

# Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016



Jennifer J. Frost, Mia R. Zolna, Lori F. Frohwirth, Ayana Douglas-Hall, Nakeisha Blades, Jennifer Mueller, Zoe H. Pleasure and Shivani Kochhar

*Corrected November 13, 2019. See note on page 2.*

## Key Points

- In 2016, 20.6 million U.S. women were likely in need of public support for contraceptive services and supplies.
- Between 2010 and 2016, the number of women likely in need of public support for contraceptive services and supplies rose 8% overall. Among women below 250% of federal poverty guidelines, there was a 12% increase; among adolescents, there was a 5% decline.
- Between 2013 and 2016, the number of women likely in need of public support for contraceptive services who had neither public nor private health insurance fell more than one-third (36%), from 5.6 million to 3.6 million. States that implemented the Affordable Care Act's Medicaid expansion experienced particularly large declines.
- Between 2010 and 2016, the overall number of women receiving publicly supported contraceptive services remained stable at about nine million women. However, the number of women served by different types of providers shifted dramatically over this period.
- While Title X-funded sites continued to serve the largest segment of women receiving publicly supported care, their patient load fell by 25%, from 4.7 million in 2010 to 3.5 million in 2016. The number of contraceptive patients served by other public clinics that do not receive Title X funding rose by 29% and the number of women receiving Medicaid-funded contraceptive services from private providers rose by 19%.
- In 2016, women who obtained contraceptive services from all publicly supported providers were able to postpone or avoid two million pregnancies that they would have been unable to prevent without access to publicly supported care. Women who obtained contraceptives from Title X-funded clinics avoided 755,000 pregnancies.
- Screening and vaccination services provided at family planning visits with all publicly supported providers helped patients avoid more than 12,000 cases of pelvic inflammatory disease and nearly 2,000 cases of cervical cancer in 2016. More than 100,000 chlamydia infections, 18,000 gonorrhea infections and 800 cases of HIV were prevented among the partners of women obtaining publicly funded contraceptive care.



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*Correction note:* Changes were made to correct errors in our original estimates of the proportion of adolescents and adult women below 250% of the federal poverty level who were uninsured in 2016. Corrections were made for some state and subgroup estimates on Tables 5 and 6 and on pages 12–13 of the report, although the national estimate for the proportion of all women with likely need for contraceptive services who were uninsured did not change. None of the corrections change the study's summary findings or conclusions.

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## Background

The vast majority of women\* in the United States rely on contraception to prevent pregnancy at some point in their lives, and many need ongoing or periodic access to sexual and reproductive health care providers in order to obtain contraceptive counseling and supplies. The ability to have information on and choose from a wide range of contraceptive methods helps to ensure that women and their partners can obtain the methods that work best for their personal situation and current stage in life. Many women, however, cannot afford to pay for contraceptives and related services; others may be concerned with confidentiality when seeking care. These women are among many who turn to publicly supported providers to obtain the care they need and want.

A nationwide network of publicly supported clinics has long been the critical source of contraceptive care for adolescents and low-income adults. This network includes sites that are funded through the national Title X family planning program—the only federal grant program dedicated to providing subsidized contraceptive and related sexual and reproductive health services, with a focus on serving individuals who are disadvantaged in their access to health care—as well as sites that receive other types of public funding. Each year, this network serves millions of women and helps them prevent more than a million pregnancies and hundreds of thousands of births and abortions.<sup>1</sup> In addition to this network of safety-net clinics, many women enrolled in Medicaid receive publicly supported contraceptive care from clinicians at private providers' offices.

Estimating how many women are potential patients for this care and how many women publicly supported providers collectively serve is crucial for the planning and design of health care delivery systems and for measuring the impact of those services. Moreover, in a time of unprecedented change in health care financing and increased access to health insurance coverage, as well as significant threats to this access, it is even more important to continue monitoring the role and impact of publicly funded providers and programs.

Since the 1970s, the Guttmacher Institute has periodically estimated potential demand for contraceptive services and supplies in the United States, focusing on the number of women who likely need public support to obtain

this care because of their income or age.<sup>2–7</sup> Specifically, these estimates represent the number of women who, at some point during the year, may have a potential demand for contraceptive services or supplies because they desire to avoid or delay becoming pregnant. In the past, we referred to these estimates as “women in need” of contraceptive services and supplies generally, or of publicly supported contraceptive services and supplies specifically. In this report, we have revised our terminology and definitions to be more explicit about what each indicator is measuring (see Key Definitions, pages 5 and 6).

It is important to note that our definition of potential demand for contraceptive care may include some women who do not actually want and will not seek contraceptive care. For some women, pregnancy intentions or desires are fluid and can change, even within a short period of time.<sup>8</sup> Our estimates represent the total number of women who could potentially seek contraceptive services during the year to prevent a pregnancy that they would like to postpone or avoid (regardless of whether they obtain care).

It is also important to note that our definition of likely need for public support for services is based on income level and age and represents eligibility for public support at Title X–funded clinics. However, many women who fit this definition have public health insurance, such as Medicaid, and a relatively smaller proportion have private health insurance. In either case, low-income women with public or private insurance often obtain care from publicly supported clinics for a number of reasons. These sites typically accept public insurance; they offer reduced-fee or free services to women who cannot use their insurance for confidentiality reasons or because it does not cover the care they want; and they provide high-quality contraceptive care.

Since 1995, we have periodically produced state- and county-level estimates of the likely need for publicly supported contraceptive services and supplies, along with data on the number of women who receive publicly supported contraceptive care. Since 2010, our reports have also included state-level information on the impact that providing publicly supported contraceptive services has on helping women prevent pregnancies and other health outcomes that they want to avoid or delay. Most recently, we published estimates for this full set of indicators at

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\*See Key Definitions, page 5, regarding our use of the terms “women” and “female” to describe experiences of individuals throughout this report.

the national, state and county levels for 2010<sup>7</sup> and at the national and state levels for 2014.<sup>9</sup> We have also published data on the numbers of women receiving publicly supported contraceptive care for 2015 at the national, state and county levels.<sup>1</sup>

This report provides updated estimates for 2016 for the following key indicators measuring the likely need for, actual provision of, and—by helping women achieve their reproductive goals—the impact of publicly supported contraceptive and related sexual and reproductive health services:

- The numbers of women who likely need public support for contraceptive services and supplies according to age, income level, race and ethnicity, and health insurance status.
- The numbers of women who received contraceptive services at all publicly supported family planning providers, including those served at publicly supported clinics and Medicaid enrollees served by private providers.

- The numbers of reproductive health outcomes prevented among women who received publicly supported contraceptive care, such as pregnancies that they would have wanted to postpone or avoid, pelvic inflammatory disease (PID), abnormal cervical cell or cervical precancer cases, and cancer, as well as STIs prevented among women and their partners through testing and vaccines provided in publicly supported family planning settings.
- The cost savings in public funds that result from preventing negative health outcomes.

This report highlights national-level findings and trends, and includes summary tables of national and state data. Detailed county-level estimates of numbers and characteristics of women who likely need public support for contraceptive services can be found in the Guttmacher Institute's online county-level Data Center at <https://data.guttmacher.org/counties>.

#### BOX 1

### Key Definitions

We used the following definitions in our analyses:<sup>†</sup>

- Women are counted as having a **potential demand for contraceptive services and supplies** if they are aged 13–44 and meet the following three criteria:

- (1) they have ever had voluntary penile-vaginal intercourse;‡
- (2) they are able to or believe they are able to conceive (we include women for whom neither they nor their partner(s) have been contraceptively or noncontraceptively sterilized, and who do not believe that they are unable to conceive for any other reason); and
- (3) they are neither pregnant nor trying to become pregnant during all of the given year.

- **Women likely need public support for contraceptive services and supplies** if they meet the above criteria and are aged 20 or older with a family income below 250% of the federal poverty level (FPL; less than \$50,400 for a family of three in 2016) or are younger than 20. All adolescents who have a potential demand for contraceptive services, regardless of their family income, are assumed to have a likely need for public support because of their heightened need for confidentiality in obtaining care (which may not be provided if they depend on their family's resources or private insurance). The income level used in this definition of likely need was set based on Title X eligibility guidelines, which classify patients whose income is under 250% of

FPL as eligible for reduced-fee services. Patients whose income is under 100% of FPL (less than \$20,160 for a family of three in 2016) are eligible for free services. Eligibility for adolescents is based on their own (not their parents') resources, so most are eligible for free services. It is important to note that other public programs, such as Medicaid, use different income levels in their eligibility criteria that are set by state policy and are typically lower than 250% of FPL. To accommodate variation in how these estimates are used, we present detailed income-level groups that allow users to estimate likely need for public support for services according to income levels that may be different from the ones used here.

*(continued on page 6)*

<sup>†</sup>Some terminology used in these definitions has changed from previous reports. These changes reflect an attempt to clarify more precisely what each indicator measures; however, the methodology and data used remain the same. <sup>‡</sup>Estimates are based on individuals who have ever had voluntary sex, not those who have been sexually active in the past one or three months, because the intent of this indicator is to measure the potential number of women who may decide to seek contraceptive services at any time over a one-year period.

*Key Definitions (continued)*

- A **publicly supported clinic** is a site that offers contraceptive services to the general public and uses public funds (e.g., federal, state or local funding through programs such as Title X, Medicaid or the federally qualified health center program) to provide free or reduced-fee services to at least some patients. Sites must serve at least 10 contraceptive patients per year. These sites are operated by a diverse range of providers, including public health departments, Planned Parenthood affiliates, hospitals, federally qualified health centers and other independent organizations. In this report, these sites are referred to as “clinics”; other Guttmacher Institute reports may use the synonymous term “centers.”
- **Private health care providers** may offer publicly supported contraceptive services to women who are enrolled in Medicaid or other state-sponsored public health insurance programs. This care is

typically provided in a doctor’s office and involves physicians as well as other types of clinicians.

- A **female contraceptive patient** is a woman who made at least one visit for contraceptive services during the 12-month reporting period. Sites were asked to report the number of all unduplicated female patients who made at least one visit and received any of the following services: a medical examination related to the provision of a contraceptive method; contraceptive supplies only (after an initial visit); contraceptive counseling and a method prescription, while deferring a medical examination; or a nonmedical contraceptive method, even if a medical examination was not performed, as long as a patient chart was maintained. Among clinics, a small proportion of patients who paid for their visit using private insurance or who paid the full fee for services because their income was above the threshold

for free or reduced-fee services are counted among the total number of contraceptive patients served. Among private providers, only contraceptive patients who paid for their visit using Medicaid are counted.

- We use the terms **female** and **women** to refer to individuals who may have the ability to become pregnant. The data sources used in our analyses (detailed on page 7), from which these designations originated, do not provide any further detail on the sex or gender identity of respondents. For example, our estimates of women who likely need public support for contraceptive care are based on individuals’ self-identification as women on the U.S. census and on the National Survey of Family Growth and our estimates of women who received publicly supported care are based on providers reporting the number of individuals who are classified as female in their patient data systems.

# Methodology

## Estimating likely need for public support for contraceptive services and supplies

We estimated the number of U.S. women in 2016 with a potential demand for contraceptive services and supplies and who likely need public support for this care by age and by income level, using three data sources:

1. U.S. Census Bureau reports for the number of women in each U.S. county in 2016, by age-group (13–17, 18–19, 20–29 and 30–44) and by race and ethnicity (non-Hispanic white, non-Hispanic black, Hispanic, and other or multiple races<sup>10</sup>);

2. Analysis of the 2014–2016 American Community Survey (ACS) to obtain distributions of women according to marital status (married and living with husband or not married) and family income as a percentage of the federal poverty level (FPL; less than 100%, 100–137%, 138–199%, 200–249% and more than 250%) for each age-group by race and ethnicity;<sup>11–16</sup> and

3. Analysis of the 2011–2015 National Survey of Family Growth (NSFG) to estimate the proportion of women who have a potential demand for contraceptive services (because they were sexually experienced, able to conceive, and not pregnant or trying) for each demographic group (by age, race and ethnicity, marital status and income level as a percent of FPL).

Estimates were produced by combining 2016 population data from the U.S. Census Bureau with information on income level and marital status from the 2014–2016 ACS and characteristics of women from the 2011–2015 NSFG. We calculated the proportion of women in various population groups who met the specified criteria (detailed in Key Definitions) indicating their potential to seek contraceptive services and supplies during the year using the 2011–2015 NSFG, a nationally representative cross-sectional survey of 11,300 women aged 15–44 conducted by the U.S. National Center for Health Statistics. The proportion of women with the potential to seek contraceptive services in population groups defined by each age by marital status by income level by race and ethnicity group were then applied to county-level estimates of the number of women in each of these population groups. Estimates were made at the county level and then summed to obtain state and national estimates. For further explanation of this methodology, see the [Methodological Appendix](https://www.guttmacher.org/report/publicly-supported-FP-services-us-2016), <https://www.guttmacher.org/report/publicly-supported-FP-services-us-2016>.

