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Moving Forward: Family Planning in the Era of Health Reform

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Adam Sonfield
Kinsey Hasstedt
Rachel Benson Gold

Acknowledgments

Moving Forward: Family Planning in the Era of Health Reform was written by Adam Sonfield, Kinsey Hasstedt and Rachel Benson Gold, all of the Guttmacher Institute. The report was edited by Jared Rosenberg and copyedited by Haley Ball.

The authors thank the following Guttmacher Institute colleagues for their assistance and advice at various stages of the report's preparation: Andrea Rowan for research, fact checking, editorial and design support; Lawrence B. Finer, Jennifer J. Frost and Jesse Philbin for additional research; and Susan A. Cohen, Lawrence B. Finer, Jennifer J. Frost, Susheela Singh, Gustavo Suárez and Cynthia Summers for reviewing drafts of the report.

An early draft of the report benefited from input from Beth De Santis, South Carolina Department of Health and Environmental Control; Lorrie Gavin, Centers for Disease Control and Prevention; George A. Hill and Evelyn Kieltyka, Family Planning Association of Maine; Susan Moskosky, Office of Population Affairs; and Julie Rabinovitz, California Family Health Council.

The Guttmacher Institute gratefully acknowledges the general support it receives from individuals and foundations, including major grants from The William and Flora Hewlett Foundation and the David and Lucile Packard Foundation, which undergirds all of the Institute's work. The conclusions and opinions expressed in this publication are those of the authors.

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Executive Summary

Modern contraception has given women and couples the means to control whether and when to have children. Moreover, it has had important public health consequences for women and families, and has advanced women's self-sufficiency and their educational, social and economic opportunities and outcomes. Nonetheless, many women and couples find it difficult to avoid pregnancies they do not want, and to successfully time and space wanted pregnancies.

■ About half of U.S. pregnancies—more than three million each year—are unintended. By age 45, more than half of all U.S. women will have had an unintended pregnancy.

■ Barriers to access are particularly salient for those disadvantaged by their age or income. More than 19 million U.S. women need publicly supported contraceptive services. Of those in need, 5.8 million—or 30%—are uninsured.

■ The unintended pregnancy rate for poor women is more than five times that for higher income women.

Publicly Funded Family Planning Today

Government programs—notably, the Title X national family planning program and the joint federal-state Medicaid insurance program—have worked together for decades to improve access to contraceptive and related care. Typically, Medicaid pays for core clinical care, while Title X and other grant programs buttress the system of family planning centers and fill gaps in services and coverage.

■ Title X supports a diverse, nationwide network of health centers that provide family planning services. Health centers can use Title X's flexible funding to bolster infrastructure, serve clients who are uninsured or unable to use their coverage because of concerns about confidentiality and meet their clients' particular needs.

■ The Title X program sets standards for the provision of publicly supported family planning services across the United States, ensuring that care is voluntary, confidential, affordable and effective. Title X–supported health centers generally provide higher quality contraceptive care than other providers, including methods provided on site, protocols to help women avoid gaps in use and in-depth counseling tailored to clients' needs.

■ Over the past two decades, Medicaid has become the dominant source of public family planning spending. Medicaid's increased role has been buoyed by expansions of Medicaid coverage specifically for family planning in many states since the mid-1990s.

The Impact of the U.S. Family Planning Effort

Research demonstrates the impact of the publicly funded family planning effort for women, families and society by expanding contraceptive use, preventing unintended pregnancies, and improving maternal and child health.

■ In 2010, 8.9 million clients received publicly funded contraceptive services—47% of women in need of publicly supported care. Family planning centers provided services to 6.7 million contraceptive clients; Title X–supported centers served seven in 10 of those clients.

■ Health centers are many women's entry point into the health care system, and the package of sexual and reproductive health services provided is at least as comprehensive as during an annual exam by a private doctor. Thus, it is no surprise that six in 10 women who obtain care at a center consider it their usual source of medical care, and for four in 10, that center is their only source of care.

■ By providing millions of women with access to contraceptive services they want and need, publicly funded

family planning in 2010 helped women to avoid 2.2 million unintended pregnancies. Without these services, the rates of unintended pregnancy, unplanned birth and abortion would be 66% higher than they currently are.

■ Every public dollar invested in helping women avoid pregnancies they did not want to have saves $5.68 in Medicaid expenditures that otherwise would have gone to pregnancy-related care; in 2010, that amounted to a net government savings of $10.5 billion.

Expanding Coverage in the Era of Health Reform

Expansions in public and private health insurance under the Affordable Care Act (ACA) mean that more women and men are gaining coverage for family planning and related reproductive health services. To thrive under health reform and best serve their clients, publicly supported health centers will need to become very good at working with and securing contracts from the health plans that dominate the public and private insurance markets.

■ The ACA expands Medicaid for women and men with family incomes below 138% of poverty, but the U.S. Supreme Court ruled that states cannot be compelled to opt into that expansion. States refusing to expand Medicaid are leaving millions of low-income residents in a "donut hole" with no access to affordable coverage.

■ For higher-income individuals, the ACA is expanding access to private insurance through new marketplaces and subsidies to make coverage affordable. The ACA requires all new private health plans to cover the full range of contraceptive methods, services and counseling without any out-of-pocket costs for the patient.

■ Medicaid family planning expansions continue to have a role to play and were made easier for states to initiate under the ACA. They can provide limited but vital coverage in states not yet participating in the full-benefit Medicaid expansion, and in all states, they can provide coverage for women experiencing lapses in full-benefit coverage, enrollment difficulties and concerns about confidentiality.

■ Despite the ACA's coverage expansions, Title X and other flexible grant funding will be needed to provide services to those falling through the cracks of health reform; to pay for services not covered under Medicaid or private insurance, such as intensive counseling and outreach; and to support and improve health centers' infrastructure.

Accessing Care in the Era of Health Reform

Availability of public or private coverage would mean little to the U.S. family planning effort without capacity in the health care system to meet the need for care.

■ The ACA relies on federally qualified health centers (FQHCs) to help address provider shortages. FQHCs have long been required to make contraceptive services available, either directly or by referral, and have become increasingly important as family planning providers, though that care varies considerably in scope and quality.

■ Reproductive health–focused providers serve about 70% of all contraceptive clients of health centers, and they have distinct advantages in the attention, skills and experience they can provide to clients.

■ Because they are the entry point to the health care system for many of their clients, reproductive health–focused providers will continue to play important roles in connecting clients to other types of care and to health insurance coverage for which they may be eligible.

Moving Forward

The U.S. family planning effort has helped tens of millions of disadvantaged women and men to plan their families and protect their health. For this effort to meet the challenges of today's evolving health care system, ever-tightening government budgets, and political attacks on funding sources and providers, stakeholders must find ways to secure the effort's funding and its provider network.

■ To maximize the potential of Medicaid for the family planning effort, governors and legislators in all states should extend Medicaid coverage to their residents. Moreover, policymakers should ensure that all Medicaid recipients have coverage for the full range of family planning and related services, that Medicaid reimbursement rates are sufficient to cover providers' costs and sustain the provider network, and that states can initiate and continue Medicaid family planning expansions with a minimum of red tape.

■ Congress should ensure that Title X providers have the funding necessary to maintain and expand the scope and quality of their care. Similarly, state policymakers should fund their own family planning grant programs based on the needs of their communities and avoid policies that disadvantage or disqualify reproductive health–focused providers from government funding.

■ Congress should eliminate eligibility restrictions on public and private insurance coverage for all lawfully present immigrants. The Obama administration should enable young adults recognized as lawfully present under the Deferred Action for Childhood Arrivals program to purchase coverage through the health insurance marketplaces and to receive subsidies to make this coverage affordable.

■ Title X program guidelines should serve as the basis for standards of family planning services provided by FQHCs. Reproductive health–focused providers should be prioritized for federal and state funding to help clients navigate the enrollment process and designated essential community providers for health plan networks. Providers themselves should explore opportunities to collaborate with other safety-net providers and to become part of health care models promoting coordinated patient care.

Chapter 1

The Essential Role of Family Planning

It has been five decades since the first oral contraceptives were approved by the U.S. Food and Drug Administration in 1960, and those decades have proven revolutionary. What quickly became known simply as "the pill" gave women and couples a method of contraception that is effective, convenient and reversible. The pill has been followed by an array of other reliable, reversible methods, including the IUD, the implant, the injectable, the ring and the patch. Together with modern techniques for female and male sterilization, and with barrier methods such as condoms, women and men today have numerous options, and contraception has become a routine part of American life. More than 99% of reproductive-age women who have ever had sex with a man have relied on a form of contraception at some point in their lives.[1]

Widespread access to reliable contraceptives, in turn, has meant that women and couples in the United States have the means to avoid unintended pregnancy and, by doing so, can exercise meaningful control over whether and when to have children. Most have chosen to have smaller families: The average number of children in a U.S. family has dropped from nearly four in 1957 to around two today.[2,3] In addition, contraception has helped many Americans to delay when they first become parents: The teen birthrate has fallen by two-thirds since its peak in 1957,[4] while birthrates for women in their 30s and 40s have increased substantially.[5]

Contraceptive access has also had important public health consequences for women and families, because it allows women to time and space their births, and thereby avoid adverse outcomes associated with short pregnancy spacing (Figure 1.1).[6] Nonetheless, about one-third of U.S. pregnancies occur within 18 months of a previous birth;[7] such short pregnancy spacing has been linked to poor birth outcomes, including premature birth and low birth weight.[8–10] And because unintended pregnancy is strongly linked to short pregnancy spacing, eliminating unintended pregnancies could reduce the proportion of closely spaced births to about one-quarter of all births.[7]

In addition to allowing couples to avoid unintended pregnancies, contraceptive use allows them to plan the pregnancies they want. Being able to prepare for a pregnancy

FIGURE 1.1

Access to contraceptive services and supplies helps women to plan their pregnancies, which has positive consequences for maternal and child health.

can help women achieve healthy behaviors before, during and afterward, such as initiating prenatal care early in pregnancy, taking prenatal vitamins, reducing or stopping smoking and drinking, and starting and sustaining breast-feeding.[11–14]

Moreover, by helping women have fewer births over their lifetime, contraceptive use decreases women's likelihood of pregnancy-related morbidity and mortality.[15,16] The risk of such adverse outcomes is particularly high for women who are near the end of their reproductive years and for those with medical conditions that may be exacerbated by pregnancy. Although reversible contraceptives—like virtually all medications and medical devices—are not without risk, they pose a far less serious risk than do pregnancy or childbirth.[17]

It was for such public health reasons that the federal Centers for Disease Control and Prevention identified the development of and improved access to effective contraception as one of the top 10 public health achievements of the 20th century, alongside the smallpox and polio vaccines, and reductions in tobacco use.[18] A panel of the Institute of Medicine in 2011 cited similar reasons for including contraceptive methods and counseling in its recommended package of clinical preventive services for women.[19]

Benefits Beyond Health

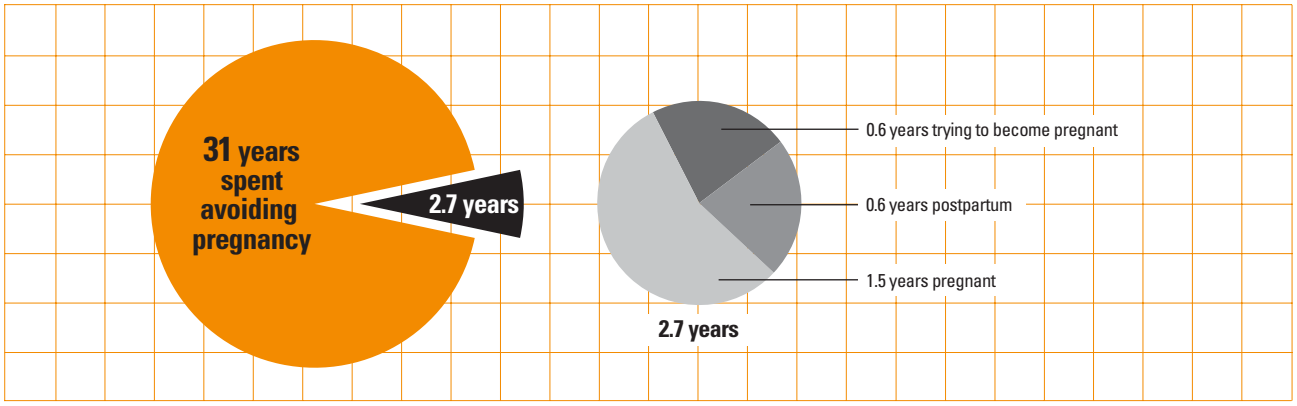
The ability to plan whether and when to have children that contraceptive use provides has contributed substantially toward the goals of women's equality and social justice—a fact that women themselves recognize. In a 2011 survey of more than 2,000 women seeking contraceptive services at U.S. reproductive health–focused providers, a majority said it was definitely true that, over the course of their lives, access to contraception had enabled them to take better care of themselves or their families (63%), support themselves financially (56%), complete their education (51%), or get or keep a job (50%).[20] When asked why they were seeking contraceptive services at that moment, women provided similar answers, including not being able to afford to care for a baby or another baby at that time (65%), not being ready to have children (63%), feeling that contraception gives them better control over their life (60%) and wanting to wait to have a baby until life is more stable (60%).

A considerable body of evidence from the past three decades has confirmed the social and economic benefits of family planning that have long been self-evident to women.[21,22] These benefits begin with educational attainment. Research indicates that states' granting legal access to contraception to young women—before they made lifelong decisions about education, employment and marriage—was a major factor in the substantial increases over the final decades of the 20th century in women's pursuit of college education and advanced professional degrees, such as in law, medicine, dentistry and business administration.[23–26]

Access to effective contraception has also helped improve women's status and participation in the labor force. Historically, young women's legal access to the pill has contributed to the trend of more women pursuing full-time jobs outside the home and careers with higher pay and prestige.[23,24,27–29] Planning for, delaying and spacing births still appear to help most women achieve their career goals.[30,31] These trends are tied to advancements in women's educational credentials, and to the recognition by women and their potential employers that women can pursue a career with far less fear of it being interrupted by an unplanned pregnancy.

FIGURE 1.2

The typical American woman wants to have two children; to accomplish that goal, she will spend close to three years pregnant, postpartum or attempting to become pregnant and about three decades trying to avoid pregnancy.



Note The typical woman is able to become pregnant for 34 years; the average age at first sex is 18, and the the average age of menopause is 51.
Source See Appendix 1.

Through these investments in education and careers, contraception has helped increase women's earning power and narrow the gender gap in pay.[23,32] By delaying the birth of a first child until her late 20s or 30s, a working mother—particularly if she is highly educated—can reduce the degree to which she is paid less than her childless peers and decrease her chances of needing public assistance.[33–36]

Education and career decisions are also tied closely to decisions about marriage, and studies suggest that the advent of the pill helped spark the United States' trend toward later marriage.[24,26,37] Postponing marriage allows women and men the time they need to determine what they want out of a relationship and to enter into marriages that are more likely to endure. Research indicates that unplanned births are tied to increased conflict and decreased satisfaction in relationships, and ultimately with elevated odds that a relationship will fail.[38–41]

Given its connections to so many central aspects of people's lives, it makes sense that the ability to successfully determine whether and when to have children is also related to an individual's mental health and happiness. Women and men who experience an unplanned pregnancy are particularly likely to experience depression, anxiety and a decreased perception of happiness.[11,38,42]

Finally, contraceptive use and pregnancy planning can improve the well-being of children. Contraception gives people time to prepare themselves for parenthood, and for the emotional and economic investments needed to help their children succeed,[42,43] which in turn may positively influence their children's mental and behavioral development, and educational achievement.[43–46]

For all these reasons, *The Economist,* in the magazine's review of the last millennium, concluded that "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."[47] Before the pill, "the unpredictability of the arrival of children meant that the rights of many women were more theoretical than actual." Since its advent, "women have taken a giant step towards their rightful position of equal partnership with men."

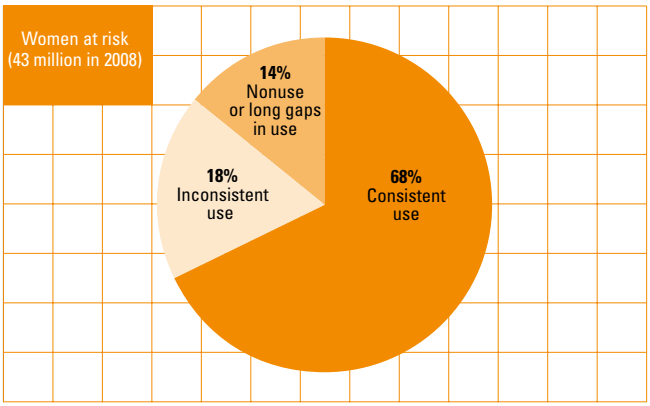
More Work to Do

Although contraceptive access has had enormous benefits for generations of U.S. women and families, there is still much room for progress.[48] For individual women and couples, effective contraceptive use can be a difficult proposition. The typical American woman wants to have two children;[49] to accomplish that goal, she will spend about three years pregnant, postpartum or attempting to become pregnant, and about three decades trying to avoid pregnancy (Figure 1.2, page 7).

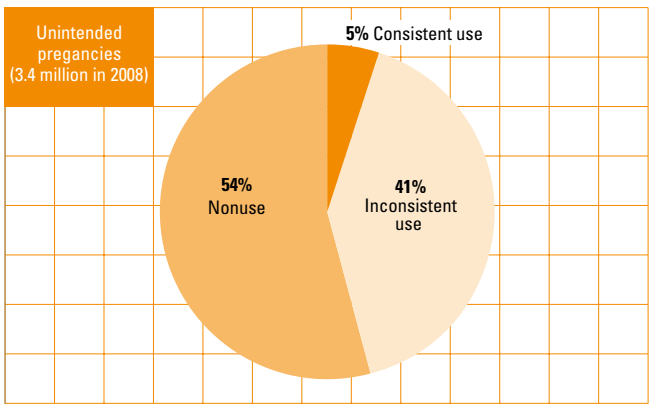
Without contraception, having only two children can be nearly impossible: Couples not using a contraceptive method have approximately an 85% chance of an unintended pregnancy within 12 months.[50] Yet, couples practicing contraception are not guaranteed to meet their childbearing goal. Although almost all modern methods have very low failure rates if used perfectly, many methods—especially those that require routine user involvement,

FIGURE 1.3

The two-thirds of women who practice contraception consistently all year account for only 5% of unintended pregnancies.



By consistency of method use all year



By consistency of method use during month of conception

Notes "Nonuse" includes women who were sexually active, but did not use any method of contraception. "Long gaps in use" includes women who did use a contraceptive during the year, but had gaps in use of a month or longer when they were sexually active. "Inconsistent use" includes women who used a method in all months that they were sexually active, but missed taking some pills, or skipped use or incorrectly used their barrier method or condom during some acts of intercourse. "Consistent use" includes women without any gaps in use who used their method consistently and correctly during all months when they were sexually active, including those who used a long-acting or permanent method.

Source See Appendix 1.

such as taking a pill each day or using a condom each time one has sex—are difficult to use perfectly for decades.

What this means, in practice, is that women are at highest risk of unintended pregnancy if they fail to use contraceptives at all, but are still at considerable risk if they use them improperly. Indeed, 95% of unintended pregnancies each year occur among women who use contraceptives inconsistently or not at all, and only 5% occur among the two-thirds of women who consistently and correctly practice contraception all year (Figure 1.3, page 8).

Because so many women use contraceptives imperfectly, by age 45, more than half of all American women will have experienced an unintended pregnancy, and three in 10 will have had an abortion.[51,52] Progress in reducing the risk of unintended pregnancy has stalled in recent decades: The U.S. unintended pregnancy rate fell from 59 per 1,000 women aged 15–44 in 1981 to 49 per 1,000 in 1994, but climbed again to 54 per 1,000 by 2008.[53]

The 2008 rate translates into more than three million unintended pregnancies each year—roughly half of all pregnancies.[53] Two-thirds of all births resulting from unintended pregnancies are paid for by public insurance programs, such as Medicaid. This meant $12.5 billion in public costs for maternity and infant care in 2008 (Figure 1.4).[54]

Beneath those discouraging overall figures are disturbing and growing disparities among U.S. women (Figure 1.5, page 10).[55] Between 1994 and 2008, the unintended pregnancy rate rose 56% among women with incomes below the federal poverty level ($19,530 for a family of three in 2013[56]).[53,55] Over the same period, the rate fell by 24% among women with incomes at or above 200% of the poverty level. By 2008, the unintended pregnancy rate for poor women was more than five times that for higher income women (137 vs. 26 per 1,000 women).[53] There are similarly distressing disparities by education, race and ethnicity. Women without a high school degree have more than three times the unintended pregnancy rate of college graduates, and black and Hispanic women each have more than twice the rate of white women.

