	55,966
California	1,008	1,307,450	267,190	269,300	119,700	112,400	54.8	50.4	568,152
Colorado	155	138,260	30,790	28,500	12,700	11,900	51.0	8.2	69,400
Connecticut	70	84,750	22,070	17,500	7,800	7,300	50.5	–9.6	41,900
Delaware	28	24,380	7,940	5,000	2,200	2,100	56.5	5.8	15,702
D.C.	35	20,950	4,320	4,300	1,900	1,800	57.3	–7.5	13,023
Florida	321	345,490	95,470	71,200	31,700	29,700	35.6	13.3	177,305
Georgia	312	188,380	45,490	38,800	17,300	16,200	34.0	–23.3	168,964
Hawaii	39	14,970	4,760	3,100	1,400	1,300	22.1	–32.9	10,663
Idaho	78	43,980	10,590	9,100	4,000	3,800	42.7	–14.1	28,773
Illinois	254	222,850	57,810	45,900	20,400	19,200	32.6	7.8	113,606
Indiana	92	141,470	36,100	29,100	12,900	12,100	40.4	1.8	84,254
Iowa	91	95,370	24,800	19,600	8,700	8,200	58.9	7.3	88,030
Kansas	108	49,710	10,500	10,200	4,500	4,300	32.5	–27.9	36,530
Kentucky	196	134,420	25,540	27,700	12,300	11,600	52.9	5.3	97,223
Louisiana	95	65,950	13,430	13,600	6,000	5,700	22.2	–12.8	67,186
Maine	80	40,230	11,960	8,300	3,700	3,500	50.2	2.3	20,587
Maryland	138	102,570	33,110	21,100	9,400	8,800	39.7	–3.5	68,647
Massachusetts	141	148,470	41,880	30,600	13,600	12,800	46.3	25.2	102,145
Michigan	241	227,400	60,540	46,800	20,800	19,500	40.6	1.8	188,104
Minnesota	152	103,500	30,750	21,300	9,500	8,900	40.9	3.3	87,532
Mississippi	172	83,850	23,650	17,300	7,700	7,200	42.6	–32.1	34,512
Missouri	185	116,240	27,170	23,900	10,600	10,000	33.4	–31.1	65,351
Montana	67	35,840	9,610	7,400	3,300	3,100	56.1	–17.5	17,664
Nebraska	40	40,150	8,550	8,300	3,700	3,500	39.5	30.7	23,449
Nevada	59	45,630	10,360	9,400	4,200	3,900	30.5	–19.5	21,901
New Hampshire	35	33,540	13,380	6,900	3,100	2,900	50.4	–6.7	16,820
New Jersey	98	146,960	36,250	30,300	13,500	12,600	38.1	11.8	67,521
New Mexico	200	95,330	24,730	19,600	8,700	8,200	68.3	34.5	53,248
New York	417	457,590	117,110	94,300	41,900	39,400	38.7	5.6	353,767
North Carolina	181	175,250	41,290	36,100	16,100	15,100	34.8	–9.3	92,280
North Dakota	34	20,210	4,830	4,200	1,900	1,800	52.6	22.5	11,725
Ohio	190	193,440	59,790	39,800	17,700	16,600	30.0	–2.7	121,488
Oklahoma	161	102,140	25,310	21,000	9,300	8,800	46.2	22.8	58,671
Oregon	136	147,420	36,350	30,400	13,500	12,700	61.9	59.6	41,064
Pennsylvania	296	294,630	92,780	60,700	27,000	25,300	41.7	1.7	70,094
Rhode Island	32	20,800	4,750	4,300	1,900	1,800	32.0	–4.0	17,047
South Carolina	141	115,470	25,340	23,800	10,600	9,900	44.4	28.7	70,702
South Dakota	84	28,070	6,270	5,800	2,600	2,400	64.0	32.9	10,350
Tennessee	194	93,750	28,360	19,300	8,600	8,100	26.6	–32.2	102,163
Texas	426	473,230	100,210	97,500	43,300	40,700	32.2	–14.0	415,457
Utah	69	47,340	15,090	9,800	4,400	4,100	25.9	0.7	36,591
Vermont	31	27,960	6,480	5,800	2,600	2,400	72.8	37.7	8,401
Virginia	182	103,110	28,560	21,200	9,400	8,800	26.6	–24.2	51,927
Washington	215	238,770	61,970	49,200	21,900	20,500	60.9	26.8	183,198
West Virginia	148	53,740	14,040	11,100	4,900	4,600	48.1	–24.2	60,638
Wisconsin	122	120,850	38,840	24,900	11,100	10,400	41.9	–17.8	60,690
Wyoming	39	18,710	5,390	3,900	1,700	1,600	58.0	21.9	15,045
	1	2	3	4	5	6	7	8	9

Sources: Columns 1–3: Reference 15. **Columns 4–6:** Reference 50. **Columns 7–8:** Reference 15. **Column 9:** Reference 48. **Columns 10–12:** Reference 15. **Columns 13–15:** Reference 50. **Columns 16–17:** Reference 15.