## Women served at publicly funded family planning clinics

We estimated the number of U.S. women who received contraceptive services and supplies at publicly supported family planning clinics in 2016, at both state and national levels, using multiple sources:

1. The number of women receiving contraceptive care at Title X–funded family planning clinics was drawn from 2016 Title X program data, tabulated by state, excluding men and those served in U.S. territories.<sup>17</sup> These clinics accounted for 58% of all female contraceptive patients served at family planning clinics.

2. The number of women served at other publicly supported clinics—those clinics that do not receive Title X funds—was estimated by starting with published state tabulations of women served by such clinics in 2015 (the most recent year available).<sup>1</sup> We then projected the state-level change in the number of patients served at these sites between 2015 and 2016 using data from the Health Resources and Services Administration (HRSA) on the number of women aged 15–44 who were served in 2015 and 2016 at federally qualified health centers (FQHCs).<sup>18</sup> We calculated the percentage change between years using the HRSA data and applied the state-level percentage change to the 2015 number of contraceptive patients served in each state to estimate the number served in 2016. Because women served at FQHCs constitute nearly half of all women served at non-Title X–funded clinics (48%), we reasoned that this projection method was the best method available.

For further detail, including the detailed methodology for collecting 2015 data on patients served, see the Methodological Appendix.

## Women receiving Medicaid-funded contraceptive services from private providers

We estimated the national number of women receiving Medicaid-funded contraceptive services from private providers using information from the 2011–2015 NSFG<sup>19</sup> on the type of provider respondents reported visiting for contraceptive services and how they reported paying for their visit. Among the 25 million women who reported receiving at least one contraceptive service in the prior 12 months, 73% (18.7 million women) reported receiving that

care at a private provider's office; 17% (3.2 million women) of those who went to a private provider reported that their contraceptive visit had been paid for by Medicaid. A previous report<sup>7</sup> used data from the 2002 and 2006–2010 NSFG to make similar estimates for 2001 and 2010. Recent analyses of the 2011–2015 NSFG uncovered some inconsistencies in how women report their insurance status and their payment source for contraceptive services. To account for these inconsistencies, we constructed a corrected payment source variable for the current analysis. To be consistent across years, we have revised our 2001 and 2010 estimates of the number of women using Medicaid for contraceptive services at private providers based on the corrected payment source variable, and these numbers are somewhat higher than the previously published numbers. There are no data available to estimate the number of women who receive Medicaid-funded contraceptive services from private providers by state.

## Extent to which publicly supported providers are meeting likely need for care

We estimated the extent to which current providers are meeting the likely need for public support for contraceptive care as the ratio of the number of female patients receiving publicly supported contraceptive services to the number of women who likely need public support for contraceptive services and supplies.

It is important to note that these estimates cannot be used to derive a measure of “unmet need” for publicly supported contraceptive care. Some women who likely need public support for contraceptive services, but who are not counted here, may have obtained contraceptive services or methods from other sources (including pharmacies or private providers) that they pay for out of pocket or through private health insurance.

National estimates of the extent to which potential demand for publicly supported contraceptive care is met include all women receiving contraceptive care from publicly supported clinics, as well as Medicaid patients who received such care from private providers. State estimates represent the extent to which potential demand is met by publicly supported clinics only.

## Impact of services provided during publicly supported family planning visits

**Pregnancies avoided or postponed.** Services provided during publicly supported family planning visits help women achieve the reproductive health outcomes they desire, including avoiding or postponing pregnancy. We

estimated the numbers of pregnancies that were postponed or avoided by the provision of publicly supported contraceptive services in 2016 using methodology that is comparable to previous analyses.<sup>20–22</sup>

We began with the total numbers of adult and adolescent female contraceptive patients served (including patients served at publicly supported clinics and Medicaid recipients who received contraceptive services from private providers). We adjusted these numbers based on the fact that some patients served do not obtain or use a contraceptive method. In 2016, 86% of women served at Title X clinics reported current use of a contraceptive method.<sup>17</sup> We assumed that this same percentage applied to all clinics and to private providers serving Medicaid recipients and estimated the total number of method users who received publicly supported contraceptive care in 2016 to be 86% of all patients served and 86% of adolescent patients served.

Next, we estimated the total number of pregnancies avoided or postponed in 2016 for all women, and for adolescents separately, by multiplying the number of method users—nationally and in each state—by the ratio of pregnancies prevented per 1,000 method users. This ratio was updated for this analysis and is estimated to be 249 pregnancies prevented per 1,000 method users. A summary of the steps taken to calculate this ratio are listed below. Details for each step can be found in the Methodological Appendix.

- Examined the actual contraceptive method-mix distribution for a national sample of recipients of public-sector family planning services.<sup>19</sup>
- Compared actual use with an estimated hypothetical method-mix distribution scenario for these women in the absence of publicly funded services. The hypothetical scenario is based on measuring the method mix of similar women who did not use publicly funded contraceptive services in the prior year, but had the potential to use these services in the future.
- For both actual use and the hypothetical scenario, estimated the number of pregnancies that each group would experience in one year based on their method-mix distribution and the one-year typical contraceptive failure rates for each method<sup>23</sup> (each estimated separately for women by age, race and ethnicity, income level and marital status). Expected pregnancies were further discounted based on the difference between the number of pregnancies predicted using one-year typical contraceptive failure rates and the documented number of pregnancies actually experienced by all contraceptive method users in the United States in 2013. This adjusts for the fact that not all women use their method for an entire year and for the fact that women who have used



their method for longer than 12 months may have failure rates that are lower than the rates experienced during the first year of method use.

- For both actual use and the hypothetical scenario, we then estimated the number of pregnancies expected per 1,000 public-sector family planning patients.
- Finally, we computed the number of pregnancies prevented per 1,000 women by subtracting the number of pregnancies expected among current patients from the number of pregnancies expected under the hypothetical scenario that would occur in the absence of publicly funded services.

Using the resulting estimate for pregnancies prevented, we classified pregnancies by expected outcome based on the most recent national data on observed outcomes in each category.<sup>24</sup> Overall, we estimated that 47% of pregnancies in 2016 conceived when women would have rather avoided or delayed them resulted in a birth, 34% in an elective abortion and 19% in miscarriage; for adolescents, those proportions are 52%, 29% and 19%, respectively.

**Negative sexual and reproductive health outcomes prevented.** We also estimated the impact of testing for STIs and HIV, as well as routine gynecologic care such as Pap and HPV tests and HPV vaccines, during publicly supported contraceptive visits. These services, along with treatment provided on-site or by referral for patients who test positive, prevent a range of negative outcomes among women (including PID, abnormal or precancer cases, and cancer) and their partners (including STIs, such as chlamydia and gonorrhea, and HIV).

We began this analysis by estimating the number of women we expected would forgo preventive sexual and reproductive health care if they lost access to publicly supported contraceptive services. These estimates were based on the same hypothetical scenario of similar women described above. We assumed that all women in the hypothetical scenario who continued to use short-acting prescription methods (10% were calculated to use pills, patch, injectable or ring) would also continue to receive preventive services. For women who might switch to a nonprescription or no method or continue to use their long-acting reversible contraceptive (LARC) method and therefore would not necessarily make a visit for contraceptive services, we looked at similar women in the NSFG<sup>19</sup> and found that among this subgroup, 21% received a preventive gynecologic service (made a visit that included a Pap test and/or pelvic exam) during the year. Combining these findings, we estimated that 28% of women would continue to get preventive care if they lost access to publicly supported services, but 72% would not. For the small

number of men who receive care from publicly funded clinics (the majority of whom receive STI services), we assumed that all of them would forgo preventive services in the absence of public support for that care.

A brief summary of the key steps for estimating outcomes prevented follows. Further details are included in the Methodological Appendix.

**Chlamydia and gonorrhea testing.** We estimated the proportion of women and men who would forgo testing for chlamydia and gonorrhea using data on the proportions currently tested at Title X clinics.<sup>17</sup> State-level data on the proportions of family planning clinic patients who tested positive for chlamydia or gonorrhea came from the Centers for Disease Control and Prevention (CDC).<sup>25,26</sup> From these data, we estimated state-specific measures for the proportion of patients who would have a positive chlamydia or gonorrhea test among those receiving services at Title X–supported family planning clinics and applied these proportions to the numbers of patients estimated to forgo care who were served at all clinics and by private providers for women on Medicaid. We used information from other researchers to estimate treatment rates and the likelihood of specific health outcomes, such as PID, in the absence of treatment. In addition, we estimated the number of infections that would have been prevented among the partners of patients who received testing during publicly supported contraceptive visits and the outcomes from preventing those infections.

**HIV testing.** We estimated the proportion of women and men who would forgo testing for HIV using data on the proportions currently tested at Title X clinics.<sup>17</sup> Data on the proportion who would have a positive test came from both Title X patient data and from the CDC.<sup>27</sup> We applied this information to the numbers of patients estimated to forgo care who were served at all clinics and by private providers for women on Medicaid. Further adjustments and estimates of the number of HIV infections that would have been prevented among the partners of patients testing positive were based on information from other researchers.

**Cervical cancer testing and prevention.** We estimated the proportion of women who would not have received Pap and HPV testing and vaccinations had they forgone care at all clinics and from private providers for women on Medicaid. For the testing analysis, we used data on the proportion of female patients who obtained a Pap test at Title X clinics<sup>17</sup> as a proxy for the proportion tested at all publicly funded clinics. We combined that information with data on patients who would have received a Pap test alone and those who would have received both Pap and

HPV testing, according to data from a survey of U.S. family planning clinics.<sup>28</sup> To estimate numbers of cervical cancer cases and deaths prevented, we then applied information on the incidence of cervical cancer cases and deaths to patients with and without testing and under different testing scenarios<sup>29</sup> that matched U.S. cervical cancer screening guidelines.<sup>30</sup> For the prevention analysis, we used the ratio of the number of HPV vaccines administered to the number of female patients seen at Planned Parenthood clinics nationally in 2016<sup>31,32</sup> as a proxy for the ratio of vaccinations provided at all publicly supported family planning clinics. We used published estimates of the number of abnormal Pap tests, precancerous lesions, cervical cancer cases and cervical cancer deaths per 100,000 women vaccinated<sup>33</sup> to calculate the number of events averted among the population receiving services at publicly supported family planning facilities. We used published data on the number of other HPV-attributable cancers (including vulvar, vaginal, anal/rectal and oropharyngeal cancers) prevented by vaccination<sup>34,35</sup> to estimate the number of cancer cases prevented.

**Public cost savings.** Helping women and couples achieve their reproductive goals and avoid negative sexual and reproductive health outcomes improves the lives of women and their families in many ways. In addition to the health and personal benefits that derive from publicly supported contraceptive services, there are public cost

savings from helping people realize their reproductive goals and avoid negative sexual and reproductive health outcomes.

Specifically, we estimated the public costs for medical care that would have been incurred in the absence of publicly funded family planning services as:

- Medicaid costs associated with prenatal care, delivery, postpartum care and medical care for children through five years old for pregnancies that were averted by women’s use of contraception; and
- Medicaid costs associated with adverse health outcomes for women and their partners that would have occurred in the absence of STI testing or HPV testing and vaccines received at family planning visits.

After summing these costs to obtain gross cost savings, we subtracted the estimated total public cost used to provide family planning services in publicly supported settings to obtain net cost savings. Total public costs for family planning services were estimated by calculating the state-level public revenues per patient (including federal funds from Medicaid and Title X, as well as other federal, state and local funding) used to support the provision of services at Title X clinics. For 2016, the national average public cost for family planning services was estimated to be \$316 per patient. Details of these calculations can be found in the Methodological Appendix.

BOX 2

**Table Notes**

This report is the source for all 2016 data in the accompanying tables and figures. Data for earlier years (numbers of women who likely need public support for contraceptive services and supplies in 2000, 2006 and 2010, and numbers of contraceptive patients served in 2001, 2006, 2010 and 2015) have most recently been provided in our 2010 and 2015 reports.<sup>1,20</sup>

- All population and patient estimates; numbers of pregnancies, births and abortions averted; and

most estimates of the number of adverse health outcomes avoided through STI and HPV testing and vaccines have been rounded to the nearest 10. State and population group totals, therefore, do not always sum to the national total.

- Racial and ethnic group totals do not sum to the overall total on state-level tables because the group of women reporting other or multiple races is not shown separately, although it is included in the overall total. Our methodology for

estimating numbers of women who likely need public support for contraceptive services and supplies is based on estimating the proportion of women according to multiple demographic characteristics and their likely need for publicly supported care using the NSFG and applying those proportions to county-level census data; therefore, it is not possible to look separately at groups with small numbers of women, such as those who identify as indigenous or Asian and Pacific Islander.