Disparities in unintended pregnancy are related to a broad spectrum of other health disparities. For example, maternal mortality is especially common among black women, who have a rate roughly triple that of either their white or Latina peers.[57] Beyond reproductive health, there are numerous other inequities in health care and health outcomes that are tied to poverty, race and education, including disparities in the rates of serious diseases (e.g., heart disease, cancer and diabetes) and in the use of diagnostic, preventive and treatment services.[58] All of this echoes broader social and economic inequities in the United States.

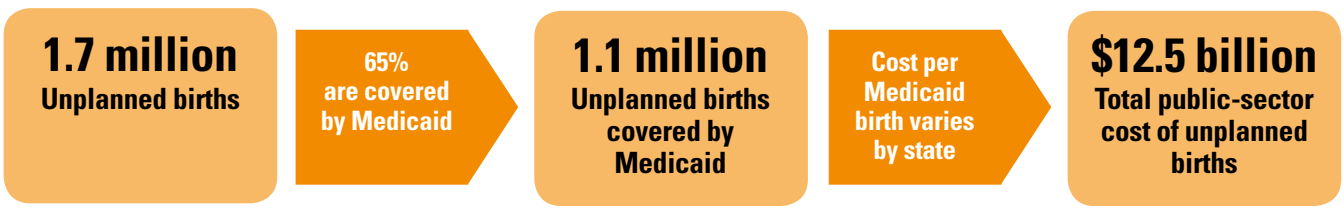
Immigrant women are an additional group facing such disparities and inequities.[59] For example, the limited evidence available about immigrant women suggests that they are less likely than U.S.-born women to use preventive reproductive health services, including contraceptive services.[60] This likely reflects the fact that immigrant women are particularly likely to be low-income, young and women of color—demographic characteristics linked to adverse sexual and reproductive health outcomes, including unintended pregnancy and STIs. Similarly, cervical cancer disproportionately afflicts and causes the deaths of immigrant women, particularly Latinas and women in certain Asian communities, likely because many of these women go without timely screenings.[61]

Expanding Access

To address disparities in contraceptive use and unintended pregnancies, women and men need access to comprehensive, affordable, high-quality family planning information and services. That means having a broad range of contraceptive options, so that individuals can select a method that they can use effectively. Which method they choose will depend on their specific life cir-

FIGURE 1.4

In addition to the health, social and economic costs to women and families, taxpayers pay a steep price for unintended pregnancy.



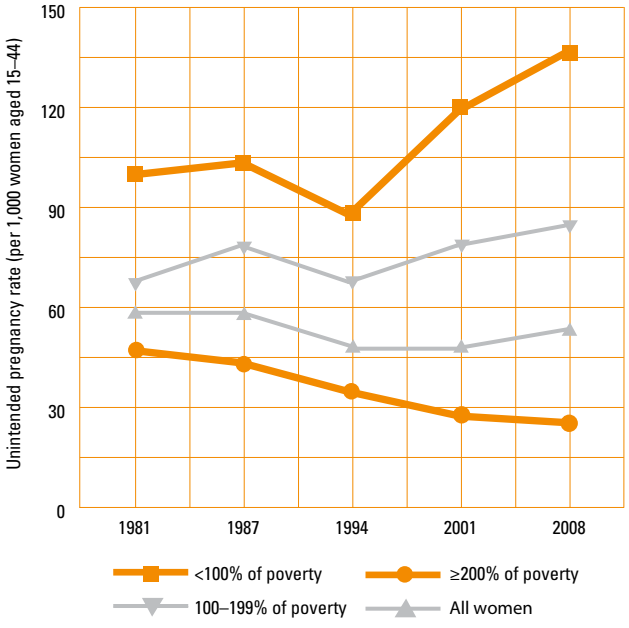
Source Reference 54.

cumstances, sexual behavior and health needs, and on the side effects they experience from specific methods. An individual's method choice may also differ over time: Most women have used four or more contraceptive methods by their early 40s.[62] Beyond method choice, women and men need access to clear, accurate information about the benefits and drawbacks of each contraceptive option and about their personal risk of unintended pregnancy and STIs. They need access to well-trained health care providers who are knowledgeable about family planning needs and options, comfortable discussing issues related to sex, and capable of providing linguistically and culturally appropriate care. Finally, women and men without substantial financial resources need access to free or subsidized care, or to public or private health insurance, to help pay for their care.

This final issue—affordability—is particularly salient for millions of people. A 2004 survey, for example, found that one-third of women using reversible contraceptives would switch methods if they did not have to worry about cost;[63] these women were almost twice as likely as others to rely on lower cost, less effective methods. According to another study of 10,000 women in the St. Louis area, when offered the choice of any contraceptive method at no cost, two-thirds chose long-acting methods—a level far higher than in the general population.[64] Insurance coverage is designed to help people overcome these financial barriers, so it is not surprising that uninsured women are less likely than those with private insurance or Medicaid to receive any sexual or reproductive health service, any contraceptive service, or any STI or HIV service.[65] Similarly, studies show that lack of insurance is associated with reduced use of prescription contraceptives.[66–68] In addition, insurance coverage appears to be linked with unintended pregnancy: In an analysis that controlled for a wide range of measures possibly related to variation in state unintended pregnancy rates, an increase in the proportion of women without coverage was associated with elevated unintended pregnancy rates, and an increase in the proportion of women with Medicaid coverage was associated with reduced unintended pregnancy rates.[69]

FIGURE 1.5

Over the past two decades, unintended pregnancy has become increasingly concentrated among low-income women.



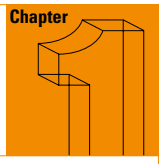
Source Reference 55.

The federal and state governments have, for decades, worked to improve affordability and other forms of access for young and low-income women and men. Title X of the Public Health Service Act—enacted by Congress in 1970—is the sole federal program devoted entirely to family planning. It is a central source of grant funding for a nationwide network of thousands of health centers that provide family planning and related services, and it sets national standards for high-quality family planning care. Medicaid—a joint federal-state public health insurance program—is a vital partner in the overall family planning effort and provides the vast majority of the public dollars supporting such services. Together, the care funded and provided through these and other programs helps millions of women and men each year to practice contraception effectively, and to avoid unintended pregnancy and other negative health outcomes. Yet, the national investment in family planning has never been enough to provide services to all who need them. Millions of women and men continue to have unmet need for care, which contributes to the nation's persistent disparities.

The Affordable Care Act (ACA) of 2010—sometimes known as Obamacare—has the potential to help address the unmet need for affordable family planning care. If implemented well, health reform could extend comprehensive health coverage to tens of millions of individuals who would otherwise be uninsured, through expanded eligibility for Medicaid and through federal subsidies to purchase private insurance from new health insurance marketplaces. The ACA should also mean better coverage for family planning care: Most women's insurance, whether Medicaid or private coverage, will cover a full range of contraceptive methods and many other preventive reproductive health services without out-of-pocket costs, such as copayments or deductibles. Together, expanded insurance eligibility and better family planning coverage should significantly reduce the financial barriers that millions of women face to choose a method that they can use consistently and effectively. At the same time, implementation of the ACA poses numerous challenges and opportunities for family planning programs and providers.

This report is intended to describe what the overall family planning effort achieves today and provide a road map of

what it could accomplish in the future, if the challenges and opportunities of the ACA are met. In Chapter 2, we discuss the current shape of the overall family planning effort, with a focus on the complementary roles of Title X and Medicaid. In Chapter 3, we walk through the impact of family planning programs and examine the women and men served; the contraceptive and related care provided; and the health and financial benefits accumulated for individuals, families and society. In Chapter 4, we look at the challenge of paying for the overall family planning effort in the years to come, including the potential role of the ACA's coverage expansions and the continuing need for Title X. In Chapter 5, we explore the continuing challenge of ensuring access to care and highlight the central role of reproductive health–focused providers as the entry point to the health care system for millions of women and men. Finally, in Chapter 6, we make recommendations for how policymakers can help the overall family planning effort meet these challenges and capitalize on the opportunities that it faces in an evolving 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 ($19,530 for a family of three in 2013).[56]

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 (e.g., Asians) are not discussed in detail, because the national surveys upon which much 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 a package of services that includes 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.

OVERALL FAMILY PLANNING EFFORT

The nationwide public effort to deliver family planning services and supplies to women in need of publicly supported care in the United States. This includes all forms of government funding (federal, state and local dollars), as well as all providers who offer services using those public funds; such provider types include private physicians paid through public insurance programs (typically Medicaid) and the network of health centers that provide family planning services.

HEALTH CENTER THAT PROVIDES FAMILY PLANNING SERVICES

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. Some of these centers receive Title X grant support, while others do not; some are reproductive health–focused providers, while others provide contraceptive services as part of a more comprehensive package of primary care. These sites are operated by a diverse range of provider agencies, including health departments; Planned Parenthood affiliates; hospitals; federally qualified health centers (FQHCs); and other, independent organizations. In this report, "center" is used instead of the synonymous term "clinic."

TITLE X–SUPPORTED CENTER

A health center that receives any Title X funds. All family planning 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 or completely through another funding source, such as Medicaid. Some providers supported by Title X are reproductive health–focused providers, while others provide contraceptive services as part of a more comprehensive package of primary care.

REPRODUCTIVE HEALTH–FOCUSED PROVIDER

A health center with a focus on providing family planning and related sexual and reproductive health services. They are distinguished from FQHCs and other health centers that provide contraceptive services as part of a more comprehensive package of primary care. Some of these centers receive Title X grant support, while others do not.

UNINTENDED PREGNANCY

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

WOMEN IN NEED OF PUBLICLY SUBSIDIZED CONTRACEPTIVE SERVICES

Women aged 13–44 who are sexually active; are 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.)

Chapter 2

Publicly Funded Family Planning Today

Access to contraceptive services is a continual and pressing need in the United States. Slightly more than half of all U.S. women of reproductive age—some 37 million women—were in need of contraceptive services in 2010, meaning that they were sexually active and able to become pregnant, but not trying to become pregnant.[70]

As was true in the 1960s, when the overall family planning effort first gained traction, many women currently in need of care face significant cost and other systemic barriers to obtaining a method that they can use effectively. In 2010, some 19.1 million women were in need of publicly funded contraceptive care because they were in need of contraception and were either adults with a family income below 250% of the federal poverty level (about $45,775 for a family of three in 2010[71]) or younger than age 20 and, therefore, presumed to have a low personal income (Figure 2.1, page 13).[70] This was an increase of 17% from 2000, when 16.4 million women were in need of contraception. This increase is unsurprising, given the economic downturn that occurred in the latter part of the decade, and is likely a result both of more women living below 250% of poverty, and of more women and couples choosing not to grow their families in tight economic times.

Federal and state government programs have worked together for decades now to narrow the contraceptive access gap between women with the resources necessary to successfully determine whether and when to have children, and those without. These programs have helped to establish and maintain a nationwide network of health centers that make use of public funds to deliver the family planning services needed by disadvantaged women.

All together, the federal and state governments spent nearly $2.4 billion in 2010 on family planning services in the United States (Figure 2.2, page 14).[72] Medicaid accounted for 75% or $1.8 billion, and Title X accounted for 10% or $228 million. In addition, three federal block grants—maternal and child health (MCH), social services and Temporary Assistance for Needy Families (TANF)—together accounted for 3% or $79 million of public expenditures. Finally, all but six states and the District of Columbia reported using some of their own revenues (in addition to funds required to match federal grants) to provide family planning services; state funds comprised the remaining 12% or $294 million of total public funding for contraception.

Title X and Medicaid are fundamentally different programs that together form the core of the nation's overall family planning effort. Title X—the only federal program dedicated to providing family planning services to individuals disadvantaged because of income or age—is a federal grant program that supports a nationwide network of health centers that provide family planning services. Medicaid, on the other hand, is an insurance program. Medicaid dollars directly reimburse providers—including private physicians and health centers that provide family planning services—for care to low-income individuals who meet the program's eligibility criteria and are enrolled in the program.

Title X: The Programmatic Mainstay

Created in 1970 with broad bipartisan support, Title X was a key step toward trying to make effective contraceptive options just as accessible to low-income women as to more affluent women. More than 40 years later, Title X remains the signature program of the nation's overall family planning effort. It sets guidelines that are the gold standard for U.S. family planning care, and helps

providers to serve clients who lack insurance coverage and to deliver the full package of services needed to promote effective and consistent contraceptive use.

Supporting a Diverse Network

Title X's public and private grantees distribute funding to state and local health departments, as well as to nongovernmental organizations, such as federally qualified health centers (FQHCs), Planned Parenthood affiliates and other independent agencies, such as family planning councils.[73] In 2010, Title X supported 4,100 family planning provider sites throughout all 50 states and the District of Columbia, which collectively delivered contraceptive care to more than 4.7 million women, including 1.1 million teens, as well as to approximately 400,000 men.[70,74]

Health departments have long constituted the largest proportion of Title X–supported centers, accounting for 53% of Title X sites in 2010 and serving 36% of women who received care from centers that year (Figure 2.3, page 15).[70] FQHCs and centers operated by Planned Parenthood affiliates comprised about the same proportion of Title X–funded sites (14% and 13%, respectively); however, FQHCs served only 9% of women, while Planned Parenthood health centers served 37%—meaning that Planned Parenthood affiliates provided care to four times as many family planning clients per site. Centers operated by hospitals and other agencies together served 18% of clients.

Because Title X grants offer up-front funding to providers (rather than payment after-the-fact, as with Medicaid or private insurance), the program provides essential infrastructure support that allows health centers providing family planning services to keep their doors open for clients. Up-front funding helps supply a cash-flow cushion for providers who are often operating on tight and uncertain budgets. More specifically, Title X recipients use the program's flexible grant funding in a variety of ways to address staff-related issues, including hiring individuals capable of meeting communities' need for linguistic or culturally appropriate care, training staff on the latest medical techniques or to provide tailored counseling for clients with special needs, maintaining sufficient staff to operate outside regular business hours and paying sufficient wages to staff at all levels to reduce high turnover rates that often plague health centers.[75–77] Providers may also use Title X funds for operational investments, such as utilizing advanced technologies and facilitating more accessible and efficient client care.[78]

Setting the Standard of Care

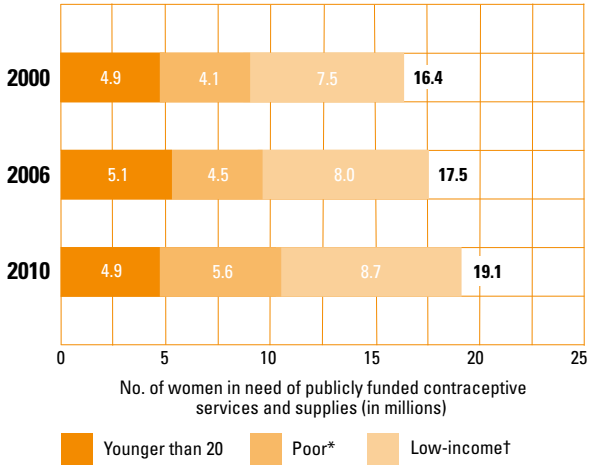
Another reason that Title X is important is that it sets standards for the provision of publicly supported family planning services across the United States. The principles of high-quality care defined in the Title X statute, regulations and program guidelines apply to all women and men served under a health center's Title X project, even if an individual's care is paid partially or entirely by another public program, private insurance or the client herself.

One of these principles is that family planning care must be voluntary. The policymakers who crafted Title X recognized that public-sector contraceptive initiatives can be a double-edged sword. On one hand, women's ability to determine for themselves whether and when to have children is integral to their obtaining other life goals, such as education, employment and economic stability. But history—including U.S. history—has shown that although contraception is overwhelmingly beneficial, it can be misused as a tool of social control: Deliberate campaigns have been waged to limit the fertility of women of color, low-income women and women with disabilities.[79] Thus, to guarantee that participation would be truly voluntary, policymakers included key patient protections from the program's inception. Notably, Title X requires that clients be offered a broad range of contraceptive methods from which they can make a choice and expressly prohibits its conditioning the receipt of government assistance on the acceptance of any particular contraceptive method or other services.[80]

Second, program regulations require that centers receiving funding through Title X must ensure confidentiality for all their clients.[81] Confidentiality is important to women regardless of age, income or insurance status, but is particularly vital for teenagers. Although most teens receiving family planning care report that a parent knows of their visit, the consequences of requiring parental involvement would be severe for many others: According to one survey of U.S. minors, 18% said that if parental consent were required for prescription contraceptives,

FIGURE 2.1

Poor and low-income adult women account for the growing number of women in need of publicly supported contraceptive services.

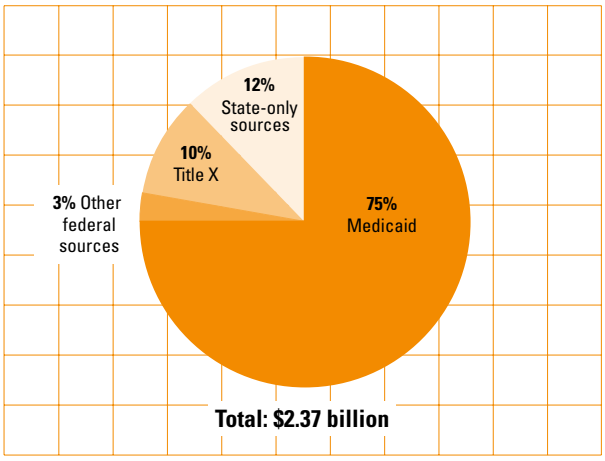


*Women aged 20–44 with family income less than 100% of the federal poverty level.
†Women aged 20–44 with family income at 100–249% of the federal poverty level.

Source Reference 70.

FIGURE 2.2

Medicaid provides three-quarters of the public dollars spent for family planning in the United States.



Public expenditures on family planning client services, FY 2010

Source Reference 72.

they would have sex using no contraceptive method or rely on rhythm or withdrawal—choices associated with elevated risk of unintended pregnancy and STIs;[82] only 1% said that their only response would be to stop having sex.

Third, providers receiving any Title X funds must deliver services to clients regardless of their income. Consistent with the program's prioritization of low-income individuals, uninsured clients with an income below the federal poverty level must be provided care free of charge;[80] other clients are assessed a fee according to a sliding scale on the basis of their income, with those with an income above 250% of poverty being responsible for the full cost of their services. Minors seeking confidential care must be assessed fees on the basis of their own income, rather than their family's.

Furthermore, Title X standards promote the principle of informed consent through neutral, factual counseling. The Title X statute has always expressly prohibited the use of grant dollars to fund abortion. However, pregnancy testing is a core service supported by Title X,[83] 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.[84]

Finally, the program sets the standard for accountability for publicly funded family planning in the United States. Title X grantees have been required since the program's inception to collect data on the demographic characteristics of the clients they serve, the revenues they receive and the services they provide. As will be demonstrated in Chapter 3, these data clearly document Title X's effectiveness in providing family planning and broader health services to clients, and unequivocally demonstrate the public's return on its investment.

Serving Uninsured Clients

Title X funds are also critical to enabling health centers that provide family planning services to serve clients who have no source of third-party reimbursement. The impact of this funding—and of the commitment to serving disadvantaged clients that all Title X providers must demonstrate—can be seen in the fact that half of clients served at Title X–supported centers do not use insurance for their visit.[65]

Many of those who are uninsured are prohibited from coverage because of their immigration status. Provisions adopted over the span of several decades bar many immigrants from Medicaid, including documented immigrants during their first five years of lawful residency, young people brought to the United States as young children (a group commonly referred to as DREAMers) and those who are undocumented.[59] Unlike Medicaid and other federal means-tested public benefit programs, Title X funds may be used to serve clients regardless of their immigration status.[85]

In addition, Title X funds are sometimes used to provide services to privately insured clients who are afraid to use their coverage because of concerns about confidentiality. Widely used claims processing procedures—most notably the practice of sending explanation-of-benefit forms to the policyholder, who is often a parent or a spouse—make it virtually impossible for someone insured as a dependent to access confidential care using their insurance.[86] Nearly one in five insured women obtaining care at reproductive health–focused providers who do not plan to use their insurance coverage to pay for their care say that they are doing so because of confidentiality concerns.[87] Not surprisingly, teens—who are almost always insured as dependents on someone else's policy—are the most likely to cite confidentiality as the reason for not using their coverage; 31% of insured teens not using their insurance for care say it is because of confidentiality concerns.