Title X–supported family planning centers and female contraceptive clients served, 2006								U.S./state
No.			No. of unintended events averted			% of need met by Title X centers	% change in need met by Title X centers, 1994–2006	
All centers	All clients	Clients aged <20	Pregnancies	Births	Abortions			
4,261	4,728,950	1,208,210	974,100	433,100	406,600	27.0	7.4	U.S. total
81	67,700	18,210	13,900	6,200	5,800	24.5	–23.8	Alabama
5	7,650	2,350	1,600	700	700	19.9	–3.5	Alaska
46	57,470	12,700	11,800	5,200	4,900	14.2	21.9	Arizona
97	106,820	31,970	22,000	9,800	9,200	59.9	27.6	Arkansas
291	823,370	174,280	169,600	75,400	70,800	34.5	51.9	California
57	49,950	13,870	10,300	4,600	4,300	18.4	–18.5	Colorado
24	41,420	11,970	8,500	3,800	3,500	24.7	–17.9	Connecticut
26	23,390	7,700	4,800	2,100	2,000	54.2	43.1	Delaware
30	10,820	2,770	2,200	1,000	900	29.6	–15.6	D.C.
194	244,330	62,480	50,300	22,400	21,000	25.2	20.1	Florida
250	165,620	40,230	34,100	15,200	14,200	29.9	–19.6	Georgia
39	14,970	4,760	3,100	1,400	1,300	22.1	–25.2	Hawaii
41	30,580	7,210	6,300	2,800	2,600	29.7	–30.1	Idaho
108	141,010	37,420	29,000	12,900	12,100	20.6	–11.2	Illinois
40	51,450	14,220	10,600	4,700	4,400	14.7	–31.3	Indiana
72	80,680	20,760	16,600	7,400	6,900	49.9	12.0	Iowa
86	42,180	9,240	8,700	3,900	3,600	27.6	–10.2	Kansas
161	114,380	20,460	23,600	10,500	9,900	45.0	–2.9	Kentucky
73	54,330	10,650	11,200	5,000	4,700	18.3	–1.8	Louisiana
46	30,440	9,710	6,300	2,800	2,600	38.0	–10.7	Maine
82	78,530	22,430	16,200	7,200	6,800	30.4	8.3	Maryland
75	72,970	22,680	15,000	6,700	6,300	22.7	14.9	Massachusetts
137	183,030	47,710	37,700	16,800	15,700	32.7	54.1	Michigan
23	37,470	12,500	7,700	3,400	3,200	14.8	3.7	Minnesota
106	64,040	18,230	13,200	5,900	5,500	32.5	–20.4	Mississippi
96	83,770	18,200	17,300	7,700	7,200	24.1	–12.8	Missouri
31	26,960	8,100	5,600	2,500	2,300	42.2	–21.8	Montana
32	37,500	7,960	7,700	3,400	3,200	36.9	36.5	Nebraska
26	23,850	5,880	4,900	2,200	2,000	15.9	–17.9	Nevada
28	27,640	10,750	5,700	2,500	2,400	41.6	–15.0	New Hampshire
57	125,270	29,310	25,800	11,500	10,800	32.5	31.8	New Jersey
117	47,560	15,150	9,800	4,400	4,100	34.1	7.1	New Mexico
191	302,170	78,520	62,200	27,700	26,000	25.5	28.8	New York
124	145,340	34,130	29,900	13,300	12,500	28.8	14.1	North Carolina
18	15,100	4,010	3,100	1,400	1,300	39.3	11.1	North Dakota
79	120,140	37,540	24,700	11,000	10,300	18.6	–9.1	Ohio
103	69,770	19,970	14,400	6,400	6,000	31.5	23.2	Oklahoma
81	73,350	18,540	15,100	6,700	6,300	30.8	64.0	Oregon
234	259,740	82,530	53,500	23,800	22,300	36.8	4.8	Pennsylvania
17	12,700	2,390	2,600	1,200	1,100	19.5	–5.9	Rhode Island
74	97,140	21,470	20,000	8,900	8,300	37.4	40.3	South Carolina
50	13,800	3,650	2,800	1,200	1,200	31.5	–12.9	South Dakota
130	75,550	23,580	15,600	6,900	6,500	21.4	–29.2	Tennessee
158	220,240	47,130	45,400	20,200	19,000	15.0	–17.1	Texas
22	29,410	11,870	6,100	2,700	2,500	16.1	33.6	Utah
8	8,430	2,620	1,700	800	700	21.9	–5.1	Vermont
128	74,500	22,190	15,300	6,800	6,400	19.2	–6.2	Virginia
86	124,780	32,420	25,700	11,400	10,700	31.9	13.7	Washington
137	51,070	13,410	10,500	4,700	4,400	45.7	–25.0	West Virginia
22	54,010	16,110	11,100	4,900	4,600	18.7	–29.9	Wisconsin
22	14,540	4,300	3,000	1,300	1,300	45.1	10.6	Wyoming
10	11	12	13	14	15	16	17	

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CHAPTER 1 Box: Terms Used in this Report

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CHAPTER 2 Box: Meeting Men's Reproductive Health Needs

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CHAPTER 4 Box: Models for Expediting Clients' Contraceptive Care

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Guttmacher Institute
125 Maiden Lane, 7th Floor
New York, NY 10038
Telephone: 212-248-1111
Fax: 212-248-1951
Email: info@guttmacher.org

1301 Connecticut Avenue NW, Suite 700
Washington, DC 20036

www.guttmacher.org

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