# Likely Need for Public Support for Contraceptive Services

Information on patterns and trends in the numbers and characteristics of women who may need public support for contraceptive care is critical for the design and implementation of public policies and programs aimed at providing all women with access to the care they desire and that will help them best meet their reproductive goals and preserve their sexual and reproductive health. This information can also be compared with the numbers of women who obtain care from various types of providers who offer publicly supported services to better understand service delivery patterns and to identify gaps in care. Our estimates measure the potential demand for publicly supported contraceptive services and supplies over the course of one year (see Key Definitions, page 5).

- In 2016, 20.6 million U.S. women were likely in need of public support for contraceptive services and supplies (Tables 1 and 2, pages 26 and 27).
- Some 16 million women who likely need public support for contraceptive services and supplies were adults living below 250% of FPL; 6.2 million of these women had incomes below 100% of FPL.

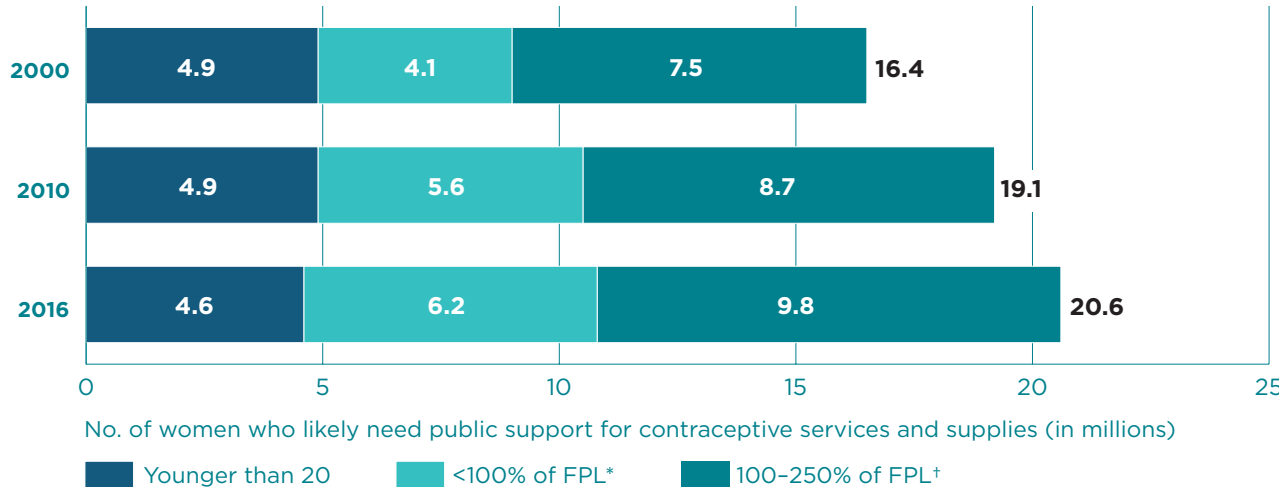
- Young women aged 13–19 accounted for more than one-quarter (4.6 million) of those who likely need public support for contraceptive services, due to their limited financial resources and the increased likelihood that they desire confidential care without having to depend on their families’ resources.
- Of all women who likely need public support for contraceptive services and supplies, 10.1 million were non-Hispanic white, 3.7 million were non-Hispanic black, 5.1 million were Hispanic, and 1.8 million were members of other or multiple racial and ethnic groups.

**Trends.** Overall, the number of women who likely need public support for contraceptive care increased by 25% over the past 16 years, rising from 16.4 million women in 2000 to 19.1 million in 2010 and to 20.6 million women in 2016. The extent of the increase has varied over time, as well as across social and demographic groups (Tables 1–3, pages 26–28 and Figure 1; Appendix Tables A–D, pages 46–51 for data on all women of reproductive age and all women with potential demand for contraceptive services and supplies).

FIGURE 1

## LIKELY NEED FOR PUBLICLY SUPPORTED CONTRACEPTIVE CARE

**Increasing numbers of low-income adult women account for the growing numbers of women who likely need public support for contraceptive care.**



- Between 2010 and 2016, the number of women who likely need public support for contraceptive care rose by 8%—an increase of 1.5 million women.
- Over this period, likely need rose the most among adult women over age 30 (14%) and among those with family incomes below 250% of FPL (12%); the number of adolescents who likely need public support for contraceptive services fell by 5%, from 4.9 million women in 2010 to 4.6 million in 2016.
- The number of Hispanic women who likely need public support for contraceptive care increased by 11%; likely need increased by 10% for black women and by 5% for white women.

**State variation.** Most states experienced an increase between 2010 and 2016 in the numbers of women likely needing public support for contraceptive care (Table 4, page 29).

- Seventeen states (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oklahoma, South Carolina, Tennessee, Texas and Virginia) and the District of Columbia experienced a 10% or greater increase between 2010 and 2016 in the number of women who likely need public support for contraceptive services or supplies. Four of these states (Florida, North Carolina, Oklahoma and Texas) experienced a 15% or greater increase.
- Only three states experienced declines in the number of women who likely need public support for contraceptive care during this period (Hawaii, Maine and New York), although these decreases were small (1–4%).

**Number uninsured.** Implementation of the Affordable Care Act (ACA) has provided many Americans with access to health insurance that was previously out of reach—including both public insurance through the federal-state Medicaid program and private insurance purchased through the ACA's health insurance marketplace (which includes federal subsidies for many low-income individuals<sup>36</sup>). As a result, the numbers of women who likely need public support for contraceptive care who were uninsured fell dramatically between 2010 and 2016, with most of the change happening between 2013 and 2016, coinciding with the period in 2014 when most of the ACA's major coverage expansions went into effect (Table 5, page 30).

It is again important to note that our estimates of the number of women who likely need public support for contraceptive services are based on their eligibility for such care at Title X-funded clinics and do not take into account whether they have public or private health insurance coverage. Many women have public coverage such as Medicaid, some have private coverage that is subsidized through the

insurance marketplace and some have private coverage from an employer that may or may not cover contraception and may or may not ensure confidentiality. Thus, publicly or privately insured women may still choose to obtain care from publicly supported clinics, both because these are places where they know they can go for high-quality, confidential contraceptive care, and also because they can still obtain free or reduced-fee care if they are unable to use their insurance. Currently, we cannot estimate precisely how many of the insured women who fit our definition of having a likely need for public support for contraceptive care have public versus private health insurance. However, we do know that among all women of reproductive age whose family income is under 100% of FPL, nearly half (49%) were covered by Medicaid in 2016 compared with 27% who had private insurance.<sup>37</sup>

- Between 2013 and 2016, both the number and proportion of women who likely need public support for contraceptive care who had neither public nor private health insurance fell dramatically—from 5.6 million (28%) to 3.6 million (17%), a decline of 36%.
- Among adolescents who likely need public support for contraceptive care, most of the change in insurance status occurred earlier than for adult women, with the proportion uninsured falling from 15% in 2010 to 11% in 2013, and to 7% in 2016. The drop in the proportion uninsured, combined with the overall drop in the number of adolescents in this category, resulted in a decline in the number of uninsured adolescents who likely need public support for contraceptive care, from 746,700 in 2010 to 339,460 in 2016.
- Among all adult women who likely need public support for contraceptive care with a family income below 138% of FPL (the income eligibility ceiling for Medicaid in states that expanded the program under the ACA), 39% (3.1 million women) were uninsured in 2010 and 36% (3.2 million women) in 2013. This proportion fell to 23% (2.0 million women) in 2016, representing a 36% drop since 2010 in the number of women uninsured.

**State variation in insurance status.** States varied widely in terms of the proportion of women who likely need public support for contraceptive services and supplies who were uninsured, and in the level of change experienced between 2013 and 2016 in the proportions uninsured (Table 6, page 31). Most notably, between 2013 and 2016, there was generally a much larger drop in the proportions of uninsured women who likely need public support for contraceptive care in those states that expanded Medicaid under the ACA compared with states that did not.

- Among all states that expanded Medicaid under the ACA by the end of 2016, the number of women who likely need public support for contraceptive care who

were uninsured fell 50% between 2013 and 2016 (from 25% to 13%). In contrast, among all states that did not expand Medicaid, the number of similar women who were uninsured fell only 18% between 2013 and 2016 (from 32% to 25%).

- In eleven states (Connecticut, Hawaii, Iowa, Kentucky, Massachusetts, Michigan, Minnesota, Ohio, Rhode Island, Vermont and West Virginia) and the District of Columbia, the proportion of women who likely need public support for contraceptive care who were uninsured in 2016 was 10% or less, and all of these states expanded Medicaid under the ACA.
- In four states (Alaska, Georgia, Oklahoma and Texas), the proportion of women who likely need public support for contraceptive care who were uninsured in 2016 was 25% or higher; the state with the highest proportion uninsured was Texas (36%). These states were among those with the highest proportions of women who likely need public support for contraceptive care who were uninsured in 2013, and only one of the four (Alaska) had expanded Medicaid under the ACA by the end of 2016.

# Availability of Publicly Supported Contraceptive Services

**A**cross the United States, publicly supported contraceptive care is provided by thousands of clinics that receive public funding through a variety of federal, state and local sources. These clinics include health departments, hospital outpatient clinics, FQHCs, Planned Parenthood clinics and facilities run by other organizations. In addition, women who are eligible for and enroll in Medicaid often obtain publicly supported contraceptive care from private providers.

Providers of publicly supported contraceptive care vary widely in terms of the number of contraceptive patients served per year and whether the provider is focused on the provision of sexual and reproductive health care or provides these services in the context of a wide offering of primary care services. Clinics that focus on sexual and reproductive health services often provide a broader mix of contraceptive methods, allowing women more choice in finding the method that is best for their situation, whereas clinics that focus on primary care often provide a more limited number of contraceptive methods. Women who obtain publicly supported care from either clinics or private providers typically receive a variety of services, including contraceptive counseling and methods; preventive gynecological care such as screenings for cervical cancer, chlamydia and gonorrhea; and treatment and referrals as needed.

## Women served by publicly supported providers

In 2016, an estimated 9.3 million women received publicly supported contraceptive services from all sources (Table 7, page 32 and Figure 2, page 15). The majority—an estimated 6.1 million contraceptive patients—were served at publicly funded clinics; an estimated 3.2 million women received Medicaid-funded contraceptive care from private providers. Among women served at clinics, 58% (3.5 million<sup>§</sup>) were served at Title X–funded clinics and 42% (2.6 million) were served at publicly supported clinics not funded by Title X (Table 8, page 33).

- In 2010 and 2016, the overall number of women who received publicly supported contraceptive services from all providers was nearly the same—9.4 million women served in 2010 and 9.3 million in 2016.

- However, the number of women served by different types of providers shifted dramatically over this six-year period. The number of contraceptive patients served by Title X–funded sites fell by 25%, from 4.7 million in 2010 to 3.5 million in 2016. In contrast, the number of contraceptive patients served by other public clinics that do not receive Title X funding rose by 29% (from 2.0 to 2.6 million) and the number of women receiving Medicaid-funded contraceptive services from private providers increased by 19% (from 2.7 to 3.2 million).
- Data from the federal Office of Population Affairs<sup>17</sup> indicate that most of the drop in Title X clinic patient numbers occurred between 2010 and 2014, with declines of 4–10% each year. Between 2014 and 2016, the annual declines have been more modest at 2–4%.
- The majority of states (42) experienced a drop or no change in the number of female contraceptive patients served at publicly funded clinics between 2010 and 2016; eight states (California, Georgia, Louisiana, Maryland, Rhode Island, Tennessee, Vermont and West Virginia) and the District of Columbia experienced an increase.
- Overall, the number of adolescent women served at all publicly supported providers fell slightly (7%) between 2010 and 2016, from 2.0 million to 1.9 million (Table 9, page 34). However, where adolescent women were served shifted considerably. The number of adolescent women served by Title X clinics fell steeply, dropping 41% (Table 10, page 35), while the number of adolescent women on Medicaid who were served by private providers rose by 22%.