Providing Cutting-Edge Care

Another impact of Title X is that the health centers supported by the program generally provide higher-quality contraceptive care than many other providers, because of these centers' commitment to family planning and because of the standards they must adhere to under the program. Title X–supported centers offer clients a choice of 10 methods, on average, and nearly seven in 10 offer at least one long-acting reversible method, such as the IUD or contraceptive implant.[88] The difference between providers that do and do not receive Title X funding is particularly pronounced among FQHCs: A nationwide survey of FQHCs' largest individual sites found that 52% of those participating in Title X offer all methods of hormonal con-

traception and other barrier methods, compared with 27% of centers without Title X support.[89]

Providers at centers that receive Title X dollars are also more likely than other providers to offer contraceptives on site rather than give a prescription that women must fill at a pharmacy or a referral to another provider for insertion of an IUD or implant (Figure 2.4, page 16).[88] Specifically, 86% of Title X–funded centers provide oral contraceptive supplies and refills on site, compared with only 39% of sites not funded by the program. Minimizing the number of trips a woman must take for contraception increases her ability to successfully obtain and begin using a method, especially for those who juggle the demands of school, family and work, or who are dependent on public or perhaps a borrowed mode of transportation—all common complicating factors in women's lives.

Moreover, providers with Title X support work hard to ensure that women are able to start their method quickly.[88] For example, Title X–supported centers are particularly likely to use the so-called "quick start" protocol, under which clients who choose to use oral contraceptives begin taking them immediately, rather than waiting until a certain point in their menstrual cycles, as some providers require. And Title X–supported centers are particularly likely to prescribe contraception without requiring a pelvic exam, a practice in line with evidence-based guidelines issued by the World Health Organization, the American College of Obstetricians and Gynecologists, and Planned Parenthood Federation of America.[90] Furthermore, centers with a Title X grant are more likely than others to provide emergency contraception to women in advance of their needing it, which enables women to have it readily available when time is of the essence.[88]

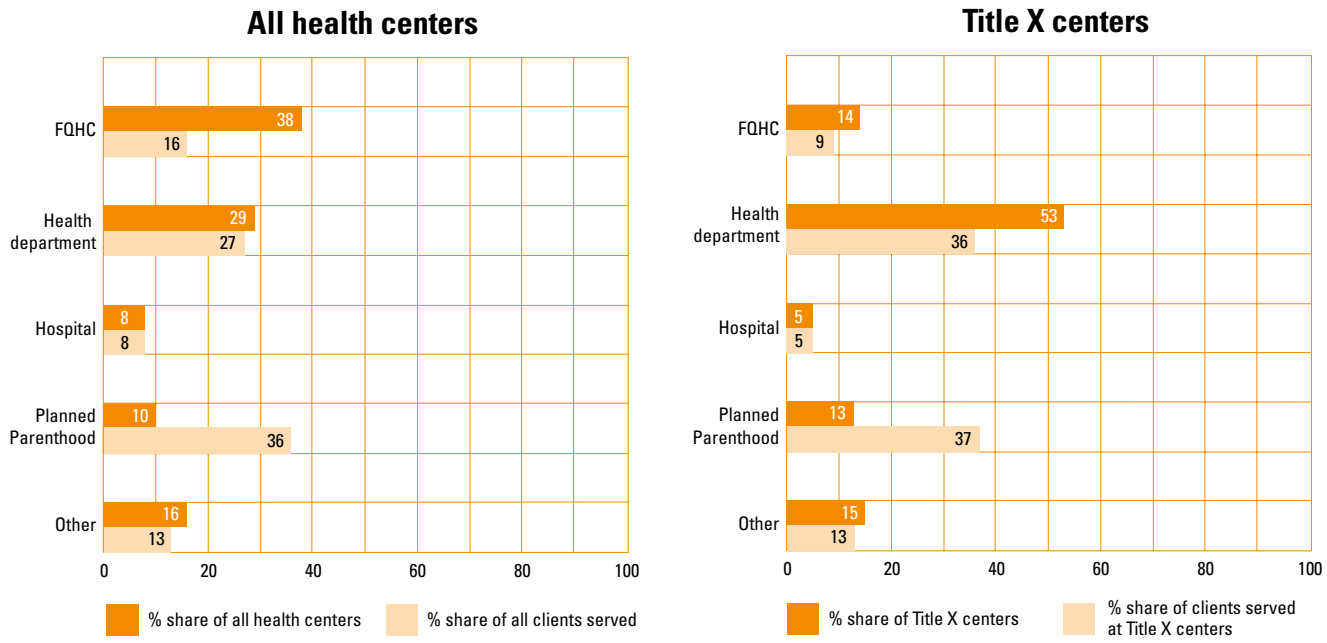
Finally, Title X–supported centers commonly provide in-depth contraceptive counseling, an important factor in effective contraceptive use that is promoted under the program's guidelines. Among FQHCs, 44% of those with Title X funding offer contraceptive counseling at their largest provider sites, compared with just 14% of those without.[89] And on the whole, counselors at Title X–supported sites spend more time with clients during initial contraceptive visits—especially those clients with special circumstances—than do counselors at sites not supported by Title X.[88]

Meeting Specialized Needs

One final reason why Title X is important is that it supports the efforts of health centers that provide family planning services to tailor their outreach and care to the specific needs of their clients. Tailored programs and

FIGURE 2.3

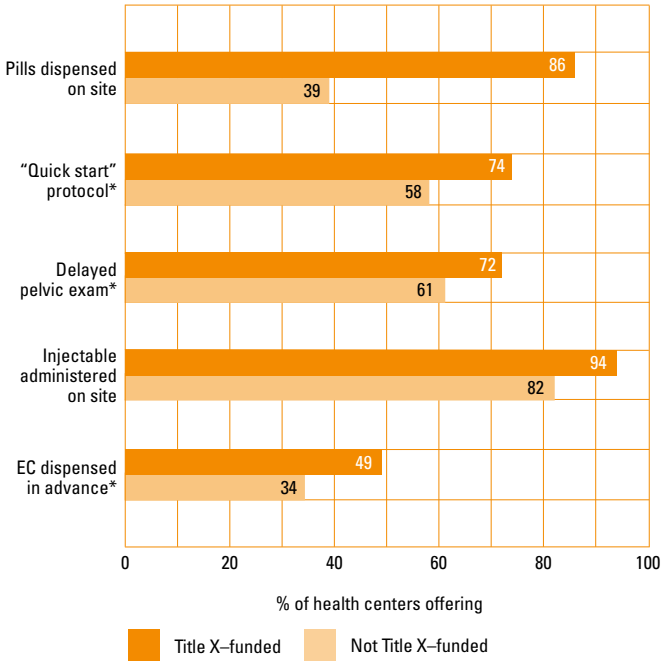
Planned Parenthood and health department sites account for most of the family planning clients served with public dollars, especially within the Title X network.



Note FQHC=federally qualified health center. **Source** Reference 70.

FIGURE 2.4

Title X–funded centers are more likely than others to take steps to make it simple for women to obtain and start using the contraceptive method of their choice without delay.



*Offered often or sometimes (as opposed to rarely or never).

Note EC=emergency contraception

Source Reference 88.

services may be particularly critical given the sensitive nature of the services provided by these centers and how they might resonate in some communities or raise concerns in others.

Title X sites have staff trained in serving groups of clients with a variety of specialized needs and operate specialized programs or outreach efforts aimed at specific groups of underserved clients.[88] Sites reported serving an average of eight different groups and offering programs or outreach to five, including homeless women, women with substance abuse issues and LGBT individuals. In California, for instance, Title X–supported centers are more likely than those without Title X support to engage in outreach with and offer services to these and other underserved groups.[78]

In addition, Title X sites are notably youth-friendly. Sites that receive Title X funding often have staff trained in meeting adolescents' particular needs, operate programs specifically tailored to serving adolescents and make additional efforts to reach out to adolescents—all reflecting the priority Title X has always put on making services accessible to this important group. Eighty-seven percent of FQHCs receiving Title X funding have staff specializing in providing care to adolescents at their largest sites, compared with 57% of FQHCs that do not receive Title X funding.[89]

Staff at Title X–supported centers spend more time with teenagers than do staff at sites not funded by the program.[88] This is important because youth often need more counseling and education than adults. Commonly, these providers make themselves accessible to teens by not requiring appointments for contraceptive refills, maintaining flexible hours, and engaging in outreach and education directed specifically to young people.[78,91]

Individuals with limited English proficiency also constitute a significant share of clients of many Title X providers. In 24% of centers supported by Title X, at least one in four clients has limited English skills.[88] Staff of Title X–supported centers tend to spend more time with these clients than do staff of other centers, and they report making special efforts to reach out to these communities and implementing special programs to help overcome language barriers to quality care.

Medicaid: The Leading Source of Funds

Medicaid is the nation's health insurance program for the poor and the bedrock of the national health care safety net. The program is jointly run by the federal government and the states. Congress and the Centers for Medicare and Medicaid Services (CMS)—the federal agency that administers Medicaid—set the basic parameters within which each state shapes and operates its own program. The federal and state governments split the costs of medical care, although states set the specific rates used to reimburse providers.

To obtain coverage under Medicaid, an individual must first meet the program's strict income eligibility and citizenship requirements. Then, one must successfully enroll in and maintain coverage under the program—tasks that have long been notoriously difficult because of the program's bureaucratic requirements. Once an individual gains Medicaid coverage, the program functions similarly to private insurance, reimbursing a provider for care delivered to the client in response to claims submitted by that provider. Medicaid will reimburse both private physicians and health centers that provide family planning services.

Family planning services have long been prioritized under Medicaid. Since 1972, federal law has required each state's Medicaid program to include coverage of voluntary family planning services and supplies for all beneficiaries of childbearing age. The federal government pays for 90% of the cost of providing family planning services to program enrollees, a higher rate than for other covered services, which leaves the states to pay for only 10%. Federal law also provides important safeguards for enrollees. For one, states and health plans are barred from requiring enrollees to make out-of-pocket payments for family planning services. Moreover, enrollees are entitled to receive

services from the provider of their choice, even if that provider is outside their health plan's network.

Realigned Funding

Over the last two decades, the roles Title X and Medicaid play in implementing the nation's family planning effort have evolved with the broader health care system. This realignment has revealed the different but highly complementary strengths of Title X and Medicaid: Basically, Medicaid pays for most of the clinical care provided, while Title X's adaptable grant dollars buttress the overall family planning effort and fill gaps in services and coverage.

Once a small portion of total expenditures, Medicaid has become the overwhelmingly dominant source of funding invested in family planning by federal and state governments (Figure 2.5).[72] Medicaid comprised 20% of family planning funding in 1980, but accounted for 75% ($1.8 billion) of all public funds spent for contraceptive services in 2010. In contrast, the share supported by Title X has decreased over the past few decades, from 44% in 1980 to 10% ($228 million) in 2010.

In many ways, this growth in family planning expenditures via Medicaid has been driven by trends throughout that massive program. Indeed, family planning is a minuscule part of the broader Medicaid program: Even though expenditures for family planning under Medicaid approached $2 billion in FY 2010, that accounted for only about 0.5% of the program's nearly $400 billion in total spending that year.[92]

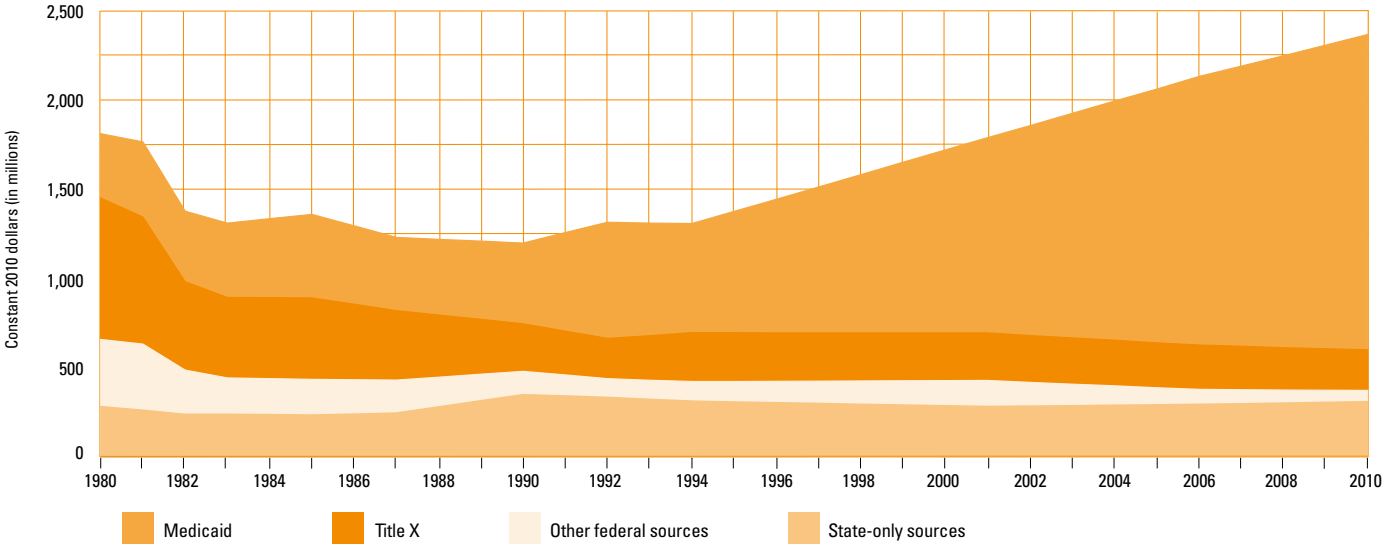
Enrollment in Medicaid and its companion program, the Children's Health Insurance Program (CHIP), increased by nearly 75% between 2000 and 2010, from 28 million to 49 million.[93] That trend can be attributed to expansions in eligibility for the programs and to growth in enrollment during the decade's economic recessions. The effect of the recession is also reflected in the increased need for contraceptive care: Over the course of only four years, from 2006 to 2010, the number of poor adult women in need of contraceptive services rose 25%—an addition of 1.1 million women.[70]

Family Planning Expansions

The increased role of Medicaid in funding the overall family planning effort has also been driven, in large measure, by state-initiated expansions of coverage specifically for family planning.[94] Since the mid-1990s, more than half the states have sought and received permission from the CMS to expand eligibility under the program specifically for family planning (but not for other services).[94] In general, these states set the income-eligibility ceiling for Medicaid-covered family planning at the same level used to determine eligibility for pregnancy-related care: typically at or near 200% of poverty. These levels were well above what, prior to the ACA, had been the regular income

FIGURE 2.5

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



Notes Inflation-adjusted data are reported in constant 2010 dollars using the Medical Care Consumer Price Index–All Urban Consumers, with $1.00 in 2010 equal to $5.19 in 1980. Other federal sources include the maternal and child health (MCH), social services and Temporary Assistance for Needy Families (TANF) block grants.

Source Reference 72.

Title X and Medicaid are fundamentally different programs that together form the core of the nation's overall family planning effort.

cut-off for Medicaid coverage in those states. In 2013, the eligibility ceiling averaged 64% of poverty across states for working parents, and most states excluded childless adults at any income level from Medicaid.[95]

Twenty-six states have expanded Medicaid eligibility for family planning services to women solely on the basis of their income, regardless of whether an individual has ever been enrolled in Medicaid; four other states have more limited expansions, typically extending family planning benefits for women otherwise losing Medicaid coverage after giving birth. States have implemented expansions through one of two processes: either by seeking a time-limited "waiver" of Medicaid rules or by a permanent amendment to their state's program.

Fourteen of the 26 states operate programs through waivers of Medicaid rules.[96] In general, these waivers are initially approved by the federal government for five years, and then can be renewed for shorter periods of time. As part of this process, states must demonstrate that their waivers will be budget-neutral to the federal government—in other words, that the federal Medicaid expenditures would not exceed the amount the federal government would have paid in the absence of the waiver.

Twelve states have utilized a more recent, expeditious and permanent option for expanding Medicaid eligibility for family planning services: a state plan amendment (SPA). The option to use a SPA to expand eligibility specifically for family planning and related services was made available as part of the ACA, in acknowledgement of the demonstrated programmatic and cost effectiveness of the family planning waiver programs. Although obtaining a family planning SPA still requires federal approval, it is intended to be a more streamlined process than that of applying for a waiver and does not need to be renewed. In addition, SPAs are not required to be proven cost-neutral. A state may not exclude individuals based on age or gender from qualifying for coverage under its family planning SPA.

These policies have reshaped the terrain of the national family planning effort, infusing much-needed new funding into the family planning system. More than 70% of the inflation-adjusted growth in family planning spending nationwide between 1994 and 2010 occurred in states with an income-based expansion in place.[97] And because the increase in Medicaid spending in states with income-based expansions generally has not been accompanied by a decline in other resources, family planning efforts in these states have more total resources available to provide high-quality care: On average, they were able to spend $221 per woman in need in FY 2010, compared with only $61 per woman in need in other states.[98]

Chapter 3

The Impact of the U.S. Family Planning Effort

Over more than four decades, policymakers and providers have knitted together Title X, Medicaid and other sources of public funding into an effective, nationwide safety net for family planning and related services. And over those same four decades, a substantial body of research has accumulated to demonstrate the impact of that safety net for women, their families and society.

According to that research, which will be outlined in this chapter, the national network of health centers that provide family planning services delivers needed family planning services each year to millions of disadvantaged women; it also advances women's health broadly, by delivering preventive health services beyond contraceptive care and often serving as a primary source of medical care. By providing contraceptive care to women who want it, the overall family planning effort helps women avoid substantial numbers of unintended pregnancies, along with the unplanned births, abortions and miscarriages that would otherwise result. Moreover, government funding for family planning is a proven, cost-effective investment that generates significant savings to taxpayers in every state.

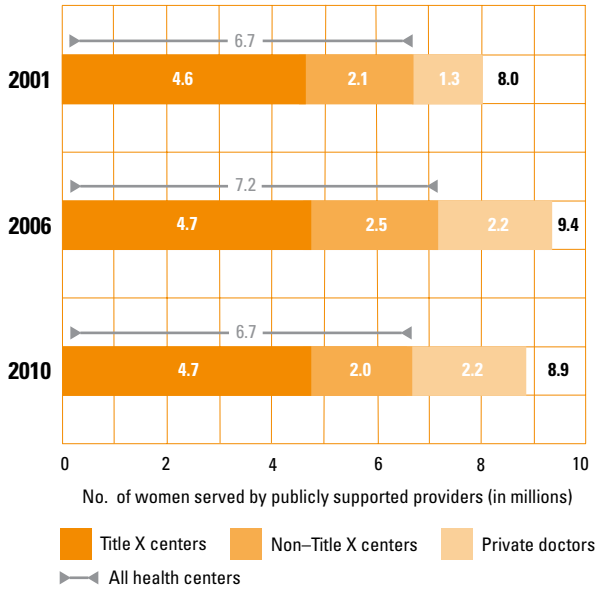
Meeting the Need

In 2010, 8.9 million women received publicly supported family planning services (Figure 3.1);[70] the overall effort reached 47% of those in need. (Not all of the remaining women had an unmet need, as an unknown proportion of women in need purchased nonprescription contraceptives from a pharmacy, paid for care out of pocket or used private insurance to receive care from a private physician.) About 2.2 million of these women (12% of those in need) saw private physicians who received Medicaid reimbursements for providing contraceptive care, and the remaining 6.7 million (35% of those in need) went to publicly funded health centers that provide family planning services. Of women who received care at a health center, 30% went to comprehensive health service providers, such as FQHCs, and 70% went to reproductive health–focused providers.[87,99]

Overall, 27% of all women in the United States who obtain contraceptive services do so at a publicly funded health center that provides family planning services.[65] These centers are particularly critical for those most likely to fall through the cracks of the U.S. health care system.

FIGURE 3.1

Most women receiving publicly supported contraceptive services obtain care from a health center.



Source Reference 70.

For instance, centers are trusted, accessible sources of contraceptive counseling and care for teens, who often lack financial resources and have confidentiality concerns that may bar them from seeking resources from their families or from even using their insurance coverage. Thirty-four percent of all teens who access contraceptive services do so at a health center that provides family planning services. Centers are also an important source of care for immigrants: Among those who receive contraceptive services in the United States, 41% of immigrant women go to a health center that provides family planning services, compared with 25% of U.S.-born women. This is unsurprising given the cost and language barriers often experienced by immigrant women—issues that centers are uniquely positioned to help women overcome.

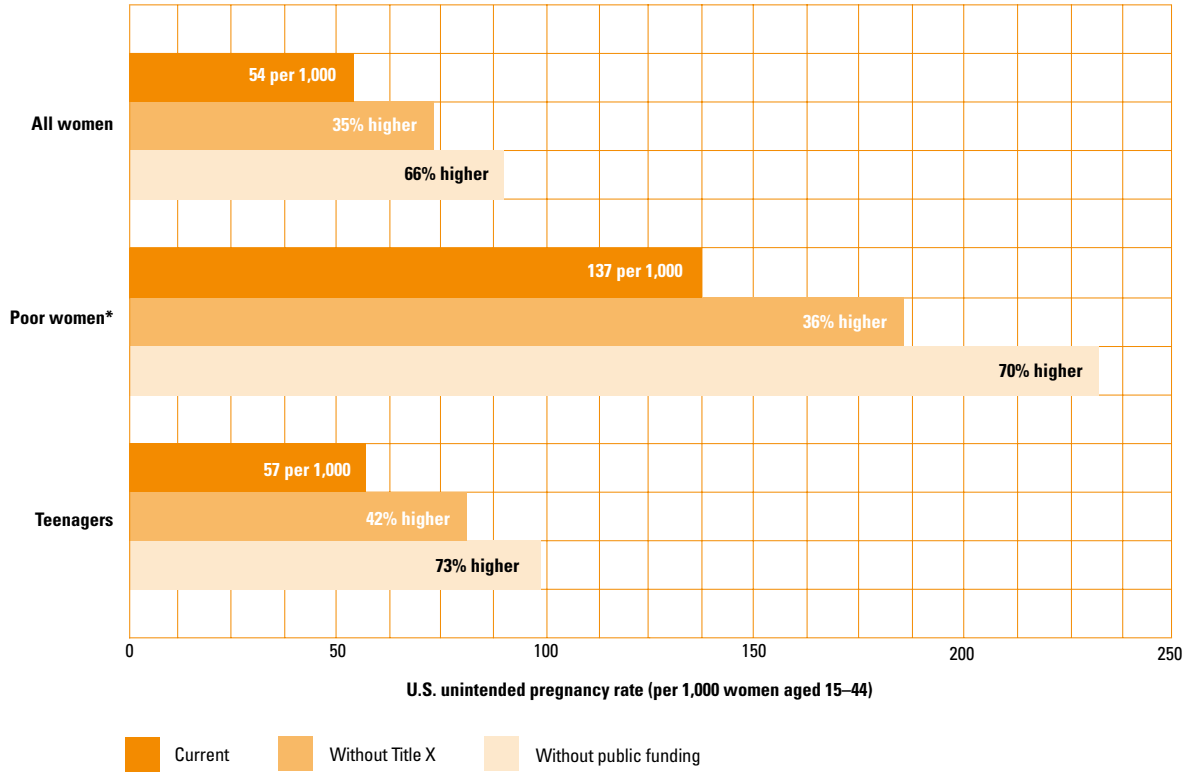
Title X continues to prove itself the heart of the overall family planning effort: In 2010, Title X–supported centers served 4.7 million contraceptive clients, meeting 25% of women's need for publicly supported contraceptive services.[70] In 2006–2010, of all those who received any contraceptive care in the United States, 25% of poor women, 36% of uninsured women and 21% of immigrant women received such care at a Title X–supported center.[65] One-third of all women who sought emergency contraception services during that period did so from a Title X site.

Health centers that provide family planning services—including reproductive health–focused providers—also play a critical role in providing related preventive health care. Such services include screening for HIV and other STIs, and for cervical and breast cancer. Often, these providers can treat conditions that they may have diagnosed in the course of a family planning visit, such as STIs or urinary tract infections. In other cases, a center that provides family planning services may refer a client to another provider for care following the diagnosis of certain conditions, such as a suspicious lump in a woman's breast or a positive HIV test—just as a private gynecologist may refer a patient to a specialist.

Title X–supported centers are a major source of these essential services.[100] In 2012 alone, Title X–supported centers tested 2.4 million clients for chlamydia; they also provided 2.7 million tests for gonorrhea, 715,000 for syphilis and 1.3 million for HIV. In that same year, these centers provided 1.2 million clients with Pap tests to detect early signs of cervical cancer and conducted 1.8 million clinical breast exams to detect warning signs of breast cancer.[73] In 2010, 18% of all U.S. women who received STI

FIGURE 3.2

Without publicly funded contraceptive services, the unintended pregnancy rate would be about two-thirds higher.



*Women aged 20–44 with a family income of less than 100% of the federal poverty level. **Source** Reference 70.

testing, treatment or counseling did so from a Title X site, as did 14% of all women who were tested for HIV.[65]

The package of basic, preventive sexual and reproductive health services routinely offered in health centers that provide family planning services—along with contraceptive services and supplies—is at least as comprehensive and often more so than what is provided to a woman visiting a private doctor during her annual exam. Given that, it is not at all surprising that many women view these centers as central to their overall health care. In fact, six in 10 women who receive services from health centers that provide family planning services—and the same proportion who receive services from Title X–supported centers—consider these providers their usual source of medical care.[65]

Preventing Unintended Pregnancies

Making effective methods of contraception available to women who want them but could not otherwise afford them reduces the number of individuals confronting the choice between seeking an abortion and having a birth for which they did not plan. In 2010, publicly funded contraceptive services helped women prevent a total of 2.2 million unintended pregnancies.[70] Of these, 1.1 million would have resulted in an unplanned birth, and 760,000 would have resulted in an abortion; the remainder would have ended in a miscarriage.

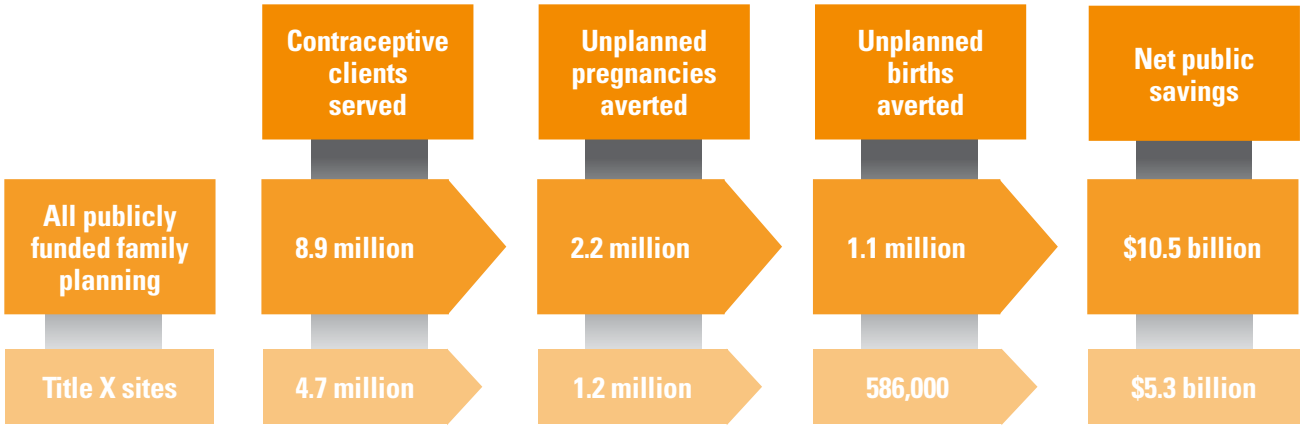
Without publicly supported family planning services, the rates of unintended pregnancy, unplanned birth and abortion in the United States each year would be 66% higher among women overall, and 73% higher among teens (Figure 3.2, page 20);[70] the rates would be 70% higher among poor women, for whom the need for publicly funded contraception has risen so significantly. This impact is particularly notable when it comes to abortion, the rate of which has generally been declining in the United States since the early 1980s:[101] Absent publicly supported services, the U.S. abortion rate would be higher than it has ever been.[70,101]

Centers that receive support through Title X are responsible for enabling women to avoid more than half of these unintended pregnancies. In 2010, the contraceptive services delivered by Title X providers enabled women to avoid 1.2 million unintended pregnancies, which would have resulted in 590,000 unplanned births and 400,000 abortions.[70] In other words, without the services provided specifically by Title X–supported centers, rates of unintended pregnancies, unplanned births and abortions in the United States would be 35% higher overall, and 42% higher among teens.

These most recent findings are consistent with decades of previous research. Indeed, there is evidence that the U.S. family planning effort has had a substantial impact on helping low-income women access contraception and prevent unplanned pregnancies dating as far back as the 1960s, when the Office of Economic Opportunity made the first federal family planning grants as part of the Johnson administration's signature War on Poverty.[102]

FIGURE 3.3

Publicly funded family planning services help millions of women each year avoid unplanned pregnancies and births, which in turn saves the federal and state governments billions of dollars—$5.68 is saved for every dollar spent.



Source Reference 70.

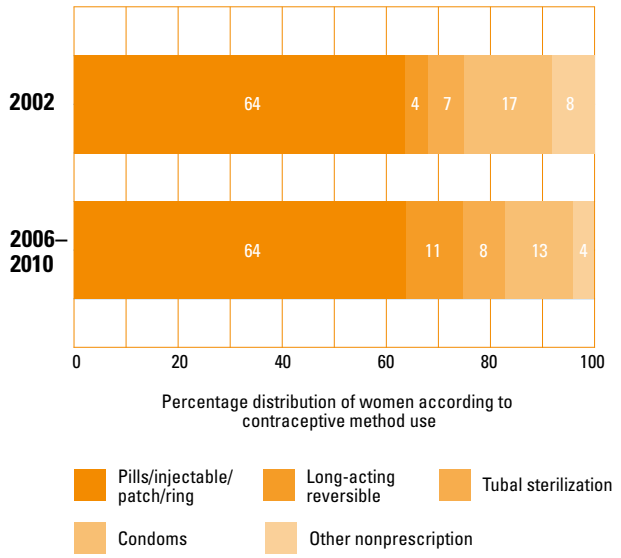
Generating Cost Savings

Helping women determine for themselves whether and when to have children not only benefits them and their families, but also leads to significant government savings. These savings accrue because 92% of women who would have had an unintended pregnancy had they not received contraceptive care at a health center would have been eligible for a Medicaid-covered birth.[103] And while the federal and state governments spent an average of just $239 in 2010 for each family planning client served that year, the average cost per Medicaid-covered birth was $12,770 (including prenatal care, delivery, postpartum care and infant care for one year).[70]

Investing in family planning services is smart government at its best: In 2010, the public investment in family planning services yielded net savings of $10.5 billion (Figure 3.3, page 21).[70] (Services provided at health centers that provide family planning services resulted in net savings of $7.6 billion, including $5.3 billion just from services provided at Title X–supported centers.) Looking at these data another way, every dollar invested to provide publicly funded contraceptive services in 2010 saved $5.68 that otherwise would have been spent to provide pregnancy and infant care under Medicaid. Absent what federal and state governments invested in family planning, the costs of unintended pregnancy would have been $25 billion, twice as high as the $12.5 billion it was in 2008.[54]

FIGURE 3.4

Users of publicly supported family planning have become increasingly likely to use long-acting reversible methods, which have extremely low failure rates.



Note Method mix among women who received publicly supported contraceptive services in last 12 months.

Source Reference 70.

Over the last decade, the cost savings resulting from publicly funded contraceptive services have increased, both in absolute dollars and when measured as a ratio of dollars saved per dollars spent on family planning programs.[70] Several factors contributed to this rise. First, family planning clients are more likely than in previous years to be using highly effective contraceptive methods, such as long-acting reversible contraceptives (Figure 3.4);[70] increased use of highly effective methods means more unintended pregnancies averted. Even more importantly, individuals who are unable to access publicly funded services are more likely than those in previous years to use either no contraceptive method or a less-effective one, such as withdrawal. This change is likely due, at least in part, to the recession. As a result, current users of publicly supported family planning are using a much more effective mix of contraceptive methods than individuals unable to access publicly funded services (Figure 3.5, page 23). Together, these factors led to the overall family planning effort's being able to help women avoid 15% more unintended pregnancies in 2010 than just four years earlier. Moreover, in line with overall national trends, more of these averted pregnancies in 2010 than in 2006 would have resulted in an unplanned birth rather than an abortion—a change that increased the cost savings.

Notably, the savings estimates discussed above consider only the costs of pregnancy-related care and a single year of infant care. However, there are a number of broader health benefits and likely cost savings that accrue to women and families through other services that often come with family planning visits, such as STI prevention and treatment or reproductive cancer detection and prevention.[6] Furthermore, the cost-benefit analysis presented here does not account for the significant economic benefits family planning services can confer to women by allowing them to obtain higher degrees of education and pursue higher paying careers.[21] Nor does this assessment include additional long-lasting and cost-saving health benefits associated with women's ability to effectively time and prepare for their pregnancies, including the increased likelihood of appropriate preconception care—a set of services recommended by the Centers for Disease Control and Prevention targeted for improving birth outcomes for mothers and infants through reducing women's biomedical, behavioral and social risk factors.[104]

Impact of Medicaid Family Planning Expansions

The Medicaid family planning expansions implemented over the last two decades were approved initially under the condition that they be evaluated extensively in each state. These program evaluations and studies by independent researchers have provided substantial additional evidence on the impact of expanding access to family planning services, including improved contraceptive use, prevention of unintended pregnancies, and improved maternal and child health.

These studies show that expanded access to care improves women's contraceptive use in three important ways.[94] First, it improves overall contraceptive use. For example, in a nationwide analysis comparing the group of expansion states with the group of states without expansions, researchers found that having an expansion was associated with measurable reductions over time in unprotected sex at last intercourse and during the past three months;[105] having an expansion was not associated with increased sexual activity.

Second, women's use of the most effective contraceptive methods increases with expanded access. In Pennsylvania, for example, women's use of highly effective methods increased from 55% before to 70% after their enrollment in the Medicaid family planning program.[106] Particularly high proportions of young adults chose these methods after enrolling in the expansion program—84% of 18–20-year-olds and 73% of 21–24-year-olds.

Finally, expanded access improves continuity of contraceptive use. Several states, such as North Carolina and South Carolina, achieved improved rates of client retention or follow-up contraceptive visits with the implementation of their Medicaid programs.[107,108] Clients in California who received a year's supply of oral contraceptives in one visit were less likely than those who received one or three pill packs at a time to experience a pregnancy or an abortion;[109] the practice of providing a year's supply of the pill at once saved the state's Medicaid program $99 per woman per year just in additional visit costs.[110]

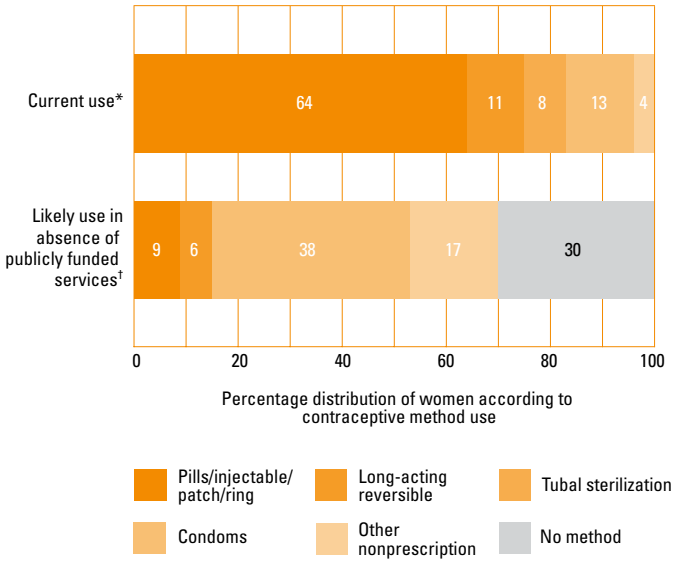
Studies of the Medicaid family planning expansions provide further evidence that increasing women's access to effective contraception has a considerable impact on preventing unintended pregnancy. For example, the services provided to women enrolled in California's expansion helped them avoid 200,000 unintended pregnancies in 2009.[111] Similarly, according to a nationwide study of the state expansions, in states where an income-based waiver was implemented, birthrates fell by 9% among all women newly eligible for Medicaid family planning coverage, and by nearly 15% among newly eligible women aged 20–24, relative to birthrates for similar women in states without family planning expansions;[105] by definition, all of the births averted by women's voluntary contraceptive use are those that would have resulted from an unplanned pregnancy.

Increased access to family planning also has an effect on teen births—the large majority of which are unplanned.[53] Two teams of economists have found that income-based family planning expansions are associated with a significant reduction in teen births, relative to teen births in states without family planning expansions.[105,112] In addition, program evaluations in states such as Oregon and Wisconsin suggested that expansion led to decreased rates of pregnancy and birth among teens;[113,114] in Arkansas, the average age at first birth among Medicaid family planning expansion enrollees increased by about 3.5 years over the program's first seven years.[115]

Evaluations of the Medicaid family planning expansions also provide evidence that improved access to contraceptive care can improve pregnancy spacing. In Arkansas, repeat births within 12 months dropped by 84% over the course of four years among women enrolled in the expansion and more quickly than among all women on Medicaid.[115] In Iowa, New Mexico and Texas, women who enrolled in and used family planning services under an expansion were less likely than women who did not avail themselves of the expansions' contraceptive care to have a repeat birth within 24 months.[116–118] Even Rhode Island's relatively small expansion—limited to women who were otherwise losing Medicaid coverage after giving birth—led to a significant decline in short pregnancy intervals: The gap in the prevalence of short pregnancy intervals between privately and publicly insured women virtually disappeared after expansion, narrowing from 11 percentage points to less than one.[119]

FIGURE 3.5

If current users of publicly supported family planning had no access to these services, most would rely on a less effective method or use no method.



*Method mix among women who received publicly supported contraceptive services in last 12 months. †Hypothetical method mix among similar women in need of services, if no services were available.

Source Reference 70.

Chapter 4

Expanding Coverage in The Era of Health Reform

For the accomplishments of the national family planning effort to continue in the years to come, and to expand the effort to reach even more of the women and men in need of publicly supported family planning care, public and private health insurance programs need to expand. The ACA holds the potential to do just that. As the law is fully implemented throughout 2014 and beyond, Medicaid's role will continue to grow, at least in those states that opt into the ACA's broad expansion of the program. Additionally, health reform will continue to make private insurance more affordable and more comprehensive.

The ability to secure health coverage through both the expansion of Medicaid and the new subsidized private plans means that low-income women and men have more options for the type of care they receive and for where they receive it. In addition, it should help the health centers to whom millions of low-income women and men turn, by creating stable new funding streams and relieving some of the pressure on Title X and other grant programs. Indeed, revenue from public and private health coverage is the overall family planning effort's best opportunity to extend its scope and help more women and men.

Even with these two expansions to publicly subsidized insurance, there will still be a need for Medicaid family planning eligibility expansions—both in states that do not opt into the broader ACA Medicaid expansion and in states that do—to help women and men who experience gaps in coverage or are unable to use their coverage. Moreover, there will be a continuing need for the Title X program and other forms of flexible grant funding to help fill the gaps in terms of who has health coverage and what services are covered, and to ensure that there are health centers on the ground to provide the care that patients need.

Expanding Medicaid

One of the most important and most contentious aspects of implementing the ACA has been securing the participation of as many states as possible in its dramatic expansion of the Medicaid program—if not in 2014, then as soon as possible afterward. The success of the Medicaid expansion is vital for the overall family planning effort, and for the women and families who depend on it.

Of the 19.1 million U.S. women in need of publicly supported contraceptive services in 2010, 5.8 million of them—or 30%—were uninsured and, therefore, particularly vulnerable to the cost pressures that may interfere with their choice and effective use of a contraceptive method (Figure 4.1, page 25).[70] More than half of uninsured women in need that year—3.1 million of them—were adults with family incomes below 138% of the federal poverty level ($26,951 for a family of three in 2013).[56]

Congress designed the ACA to provide assistance to these women and to most people living in the United States below that income ceiling (138% of poverty)—including all U.S. citizens and immigrants after five years of legal residence—through a major, nationwide expansion to Medicaid.* The U.S. Supreme Court, however, ruled in June 2012 that the federal government could not compel states to participate in this expansion, effectively making it a state's option. If all states were to participate, it would constitute a major change from the historical Medicaid program. Prior to 2014, the eligibility ceiling for a working parent varied widely across states and dipped as low as 16% of poverty in Arkansas ($3,125 for a family of three);

*The law provides for a minimum income eligibility ceiling of 133% of poverty, but counts income using a standard "disregard" of 5% of income, effectively setting that ceiling at 138% of poverty.

childless adults were typically excluded regardless of their income.[95]

Because the authors of the ACA assumed all states would join the expansion, millions of women in states that have opted out of the Medicaid expansion now find themselves in a "donut hole"—too "rich" for Medicaid, but also too poor to qualify for subsidies to help defray the cost of private coverage (Figure 4.2, page 26).[95,120] Under the ACA statute, those subsidies are set on a sliding scale for people between 100% of poverty ($19,530 for a family of three in 2013) and 400% of poverty. So unless the statute is amended, something that is currently politically unfeasible, most of the residents of states that opt out who would have been eligible for Medicaid will continue to be excluded from receiving subsidies. Only two groups are currently eligible for subsidies: those with incomes between 100% and 138% of poverty, and legal immigrants in their first five years of residence (who were given access to the subsidies because they are barred from Medicaid).