## Proportion of women with likely need served by publicly supported providers

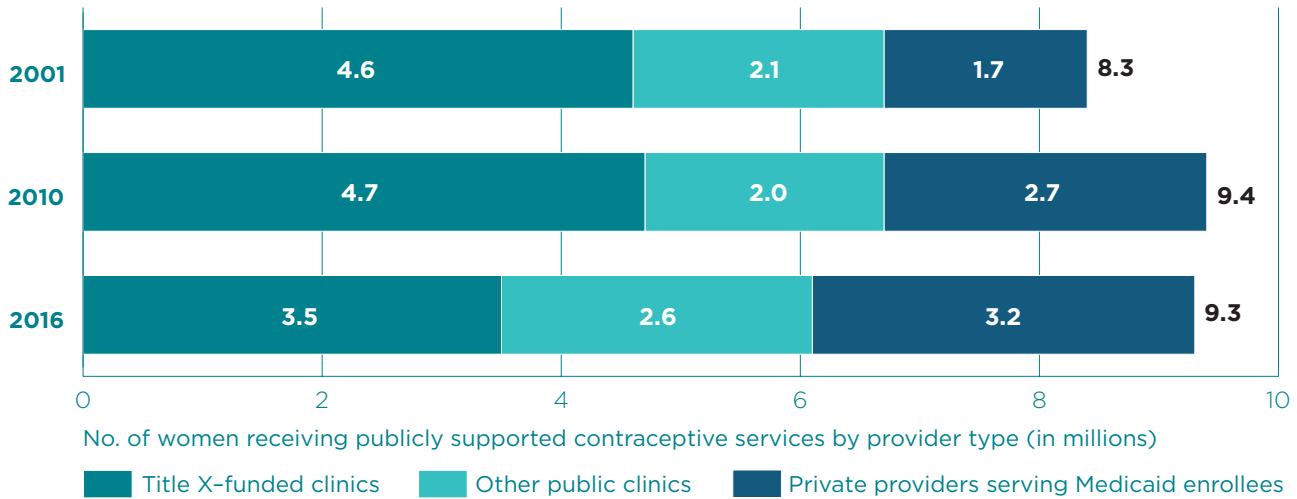
Comparing the number of women who obtained contraceptive care from publicly supported providers with the number of women who likely need such care is useful for understanding trends in access to care and variation in access across geographic locations. Due to the measurement of likely need (which includes some women who may have obtained contraceptives without public funds

<sup>§</sup>This total differs from the 4.0 million total Title X family planning users reported for 2016 in the Office of Population Affairs' *Family Planning Annual Report* because it excludes male patients and patients served in U.S. territories.

FIGURE 2

**CARE BY TYPE OF PROVIDER**

The number of women receiving publicly supported contraceptive care from Title X clinics has dropped since 2010, while the number of patients served at other publicly supported clinics and by private providers has risen.

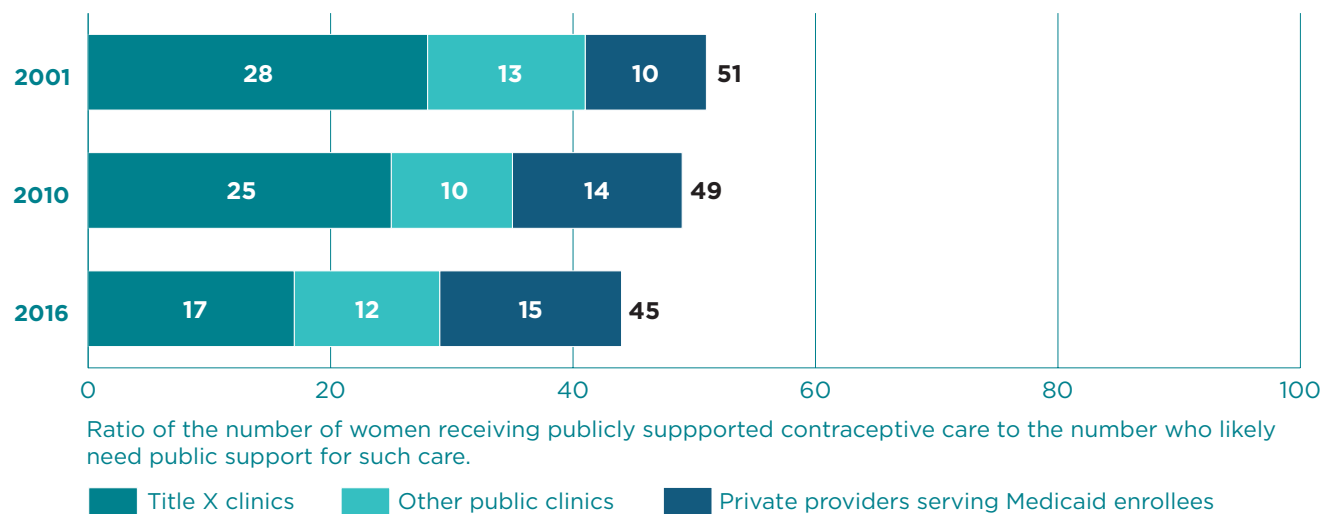


NOTE: Segments may not add to totals because of rounding.

FIGURE 3

**DECREASE IN LIKELY NEED MET**

Between 2001 and 2016, the proportion of likely need met by publicly supported providers declined.



NOTE: Segments may not add to totals because of rounding.

from private providers or over the counter and others who may have decided not to use contraception, despite not planning to become pregnant), we would never expect publicly supported providers to serve 100% of such women. However, looking at variation in the proportions served across time and location can help to identify patterns and gaps in access to care.

In 2016, publicly supported providers served 45% of women who likely need public support for contraceptive services, with more than nine million of the 21 million women who likely need care served. Seventeen percent of likely need was met by Title X–supported clinics, 12% by publicly supported clinics that do not get Title X funds and 15% by private providers serving Medicaid enrollees (Table 11, page 36 and Figure 3, page 15).

- Between 2010 and 2016, the overall proportion of likely need met by all publicly supported providers fell from 49% to 45%. This drop follows from the fact that the overall number of women receiving contraceptive services from publicly supported providers was similar across years, while the number of women who are likely to need public support for such care increased over the period.
- The proportion of likely need for publicly supported contraceptive care met by Title X–funded clinics fell from 25% in 2010 to 19% in 2014<sup>9</sup> and 17% in 2016. Publicly supported clinics that do not receive Title X funds met 12% of the likely need for such care in 2016, a slight increase from 10% in 2010 (Table 12, page 37).
- Overall, the proportion of adolescent women whose likely need for publicly supported contraceptive care was met by all providers remained stable at 41% in 2010 and 40% in 2016 (Table 11). However, the proportion of adolescents whose likely need for such care was met by Title X clinics fell sharply, from 22% to 14%. In contrast, the proportion of adolescents whose likely need for publicly supported contraceptive care was met by other (non-Title X–supported) clinics rose from 8% in 2010 to 12% in 2016 and the proportion served by private providers through Medicaid rose from 11% to 15% over the same period.
- The proportion of likely need for publicly supported contraceptive services met by all clinics in 2016 varied widely by state, from a low of 14% in Nevada to a high of 88% in the District of Columbia.



# Impact of Publicly Supported Family Planning Services

Publicly supported family planning providers help women achieve their reproductive goals by providing access to the contraceptive services that women want. A host of benefits accrue when women and families are able to plan whether, when and how many children to have.<sup>38,39</sup> One of the most basic benefits of these services is the prevention of pregnancies that women wish to postpone or avoid. During family planning visits at publicly funded providers, many women also receive testing for STIs and HIV, as well as routine gynecologic care such as Pap and HPV tests and HPV vaccines. These services, along with treatment provided on-site or by referral for women who test positive, prevent a range of negative outcomes among women (including PID, abnormal or precancer cases, and cancer) and their partners (STIs, including HIV, chlamydia and gonorrhea). To estimate the impact of publicly funded family planning services, we updated our estimation procedures using the most recent data available and applied updated cost information to generate new estimates of the public cost savings that come from preventing pregnancies and negative health outcomes among women whose care would have been paid for from public sources.

## Contraceptive method use in the absence of publicly supported care

Women who obtain contraceptive services from publicly supported providers use a variety of highly effective contraceptive methods. Based on the 2011–2015 NSFG, on average, 57% rely on hormonal methods, such as oral contraceptives, injectables, the contraceptive patch and the contraceptive ring; 18% rely on long-acting reversible methods (IUDs and implants); and 7% have had a recent tubal sterilization (Figure 4, page 18). In contrast, we estimate that a hypothetical group of similar women without access to publicly supported services would switch to a much less effective mix of contraceptive methods. Only 25% would continue to use hormonal or long-acting methods, nearly half (46%) would use either condoms or other nonprescription methods, and 28% would use no method.

- For every 1,000 women using the average mix of contraceptive methods obtained from publicly supported providers, an estimated 43 will become pregnant each year.
- For every 1,000 women using the average mix of contraceptive methods estimated for the hypothetical group

without access to publicly supported care, an estimated 293 would become pregnant each year.

- Comparing the estimated pregnancies occurring among each group, we conclude that for our 2016 analysis, 249 pregnancies are prevented for every 1,000 women using publicly supported contraceptive services. These hypothetical pregnancies would have occurred if women lost access to publicly supported care and switched to the less effective mix of methods.

Comparing our current analysis using the 2011–2015 NSFG with the analysis done for our 2010 report using the 2006–2010 NSFG, we find that the mix of methods obtained from publicly supported providers, as well as the mix of methods used by women in the hypothetical group, shifted toward use of more effective methods.

- For example, among women served by publicly supported providers, the proportion using LARC methods rose from 11% to 18%. Similarly, among women in the hypothetical group of contraceptive users, the proportion using either hormonal or LARC methods would rise from 15% to 25%.
- These shifts result in fewer estimated pregnancies per 1,000 women occurring both to women currently served by publicly supported providers (43 in 2016 compared with 62 in 2010) and to the group of hypothetical women without access to publicly supported care (293 in 2016 compared with 350 in 2010).
- Despite the fact that fewer women who obtain contraceptive care from publicly supported providers are expected to become pregnant, our updated estimate of the number of pregnancies that are prevented per 1,000 contraceptive users served at publicly supported providers has declined (from 288 in 2010 to 249 in 2016), because more women in the hypothetical group are expected to use more effective methods.

## Benefits from contraceptive use

We quantified the benefits of contraceptive use to help women prevent pregnancies that they would like to postpone or avoid by applying our updated estimate of the number of pregnancies prevented per 1,000 method users served by publicly supported providers to the number of women served in 2016. These results represent the hypothetical number of pregnancies that would have occurred in the absence of publicly supported care.

- Women who obtained contraceptives from publicly supported providers in 2016 were able to delay or avoid nearly two million pregnancies (Tables 13 and 14, pages 38 and 39 and Figure 5, page 19). More than 936,000 of those pregnancies would have resulted in births and 673,000 would have resulted in abortion; the remainder would have resulted in miscarriage.
- Publicly funded clinics alone were responsible for helping women delay or avoid more than 1.3 million pregnancies in 2016, while private providers serving Medicaid recipients helped nearly 683,000 women delay or avoid pregnancy.
- Title X-funded clinics accounted for the large majority of this benefit, helping women delay or avoid 755,000 pregnancies in 2016 (Table 15, page 40). Clinics supported by other (non-Title X) public funds helped women delay or avoid 550,000 pregnancies (Table 16, page 41).
- Publicly supported contraceptive services helped more than 500,000 adolescents avoid or postpone becoming pregnant in 2016. Title X-funded clinics helped adolescents avoid 173,000 pregnancies; clinics supported by

other (non-Title X) public funds helped adolescents avoid or postpone 149,000 pregnancies; and private providers who served adolescents on Medicaid helped adolescents avoid 187,000 of these pregnancies (Table 17, page 42).

### Benefits from STI testing

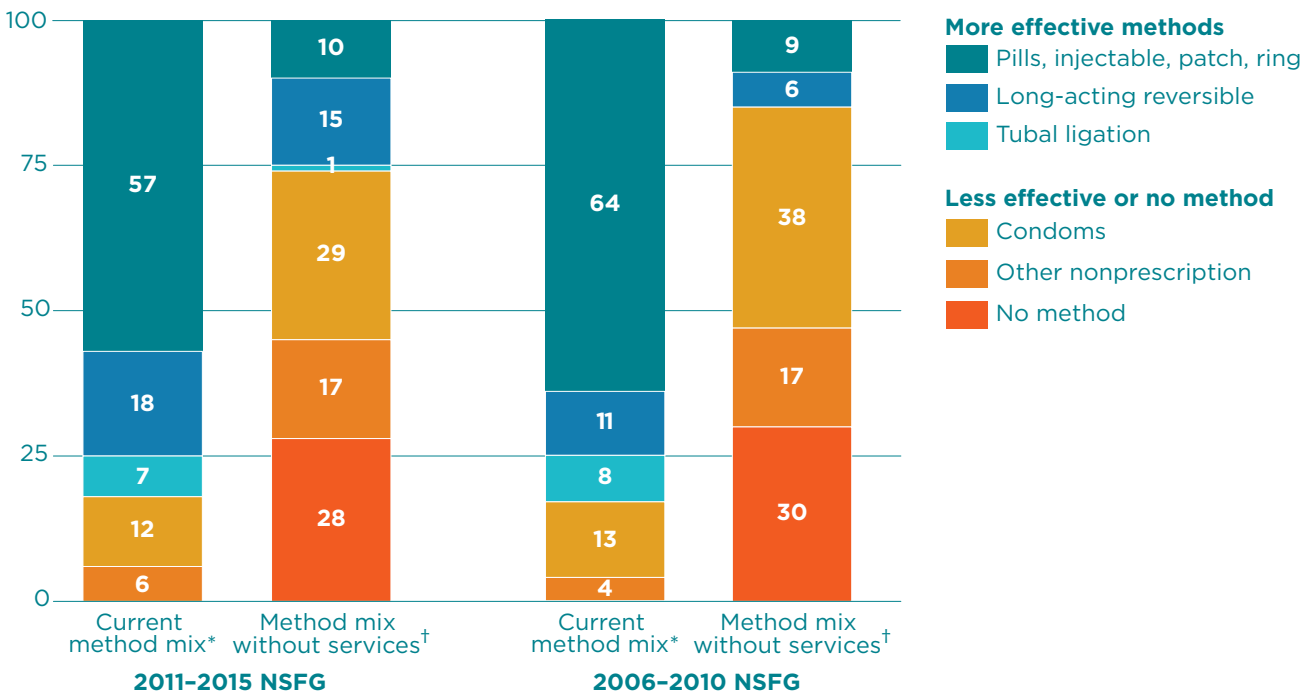
Screening for STIs, including chlamydia and gonorrhea, is an integral component of reproductive health services that is offered by 98% of publicly funded family planning clinics.<sup>28</sup> Chlamydia and gonorrhea are two of the most common STIs in the United States: An estimated 2.9 million new chlamydia infections and 820,000 new gonorrhea infections occur each year.<sup>40</sup> If left untreated, such infections can lead to a host of adverse health outcomes, including PID, infertility, ectopic pregnancy, and chronic pelvic pain in women and epididymitis in men.<sup>41</sup> HIV testing is frequently provided during family planning visits; it is offered at 94% of health centers that provide publicly supported family planning services.<sup>28</sup> It is also a preventive

FIGURE 4

#### COMPARING METHOD USE ACROSS SCENARIOS

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

% of women according to contraceptive method use



\*Method mix among women who received publicly supported contraceptive services in last 12 months.  
 †Hypothetical method mix among similar women if no publicly supported services were available.  
 NOTE: NSFG=National Survey of Family Growth.

care service for partners of individuals who learn they are HIV-positive, because it can lead to less risky behavior after a positive test result and reduced infectivity (via earlier entry into treatment for people living with HIV<sup>38</sup>), both of which significantly decrease transmission. Details for these benefits separated by type of provider can be found in Tables 13–16.

- Approximately half of all women who made a publicly funded family planning visit in 2016 received a chlamydia test; half were tested for gonorrhea and one-quarter were tested for HIV. Among men who made a publicly funded family planning visit in 2016, more than half were tested for HIV (data not shown).
- Without access to publicly funded care for family planning services, the majority of these women (72%, or some 6.7 million women) would have forgone screening for chlamydia, gonorrhea or HIV, resulting in tens of thousands of undetected and untreated STIs.
- By identifying and treating these infections, future infections among the partners of patients can be prevented. An estimated 100,000 chlamydia infections, 18,000 gonorrhea infections and 800 HIV infections were prevented among the partners of patients in 2016 (Tables 13 and 14).
- Among the patients themselves, early treatment for those testing positive for chlamydia or gonorrhea helped to prevent more than 12,000 cases of PID, which would have resulted in more than 1,000 ectopic pregnancies and 2,000 women becoming infertile.

## Benefits from cervical cancer testing and prevention

Incidence of and mortality due to cervical cancer in the United States has been declining steadily since at least the late 1990s.<sup>42</sup> However, in 2015, more than 12,000 women were diagnosed with cervical cancer and about 4,000 died from the disease. Annual health care costs of screening, treating and managing cervical cancer and related abnormalities nationally have been estimated to be as high as \$4.6 billion as of 2008, the most recent year for which data are available.<sup>43</sup> Because providers of contraceptive services often provide gynecologic care that can identify and help reduce the risk of cervical cancer, we examined the impact of two services they provide—Pap and HPV testing and HPV vaccination—on the number of cases of cervical cancer and related deaths prevented. Details for these benefits separated by type of provider can be found in Tables 13–16.

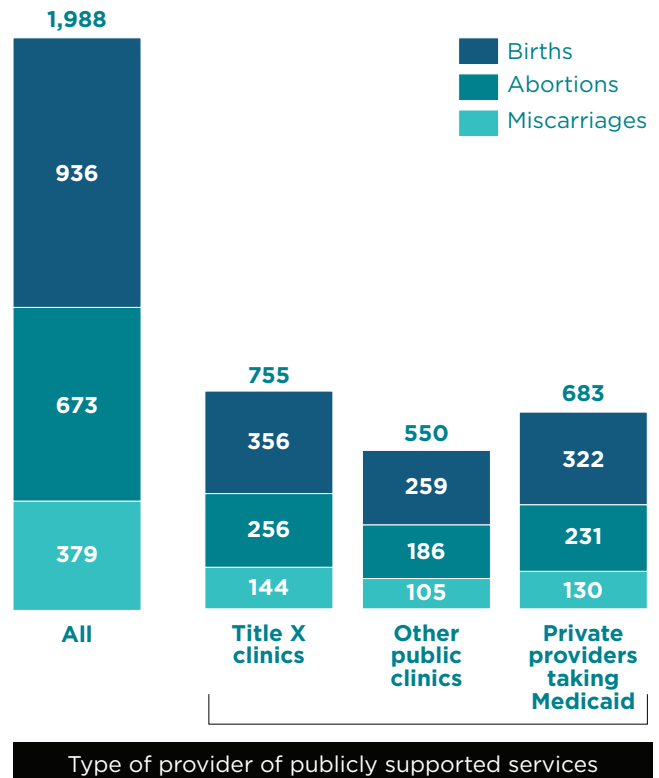
- In 2016, an estimated 1.8 million women receiving publicly supported contraceptive services also received cervical cancer testing (data not shown). Without

FIGURE 5

### PREGNANCY PREVENTION

**In 2016, publicly supported contraceptive services helped women postpone or avoid nearly two million pregnancies.**

No. of pregnancies avoided, by outcome prevented:



NOTE: Segments may not add to totals because of rounding.

publicly supported contraceptive services, an estimated 1.3 million women would have forgone or postponed cervical cancer testing that year.

- An estimated 1,860 potential cervical cancer cases were identified by this testing and treated before cancer developed, and 850 cervical cancer deaths were prevented (Table 13).
- In 2016, about 39,000 adolescent and young adult women received at least one dose of the HPV vaccine while receiving publicly supported contraceptive services (data not shown).
- HPV vaccinations provided by publicly supported providers in 2016 helped their patients avoid an estimated 4,590 cases of abnormal cervical cells, 920 cases of precancerous lesions, 50 cases of cervical cancer and 40 cases of other HPV-associated cancers, such as anal or vulvar cancer. An estimated 20 cervical cancer deaths were prevented (Tables 13 and 14).

## Cost savings

We estimated the total medical costs for services and treatments attributable to the outcomes prevented by publicly supported family planning visits, as well as the share of these costs that would have been paid for with public funds, primarily Medicaid and Medicare. Only public costs and savings are presented. In addition, our estimates include only the public cost savings for services provided to patients (or their partners) who, in the absence of publicly supported care, would have used a less effective mix of contraceptive methods or would have delayed obtaining other preventive care services. Details for cost savings separated by type of provider can be found in Tables 13 and Tables 18–20, pages 43–45.

- Without publicly supported contraceptive services in 2016, the resulting pregnancies would have cost an estimated \$14.3 billion in Medicaid-covered maternity and infant care and in medical care for young children through five years old (Tables 13 and 18). An additional \$418,000 would have been spent on care for miscarriages and ectopic pregnancies.
- In addition, an estimated \$273 million in cost savings was attributable to STI and HIV testing during family planning visits in 2016.
- An estimated \$14.5 million in cost savings was attributable to HPV sequelae being identified and treated earlier because of testing for cervical cancer (\$12.4 million) or prevented because of vaccines (\$2.0 million).
- Collectively, publicly supported family planning services resulted in an estimated total of \$15.0 billion in gross federal and state government savings in 2016.

## Net savings

We estimated the net public cost savings from publicly supported contraceptive services and related care provided during family planning visits as the difference between total gross public savings and the public cost of providing family planning services. The latter was estimated using information on the per-patient public revenues used to support family planning services at Title X–funded clinics. It is worth noting that this estimate rose considerably since our last report, from an estimated \$239 per patient in 2010 to an estimated \$316 per patient in 2016. The increase in the public cost of providing contraceptive services was not met with a similar increase in the cost savings generated per patient, resulting in slightly lower net savings compared with our analysis of 2010 data.

- The total public costs associated with providing family planning services in 2016 were estimated to be \$3.1 billion.
- Subtracting these costs from the estimated \$15.0 billion in gross public savings results in an estimated total net

public savings of \$11.9 billion in 2016.

- An estimated \$7.7 billion of the total net savings was attributable to services provided by all publicly supported clinics, \$4.4 billion of which resulted from services provided at Title X–funded clinics. Another \$4.2 billion was attributable to the Medicaid-funded family planning services provided by private physicians.
- Overall, by providing patients with services to prevent or delay pregnancies and to protect against reproductive cancers and STIs, publicly funded family planning services resulted in an estimated savings of \$4.83 for every public dollar invested.

## Discussion

**Overall trends in likely need and women served.** Since 2010, the number of U.S. women who likely need public support for contraceptive services and supplies increased from 19.1 million to 20.7 million, an 8% rise. This increase can be attributed primarily to an increase in the proportion of adult women whose family income is below 250% of FPL—a trend that largely mirrors growing income disparities in the United States over the period,<sup>44</sup> which intensified during the recession and left lasting economic consequences for women and their families. Over the same period, the number of women who received publicly supported contraceptive care remained virtually the same, resulting in a drop in the proportion of women with likely need for publicly supported care who were served (49% to 45%).

While this trend suggests that access to publicly supported contraceptive care has declined, there may be unmeasured factors, such as use of private insurance or over-the-counter contraceptives, that women are relying on to meet their reproductive goals. In fact, among women who are able to conceive, have had recent sex and are not pregnant or trying to get pregnant, 9 in 10 are using some form of contraception.<sup>45</sup> However, the high level of contraceptive use does not necessarily mean that what women see as their own needs are being fully met. Some women who are using nonprescription methods, such as condoms, may not be using the method they would ideally use if they had better access to publicly supported care and could choose from a wide range of methods. In addition, women who rely on nonprescription contraceptive methods because they are unable to access publicly supported care may also forgo cancer or STI screenings that they would have wanted. Publicly supported family planning helps people more fully access and afford the services they want, in order to meet what they see as their own needs.

**Network changes in publicly supported contraceptive care.** Between 2010 and 2016, the number of U.S. women receiving publicly supported contraceptive care from all provider types remained virtually unchanged at just over nine million. However, stability in the overall national numbers served masks unprecedented change in where U.S. women receive publicly supported contraceptive care. The share of all women served who went to Title X–supported clinics fell from 50% in 2010 to 38% in 2016. In contrast, the share of

women served by other (non–Title X) publicly supported clinics rose from 21% to 28% and the share of women served by private providers rose from 29% to 34%.

Many competing factors are likely contributors to change in the publicly supported provider network and key among these are shifting public funding streams. Between 2010 and 2016, federal appropriations to the Title X program fell from \$317 million to \$286 million;<sup>46</sup> this was a 10% drop in unadjusted dollars, but a decrease of 25% when adjusted for inflation using the consumer price index for medical care. Also, in many states and communities, shrinking state budgets, as well as targeted reductions in funding for specific programs or grantees, have led to clinic closures and reductions in clinic services, especially among Title X–funded sites.

In contrast, federal appropriations for community health centers, authorized under Section 330 of the Public Health Services Act, more than doubled during this period, from \$2.4 billion in 2010 to \$5.1 billion in 2016.<sup>47</sup> These funding increases are important for understanding the rise in both the number of FQHCs providing contraceptive care and the numbers of contraceptive patients served. Between 2010 and 2015, the number of FQHCs providing contraceptive services increased from 3,165 to 5,829, an 84% increase; the numbers of contraceptive patients served rose 78%.<sup>1</sup> Currently, approximately half of all women receiving contraceptive care from non–Title X publicly supported clinics receive services from FQHCs. The vast majority of FQHC sites serve a disproportionately small number of contraceptive patients per year (320 compared with an average of 580 for all clinics and nearly 3,000 for Planned Parenthood clinics), and they often do not provide patients with a full range of contraceptive method choices.<sup>28</sup>

Also, implementation of the ACA has decreased the number of low-income women who are uninsured, with many more women now eligible for and covered by Medicaid, particularly in states that implemented a Medicaid expansion under the ACA. Increases in the proportions of low-income women covered by public health insurance coincided with increases in the numbers of Medicaid recipients who received publicly supported contraceptive care from private providers, which rose 19% between 2010 and 2016. Among adolescents who likely need public support for contraceptive care, the shift away from clinics and toward use of private providers appears to be due both to increased numbers being covered by

and using public insurance (Children's Health Insurance Program/Medicaid) and to an increased willingness or ability of these patients to use their private health insurance to cover contraceptive visits at private providers.<sup>48</sup>

Further research is needed to fully understand the factors related to the changes in where women go for publicly supported contraceptive care and the consequences of these changes. The federal Title X family planning program remains critical to the provision of clinic-based contraceptive care. And, although there has been a significant decline in the number of patients served at Title X-funded clinics, these sites continue to serve more women than either clinics not funded by Title X or private providers serving Medicaid recipients. Moreover, despite funding cuts, individual Title X-funded clinics typically serve more contraceptive patients per year than do other clinics.<sup>28</sup> They offer their patients a greater variety of contraceptive methods, do more to facilitate method initiation and consistent method use, are more likely to advise patients about contraceptives during annual gynecologic visits, and spend more time counseling patients about contraception and sexual health.<sup>28,49,50</sup> In comparison, women who receive care from clinics that do not receive Title X funding are typically provided with a more limited choice of contraceptive options or a more limited scope of reproductive health care services. Given the increasing importance of these providers in serving women's contraceptive and reproductive health needs, it is important that they receive support and guidance in how to better meet the full scope of what women want from a contraceptive service provider. Notably, the federal government has played an important role in creating guidelines for the provision of quality family planning services<sup>51</sup> that can be used by both public and private providers to ensure that best practices are followed by all contraceptive service providers.