Supporters of reproductive health have numerous strong arguments for why states should participate in the Medicaid expansion. Most importantly, in states that have chosen to opt out, at least for now, millions of low-income women and men who are above the state's current Medicaid income ceiling are being deprived of the Medicaid coverage that could put effective contraception and other key reproductive health services within their reach. Such health care services benefit individuals and their families, as well as society as a whole. Hospitals and other health care providers have particular reason to press states to participate, because expanded Medicaid coverage can help pay for currently uncompensated care.

Moreover, under the ACA, the federal government will pick up 100% of the cost of the expansion for the first three years, and then will phase down to 90% by 2020—both far higher rates than what states receive for their traditional enrollees. Thus, states that opt out are leaving billions of federal dollars on the table that could be spent to provide desperately needed care. Under past expansions to Medicaid, such as when Congress created its sister program—the Children's Health Insurance Program (CHIP)—in the late 1990s, every state ended up participating within a few years, despite considerably lower federal reimbursement than that promised by the ACA.

Nevertheless, policymakers in 25 states say they will not expand Medicaid or are still debating the issue,[120] often citing ideological opposition to the Medicaid program and what appear to be largely unfounded concerns that the federal government will renege on its commitments and leave states to foot the bill. An analysis of data from the Urban Institute indicates that 2.1 million women aged 19–44 fall into this donut hole.[121,122]

Subsidized Private Coverage

For higher income Americans, the ACA relies on private insurance plans. Specifically, the law requires most Americans to have health insurance or else pay a penalty, and it created new marketplaces (often referred to as

FIGURE 4.1

Three in 10 U.S. women in need of contraceptive services are currently uninsured, and that proportion is particularly high among poor women.

*Among those aged 20–44. **Source** Reference 70.

"exchanges") from which individuals, families and small businesses can purchase an insurance plan. To make premiums affordable and to limit patient cost-sharing, the federal government provides subsidies to citizens and legal residents with incomes too high for Medicaid but below 400% of poverty ($78,120 for a family of three), and who do not have affordable insurance through an employer.

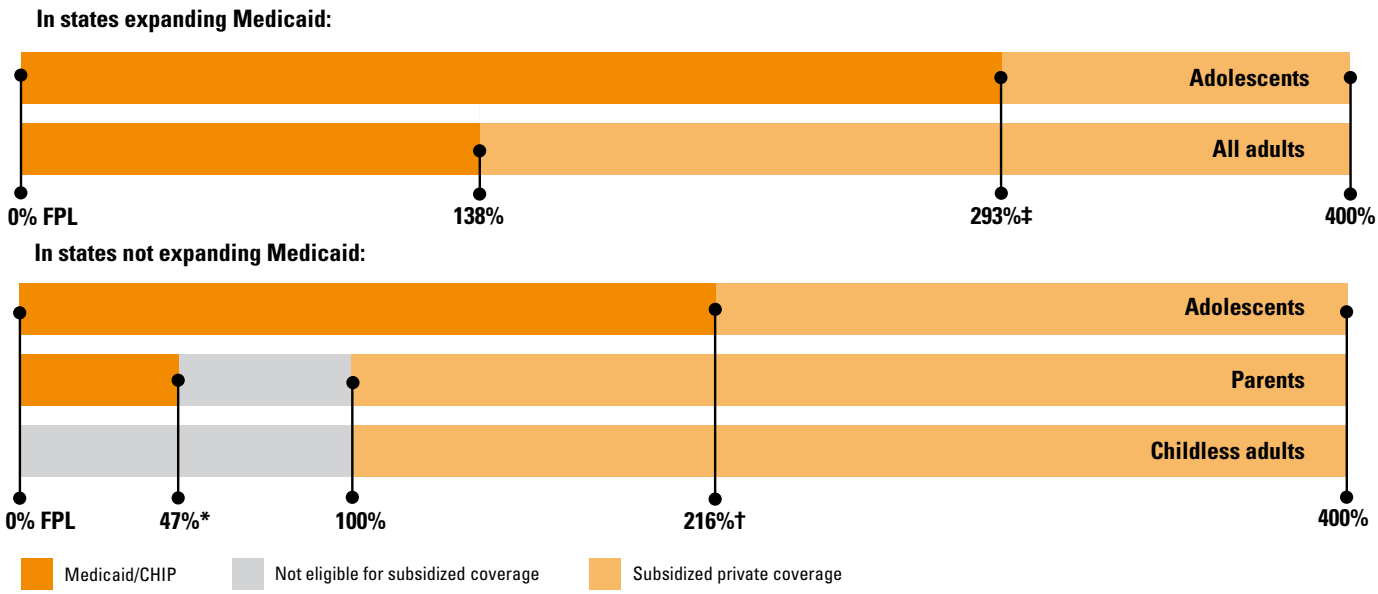
The ACA's private insurance expansion is particularly notable for the nation's family planning effort, because it is specifically designed for low-income women and men—many of whom, in the absence of affordable coverage, have long relied on discounted or free care from health centers that provide family planning services. The law includes numerous provisions designed to address issues of underinsurance—gaps and limitations in health coverage that can impair affordability and use of needed care, particularly among lower income people. For example, it curbs or eliminates such previously common practices as annual and lifetime limits on coverage, coverage denial or limitation because of preexisting medical conditions and gender rating (i.e., charging women higher premiums than men). Notably for reproductive health, all new private plans must let women visit a specialist for obstetric or gynecologic care without referral or prior authorization, which should make it significantly easier for women to obtain care from health centers that provide family planning services.

Perhaps the most important of these provisions for family planning is the requirement that all new private health plans—including those sponsored by large employers—cover a range of preventive services without any out-of-pocket costs for the patient, such as copayments or deductibles. In the reproductive health arena, that list of preventive services includes the full range of contraceptive methods, services and counseling (Figure 4.3, page 27).[19,123] In addition, it includes screening and vaccination to prevent cervical cancer; screening and counseling to prevent HIV and other STIs; screening and counseling for interpersonal and domestic violence; prenatal care services; counseling and equipment for breast-feeding; and the preventive care visits needed for women to access all of these services. The list also includes a somewhat less robust package of sexual and reproductive health services for men. The requirement to cover these services without patient cost-sharing has the potential to close gaps in care and to ensure that private health insurance fully covers all the key services provided by the overall family planning effort.

Notably, these preventive services requirements also apply to everyone who is newly eligible for Medicaid under the ACA's coverage expansion. They do not apply, however, to individuals who were traditionally eligible for Medicaid; although family planning services must be provided to traditional Medicaid enrollees without cost-sharing, there is no requirement for states to cover any specific contraceptive methods, nor to apply that cost-sharing protection to most other preventive care services.

FIGURE 4.2

In states that are not adopting health reform's expansion to full-benefit Medicaid, many of the lowest income adults will be left with no options for affordable coverage.



*Median of the eligibility cut-off points for Medicaid in states not instituting Medicaid expansions as of Jan. 28, 2014. †Median of the eligibility cut-off points for Medicaid/CHIP in states not instituting Medicaid expansions as of Jan. 28, 2014. ‡Median of the eligibility cut-off points for Medicaid/CHIP in states instituting Medicaid expansions as of Jan. 28, 2014.
Notes CHIP=Children's Health Insurance Program. FPL=federal poverty level. **Sources** References 95 and 120.

A central challenge to the successful implementation of both the ACA's major coverage expansions—and to their potential contributions to family planning—is ensuring that people actually avail themselves of their new options for health coverage. Medicaid provides a cautionary tale on this front: The Medicaid enrollment rate among eligible adults averaged only 62% across states between 2007 and 2009.[124] The Massachusetts effort at health reform—enacted in 2006—has faced similar issues, as many residents have had trouble learning about available coverage options, moving between these options and keeping up with the paperwork needed to stay enrolled.[125]

To address these problems and to make enrollment as seamless as possible, the ACA standardizes income eligibility guidelines across programs and pushes states to design a joint enrollment system for Medicaid, CHIP and many private insurance plans, so as to ensure that there is "no wrong door" for applicants.[126] Furthermore, federal regulations require the use of many techniques to streamline enrollment and renewal, such as online applications, confirmation of enrollees' information via electronic data sources and coordination in enrollment among public programs.

In addition, the ACA requires state agencies and marketplaces to provide outreach and education for potential enrollees, such as setting up Web sites and toll-free call centers for consumer assistance. The law establishes a "navigator" program, through which the marketplaces will provide funding to public or private groups—such as professional associations or consumer groups—to raise public awareness, provide impartial information and facilitate enrollment; the federal government has dedicated new funding for FQHCs to play a similar role.

Working with Health Plans

These major expansions to public and private health insurance have the potential to greatly enhance the ability of health centers to provide family planning and related sexual and reproductive health care to women and men in need of such care. For health centers to make full use of these revenue streams, however, they must become very good at working with the health plans that dominate the public and private insurance markets. Although the vast majority of health centers that provide family planning services have some experience with third-party reimbursement, for many of them, that experience begins and ends with traditional fee-for-service Medicaid programs. In 2010, only 40% had a contract with a health plan to provide contraceptive services to Medicaid enrollees, and only 33% had a contract with a private health plan (Figure 4.4, page 28).[88]

Those levels of contracting are unsustainable today, because managed care is the organizing principle for health insurance coverage in the United States. By design, nearly all of the individuals newly covered as a result of the ACA are enrolled in some type of health plan. Even before the ACA, more than seven in 10 individuals enrolled in Medicaid were covered through some type of health plan.[127,128] And of individuals with employment-related private coverage, more than 99% are enrolled in

FIGURE 4.3

The federal health reform law requires private health plans to cover a wide range of preventive care services related to sexual and reproductive health, without out-of-pocket costs for the patient.

Perinatal Health	Other Sexual and Reproductive Health Services	Additional Women's Health Care
• Preconception care visits • Prenatal care visits • Pregnancy-related screenings (anemia, gestational diabetes, Rh factor, urinary tract infections, hepatitis B, STIs) • Folic acid supplements • Alcohol misuse screening and counseling • Tobacco use counseling and cessation interventions • Breast-feeding counseling, support and supplies	• Contraceptive counseling, services and methods (as prescribed for women) • HIV and STI counseling* • STI testing (HIV, chlamydia, gonorrhea, syphilis)* • Cervical cancer screening (Pap testing and HPV testing) • HPV vaccination • Hepatitis A and B vaccination*	• Well-women visits • Domestic and interpersonal violence screening and counseling • Breast cancer prevention (mammography, genetic screening and counseling, and chemoprevention counseling)

*Service available to men as well as women.

Note The requirement to cover some of these services is limited by patient characteristics and risk factors, in accordance with expert recommendations. **Sources** Reference 19 and 123.

plans, and fewer than 1% are in what had been conventional, fee-for-service arrangements.[129]

Becoming a part of health plans' provider networks presents centers with a wide series of challenges requiring substantial investments, according to an expert panel convened by the Guttmacher Institute in November 2011.[130] That panel was composed of staff from family planning providers with a long track record of working successfully with health plans and of consultants who work to assist health centers in determining the cost of care they provide and maximizing third-party revenue. Panel members suggested that health centers considering contracting with a health plan should prepare by assessing their client profile, staff expertise and infrastructure, and addressing their weaknesses. For instance, many health centers will need to adopt or upgrade their health information technology, which is rapidly becoming a prerequisite for working with health plans—and, therefore, for being a viable health care provider in the United States. In particular, use of electronic billing facilitates timely and accurate reimbursement from private insurance plans and Medicaid, and is often required by insurers to be part of their provider network. It is also important for centers to research health plans in the local marketplace, as well as other health care providers in the community—specifically their experiences in working with plans, what distinguishes the health center from others and whether there might be partnerships or alliances to be forged.

Health centers must be able to accurately assess the complete cost of providing services to clients, to be able to determine the feasibility of reimbursement rates offered by health plans for specific services and sets of services. Many health centers—including Title X–supported centers—already have experience assessing their costs (for example, for purposes of developing a fee schedule); however, the exercise is fundamentally different when working with health plans for which the imperative is not about affordability for clients, but rather generating sufficient revenue to support the cost of providing care.

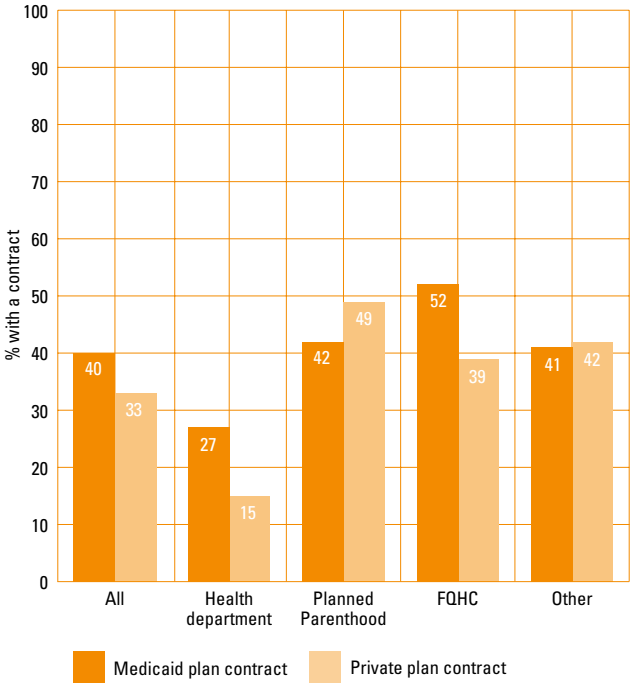
In negotiating contracts with a health plan, family planning providers should promote their ability to help the plan meet its goals. That includes improving patient health outcomes and reducing costs, through the provision of contraception and other effective and cost-effective preventive care. It also includes helping plans meet standards for establishing an adequate provider network, required under state law and the ACA, and widely used standards to demonstrate the quality of their care, such as the Healthcare Effectiveness Data and Information Set (HEDIS). In addition, family planning providers should understand which key issues are open for negotiation, such as deadlines for filing claims and the scope of services covered, and which are not—notably, in most cases, reimbursement rates.

Once a health plan contract is secured, successfully working under it requires training and technical expertise. Health centers must ensure that their clinicians are appropriately credentialed and understand limitations that plans might have on credentialing the advanced practice clinicians—such as nurse practitioners—who provide most of the care. Centers must also ensure that clinicians and front-line staff are well trained on how to properly bill insurance; that includes identifying the proper billing codes, using electronic health records and billing systems, verifying and properly formatting data before they are submitted to the plan, and quickly responding when plans report problems with a claim.

All of this expertise is necessary for providers to receive full and prompt reimbursement, but it does not all have to be developed in-house. Wherever possible, centers should consider taking advantage of economies of scale to reduce costs and leverage expertise. Agencies may want to consider outsourcing some functions, such as billing and receivables. They may also consider collaborating with other agencies: For example, one agency could research, purchase and customize an electronic health records system that others could then buy into and use.

FIGURE 4.4

In 2010, a minority of health centers that provide family planning services had contracts with a Medicaid or private health plan; however, this varied considerably by provider type.



Notes FQHC=federally qualified health center. "Other" consists of independent family planning programs and hospital-based providers.

Source Reference 88.

Medicaid Family Planning Expansions

The ACA's two broad coverage expansions have not eliminated the need for states' long-standing efforts to extend family planning coverage to people otherwise ineligible for Medicaid. Indeed, with the larger Medicaid expansion denied or delayed in so many states, these family planning expansions—whether through a state plan amendment or a waiver—may take on an even greater urgency. They are no substitute for full-fledged coverage under the ACA, but they fill an important niche for low-income women and men. Indeed, in states that refuse or delay taking up the full expansion, these programs might be the only subsidized coverage available to individuals between the state's regular Medicaid eligibility ceiling and 100% of poverty.

Of the 25 states that that have not yet chosen to opt into the ACA's broader Medicaid expansion, 14 have income-based family planning expansions already in place (Figure 4.5, page 30).[96,120] Only one of these 14 states offers full-benefit Medicaid coverage to adults up to 100% of poverty,[95] so in the remaining 13 states, the Medicaid family planning expansion serves people who are otherwise ineligible for coverage. For example, in Alabama, which has a Medicaid eligibility ceiling at 16% of poverty for parents, the states' family planning expansion could be the only subsidized coverage available for individuals without children or, for example, for someone in a family of three with an income as low as $3,125 a year.

The Medicaid family planning programs can fill other gaps likely to linger after the implementation of health care reform, even in states that do take up the broader Medicaid expansion. First, many individuals, particularly those who are young or low-income, may experience lapses in coverage over the course of a year—a phenomenon often referred to as "churning." This is often because the process of maintaining uninterrupted coverage is complicated, especially when life circumstances change and incomes fluctuate. Medicaid family planning expansions could be an important partial step to filling these gaps, at least when it comes to women's family planning needs, particularly in states that allow individuals to apply for the expansion at the point of service. Once these immediate needs are met and the woman is again in the insurance system, her case could be turned over to patient navigators who could work to reconnect her with the longer-term, full-benefit coverage she—and potentially her family—needs.

Second, Medicaid enrollment has always lagged behind eligibility—a long-standing fact that leads experts to expect that in the states opting in, the ACA's Medicaid expansion will likely reach only 60–80% of those eligible.[131] Although there may be many reasons behind this phenomenon, for some people, the issue may be that enrollment in the program is based on the family unit: i.e., the individual seeking family planning services—for instance, a teenage daughter—may not be the person in the family empowered to seek enrollment. Here again, the Medicaid family planning expansions could help fill this important void, by allowing a woman to enroll as an individual, rather than as a part of a family unit.

Finally, some women—especially those needing confidential care—may have coverage that they feel they cannot use to meet their reproductive health care needs. This might especially be a problem for teenagers seeking contraceptive or STI services, as well as for adult women who may be at risk of intimate partner violence or have other difficult family circumstances. Again, the Medicaid family planning expansion may help fill this gap, by including a so-called "good cause exception" that allows individuals who have insurance coverage they feel unable to use for sensitive services to enroll as a way to access confidential care.

Evidence for these likely gaps comes from the 2006 health reform effort in Massachusetts, upon which the ACA was partially modeled.[132] Despite impressive increases in health insurance coverage in that state after reform, some women still lack coverage of their family planning needs. In 2011, Massachusetts paid for three in 10 clients receiving services at health centers that provide family planning services in the state;[132,133] these individuals either had no coverage or had coverage they could not use for their care. The Massachusetts health department pays for care in these situations; however, in other states that lack this sort of categorical funding stream, the gap could be filled by a Medicaid family planning expansion.

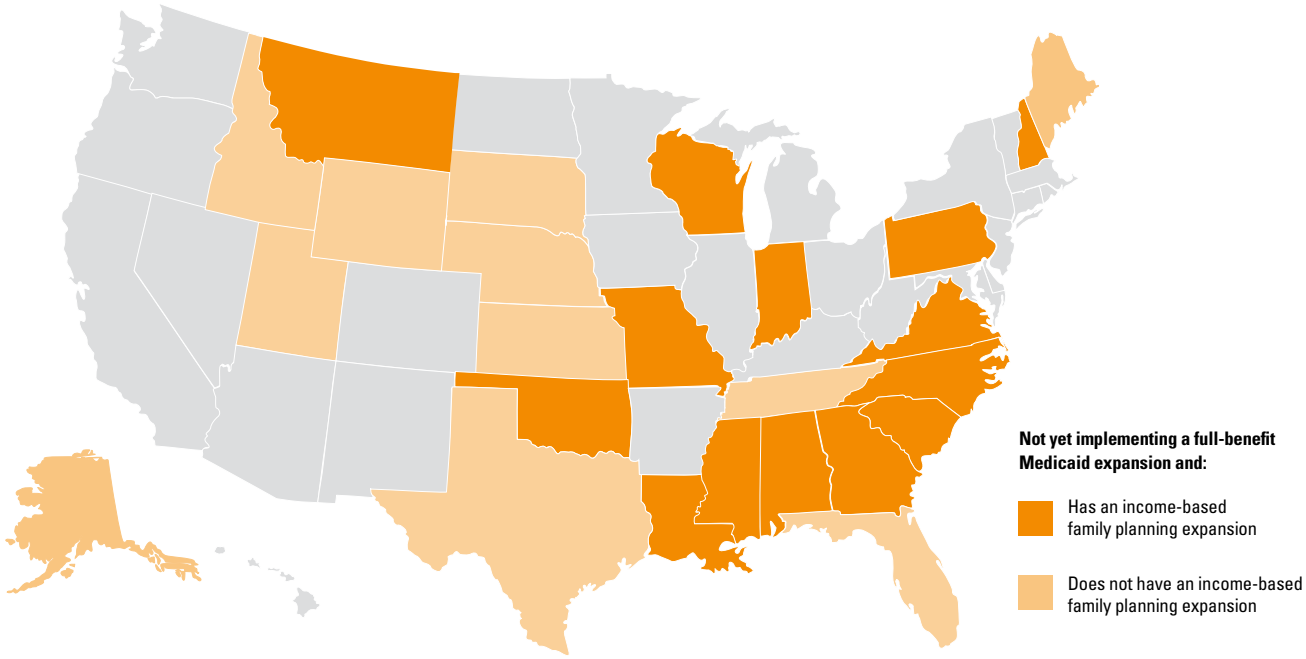
The Ongoing Need for Title X

Despite the clear benefits of the ACA's coverage expansions, there is a continuing need for the overall family planning effort and, in particular, for the flexible grant funding available through Title X. First, not everyone living in the United States will have affordable coverage options, even if the ACA is a perfect success. Notably, many immigrants—including those who are undocumented and young people granted lawful status under President Obama's Deferred Action for Childhood Arrivals program—are barred both from Medicaid and from purchasing any coverage, subsidized or not, through the new health care marketplaces.[59] The number of low-income individuals left without coverage options is considerably larger in states that have not opted into the broad Medicaid expansion and do not have a Medicaid family planning expansion in place.