### **Impact of publicly supported contraceptive care.**

Numerous health benefits accrue to women and their families when women are provided with the contraceptive and reproductive health services they desire. Key among these benefits is the prevention of pregnancies that women wish to postpone or avoid. Overall, in 2016, women obtaining publicly supported contraceptive services were able to avoid or postpone nearly two million pregnancies. These same women and their partners were able to avoid thousands, and in some cases tens of thousands, of STI infections, PID and cancers because of the care received during publicly supported family planning visits.

By helping women determine for themselves whether and when to have children and providing them with related health services, publicly supported providers generate benefits for both women and their families, as well as for society more broadly through government cost savings.

These benefits accrue because the vast majority of patients who would have become pregnant or who would need treatment for STIs, HIV and cancer would be eligible for Medicaid coverage and their medical expenses would be paid for from public funds. On average, in 2016, we estimate that serving each contraceptive patient cost \$316 in public funds; in comparison, \$22,122 was spent on each Medicaid-funded birth (including prenatal care, delivery, postpartum care, and infant and child medical care through 60 months) and hundreds of thousands were spent on each patient needing HIV or cancer treatment. After accounting for the estimated public costs for all events prevented and subtracting the public costs to provide family planning services, we estimate that in 2016, all publicly supported providers generated a total of nearly \$12 billion in net government savings. This translates to an estimated \$4.83 saved for every \$1 spent on contraceptive care for women who want this service, but are unable to afford it on their own.

Measurement of these health benefits and their cost savings follows the same methodology as in past reports and has a number of limitations. Many of these are explained in detail in a previous publication<sup>21</sup> and in the Methodological Appendix. Throughout the analysis, we have tried to use the best available parameters from published literature to model the broader impact of services, and to follow the more conservative calculation option whenever multiple options were available. It is important to note that neither the health benefits nor the cost savings estimated in this analysis represent the complete impact of the U.S. family planning effort. For example, no benefits are estimated for many common services, including counseling and education, breast exams or screening for high blood pressure; the analysis also does not extend beyond medical benefits and cost savings.

There are some important differences in the results presented here compared with our 2010 analysis. Although the numbers of events averted and their cost savings were substantial in 2016, the relative estimates of events averted per patient served and the cost savings were lower than in our analysis for 2010 (293 vs. 350 pregnancies prevented per 1,000 contraceptive users and \$4.83 vs. \$7.09 saved per dollar spent). The main reasons behind these changes include:

- A decline (14%) in the estimated number of pregnancies prevented per 1,000 contraceptive patients served that was, in part, due to the fact that women in our hypothetical group who would have lost access to publicly supported services would be more likely to continue to use LARC methods and therefore have fewer expected pregnancies in the absence of receiving care.
- A decline (36%) in cost savings from Pap and HPV testing and vaccines due to fewer women being tested

under the revised testing protocols and also because the time from testing to cancer diagnosis is increasing, likely because of the HPV vaccine.

- A minimal increase (7%) in the estimated cost per Medicaid-covered birth (\$20,720 to \$22,122 for maternity, infant and child care to 60 months) that is likely due to measurement differences in maternity costs between 2010 and 2014. In each year, we used the most reliable estimates available, but as they came from different studies, the change over time represents a smaller change than is typical for medical care.
- A 32% increase in the per-patient cost of providing publicly supported services (\$239 to \$316). This is likely due to the increased costs necessary to provide quality family planning services, such as for LARC methods and for better screening technologies, and to serve an increasingly diverse patient population, more of whom may need language translation or other services.

In some cases, the changes in expected outcomes in the absence of care represent benefits received by women who have used publicly supported services in the past that extend for longer than one year, continuing to improve their health outcomes even without access to ongoing care. For example, the benefits of having received a LARC method or an HPV vaccine from a publicly supported provider in the past may extend to women who are not current users of publicly supported services. These are public health success stories and illustrate an unmeasured impact of publicly supported contraceptive care that extends the reach of these services. If we were able to properly measure the longer term impact of all services and ensure that such benefits did not dilute our measurement of outcomes in the absence of services, then the full range of benefits of publicly funded family planning to individuals and society would likely be even greater than what we have presented here.

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TABLE 1

**Number of women who likely need public support for contraceptive services and supplies, by age-group, income level, and race and ethnicity, and percentage change between years—2000, 2010 and 2016**

Year	Total	By age-group			By income level, % of FPL (among those aged 20–44)		By race and ethnicity			
		<20	20–29	30–44	<100%	100–249%	Non-Hispanic white	Non-Hispanic black	Hispanic	Other
<b>Women who likely need public support for contraceptive services and supplies (in 000)*</b>										
<b>2000</b>	16,396	4,850	6,747	4,799	4,076	7,470	9,193	2,898	3,128	1,177
<b>2010</b>	19,144	4,881	8,443	5,820	5,576	8,688	9,559	3,380	4,587	1,618
<b>2016</b>	20,647	4,636	9,399	6,613	6,245	9,766	10,063	3,727	5,107	1,751
<b>% change 2000–2010</b>	17	1	25	21	37	16	4	17	47	37
<b>% change 2010–2016</b>	8	–5	11	14	12	12	5	10	11	8

\*Women who likely need public support for contraceptive services and supplies during a given year include adult women whose family income is below 250% of the federal poverty level and adolescents (younger than 20) of all income levels. In addition, women are included based on their potential to demand contraceptive services and supplies at some point during the year—those who have ever had voluntary sex, believe that they could conceive, and are not pregnant nor trying to get pregnant during the entire year. *Note:* FPL=federal poverty level. *Source:* See Table Notes box.

TABLE 2

**Number of women who likely need public support for contraceptive services and supplies, by age-group and income level—2010 and 2016 national summary, and 2016 state detail**

State	Women who likely need public support for contraceptive services and supplies						
	Total	By age-group (among those younger than 20)		By income level as % of FPL (among those aged 20–44)			
		<18	18–19	<100%	100–137%	138–199%	200–249%
<b>2010 total</b>	<b>19,144,100</b>	<b>2,075,640</b>	<b>2,805,240</b>	<b>5,575,570</b>	<b>2,229,050</b>	<b>3,686,590</b>	<b>2,772,220</b>
<b>2016 total</b>	<b>20,647,260</b>	<b>2,027,010</b>	<b>2,609,180</b>	<b>6,244,630</b>	<b>2,583,990</b>	<b>4,069,970</b>	<b>3,112,490</b>
<b>% change 2010–2016</b>	<b>8</b>	<b>-2</b>	<b>-7</b>	<b>12</b>	<b>16</b>	<b>10</b>	<b>12</b>
Alabama	351,220	33,810	40,390	120,940	44,460	63,250	48,360
Alaska	39,770	3,900	5,530	9,310	5,420	8,370	7,240
Arizona	465,750	41,630	56,640	143,500	61,450	91,650	70,870
Arkansas	223,810	19,370	27,340	68,970	32,560	44,420	31,160
California	2,526,010	221,670	305,760	748,320	334,600	524,850	390,800
Colorado	334,150	33,540	43,140	87,270	42,250	69,350	58,600
Connecticut	180,670	23,050	31,950	45,270	21,210	32,370	26,820
Delaware	54,050	6,060	7,660	16,480	5,580	9,890	8,380
District of Columbia	49,390	2,980	7,060	18,800	5,290	8,650	6,610
Florida	1,329,300	114,480	145,780	382,530	181,490	290,520	214,500
Georgia	741,940	73,520	90,040	236,740	88,630	146,250	106,770
Hawaii	66,120	5,440	8,050	17,400	6,710	14,910	13,610
Idaho	116,180	12,350	13,790	32,020	15,690	24,770	17,550
Illinois	779,490	83,910	100,420	241,460	92,490	144,640	116,560
Indiana	457,150	46,050	56,450	143,580	54,160	88,060	68,840
Iowa	195,480	20,510	28,430	58,720	24,080	35,440	28,300
Kansas	186,150	19,190	25,570	52,410	22,970	36,320	29,700
Kentucky	307,010	28,860	37,570	104,450	37,990	57,660	40,490
Louisiana	345,760	32,530	37,250	123,170	47,380	61,750	43,670
Maine	74,070	7,820	10,340	21,930	9,390	12,880	11,700
Maryland	308,590	39,530	46,560	80,480	32,830	58,080	51,120
Massachusetts	359,770	41,180	63,120	104,860	37,730	60,850	52,020
Michigan	649,310	68,420	79,030	214,680	79,790	117,860	89,540
Minnesota	300,810	35,910	42,760	78,910	36,170	58,030	49,020
Mississippi	233,270	21,270	28,080	82,150	29,650	42,380	29,740
Missouri	403,790	39,610	50,830	125,560	46,660	80,230	60,900
Montana	66,600	6,100	7,520	19,500	9,670	13,130	10,690
Nebraska	123,070	12,470	16,520	35,720	14,160	24,820	19,370
Nevada	193,020	17,120	19,160	52,550	26,030	43,770	34,400
New Hampshire	64,970	8,310	11,260	16,330	6,120	12,060	10,900
New Jersey	431,170	56,130	64,850	110,070	53,270	81,510	65,340
New Mexico	151,130	11,650	17,060	49,810	21,160	30,200	21,250
New York	1,179,070	115,720	157,140	376,850	142,090	219,100	168,180
North Carolina	720,450	66,720	86,400	225,810	92,660	143,540	105,320
North Dakota	47,140	4,130	6,890	13,750	5,030	8,990	8,350
Ohio	751,340	79,600	92,010	245,580	88,990	141,410	103,760
Oklahoma	278,850	24,200	31,640	87,230	36,910	57,840	41,050
Oregon	270,540	23,420	29,710	84,490	35,400	55,090	42,430
Pennsylvania	735,170	79,870	106,100	213,310	86,520	133,850	115,520
Rhode Island	65,990	6,290	10,770	19,300	7,030	11,660	10,930
South Carolina	351,550	31,800	41,780	110,700	44,140	73,560	49,570
South Dakota	53,510	5,150	7,240	16,460	6,060	9,570	9,030
Tennessee	466,350	44,400	51,950	148,900	58,740	94,610	67,750
Texas	1,950,990	184,090	237,280	582,510	256,600	402,250	288,270
Utah	213,270	24,010	28,600	51,670	24,710	45,360	38,930
Vermont	35,650	3,760	6,170	8,460	4,440	6,910	5,900
Virginia	480,930	51,810	71,660	135,390	52,980	89,320	79,770
Washington	432,940	41,660	52,300	125,110	54,110	89,500	70,260
West Virginia	117,990	11,130	13,360	43,960	13,520	20,440	15,570
Wisconsin	351,580	37,450	47,500	101,110	42,980	71,430	51,100
Wyoming	34,960	3,440	4,780	10,130	4,030	6,620	5,950

Note: FPL=federal poverty level. Source: See Table Notes box.