Moreover, Title X can pay for services and activities that may not be covered under a state's Medicaid program or subsidized private insurance. For example, providers can use Title X funds to pay for practices that many Medicaid

FIGURE 4.5

Fourteen of the 25 states that have not yet opted into health reform's expansion of full-benefit Medicaid have an income-based family planning expansion already in place.



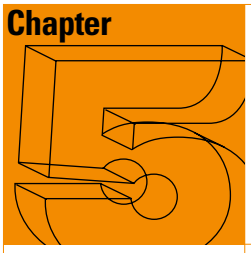
Note Texas operates an entirely state-funded program that provides family planning services to women at least 18 years of age with incomes up to 185% of the federal poverty level.
Sources References 96 and 120.

programs and private insurance plans have been slow to adopt, such as providing a six-month or year-long supply of contraceptive supplies at a single visit, or providing emergency contraception, condoms and other over-the-counter products on site at a health center that provides family planning services. Providers can also use Title X to pay for the intensive, expanded counseling needed by many clients, including teenagers, homeless and incarcerated women, women with limited English proficiency, and those facing such issues as substance abuse or domestic violence. In addition, Title X can be used by providers to 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 or private insurance, the amount providers are reimbursed is often below their actual costs: For example, Medicaid covered only 54% of the cost of an initial family planning visit in 2004.[134] Title X and other funding sources are left to fill in the gap.

Finally, Title X undergirds the infrastructure and general operations of the health centers themselves in ways that Medicaid and private insurance simply cannot. Title X funds go to centers up front as grants, rather than after the fact as reimbursement for services centers have provided to individual enrollees. Providers have long relied on that flexibility to hire, train and maintain their staff to meet the diverse needs of their clients and community. They have also depended on these grants to keep their lights on and their doors open, to adapt to unexpected budget shortfalls and to make improvements to their facilities.

Such versatility is even more vital in the era of health reform. The up-front investments in staffing, training and infrastructure needed to work effectively with health plans—and to thereby draw in new revenue to serve more clients—are substantial, and flexible funds like those provided through Title X are ideal for such investments. Those expenses include upgrading health information technology systems and training staff on their use, training clinicians and front-line staff to properly code and bill for services provided, obtaining the appropriate credentials to ensure third-party reimbursement, and devoting time and resources to researching available health plans and negotiating contracts with them. They may also include expenses related to outsourcing some administrative functions to private contractors or as part of collaborations with other health care providers.

Chapter



Accessing Care in the Era of Health Reform

In addition to adequate coverage, the second essential component for the continued success of the national family planning effort is having adequate capacity in the health care system to meet the need for care. The ACA's improvements to insurance coverage—both in terms of expanded eligibility for private and public programs, and the scope of services covered by both public and private plans without cost-sharing—are designed to increase the number of individuals able to seek routine preventive health care, including family planning services. Yet, this increased demand for care is expected to exacerbate existing provider accessibility problems. Shortages in the number of providers—particularly in medically underserved areas—are anticipated as the ACA is fully implemented.

The nation's safety net will play a crucial role in meeting the increased demand for services and in filling provider gaps. Primary care–focused providers, such as FQHCs, are of ever-increasing importance to meeting the need for publicly supported care in general and contraceptive care specifically. However, reproductive health–focused providers are the entry point to the health care system for millions of American women and have a critical role to play going forward—not only in delivering high-quality family planning services that women want, but also in connecting women to other health care they may need and to insurance coverage for which they may be eligible.

Meeting the Demand

The low-income individuals who will benefit most from expanded coverage are, unfortunately, particularly likely to have a difficult time finding a provider who accepts their newfound insurance and is equipped to serve patients who may require services outside of traditional hours, language assistance and other special accommodations. Indeed, in a 2012 Government Accountability Office survey, 38 states and territories reported challenges ensuring sufficient numbers of Medicaid providers;[135] participation of specialists in obstetrics and gynecology was frequently cited as particularly problematic. As of 2013, one-third of physicians already were not accepting new Medicaid patients,[136] in part because Medicaid's reimbursement rates historically have been much lower than those of other insurance programs.[137,138] Furthermore, the majority of individuals who could be newly insured because of the ACA reside in medically underserved communities, where health providers are already few and far between.[139]

One way this provider shortage is being addressed under health reform is through increased investment in the nation's FQHCs. These providers are a vital component of the U.S. health care system: In 2010, they provided primary care to roughly 20 million patients at more than 8,100 sites nationwide.[140] The ACA is building on this critical foundation, by expanding FQHC funding by $11 billion over five years.

FQHCs have long been required under federal law to make contraceptive services available to their clients, either directly or by referral. As of 2010, 16% of all women obtaining contraceptive services from a health center did so at a FQHC;[70] that proportion will almost certainly grow with the ACA's investment in this network. Yet, there exists a great deal of variability in the family planning services available among FQHCs, which lack standardized, network-wide guidelines for the provision of these services.[141] Thus, it is imperative that significant attention be paid to ensuring that the contraceptive services delivered in these settings be both high-quality and comprehensive.

Despite the clear and growing importance of FQHCs, reproductive health–focused providers are the brick-and-mortar foundation of the overall family planning effort. Indeed, reproductive health–focused providers deliver care to millions of women each year[99] and serve about 70% of all contraceptive clients who receive care from health centers.[87]

Given that the overwhelming majority of reproductive health–focused providers—about seven in 10—receive Title X funds, it is no surprise that they share the same strengths as Title X–funded providers overall.[88] Compared with centers that deliver family planning services in the context of broad primary care, reproductive health–focused providers spend more time with clients and offer a broader range of contraceptive methods (Figure 5.1). They are also more likely to offer methods on site, rather than by prescription; to take steps to enable women to obtain and start the method of their choice quickly; and to place a special emphasis on serving clients who may need extra assistance, including teenagers and those with limited English proficiency or facing complex medical and personal issues (e.g., homelessness, substance abuse or interpersonal violence).

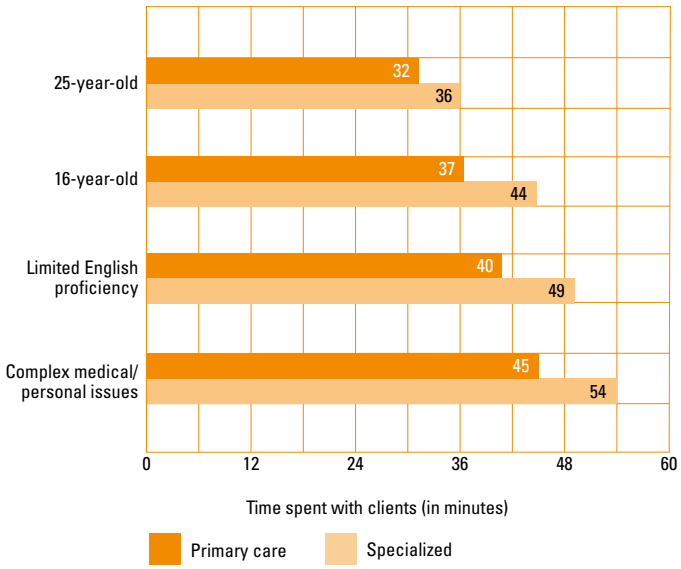
Moreover, a 2012 study of women obtaining family planning services showed that many chose to obtain contraceptive services from reproductive health–focused providers even when they had other options in their communities.[87] Most often, women indicated that they sought care at a reproductive health–focused provider because they felt that the staff treat clients with respect (Figure 5.2, page 33). In addition, women reported that the staff at reproductive health–focused providers take the time to talk with them, are knowledgeable about women's health and are easy to talk with about sensitive issues like sex and birth control. Accessibility was also a key factor in women's decisions: Large majorities touted these providers' convenient hours and locations, their range of contraceptive options and their offering methods on site, instead of by prescription—all hallmarks of the expanded provider capacity enabled by Title X funding. And more than eight in 10 women cited confidentiality—another touchstone of the Title X program—as a major motivator for choosing a reproductive health–focused provider; this was especially true for teens, for whom confidentiality was the leading reason for their provider choice.

Reproductive health–focused providers play a pivotal role in their clients' lives. In communities where women have a choice of health care providers, six in 10 of those seeking services at a reproductive health–focused provider had received at least some care elsewhere during the past year, but still sought out these providers for their reproductive health needs (Figure 5.3, page 34).[87] Moreover, for the remaining four in 10, the reproductive health–focused provider was their only source of care in the past year, either because they received all of their care—family planning or otherwise—at that center or because they received no other care aside from family planning.

This critical and unique role played by reproductive health–focused providers gives them an important place in the emerging health care system as the ACA begins to take hold. But, at the same time, it gives them a set of responsibilities and obligations to the clients they serve—and especially to those for whom the center is their main or only interaction with the health care system—to connect them both to the range of health care services they may need and to the insurance coverage for which they may be eligible.

FIGURE 5.1

Specialized family planning centers spend more time with clients—including those with complex needs—than do primary care–focused health centers.



Note Time spent with clients is an estimated average time, in minutes, for an initial client exam.

Source Reference 88.

Connecting Clients to Care

Significant medical concerns are frequently identified in the course of a family planning visit, as clinicians take clients' medical history, conduct a physical exam and screen for a host of issues, including HIV and other STIs, breast and cervical cancer, heart disease, diabetes and intimate partner violence. These medical histories and screenings are important to help providers identify the contraceptive methods that best fit their clients' needs and preferences. Beyond that, however, staff at reproductive health–focused providers understand that many clients, especially those new to the health care system, come to them with needs well beyond family planning. They may need treatment for conditions as diverse as bronchitis or eye infections, or they may have issues related to dental health, mental health or substance abuse.

Depending on their scope of practice, some reproductive health–focused providers offer on site treatment for different conditions, particularly STIs. FQHCs and other comprehensive service providers are also typically capable of managing HIV treatment and many other chronic medical conditions. In other cases, reproductive health–focused providers will refer their clients to other sources of care in the community, often helping to identify appropriate providers and to schedule appointments. Hopefully, increased coverage under the ACA will make it easier to identify providers in the community to whom clients can be referred, although it is still likely to remain a challenge in underserved communities with large numbers of poor and immigrant women.

Indeed, referral for needed care is a well-acknowledged professional obligation of medical providers. Title X program regulations and guidelines require referrals to and coordination with other health care facilities, when necessary.[83] More specifically, for referral purposes, Title X–supported centers are required to maintain a list of local health care providers, health and human services departments, hospitals, and other providers and agencies.[83] Other health centers that provide family planning services, including FQHCs, have similar obligations.

In a reflection of Title X guidelines, referral arrangements are standard practice at reproductive health–focused providers. Ninety-six percent of reproductive health–focused providers regularly refer clients to primary care agencies or other health centers for services they do not themselves provide, in communities where such other options exist.[88] Ninety-eight percent refer to private physicians in their community. These referral relationships also work both ways: Ninety percent of specialized centers say that other health centers and private physicians regularly refer clients to them. Anecdotally, some family planning centers make efforts beyond referrals, such as arranging expedited appointments with other local providers, hiring case managers to help clients get the follow-up care they need or even contracting with private physicians to offer services like colposcopy on site.[142]

FIGURE 5.2

Women report a wide variety of reasons for choosing specialized family planning centers over other providers.

Source Reference 87.

The ACA may create new opportunities for and impose additional responsibilities on reproductive health–focused providers to serve as entry points to care. The law includes numerous pilot programs of new models of health care service delivery and payment that are gaining popularity across the country, such as "medical homes" and "accountable care organizations." These models emphasize high levels of communication among providers and coordinated patient care, designed to promote providers' accountability for cost of care and health outcomes. Reproductive health–focused providers are not likely to be at the center of such arrangements, but could play an important role as specialist providers and as gateways to other primary and specialized care.

Some of the most promising opportunities involve collaborations between reproductive health–focused providers and comprehensive service providers, like FQHCs, that build on their shared mission and complementary strengths.[140] Potential strategies for collaboration fall on a continuum, from two independent organizations coordinating around referrals and information exchange at one end, to a full corporate merger at the other.

A middle-ground approach would involve an FQHC collaborating with a still independent reproductive health–focused provider.[143] Under such a collaboration, the FQHC would rely on the reproductive health center to provide family planning and patient navigation services to its patients. This model could improve access to services and continuity of care without jeopardizing the independent status of the reproductive health–focused provider; both facilities would remain independent organizations with their own corporate structures.

Such an arrangement would give FQHC patients access to a wide range of family planning services and to practitioners with specialized family planning expertise—both of which may not have been available at the FQHC—while helping to meet the needs of those who prefer to obtain their family planning services from a separate provider. In

addition, it would ensure that FQHC patients seen at the family planning site would be able to receive all necessary follow-up care, along with non–family planning services (e.g., acute care, dental care and other preventive care) through the FQHC. To promote seamless care of shared patients, the two agencies could establish an electronic information exchange that—if the agencies' systems are compatible—could facilitate the transmission of medical information and referrals between them.

Connecting Clients to Coverage

Reproductive health–focused providers are uniquely qualified to connect their clients to health insurance coverage. They serve as the only point of contact with the health care system for many of their clients, who tend to be young, relatively healthy and uninsured women. This is precisely the population that needs to get enrolled through the marketplace for the ACA to have its intended impact. And because the vast majority of clients of reproductive health–focused providers are low-income, many are eligible for Medicaid, CHIP or other forms of public coverage. Yet, millions of those eligible for public coverage—an average of roughly four in 10 across the states[124]—are not enrolled, often because they do not know that they are eligible or because they have had difficulty navigating government bureaucracy.

Of reproductive health–focused providers, 73% have Medicaid application forms that they distribute to clients on site, and 64% have staff members who assist clients in filling out these forms.[88] Many centers go further: At 54% of them, staff members are able to submit clients' completed application forms, and at 34%, staff are able to enter clients' information into the state's eligibility system themselves, so that eligible clients can often leave the center preliminarily or even fully enrolled in Medicaid. These enrollment assistance activities are almost equally common among reproductive health–focused and comprehensive health centers providing family planning services.

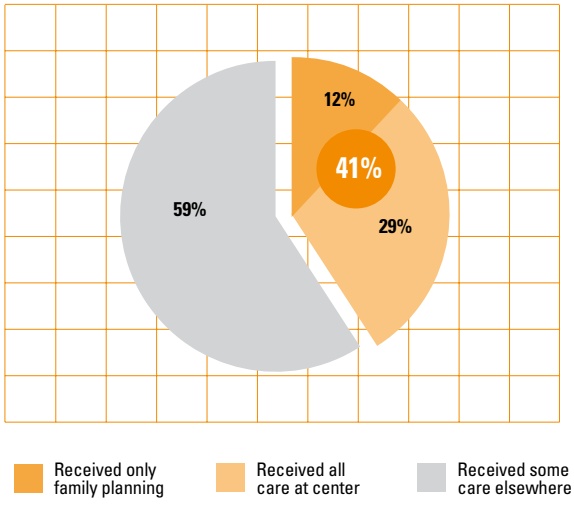
In practice, application assistance may include helping clients to choose a specific Medicaid plan that best meets their needs and to select a primary care provider in the health plan in which they have enrolled.[142] Because many clients are new to the health care system or to health insurance, they may also need assistance in the form of basic education on the different types of service providers and on the mechanics of insurance coverage (e.g., how to find providers in the plan's network and submit claims), as well as on health care terminology that may be unfamiliar (e.g., "deductible" and "co-pay"). At later visits, the health center's role may extend to providing assistance with reenrollment when a client loses coverage because of changes in eligibility or other administrative pitfalls.

Application assistance practices are all particularly common among reproductive health–focused providers in states that have established Medicaid expansion programs specifically for family planning services.[88] That is not surprising, given the importance of Medicaid as a source of payment for family planning care in expansion states. According to a 2011 review of expansion programs in 22 states, providers have worked in partnership with state officials to maximize program enrollment.[94] In fact, many of these expansion programs have pioneered new ways for clients to apply for and enroll in Medicaid during the course of their family planning visit. States have helped to train health center personnel to walk their clients through the program application and, sometimes, to even verify required documentation; in several states, a government computer system reviews the information provided and issues a real-time notice of decision. States and providers have also worked together to conduct community outreach, coordinate outreach across public programs and design educational materials for high-priority populations, such as young adults and Latinas—groups with particularly low rates of insurance.

The major expansions in public and private health insurance that have started in 2014 under the ACA make the role of reproductive health–focused providers as entry points to coverage even more vital. For instance, the federal regulations put in place to streamline enrollment systems require the use of many of the same techniques that states have been testing in their Medicaid family planning expansion programs. This means that providers experienced in assisting their clients to enroll in Medicaid may now be able to help them learn about and enroll in private

FIGURE 5.3

In communities where women have a choice of health care providers, four in 10 clients at specialized family planning centers relied on that center as their sole source of health care in the past year.



Source Reference 87.

The critical and unique role played by reproductive health–focused providers gives them responsibilities and obligations to connect clients both to the range of health care services they may need and to the insurance coverage for which they may be eligible.

insurance options as well, and to apply for and obtain federal subsidies to make that coverage affordable. Moreover, additional reproductive health–focused providers may be able to take on this challenge, as the enrollment process is streamlined.

Reproductive health–focused providers will also be counted on as partners in reaching out to and educating potential new enrollees in the coming years. Short of providing application assistance themselves, these centers could take a wide variety of other steps to help this effort, such as providing their clients with brochures, referring them to state hotlines and navigators, setting up Internet kiosks in waiting rooms and working with states to station government enrollment staff on site. In addition, providers might apply for grants to help with the outreach and application assistance processes—in essence, serving as navigators or another type of in-person assister—for 2015 and beyond.

Chapter 6

Moving Forward

The decades-long U.S. family planning effort has been a demonstrated success in helping tens of millions of disadvantaged women and men to plan their families and protect their sexual and reproductive health. Today, that effort faces considerable challenges, including evolving health care delivery and insurance systems, ever-tightening government budgets, and persistent political and ideological attacks on funding sources and providers. For women, couples and society to continue realizing the benefits of a robust national family planning effort in the years to come, policymakers, health care providers and advocates will all need to find ways to secure the effort's funding, remove persistent barriers to coverage and strengthen the safety-net provider network.

Securing Funding Streams

The rollout of the ACA has provided a rare chance to place the financial footing of the publicly funded family planning effort on stable ground. New revenue from public and private health coverage holds the potential to help millions of additional women and men receive the care they need to take control of their reproductive lives. That would mean maximizing the potential of Medicaid as the preeminent source of coverage for low-income Americans, while positioning Title X and other grant programs to meet the continuing reproductive health needs of individuals who are disadvantaged because of income or age. For this potential to become reality, state and federal policymakers will need to work together to implement the ACA's coverage expansions, while also shoring up grant funding to support the continued delivery of family planning services at safety-net health centers.

Maximizing the Potential of Medicaid

Medicaid is already the dominant source of public funding for family planning—accounting for 75% of expenditures nationwide.[72] Yet, the ACA has given states the opportunity to greatly expand eligibility for Medicaid and eliminate many of the gaps in coverage that have long existed in many states. Doing so requires concrete actions by state and federal policymakers.

- As adopted by Congress, the ACA's premise of near-universal coverage rested in no small measure on extending Medicaid eligibility to most Americans with an income of up to 138% of poverty, no matter their state of residence. Thus far, however, about half of states have opted not to expand Medicaid under the ACA, to the detriment of their residents' health. Yet, for states, there are many strong arguments in favor of expanding Medicaid, including helping millions of their most disadvantaged residents, supporting struggling safety-net hospitals and health centers, and drawing down billions in federal dollars with extraordinarily little state contribution required. Governors and state legislators should abandon their ideological resistance to health reform and utilize the federal funding available to them to extend Medicaid coverage to their residents.

- The ACA established important new requirements for private health plans to cover numerous preventive services—including the full range of contraceptive methods and counseling, and many others related to sexual and reproductive health—without any out-of-pocket costs for patients. These patient protections also apply to everyone who is newly eligible for Medicaid under the ACA's coverage expansion, but not to individuals who were eligible for Medicaid prior to the ACA. Those traditional Medicaid

enrollees are guaranteed family planning services without cost-sharing, but states have not been required to cover any specific contraceptive methods, nor to apply that cost-sharing protection to STI and cervical cancer screenings, and other preventive care services. CMS should rectify this discrepancy by ensuring that coverage for all Medicaid enrollees—whether traditionally or newly eligible—is governed by the ACA's preventive services protections.

■ For Medicaid to continue to serve as the financial backbone of the U.S. family planning effort, it must provide a level of reimbursement sufficient to cover health care providers' costs. In most states, Medicaid reimbursement rates for family planning are simply inadequate, and often there are no legal assurances that rates will rise as the cost of providing care increases. CMS and the states should take steps to ensure that these rates become and remain adequate to sustain the provider network. One option would be for Congress to link Medicaid reimbursement rates to family planning providers' costs—a protection long afforded to FQHCs. Failure to do so would mean that the increasing numbers of Medicaid enrollees under the ACA could exacerbate rather than help alleviate funding shortages already confronting many family planning providers.

■ Medicaid family planning expansions continue to be of importance even as the ACA is fully implemented. In states that have not yet adopted the expansion of full-benefit Medicaid, these family planning programs are often the only affordable coverage available to many poor women. Moreover, these programs can fill lingering gaps commonly experienced both by women who lose coverage during the course of a year because of changing life circumstances and by those with a need for confidential care. CMS should call attention to the ongoing need for the Medicaid family planning expansions and encourage states to adopt them, in part by making the processes for federal approval and renewal as expeditious as possible.

Bolstering Title X and Other Grant Programs

Even with the historic coverage expansions of the ACA, the flexible funds of Title X and other grant programs will still be needed by the nation's safety-net providers, and by the women and couples who will continue to rely on those providers. Yet, government funding for family planning services is now under perennial, unfounded attack and has been drastically cut in recent years at both the federal and state levels. Rather than slash funding, policymakers should meaningfully reinvest in these effective, cost-saving programs.

■ Not only has funding for Title X not increased sufficiently for the program to keep up with the increasing number of women in need of care and with the increasing cost of that care, but funding for Title X has, in fact, rapidly declined in recent years. At $281.3 million, the program's FY 2013 funding level was more than $36 million less than it was just three years earlier.[144] Moreover, in 2011, the House of Representatives for the first time voted to eliminate the program entirely. Moving forward, the federal government should ensure not only that Title X survives, but that it is funded at an appropriately robust level. This means ensuring Title X providers have the resources they need to keep their doors open, to invest in new technologies and training necessary to remain viable in an evolving health care system, and to provide the time-intensive family planning care their clients need. Moreover, Title X funds should be sufficient to guarantee that women relying on Title X–supported services consistently have the same range of contraceptive options as privately insured women—including long-acting reversible methods (LARCs), which are extremely effective, but have high up-front costs.

■ In some states, ideologically driven campaigns have led to steep cuts in state-level appropriations for family planning or to state policies that disadvantage or disqualify reproductive health–focused providers from obtaining government funding. These baseless attacks have made it difficult for providers to meet their clients' needs. State policymakers should determine funding levels based on the needs of their communities and the demonstrated impact family planning programs have in improving health and economic security for women and their families.

■ The Department of Health and Human Services should recognize the Office of Population Affairs (OPA) as the locus of federal policy on domestic family planning, both in policy and in practice. OPA should be charged with coordinating the federal domestic family planning effort, so that all federal activities related to family planning—through the Health Resources and Services Administration, CMS, CDC and other agencies—can best meet the reproductive health needs of America's women and families.

Removing Barriers to Coverage

The coverage advances of the ACA will not benefit everyone uniformly. Millions of women and men will remain ineligible for health insurance coverage, or they will be unable to use their coverage for sensitive services—such as family planning—because of confidentiality concerns, which will additionally strain an already overburdened safety-net system. For all individuals to obtain the affordable, high-quality and confidential care they need, legal barriers to usable coverage must be lifted.

■ Immigrants face myriad barriers to accessing the coverage they need. Lawfully present immigrants are ineligible for coverage through Medicaid and CHIP during their first five years of legal residency. The laws imposing this senseless ban and all other waiting periods should be repealed. Moreover, private coverage should be made accessible to all lawfully present immigrants. Most immediately, an administrative policy change should be made to enable

the so-called DREAMers—young adults who came to this country as children and who can be recognized as lawfully present under the Deferred Action for Childhood Arrivals program—to purchase coverage through the health insurance marketplaces and to receive income-based subsidies to make this coverage affordable.

■ Billing and claims processing procedures widely used in private health insurance routinely, albeit inadvertently, make it impossible for anyone insured as a dependent on someone else's policy to obtain sensitive services confidentially; most often, disclosure occurs when insurers send an explanation of benefits form to the policyholder when care is obtained by anyone covered under the policy. With the ACA bringing coverage to millions of Americans, including young adults who are now able to remain covered as dependents on their parents' policy until age 26, addressing this problem is crucial. Federal and state governments should recognize that the inability to obtain sensitive services—including key reproductive health services—could endanger individuals, by leading them to forgo necessary care, and take steps to ensure that they have the privacy protection they need.

Securing the Provider Network

The coverage expansions at the heart of the ACA are almost certain to expand the demand for health care. Meeting that demand will require a thriving network of health care providers that is funded and organized so as to be able to make high-quality care accessible to those who need it. Policymakers at all levels need to take the steps necessary to ensure that individuals are able to obtain the full range of family planning services that they need and deserve.

Ensuring Quality Care for FQHC Patients

FQHCs already serve a significant proportion of disadvantaged individuals obtaining family planning services; given the major investments the ACA makes in FQHCs, their importance in providing publicly funded family planning services is almost certain to grow. Because of that reality, it is critical that the women and men who obtain their care through FQHCs receive high-quality services, including the full range of contraceptive methods.

■ Guidelines developed for the Title X program set the standard for the delivery of high-quality family planning services to individuals who are disadvantaged by their age or income. These guidelines, which can readily be adapted for other safety-net providers, should serve as the basis for standards for the family planning services provided by FQHCs.

■ In particular, individuals obtaining contraceptive services through FQHCs should be able to access the full range of contraceptive methods, including the extremely effective LARCs. Doing so will involve an investment in staffing, to ensure that trained providers are readily available to FQHC clients. Moreover, FQHCs should take steps to ensure that family planning clients can obtain the method of their choice on site, without having to make a separate trip to a pharmacy to fill a prescription, and to adequately safeguard client confidentiality.

Leveraging the Network of Reproductive Health–Focused Providers

Health care providers specializing in the delivery of family planning and related services are at the heart of the national effort to provide contraceptive services to individuals disadvantaged by virtue of their age or income. These safety-net health care centers bring distinct strengths to the table through their focus on meeting the range of clients' family planning needs. Investing in this network and integrating these providers into broader changes in health care delivery systems redounds to the benefit of patients, communities and the nation as a whole.

■ Safety-net family planning providers—including many that receive funding through Title X—are uniquely placed to help connect uninsured individuals with the insurance coverage for which they are eligible. The Title X network serves exactly those individuals the ACA's coverage expansions seek to reach; almost two in three clients served at Title X sites are uninsured, and about the same proportion are young adults aged 18–29.[73] As a result, reproductive health–focused providers should be at the heart of enrollment assistance efforts and prioritized to receive federal and state funding that supports the staff time and resources needed to help clients navigate the enrollment process.

■ Integrating into health plan networks will be critical to the ongoing viability of reproductive health–focused providers. Although it may mean operational adjustments, such as use of new technology and staffing changes, this transition will only strengthen providers' ability to fulfill their underlying mission of providing quality care to the underserved. These providers are well positioned to present a compelling case as to why health plans should want to include them in their networks, because they can help plans meet network adequacy standards, excel on quality indicators and meet enrollees' needs.

■ To successfully integrate into health plan networks, many of these providers will need help to adjust their staffing configurations and acquire new skills. The support available to assist other safety-net providers should be equally available to reproductive health–focused providers. That includes support for acquiring and using the health information technology that will be a prerequisite for participating in the emerging health care marketplace, as well as technical assistance to build and enhance skills, such as billing, coding and claims processing. It also includes funding and equal opportunity to obtain placements through the National Health Service Corps; that program provides a way to grow the supply of health care providers experienced in serving disadvan-

taged communities going forward, while helping address the critical shortage of providers many safety-net health centers are confronting today.

■ To ensure that the millions of newly insured Americans have somewhere to go for high-quality care, and that those who already place their trust in reproductive health–focused providers are able to continue with that care, these safety-net centers should be uniformly designated as essential community providers (ECPs). This provider designation is afforded special protections under the ACA, wherein health plans are expected to contract specifically with ECPs to be offered on the insurance marketplaces, and policymakers at all levels should develop and implement standards that require health plans to meaningfully include ECPs in their networks.

■ Although they may retain their focus on providing family planning services to disadvantaged individuals, reproductive health–focused providers should look to be part of the various systems and structures that are developing as the health care marketplace evolves. This may mean strengthening efforts to collaborate with other safety-net providers in their communities, such as FQHCs; OPA and the Health Resources and Services Administration should work together to encourage these collaborations and alliances. It may also mean becoming involved in emerging health care structures in their communities, such as accountable care organizations (ACOs), groups of primary and specialty care providers that are expected to communicate and coordinate their care around the individual client. Such models are intended to improve quality of care while reducing costs.

■ To more easily integrate into the emerging marketplace, reproductive health–focused providers should consider seeking formal designation by the National Committee for Quality Assurance. Although designation as a comprehensive medical home may be beyond the scope of most reproductive health–focused providers, they may nonetheless meet the requirements for being a patient-centered specialty practice (PCSP). This newer designation recognizes specialty practices that successfully coordinate patient care and communicate with primary care providers, specialists and patients. Obtaining the PCSP designation may help reproductive health–focused providers negotiate contracts with health plans and successfully argue for inclusion in ACOs.

From the halls of Congress to many state legislatures, family planning services and the providers who make them available in communities have come under unprecedented attack in recent years. Yet, the need for family planning is greater than ever, and the case for the national family planning effort remains strong: Publicly funded family planning services have been soundly demonstrated to improve the lives and futures of clients, their families and their communities, while generating significant cost savings for governments at all levels.

Indeed, many policymakers, providers and, most of all, women themselves have staunchly defended the continued availability of publicly supported contraceptive care. It is imperative that the national family planning effort is strengthened through adequate funding, the elimination of barriers to coverage and appropriate recognition of its network of providers as the essential community resources they are, so that the family planning services that are so essential to women's lives continue to be accessible now and in the years ahead.

Appendix 1: Methodological Notes

The vast majority of the data cited in this report come from prior published research, as indicated in the references. Two of the figures, however, are based on new pieces of analysis that were conducted specially for this report. The methodologies for both are updates of prior published analyses and are described below.

Methodology for Figure 1.2

Figure 1.2 contrasts the average number of years women spend at risk for unintended pregnancy with the average number of years they spend pregnant, postpartum or trying to become pregnant. It demonstrates the need for contraception over long periods of a woman's life.

Desired number of children

According to tabulations of data from the General Social Survey data from 2006–2010, the median and modal number of children desired by Americans is two.

Period of risk

To calculate the time at risk for pregnancy, we first established the median total number of years during which a woman is sexually active and able to conceive. The median age at first sex is 17.8,[145] and the median age at menopause is 51.[146,147] Women aged 51 are, on average, 51.5 years old. The average total time exposed to the risk for pregnancy is, therefore, 51.5 – 17.8, or 33.7 years.

Time spent trying to become pregnant

Our estimate of total time spent trying to become pregnant incorporates both pregnancies that end in birth and pregnancies that end in miscarriage.* We used a published estimate of average time to conception, three months.[148] To obtain the total time spent trying to achieve two desired pregnancies, we multiplied three months by two, for a total of six months or 0.5 years. We also multiplied three months by the mean number of miscarriages per woman, 0.4, for a total of 1.2 months or 0.1 years. Summing these, we get a total of 0.6 years trying to become pregnant.

Time spent pregnant

We used data from the 2006–2010 National Survey of Family Growth (NSFG) to calculate the average time spent pregnant for both pregnancies ending in birth and those ending in miscarriage. We multiplied the average time for a pregnancy ending in birth, 38.4 weeks, by two pregnancies to obtain the total amount of time pregnant with pregnancies ending in birth, 76.8 weeks or 1.47 years. According to the NSFG, the average pregnancy ending in miscarriage lasts 10 weeks. A common published estimate for the number of miscarriages is 20% of live births plus 10% of abortions;[149] under the assumption of two live births and no abortions per woman, we used 20% × 2 = 0.4 miscarriages per woman for our calculation. So, to obtain the total time spent pregnant with pregnancies ending in miscarriages, we multiplied 10 weeks × 0.4 miscarriages per woman = four weeks or 0.07 years. By summing the birth and miscarriage estimates, we obtain an estimate of 1.54 years pregnant.

Time spent postpartum and not at risk of pregnancy

Our calculation of the average postpartum period includes two components: biological postpartum infecundability and infecundity due to breast-feeding. We made the conservative (for this analysis) assumption that women would be protected for the entire time they were breast-feeding. The minimum postpartum infecundability period (due to sexual abstinence and biological factors) is six weeks (0.12 years).[150] Using the NSFG, we determined that about 70% of women breast-feed, with a median duration of 17 weeks (0.33 years). So (30% × 0.12 years) + (70% × 0.33 years) = 0.26 years. By multiplying this time by the two births per woman, we get 0.53 years postpartum. We also added six weeks of postpregnancy infecundability for the 0.4 miscarriages per woman, for 0.05 years. We summed these to obtain a total of 0.57 years of postpregnancy infecundability.

Totals

The sum of the three periods when women are not at risk of pregnancy (trying, pregnant and postpartum) is 0.60 years + 1.54 years + 0.57 years = 2.7 years. Finally, we subtracted this amount from the total time at risk above (33.7 years) to obtain the total time during which the average woman is exposed to risk for unintended pregnancy, 31.0 years.

Methodology for Figure 1.3

Figure 1.3 contrasts contraceptive use patterns over one year among all women at risk for unintended pregnancy with contraceptive use during the month of conception among women having unintended pregnancies. It demonstrates the importance of consistent contraceptive use.

Contraceptive use among women at risk for unintended pregnancy

Data on women's one-year contraceptive use patterns were estimated using the 2006–2010 NSFG for all 43 million women aged 15–44 who were at risk for unintended pregnancy (i.e., they were sexually active at any time in

*Under the assumption that women achieve their childbearing goals within the bounds of biological possibility (i.e., miscarriages would still happen), all pregnancies would be desired and, thus, no pregnancy would end in abortion. The proportion of desired pregnancies ending in abortion is small enough that our calculation of time spent pregnant was not affected by its inclusion, and so we did not incorporate this outcome into our estimate.

the past 12 months; capable of becoming pregnant; and not currently pregnant, postpartum or trying to get pregnant). We used the month-by-month calendar data in the NSFG to determine whether any contraceptive method was used and whether the woman was sexually active during each of the 12 months prior to the interview.

Women were classified as being nonusers or having long gaps in use (14%) if they reported being sexually active but using no method during all of the prior 12 months (2%) or sexually active but using no method during at least one of the prior 12 months (12%).The remaining 86% of women at risk reported using some method of contraception during each of the months they reported having had sex—31% reported contraceptive sterilization and 55% reported reversible methods. Using data from the Guttmacher Institute's Contraceptive Change and Continuity Study, reversible method users were divided into consistent and inconsistent users. Consistent use over one year was defined as using a reversible method perfectly during the six months preceding waves one and two of the study. Waves were conducted six months apart, resulting in consistency data for the full year preceding the second wave. Specifically, consistent users were tho se who did not miss taking any pills, were never late getting their injection, or used their barrier method or condom every time they had sex. Inconsistent users were the remainder: those who missed at least one pill, were late getting an injection at least once or had sex without using their barrier method at least once.

We then applied the method-specific consistency proportions to the distribution of reversible method users in the NSFG to obtain an overall weighted proportion of method users according to consistency of use: One-third of reversible method users (18% of all women at risk) were classified as inconsistent users, and two-thirds of reversible method users (37% of all women at risk) were classified as consistent users. Combining consistent reversible method users and users of sterilization results in a total of 68% of women at risk reporting consistent use over one year.

Contraceptive use at conception among women having unintended pregnancies

The proportion of unintended pregnancies that were attributable to no method being used in the month of conception was estimated using information on unplanned births and miscarriages from the 2006–2010 NSFG pregnancy file (looking at pregnancies that occurred to respondents in the five years prior to the interview) and information on abortions from the Guttmacher Institute's 2008 Abortion Patient Survey. The proportions of pregnancies occurring when no method was used from each source were then applied to the actual number of unplanned births, abortions and miscarriages that occurred in 2008.[53] Of the 3.4 million total unintended pregnancies that occurred in 2008, some 1.8 million (54%) were attributable to no method having been used in the month of conception.

Among unintended pregnancies that were conceived in months when a contraceptive had been used (some 1.6 million), we estimated how many would have been expected to occur among women who used their method perfectly but who experienced method failure (i.e., pregnancies to consistent users) and how many would have been expected to occur among women who used their method inconsistently. We began with data from the 2006–2010 NSFG on the numbers of women at risk of unintended pregnancy using each method. Total expected pregnancies among this population of users over one year were estimated by multiplying the number of women using each method by the one-year typical use failure rate for the method.[50] Expected pregnancies attributable to method failure (even if the method were used perfectly) were estimated by multiplying the number of women using each method by the perfect-use failure rate for the method. We assumed that pregnancies attributable to perfect use were a subset of the total number of pregnancies among women using the method, and estimated the method-specific proportions attributable to perfect use by dividing the number expected under perfect use by the number expected under typical use.

We then applied the method-specific proportions of pregnancies attributable to perfect use to the actual number of unintended pregnancies that occurred in 2008 among women using each method. Summing across methods resulted in the total number of unintended pregnancies in 2008 attributable to method failure among women using their method perfectly (some 184,000, or 5%). The remainder of unintended pregnancies to women in 2008 (some 1.4 million, or 41%) were attributable to women who used their method inconsistently.