TABLE 3

**Number of women who likely need public support for contraceptive services and supplies, by race and ethnicity,\* age-group and income—2010 and 2016 national summary, and 2016 state detail**

State	Women who likely need public support for contraceptive services and supplies								
	Non-Hispanic white			Non-Hispanic black			Hispanic		
	Total	Aged <20	Aged 20–44 and <250% of FPL	Total	Aged <20	Aged 20–44 and <250% of FPL	Total	Aged <20	Aged 20–44 and <250% of FPL
<b>2010 total</b>	<b>9,558,360</b>	<b>2,700,330</b>	<b>6,858,540</b>	<b>3,379,360</b>	<b>860,480</b>	<b>2,517,900</b>	<b>4,587,240</b>	<b>929,630</b>	<b>3,656,820</b>
<b>2016 total</b>	<b>10,062,630</b>	<b>2,611,200</b>	<b>7,451,430</b>	<b>3,726,600</b>	<b>724,660</b>	<b>3,001,940</b>	<b>5,107,260</b>	<b>981,850</b>	<b>4,125,410</b>
<b>% change 2010–2016</b>	<b>5</b>	<b>–3</b>	<b>9</b>	<b>10</b>	<b>–16</b>	<b>19</b>	<b>11</b>	<b>6</b>	<b>13</b>
Alabama	184,860	44,510	140,350	136,500	24,010	112,490	17,990	3,400	14,590
Alaska	19,980	5,370	14,610	1,740	440	1,300	4,140	810	3,340
Arizona	181,020	44,590	136,430	25,160	5,160	19,990	207,770	40,320	167,450
Arkansas	140,190	31,230	108,960	50,790	9,220	41,570	22,470	4,440	18,020
California	630,140	161,870	468,270	170,290	34,530	135,760	1,366,050	263,760	1,102,300
Colorado	186,770	47,080	139,690	17,410	3,540	13,880	105,270	21,600	83,670
Connecticut	86,370	35,030	51,340	30,400	6,700	23,690	50,440	10,140	40,300
Delaware	26,320	7,560	18,760	16,310	3,860	12,450	8,020	1,530	6,490
District of Columbia	12,700	2,990	9,720	27,700	5,540	22,150	5,990	1,010	4,980
Florida	531,220	120,950	410,280	322,630	57,930	264,700	410,370	70,220	340,150
Georgia	303,180	77,600	225,580	308,460	61,270	247,190	89,080	17,020	72,070
Hawaii	13,940	2,310	11,630	1,510	340	1,170	10,800	2,280	8,520
Idaho	88,360	20,780	67,580	940	250	700	20,610	4,090	16,530
Illinois	363,670	102,260	261,410	174,260	32,690	141,580	187,430	39,230	148,200
Indiana	323,770	77,560	246,200	65,630	11,880	53,750	42,870	8,730	34,140
Iowa	152,930	40,280	112,650	13,120	2,420	10,700	16,860	3,950	12,910
Kansas	123,820	31,960	91,860	15,470	3,080	12,390	32,460	6,920	25,540
Kentucky	244,470	54,710	189,760	36,140	6,750	29,390	14,080	2,650	11,420
Louisiana	156,010	36,550	119,460	157,640	27,980	129,650	19,020	3,030	15,980
Maine	66,770	16,530	50,230	2,050	460	1,580	1,780	430	1,350
Maryland	120,450	40,890	79,560	119,180	30,090	89,090	43,070	8,750	34,320
Massachusetts	203,650	72,820	130,830	39,660	9,060	30,600	76,370	14,490	61,890
Michigan	420,410	104,690	315,720	138,670	24,740	113,940	46,130	9,750	36,380
Minnesota	204,040	60,130	143,900	34,500	6,600	27,900	26,590	5,570	21,020
Mississippi	99,180	24,400	74,780	120,030	22,430	97,600	7,840	1,400	6,450
Missouri	287,590	68,780	218,810	71,100	13,130	57,980	22,590	4,690	17,900
Montana	53,540	11,520	42,020	220	60	160	3,650	700	2,950
Nebraska	84,590	21,940	62,650	9,370	1,690	7,690	20,350	3,920	16,430
Nevada	69,040	14,490	54,550	23,560	3,960	19,610	75,570	14,210	61,360
New Hampshire	55,130	17,530	37,600	1,530	360	1,170	3,890	870	3,010
New Jersey	161,980	65,210	96,770	86,890	19,560	67,330	141,030	26,170	114,860
New Mexico	39,480	7,960	31,510	2,710	560	2,150	86,130	17,140	68,990
New York	492,560	146,780	345,780	222,170	47,860	174,310	316,320	56,330	259,990
North Carolina	365,500	87,290	278,210	213,180	40,270	172,910	94,370	17,440	76,920
North Dakota	35,850	9,250	26,610	2,520	330	2,190	2,540	460	2,080
Ohio	524,810	130,320	394,490	146,910	26,190	120,720	38,110	7,630	30,480
Oklahoma	156,490	33,550	122,940	29,970	5,520	24,450	39,370	7,730	31,640
Oregon	182,920	37,150	145,770	6,940	1,360	5,580	52,430	10,070	42,360
Pennsylvania	469,440	134,640	334,800	126,840	25,330	101,500	90,830	16,720	74,110
Rhode Island	38,480	11,560	26,920	5,670	1,320	4,350	16,280	3,080	13,200
South Carolina	177,980	42,490	135,480	134,540	24,080	110,460	25,010	4,460	20,550
South Dakota	38,280	9,990	28,280	1,480	250	1,230	2,650	530	2,130
Tennessee	300,540	66,510	234,020	114,140	20,720	93,420	33,010	5,790	27,220
Texas	571,540	151,450	420,090	297,730	58,830	238,890	978,120	191,590	786,530
Utah	153,770	41,320	112,460	2,800	630	2,180	39,330	7,960	31,370
Vermont	31,580	9,000	22,580	670	230	440	940	270	680
Virginia	250,110	72,720	177,390	129,640	28,550	101,100	61,100	12,560	48,540
Washington	256,610	60,720	195,890	22,980	4,410	18,570	85,210	16,860	68,350
West Virginia	106,320	22,220	84,090	5,640	1,090	4,560	2,600	470	2,130
Wisconsin	246,230	65,350	180,880	40,760	7,330	33,430	38,140	7,670	30,470
Wyoming	28,060	6,780	21,290	450	60	390	4,180	1,000	3,180

\*Women of other or multiple races are excluded here. Note: FPL=federal poverty level. Source: See Table Notes box.

TABLE 4

**Number of women who likely need public support for  
contraceptive services and supplies, and percentage change  
between 2010 and 2016—national summary and state detail,  
2000, 2010 and 2016**

State	Women who likely need public support for contraceptive services and supplies			
	2000	2010	2016	% change 2010–2016
<b>Total</b>	<b>16,396,050</b>	<b>19,144,100</b>	<b>20,647,260</b>	<b>8</b>
Alabama	275,750	320,280	351,220	10
Alaska	32,230	37,400	39,770	6
Arizona	314,600	429,830	465,750	8
Arkansas	165,250	198,090	223,810	13
California	2,110,740	2,472,310	2,526,010	2
Colorado	229,000	307,160	334,150	9
Connecticut	161,100	175,950	180,670	3
Delaware	39,760	50,450	54,050	7
District of Columbia	41,260	44,560	49,390	11
Florida	848,380	1,116,280	1,329,300	19
Georgia	472,120	648,120	741,940	14
Hawaii	61,390	67,880	66,120	–3
Idaho	80,360	112,370	116,180	3
Illinois	694,420	767,110	779,490	2
Indiana	357,070	422,430	457,150	8
Iowa	168,760	182,930	195,480	7
Kansas	157,410	177,400	186,150	5
Kentucky	240,430	273,030	307,010	12
Louisiana	309,360	310,720	345,760	11
Maine	78,700	77,520	74,070	–4
Maryland	243,480	277,170	308,590	11
Massachusetts	333,710	351,830	359,770	2
Michigan	562,410	623,060	649,310	4
Minnesota	253,250	287,010	300,810	5
Mississippi	194,380	213,460	233,270	9
Missouri	342,080	387,790	403,790	4
Montana	54,990	60,200	66,600	11
Nebraska	102,430	110,640	123,070	11
Nevada	110,030	172,670	193,020	12
New Hampshire	62,840	63,840	64,970	2
New Jersey	395,100	414,670	431,170	4
New Mexico	127,390	144,920	151,130	4
New York	1,195,150	1,187,850	1,179,070	–1
North Carolina	455,030	619,570	720,450	16
North Dakota	41,810	42,290	47,140	11
Ohio	657,860	710,200	751,340	6
Oklahoma	217,250	241,450	278,850	15
Oregon	196,920	251,590	270,540	8
Pennsylvania	715,330	734,640	735,170	0
Rhode Island	66,370	66,060	65,990	0
South Carolina	244,440	307,870	351,550	14
South Dakota	47,370	50,600	53,510	6
Tennessee	331,390	410,670	466,350	14
Texas	1,303,550	1,690,150	1,950,990	15
Utah	147,120	198,200	213,270	8
Vermont	37,550	35,560	35,650	0
Virginia	365,760	421,280	480,930	14
Washington	318,990	401,600	432,940	8
West Virginia	110,200	110,870	117,990	6
Wisconsin	294,440	332,520	351,580	6
Wyoming	29,340	32,050	34,960	9

Source: See Table Notes box.

TABLE 5

**Estimated number of women who likely need public support for contraceptive services and supplies who are uninsured and the percentage of women who are uninsured, both by age-group and income level—2010, 2013 and 2016 national summary and 2016 state detail**

State	Estimated no. of women who likely need public support for contraceptive services and supplies who are uninsured				% of women who are uninsured			
	Total	Aged <20	Income level, % of FPL (among those aged 20–44)		Total	Aged <20	Income level, % of FPL (among those aged 20–44)	
			<138%	138–249%			<138%	138–249%
<b>2010 Total</b>	5,756,800	746,700	3,079,100	1,931,000	30	15	39	30
<b>2013 Total</b>	5,590,770	540,700	3,174,090	1,875,980	28	11	36	28
<b>2016 Total</b>	3,603,370	339,460	2,033,500	1,230,410	17	7	23	17
<b>% change 2010–2013</b>	–3	–28	3	–3	na	na	na	na
<b>% change 2013–2016</b>	–36	–37	–36	–34	na	na	na	na
Alabama	70,430	4,650	45,540	20,240	20	6	28	18
Alaska	10,430	920	4,540	4,970	26	10	31	32
Arizona	79,630	11,520	42,640	25,460	17	12	21	16
Arkansas	35,370	3,950	20,300	11,110	16	8	20	15
California	354,590	29,880	190,570	134,130	14	6	18	15
Colorado	46,780	4,260	23,230	19,290	14	6	18	15
Connecticut	18,250	1,400	8,880	7,960	10	3	13	13
Delaware	5,950	270	2,750	2,930	11	2	12	16
District of Columbia	3,740	280	1,290	2,180	8	3	5	14
Florida	319,980	30,690	180,490	108,800	24	12	32	22
Georgia	198,510	18,650	119,440	60,420	27	11	37	24
Hawaii	5,670	730	2,920	2,020	9	5	12	7
Idaho	24,760	2,080	15,050	7,630	21	8	32	18
Illinois	103,130	7,950	59,360	35,810	13	4	18	14
Indiana	71,880	7,780	38,750	25,340	16	8	20	16
Iowa	15,050	1,670	8,380	5,000	8	3	10	8
Kansas	36,460	2,850	23,590	10,020	20	6	31	15
Kentucky	25,980	2,660	14,850	8,470	8	4	10	9
Louisiana	64,110	4,420	41,470	18,220	19	6	24	17
Maine	9,640	1,500	4,250	3,900	13	8	14	16
Maryland	41,270	4,390	19,960	16,920	13	5	18	15
Massachusetts	12,340	1,460	5,550	5,330	3	1	4	5
Michigan	63,230	4,660	35,650	22,930	10	3	12	11
Minnesota	28,860	2,420	14,400	12,040	10	3	13	11
Mississippi	53,350	4,650	35,050	13,650	23	9	31	19
Missouri	79,200	7,420	46,190	25,590	20	8	27	18
Montana	9,640	1,150	4,950	3,540	14	8	17	15
Nebraska	25,580	2,360	14,380	8,840	21	8	29	20
Nevada	41,340	4,150	22,800	14,390	21	11	29	18
New Hampshire	8,100	1,200	3,290	3,620	12	6	15	16
New Jersey	79,580	6,540	43,530	29,510	18	5	27	20
New Mexico	21,620	2,160	11,560	7,900	14	8	16	15
New York	128,150	11,160	68,290	48,700	11	4	13	13
North Carolina	160,080	11,530	95,360	53,200	22	8	30	21
North Dakota	8,200	1,090	4,720	2,400	17	10	25	14
Ohio	69,840	7,920	36,460	25,460	9	5	11	10
Oklahoma	76,450	7,380	42,940	26,130	27	13	35	26
Oregon	28,610	2,640	17,140	8,830	11	5	14	9
Pennsylvania	81,160	9,870	37,720	33,570	11	5	13	13
Rhode Island	4,720	530	2,350	1,840	7	3	9	8
South Carolina	67,670	5,250	41,240	21,190	19	7	27	17
South Dakota	8,220	1,070	5,800	1,340	15	9	26	7
Tennessee	77,270	5,690	45,780	25,800	17	6	22	16
Texas	693,300	72,310	404,620	216,370	36	17	48	31
Utah	33,130	3,570	18,080	11,490	16	7	24	14
Vermont	1,500	60	600	840	4	1	5	7
Virginia	96,540	9,430	51,690	35,410	20	8	27	21
Washington	52,700	3,870	27,480	21,350	12	4	15	13
West Virginia	8,270	350	4,930	2,990	7	1	9	8
Wisconsin	37,250	4,300	19,830	13,120	11	5	14	11
Wyoming	5,830	760	2,840	2,230	17	9	20	18

Note: FPL=federal poverty level. na=not applicable. Source: See Table Notes box.