APPENDIX TABLE 1 State data on women in need

U.S./state	No. of women aged 13–44, 2010	No. of women in need of publicly funded contraceptive services and supplies, 2010					
		All	Aged 13–19	Aged 20–44			
				<100% poverty	100–137% poverty	138–199% poverty	200–249% poverty
U.S. total	66,419,460	19,144,100	4,880,320	5,575,570	2,229,050	3,686,590	2,772,220
Alabama	1,022,450	320,280	79,420	104,590	36,990	59,470	39,900
Alaska	153,090	37,400	10,980	10,420	3,970	7,300	4,740
Arizona	1,349,610	429,830	94,810	128,200	58,510	83,690	64,640
Arkansas	607,900	198,090	47,430	60,820	25,370	38,040	26,450
California	8,393,180	2,472,310	568,260	704,790	314,440	516,820	367,950
Colorado	1,088,870	307,160	69,810	91,270	39,450	60,840	45,670
Connecticut	738,970	175,950	50,990	50,410	17,190	32,820	24,520
Delaware	190,320	50,450	14,560	13,170	4,960	9,500	8,260
District of Columbia	167,470	44,560	10,790	17,190	3,990	7,440	5,150
Florida	3,782,800	1,116,280	259,230	311,960	133,900	233,450	177,740
Georgia	2,205,910	648,120	160,190	195,190	75,450	128,540	88,670
Hawaii	278,220	67,880	17,910	16,930	7,610	12,880	12,550
Idaho	328,770	112,370	25,340	29,080	14,440	25,550	17,980
Illinois	2,805,470	767,110	227,160	214,310	81,520	139,420	104,700
Indiana	1,375,360	422,430	119,720	121,130	47,260	75,670	58,690
Iowa	615,300	182,930	55,930	49,310	18,720	30,270	28,650
Kansas	592,910	177,400	51,360	45,110	21,570	35,040	24,360
Kentucky	909,390	273,030	67,000	86,980	32,320	49,370	37,390
Louisiana	987,600	310,720	76,040	101,570	36,030	55,800	41,250
Maine	257,550	77,520	19,050	21,320	9,980	15,540	11,610
Maryland	1,268,630	277,170	87,140	67,990	25,150	52,450	44,430
Massachusetts	1,430,910	351,830	95,630	108,140	34,520	61,750	51,780
Michigan	2,051,780	623,060	185,590	183,000	66,170	108,830	79,560
Minnesota	1,114,610	287,010	90,830	71,950	30,160	51,180	42,850
Mississippi	644,200	213,460	56,170	68,970	25,350	37,540	25,400
Missouri	1,254,060	387,790	108,250	110,620	43,270	72,400	53,190
Montana	191,690	60,200	15,200	15,690	7,270	13,070	8,950
Nebraska	378,850	110,640	33,200	27,270	13,290	21,280	15,630
Nevada	585,730	172,670	37,310	46,190	21,500	38,630	29,040
New Hampshire	267,020	63,840	20,380	15,530	5,580	11,670	10,690
New Jersey	1,854,510	414,670	117,870	110,130	43,150	80,060	63,450
New Mexico	426,120	144,920	32,570	43,320	19,860	28,470	20,670
New York	4,289,390	1,187,850	288,080	368,620	135,940	223,540	171,660
North Carolina	2,070,090	619,570	150,760	191,590	71,900	119,020	86,300
North Dakota	137,050	42,290	12,400	11,560	4,410	6,190	7,670
Ohio	2,386,230	710,200	206,750	211,750	74,670	121,020	96,040
Oklahoma	784,610	241,450	58,850	67,800	28,740	50,650	35,350
Oregon	801,580	251,590	53,530	77,760	30,730	50,580	38,950
Pennsylvania	2,599,600	734,640	194,440	214,110	79,400	132,410	114,210
Rhode Island	227,270	66,060	17,180	18,690	6,830	13,100	10,240
South Carolina	985,250	307,870	75,570	95,250	35,540	57,750	43,810
South Dakota	162,990	50,600	15,140	14,370	5,840	8,890	6,400
Tennessee	1,354,890	410,670	97,760	128,040	49,260	77,690	57,970
Texas	5,689,320	1,690,150	396,120	505,220	218,590	338,940	231,170
Utah	644,840	198,200	47,040	47,560	22,560	42,640	38,380
Vermont	125,680	35,560	10,660	9,590	3,450	6,980	4,900
Virginia	1,752,430	421,280	119,560	118,150	44,270	77,460	61,880
Washington	1,441,110	401,600	94,630	117,210	47,440	78,790	63,500
West Virginia	363,430	110,870	27,100	36,540	13,410	18,100	15,740
Wisconsin	1,170,950	332,520	99,720	91,240	33,170	62,210	46,150
Wyoming	113,500	32,050	8,910	7,970	3,960	5,850	5,390

Source: Reference 70.

No. of uninsured women in need of publicly funded contraceptive services and supplies, 2010						U.S./state
All	Aged 13–19	Aged 20–44				
		<100% poverty	100–137% poverty	138–199% poverty	200–249% poverty	
5,756,800	746,700	2,170,700	908,400	1,235,800	695,200	U.S. total
94,500	9,700	44,900	13,600	18,500	7,700	Alabama
11,500	1,700	4,200	1,400	2,800	1,500	Alaska
134,900	19,300	47,500	23,100	28,200	16,700	Arizona
72,000	8,500	30,800	11,800	14,100	6,800	Arkansas
833,100	99,800	283,200	137,500	198,600	114,000	California
99,900	11,500	37,600	17,700	20,900	12,300	Colorado
32,000	4,300	11,300	3,800	8,000	4,700	Connecticut
9,200	1,400	3,200	1,000	1,800	1,800	Delaware
3,900	700	1,600	400	800	500	District of Columbia
447,300	61,100	154,700	69,700	102,000	59,900	Florida
240,800	29,900	100,300	36,800	49,600	24,200	Georgia
8,500	1,200	3,400	1,200	1,300	1,400	Hawaii
38,600	4,800	13,600	6,700	8,900	4,700	Idaho
194,500	26,600	72,300	29,100	42,100	24,400	Illinois
117,700	16,400	47,300	18,100	22,800	13,100	Indiana
35,600	5,600	13,100	6,400	6,800	3,700	Iowa
48,600	6,700	18,200	8,600	10,500	4,600	Kansas
81,500	8,700	35,100	13,500	15,100	9,100	Kentucky
105,400	11,100	47,000	15,800	20,200	11,200	Louisiana
11,200	1,600	3,300	2,100	2,200	2,000	Maine
69,700	8,800	23,900	9,500	15,800	11,700	Maryland
25,800	3,400	9,500	3,500	5,700	3,700	Massachusetts
135,800	18,100	51,800	21,500	28,500	15,800	Michigan
50,300	8,600	16,100	7,400	11,500	6,700	Minnesota
68,100	10,200	28,900	9,900	12,300	6,800	Mississippi
105,100	13,400	42,100	16,600	22,000	11,000	Missouri
19,800	3,100	6,600	2,700	4,700	2,700	Montana
27,500	3,500	10,700	4,600	5,700	3,000	Nebraska
72,200	9,800	26,100	11,400	15,500	9,500	Nevada
15,200	2,100	5,000	2,100	3,700	2,300	New Hampshire
118,100	14,800	41,400	16,500	28,200	17,100	New Jersey
54,200	7,000	20,500	9,400	10,400	6,900	New Mexico
254,400	27,500	93,400	38,000	58,800	36,700	New York
202,300	25,800	81,900	32,000	41,200	21,400	North Carolina
7,700	1,100	3,000	1,500	1,200	1,000	North Dakota
158,600	24,600	58,900	24,300	32,400	18,400	Ohio
88,600	11,200	35,000	13,100	19,600	9,600	Oklahoma
84,900	8,800	33,400	13,200	19,100	10,400	Oregon
141,900	16,700	51,400	23,200	31,700	18,900	Pennsylvania
13,900	1,900	4,300	1,500	3,700	2,400	Rhode Island
97,900	12,900	38,800	15,200	19,400	11,500	South Carolina
12,600	2,100	4,700	2,500	2,400	1,000	South Dakota
104,800	11,700	43,600	17,300	21,200	10,900	Tennessee
782,100	106,700	305,200	125,600	161,200	83,500	Texas
54,400	6,900	18,500	9,300	12,400	7,300	Utah
4,500	700	1,200	500	1,100	900	Vermont
115,600	14,900	44,300	18,000	24,400	14,000	Virginia
115,000	12,000	42,400	18,800	26,200	15,600	Washington
34,600	4,000	14,900	5,800	6,100	3,800	West Virginia
54,100	8,900	19,300	8,800	11,300	5,700	Wisconsin
10,100	1,400	3,400	1,600	2,200	1,600	Wyoming

APPENDIX TABLE 2 State data on public expenditures

U.S./state	Public expenditures for family planning client services, FY 2010 (in 000s of dollars)					Total expenditures per woman in need (in dollars), FY 2010	% change in inflation-adjusted expenditures per woman in need, FY 1994–2010
	All	Medicaid	Title X	State-only sources	Other*		
U.S. total	2,370,627	1,769,952	227,830	293,945	78,900	124	56
Alabama	47,056	34,279	5,873	5,898	1,006	147	49
Alaska	5,487	2,125	1,904	1,375	84	147	283
Arizona	64,707	58,493	5,238	76	900	151	513
Arkansas	30,073	25,558	4,187	328	0	152	175
California	605,647	518,870	18,103	68,674	0	245	235
Colorado	24,562	11,390	2,890	10,281	u	80	104
Connecticut	11,446	7,594	1,909	941	1,002	65	–37
Delaware	7,219	5,618	908	693	0	143	38
District of Columbia	5,355	4,612	742	0	nr	120	82
Florida	103,078	66,009	11,465	25,604	0	92	–9
Georgia	92,139	78,610	4,773	312	8,443	142	112
Hawaii	8,418	6,055	1,443	920	0	124	80
Idaho	7,746	3,073	1,712	2,373	588	69	74
Illinois	57,003	40,705	7,752	3,836	4,710	74	47
Indiana	22,381	14,559	4,461	851	2,510	53	65
Iowa	20,001	16,536	3,217	248	0	109	86
Kansas	10,564	2,559	2,459	5,545	0	60	41
Kentucky	53,422	37,678	5,239	9,234	1,270	196	115
Louisiana	39,311	34,515	3,227	0	1,570	127	568
Maine	7,576	4,381	2,124	654	417	98	–23
Maryland	47,563	38,510	2,993	6,061	0	172	55
Massachusetts	50,927	40,664	6,535	3,727	0	145	94
Michigan	54,084	38,995	6,866	6,061	2,162	87	21
Minnesota	21,985	13,564	2,215	9	6,198	77	–6
Mississippi	25,271	20,082	5,189	nr	nr	118	33
Missouri	45,735	40,238	5,117	380	0	118	25
Montana	4,467	1,518	2,448	491	10	74	–10
Nebraska	7,445	5,656	1,789	nr	0	67	59
Nevada	7,130	4,070	2,661	44	354	41	–56
New Hampshire	4,597	2,077	1,566	928	26	72	–43
New Jersey	36,392	20,615	8,995	4,597	2,185	88	36
New Mexico	12,466	10,408	558	1,500	0	86	12
New York	127,512	82,983	11,569	29,434	3,525	107	–30
North Carolina	79,230	32,541	7,776	30,508	8,406	128	47
North Dakota	2,098	653	956	439	50	50	–28
Ohio	41,673	31,004	9,094	1,094	480	59	0
Oklahoma	31,021	22,191	2,865	5,965	0	128	91
Oregon	41,284	35,756	2,547	2,112	869	164	104
Pennsylvania	89,419	75,619	9,289	2,511	2,000	122	98
Rhode Island	3,747	2,183	1,328	113	124	57	165
South Carolina	33,729	25,022	7,039	1,604	63	110	2
South Dakota	3,236	1,991	1,244	nr	nr	64	110
Tennessee	55,608	42,668	6,648	5,724	568	135	158
Texas	148,372	92,087	13,934	19,644	22,707	88	–4
Utah	6,241	4,150	1,600	323	168	31	–32
Vermont	5,187	4,167	832	3	185	146	2
Virginia	32,607	28,235	4,372	nr	0	77	–37
Washington	67,304	41,738	3,901	21,665	0	168	151
West Virginia	11,623	5,678	2,310	665	2,970	105	24
Wisconsin	47,131	30,197	3,187	10,500	3,248	142	109
Wyoming	2,351	1,472	778	nr	100	73	–27

*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:** Reference 72 and 98.

APPENDIX TABLE 3

State data on publicly funded family planning services, 2010

U.S./state	Health centers providing family planning	Female contraceptive clients		No. of unintended outcomes averted			% of need met by centers	Cost savings from center services, 2010 (in millions of dollars)
		All clients	Clients aged <20	Pregnancies	Births	Abortions		
U.S. total: all publicly supported providers	na	8,916,280	na	2,229,890	1,105,760	760,770	46.6	10,467
Private doctors serving Medicaid recipients	na	2,210,000	na	552,690	274,060	188,570	11.5	2,906
U.S. total: publicly funded health centers	8,409	6,706,280	1,457,330	1,677,200	831,700	572,200	35.0	7,561
Alabama	168	115,460	28,400	28,900	14,300	9,900	36.0	92
Alaska	118	23,500	4,590	5,900	2,900	2,000	62.8	53
Arizona	184	97,610	18,780	24,400	12,100	8,300	22.7	150
Arkansas	145	83,940	19,140	21,000	10,400	7,200	42.4	105
California	1,085	1,529,820	293,960	382,600	189,700	130,500	61.9	1,412
Colorado	177	150,040	27,800	37,500	18,600	12,800	48.8	110
Connecticut	90	74,170	16,080	18,500	9,200	6,300	42.2	133
Delaware	32	24,180	8,040	6,000	3,000	2,000	47.9	39
District of Columbia	29	24,220	5,250	6,100	3,000	2,100	54.4	10
Florida	320	295,180	66,450	73,800	36,600	25,200	26.4	187
Georgia	302	154,060	40,660	38,500	19,100	13,100	23.8	182
Hawaii	45	23,910	5,930	6,000	3,000	2,000	35.2	45
Idaho	83	32,810	7,510	8,200	4,100	2,800	29.2	48
Illinois	250	200,180	47,920	50,100	24,800	17,100	26.1	225
Indiana	92	110,380	26,280	27,600	13,700	9,400	26.1	116
Iowa	105	83,930	21,900	21,000	10,400	7,200	45.9	121
Kansas	106	50,290	9,190	12,600	6,200	4,300	28.3	70
Kentucky	196	104,330	18,900	26,100	12,900	8,900	38.2	160
Louisiana	129	65,130	16,400	16,300	8,100	5,600	21.0	116
Maine	94	32,990	8,270	8,300	4,100	2,800	42.6	26
Maryland	124	89,170	22,680	22,300	11,100	7,600	32.2	139
Massachusetts	186	106,120	27,590	26,500	13,100	9,000	30.2	165
Michigan	222	156,420	35,560	39,100	19,400	13,300	25.1	146
Minnesota	123	92,410	17,930	23,100	11,500	7,900	32.2	94
Mississippi	187	83,200	27,190	20,800	10,300	7,100	39.0	60
Missouri	193	95,870	21,400	24,000	11,900	8,200	24.7	113
Montana	73	34,390	8,220	8,600	4,300	2,900	57.1	38
Nebraska	40	32,600	6,210	8,200	4,100	2,800	29.5	44
Nevada	56	36,480	6,980	9,100	4,500	3,100	21.1	19
New Hampshire	35	23,900	5,230	6,000	3,000	2,000	37.4	10
New Jersey	104	145,740	27,880	36,400	18,000	12,400	35.1	236
New Mexico	156	68,760	15,780	17,200	8,500	5,900	47.4	88
New York	388	436,080	92,210	109,100	54,100	37,200	36.7	629
North Carolina	205	164,450	30,620	41,100	20,400	14,000	26.5	190
North Dakota	38	18,580	4,090	4,600	2,300	1,600	43.9	17
Ohio	181	156,880	37,980	39,200	19,400	13,400	22.1	173
Oklahoma	173	109,800	25,140	27,500	13,600	9,400	45.5	103
Oregon	166	131,620	28,790	32,900	16,300	11,200	52.3	72
Pennsylvania	278	263,390	64,650	65,900	32,700	22,500	35.9	262
Rhode Island	22	23,070	4,630	5,800	2,900	2,000	34.9	41
South Carolina	161	110,060	22,550	27,500	13,600	9,400	35.7	170
South Dakota	85	23,070	5,040	5,800	2,900	2,000	45.6	28
Tennessee	214	87,740	22,950	21,900	10,900	7,500	21.4	74
Texas	409	431,760	86,380	108,000	53,600	36,800	25.5	503
Utah	73	56,390	10,220	14,100	7,000	4,800	28.5	66
Vermont	42	17,150	3,980	4,300	2,100	1,500	48.2	11
Virginia	200	95,060	21,320	23,800	11,800	8,100	22.6	176
Washington	215	162,130	36,650	40,500	20,100	13,800	40.4	239
West Virginia	154	47,940	11,300	12,000	6,000	4,100	43.2	72
Wisconsin	121	114,280	30,970	28,600	14,200	9,800	34.4	154
Wyoming	35	15,690	3,800	3,900	1,900	1,300	49.0	29

Notes: na=not applicable or not available. Data broken down by type of provider are available from the original source. **Source:** Reference 70.

APPENDIX TABLE 4

State data on Title X–supported family planning services, 2010

U.S./state	Title X–supported centers	Female contraceptive clients		No. of unintended outcomes averted			% of need met by Title X centers	Cost savings from Title X center services, 2010 (in millions of dollars)
		All clients	Clients aged <20	Pregnancies	Births	Abortions		
U.S. total	4,111	4,724,250	1,054,810	1,181,500	585,900	403,100	24.7	5,342
Alabama	80	103,660	25,520	25,900	12,800	8,800	32.4	82
Alaska	6	6,810	1,650	1,700	800	600	18.2	14
Arizona	37	42,740	9,290	10,700	5,300	3,700	9.9	66
Arkansas	89	77,070	18,170	19,300	9,600	6,600	38.9	97
California	325	1,100,770	225,080	275,300	136,500	93,900	44.5	1,016
Colorado	55	57,860	14,960	14,500	7,200	4,900	18.8	43
Connecticut	25	38,140	7,770	9,500	4,700	3,200	21.7	68
Delaware	28	23,880	7,870	6,000	3,000	2,000	47.3	39
District of Columbia	26	21,060	3,930	5,300	2,600	1,800	47.3	9
Florida	173	228,710	51,530	57,200	28,400	19,500	20.5	145
Georgia	214	132,510	36,000	33,100	16,400	11,300	20.4	156
Hawaii	41	23,570	5,850	5,900	2,900	2,000	34.7	44
Idaho	41	22,910	5,410	5,700	2,800	1,900	20.4	33
Illinois	89	112,380	26,250	28,100	13,900	9,600	14.6	126
Indiana	35	39,850	9,350	10,000	5,000	3,400	9.4	42
Iowa	79	66,660	17,870	16,700	8,300	5,700	36.4	97
Kansas	78	39,670	7,350	9,900	4,900	3,400	22.4	55
Kentucky	150	96,770	16,710	24,200	12,000	8,300	35.4	149
Louisiana	77	46,810	11,510	11,700	5,800	4,000	15.1	83
Maine	43	25,210	6,610	6,300	3,100	2,100	32.5	20
Maryland	73	74,620	17,840	18,700	9,300	6,400	26.9	117
Massachusetts	82	64,640	18,990	16,200	8,000	5,500	18.4	101
Michigan	110	116,770	26,680	29,200	14,500	10,000	18.7	109
Minnesota	45	52,840	8,270	13,200	6,500	4,500	18.4	53
Mississippi	117	66,210	22,000	16,600	8,200	5,700	31.0	47
Missouri	98	60,980	12,790	15,300	7,600	5,200	15.7	72
Montana	27	24,040	6,300	6,000	3,000	2,000	39.9	26
Nebraska	28	29,160	5,560	7,300	3,600	2,500	26.4	39
Nevada	22	23,890	5,160	6,000	3,000	2,000	13.8	13
New Hampshire	25	21,930	4,710	5,500	2,700	1,900	34.4	9
New Jersey	58	122,660	21,420	30,700	15,200	10,500	29.6	199
New Mexico	82	36,720	9,920	9,200	4,600	3,100	25.3	48
New York	180	318,800	63,330	79,700	39,500	27,200	26.8	459
North Carolina	118	133,160	24,370	33,300	16,500	11,400	21.5	154
North Dakota	18	13,540	3,260	3,400	1,700	1,200	32.0	12
Ohio	76	97,040	26,640	24,300	12,000	8,300	13.7	107
Oklahoma	102	72,350	18,100	18,100	9,000	6,200	30.0	68
Oregon	92	68,160	15,410	17,000	8,400	5,800	27.1	37
Pennsylvania	212	233,240	56,500	58,300	28,900	19,900	31.7	232
Rhode Island	18	21,340	4,330	5,300	2,600	1,800	32.3	37
South Carolina	68	91,390	18,470	22,900	11,400	7,800	29.7	142
South Dakota	47	10,230	3,100	2,600	1,300	900	20.2	13
Tennessee	123	72,800	18,700	18,200	9,000	6,200	17.7	61
Texas	180	251,600	53,600	62,900	31,200	21,500	14.9	293
Utah	19	37,690	7,820	9,400	4,700	3,200	19.0	45
Vermont	8	6,320	1,680	1,600	800	500	17.8	4
Virginia	135	75,960	18,110	19,000	9,400	6,500	18.0	140
Washington	72	107,570	25,470	26,900	13,300	9,200	26.8	158
West Virginia	149	46,450	10,850	11,600	5,800	4,000	41.9	69
Wisconsin	17	53,230	13,770	13,300	6,600	4,500	16.0	72
Wyoming	19	11,910	2,980	3,000	1,500	1,000	37.2	23

Note: Data broken down by type of provider are available from the original source. **Source:** Reference 70.

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Moving Forward: Family Planning in the Era of Health Reform is available online at www.guttmacher.org. To obtain additional print copies please contact info@guttmacher.org.

ISBN number: 978-1-934387-17-7

Suggested citation: Sonfield A, Hasstedt K and Gold RB, *Moving Forward: Family Planning in the Era of Health Reform,* New York: Guttmacher Institute, 2014.

Design: Emerson, Wajdowicz Studios/NYC/www.designEWS.com
Cover photo: © Jozef Polc/iStockphoto

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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