TABLE 6

**Percentage, estimated number and percentage change in the number of women who likely need public support for contraceptive services and supplies who are uninsured, by state and state Medicaid expansion status under the Affordable Care Act—2013 and 2016**

State	Women who likely need public support for contraceptive services and supplies who are uninsured				% change 2013–2016
	2013 (%)	2016 (%)	2013 (No.)	2016 (No.)	
<b>Total</b>	<b>28</b>	<b>17</b>	<b>5,590,770</b>	<b>3,603,370</b>	<b>-36</b>
<b>Medicaid expansion states</b>	<b>25</b>	<b>13</b>	<b>3,046,510</b>	<b>1,529,700</b>	<b>-50</b>
Alaska	35	26	14,660	10,430	-29
Arizona	31	17	142,030	79,630	-44
Arkansas	31	16	62,320	35,370	-43
California	31	14	834,810	354,590	-58
Colorado	27	14	87,750	46,780	-47
Connecticut	19	10	34,730	18,250	-47
Delaware	18	11	9,850	5,950	-40
District of Columbia	11	8	4,910	3,740	-24
Hawaii	14	9	9,840	5,670	-42
Illinois	23	13	182,540	103,130	-44
Indiana	27	16	117,200	71,880	-39
Iowa	17	8	30,620	15,050	-51
Kentucky	29	8	81,230	25,980	-68
Louisiana	32	19	102,530	64,110	-37
Maryland	20	13	59,560	41,270	-31
Massachusetts	7	3	26,220	12,340	-53
Michigan	20	10	128,290	63,230	-51
Minnesota	15	10	45,420	28,860	-36
Montana	30	14	19,350	9,640	-50
Nevada	38	21	70,880	41,340	-42
New Hampshire	23	12	14,570	8,100	-44
New Jersey	30	18	129,320	79,580	-38
New Mexico	35	14	51,570	21,620	-58
New York	19	11	229,710	128,150	-44
North Dakota	19	17	8,700	8,200	-6
Ohio	20	9	143,860	69,840	-51
Oregon	28	11	75,120	28,610	-62
Pennsylvania	20	11	150,630	81,160	-46
Rhode Island	23	7	14,740	4,720	-68
Vermont	11	4	4,080	1,500	-63
Washington	30	12	127,940	52,700	-59
West Virginia	28	7	31,530	8,270	-74
<b>States without a Medicaid expansion</b>	<b>32</b>	<b>25</b>	<b>2,544,250</b>	<b>2,073,660</b>	<b>-18</b>
Alabama	28	20	89,250	70,430	-21
Florida	36	24	438,510	319,980	-27
Georgia	35	27	240,510	198,510	-17
Idaho	30	21	34,000	24,760	-27
Kansas	26	20	46,920	36,460	-22
Maine	19	13	15,680	9,640	-39
Mississippi	30	23	68,450	53,350	-22
Missouri	26	20	101,660	79,200	-22
Nebraska	22	21	25,650	25,580	0
North Carolina	30	22	198,330	160,080	-19
Oklahoma	33	27	83,880	76,450	-9
South Carolina	30	19	94,640	67,670	-28
South Dakota	23	15	11,720	8,220	-30
Tennessee	25	17	105,310	77,270	-27
Texas	43	36	755,160	693,300	-8
Utah	26	16	54,730	33,130	-39
Virginia	26	20	115,450	96,540	-16
Wisconsin	16	11	54,860	37,250	-32
Wyoming	27	17	9,540	5,830	-39

Source: See Table Notes box.

TABLE 7

**Number of female patients receiving publicly supported contraceptive services from all provider types, national summary, and by state for publicly supported clinics—2001, 2010 and 2016**

State	Female patients at publicly supported providers				
	2001	2010	2016	% change 2001–2010	% change 2010–2016
<b>All publicly supported providers</b>	<b>8,341,920</b>	<b>9,384,850</b>	<b>9,272,700</b>	<b>13</b>	<b>-1</b>
<b>Private providers serving Medicaid enrollees</b>	<b>1,678,350</b>	<b>2,678,570</b>	<b>3,184,510</b>	<b>60</b>	<b>19</b>
<b>Publicly supported clinics</b>	<b>6,663,570</b>	<b>6,706,280</b>	<b>6,088,190</b>	<b>1</b>	<b>-9</b>
Alabama	113,310	115,460	97,600	2	-15
Alaska	24,530	23,500	21,640	-4	-8
Arizona	100,680	97,610	88,140	-3	-10
Arkansas	81,340	83,940	50,960	3	-39
California	1,014,890	1,529,820	1,618,010	51	6
Colorado	132,890	150,040	115,490	13	-23
Connecticut	70,560	74,170	68,130	5	-8
Delaware	20,600	24,180	16,080	17	-33
District of Columbia	19,140	24,220	43,600	27	80
Florida	266,100	295,180	214,450	11	-27
Georgia	199,840	154,060	194,910	-23	27
Hawaii	9,020	23,910	13,830	165	-42
Idaho	41,720	32,810	20,880	-21	-36
Illinois	206,340	200,180	190,230	-3	-5
Indiana	147,260	110,380	76,100	-25	-31
Iowa	69,230	83,930	52,150	21	-38
Kansas	57,660	50,290	34,380	-13	-32
Kentucky	133,450	104,330	69,620	-22	-33
Louisiana	82,810	65,130	71,050	-21	9
Maine	49,150	32,990	25,520	-33	-23
Maryland	82,230	89,170	97,980	8	10
Massachusetts	138,640	106,120	90,830	-23	-14
Michigan	233,810	156,420	105,650	-33	-32
Minnesota	103,880	92,410	76,550	-11	-17
Mississippi	121,240	83,200	52,870	-31	-36
Missouri	108,590	95,870	84,920	-12	-11
Montana	33,920	34,390	24,050	1	-30
Nebraska	35,170	32,600	29,960	-7	-8
Nevada	47,730	36,480	26,430	-24	-28
New Hampshire	30,680	23,900	18,950	-22	-21
New Jersey	129,630	145,740	117,930	12	-19
New Mexico	68,500	68,760	52,620	0	-23
New York	446,500	436,080	433,960	-2	0
North Carolina	194,250	164,450	116,640	-15	-29
North Dakota	16,010	18,580	10,790	16	-42
Ohio	201,040	156,880	153,080	-22	-2
Oklahoma	95,260	109,800	84,710	15	-23
Oregon	123,270	131,620	107,100	7	-19
Pennsylvania	293,900	263,390	233,560	-10	-11
Rhode Island	16,200	23,070	27,080	42	17
South Carolina	139,070	110,060	89,700	-21	-18
South Dakota	22,950	23,070	11,200	1	-51
Tennessee	102,870	87,740	104,170	-15	19
Texas	540,620	431,760	414,860	-20	-4
Utah	41,660	56,390	38,420	35	-32
Vermont	20,620	17,150	19,750	-17	15
Virginia	97,150	95,060	76,520	-2	-20
Washington	168,510	162,130	135,400	-4	-16
West Virginia	59,400	47,940	77,660	-19	62
Wisconsin	93,010	114,280	83,110	23	-27
Wyoming	16,770	15,690	8,970	-6	-43

Source: See Table Notes box.



TABLE 8

**Number of women receiving contraceptive services from publicly supported clinics by clinic funding type, and percentage change—national summary and state detail, 2010 and 2016**

State	Female patients at clinics receiving Title X funds			Female patients at clinics receiving other public funds*		
	2010	2016	% change 2010–2016	2010	2016	% change 2010–2016
<b>Publicly funded clinics</b>	<b>4,724,250</b>	<b>3,522,120</b>	<b>-25</b>	<b>1,982,030</b>	<b>2,566,070</b>	<b>29</b>
Alabama	103,660	85,460	-18	11,800	12,130	3
Alaska	6,810	7,280	7	16,690	14,360	-14
Arizona	42,740	30,620	-28	54,870	57,520	5
Arkansas	77,070	46,840	-39	6,870	4,120	-40
California	1,100,770	905,950	-18	429,050	712,060	66
Colorado	57,860	41,680	-28	92,180	73,810	-20
Connecticut	38,140	34,620	-9	36,030	33,510	-7
Delaware	23,880	15,000	-37	300	1,090	263
District of Columbia	21,060	37,650	79	3,160	5,950	88
Florida	228,710	118,760	-48	66,470	95,690	44
Georgia	132,510	90,700	-32	21,550	104,210	384
Hawaii	23,570	12,690	-46	340	1,140	235
Idaho	22,910	10,610	-54	9,900	10,270	4
Illinois	112,380	100,260	-11	87,800	89,970	2
Indiana	39,850	24,930	-37	70,530	51,170	-27
Iowa	66,660	34,740	-48	17,270	17,420	1
Kansas	39,670	24,570	-38	10,620	9,810	-8
Kentucky	96,770	47,110	-51	7,560	22,510	198
Louisiana	46,810	40,860	-13	18,320	30,180	65
Maine	25,210	18,300	-27	7,780	7,220	-7
Maryland	74,620	64,000	-14	14,550	33,980	134
Massachusetts	64,640	57,020	-12	41,480	33,800	-19
Michigan	116,770	60,540	-48	39,650	45,110	14
Minnesota	52,840	47,490	-10	39,570	29,050	-27
Mississippi	66,210	35,380	-47	16,990	17,490	3
Missouri	60,980	40,520	-34	34,890	44,400	27
Montana	24,040	17,470	-27	10,350	6,580	-36
Nebraska	29,160	24,400	-16	3,440	5,570	62
Nevada	23,890	10,600	-56	12,590	15,820	26
New Hampshire	21,930	16,110	-27	1,970	2,850	45
New Jersey	122,660	90,300	-26	23,080	27,630	20
New Mexico	36,720	14,830	-60	32,040	37,790	18
New York	318,800	276,110	-13	117,280	157,850	35
North Carolina	133,160	88,680	-33	31,290	27,960	-11
North Dakota	13,540	6,420	-53	5,040	4,370	-13
Ohio	97,040	79,060	-19	59,840	74,020	24
Oklahoma	72,350	49,360	-32	37,450	35,350	-6
Oregon	68,160	45,560	-33	63,460	61,540	-3
Pennsylvania	233,240	174,920	-25	30,150	58,640	94
Rhode Island	21,340	22,060	3	1,730	5,010	190
South Carolina	91,390	64,740	-29	18,670	24,960	34
South Dakota	10,230	4,950	-52	12,840	6,260	-51
Tennessee	72,800	74,920	3	14,940	29,250	96
Texas	251,600	150,340	-40	180,160	264,520	47
Utah	37,690	27,270	-28	18,700	11,140	-40
Vermont	6,320	8,700	38	10,830	11,050	2
Virginia	75,960	52,520	-31	19,100	24,000	26
Washington	107,570	84,550	-21	54,560	50,850	-7
West Virginia	46,450	66,500	43	1,490	11,160	649
Wisconsin	53,230	31,670	-41	61,050	51,440	-16
Wyoming	11,910	6,490	-46	3,780	2,480	-34

\*Excluding clinics that receive Title X funding. Source: See Table Notes box.

TABLE 9

**Number of female adolescents receiving publicly supported contraceptive services from all provider types, national summary and by state for publicly supported clinics—2010 and 2016**

State	Adolescent patients at publicly supported providers				
	2001	2010	2016	% change 2001–2010	% change 2010–2016
<b>All publicly supported providers</b>	<b>2,292,830</b>	<b>2,012,659</b>	<b>1,869,040</b>	<b>-12</b>	<b>-7</b>
<b>Private providers serving Medicaid enrollees</b>	<b>420,410</b>	<b>555,329</b>	<b>679,840</b>	<b>32</b>	<b>22</b>
<b>Publicly supported clinics</b>	<b>1,872,420</b>	<b>1,457,330</b>	<b>1,166,960</b>	<b>-22</b>	<b>-20</b>
Alabama	35,690	28,400	20,300	-20	-29
Alaska	7,210	4,590	4,750	-36	3
Arizona	26,240	18,780	16,500	-28	-12
Arkansas	23,440	19,140	10,610	-18	-45
California	246,890	293,960	252,840	19	-14
Colorado	31,500	27,800	23,720	-12	-15
Connecticut	23,620	16,080	14,160	-32	-12
Delaware	6,570	8,040	4,510	22	-44
District of Columbia	4,670	5,250	7,370	12	40
Florida	81,340	66,450	40,050	-18	-40
Georgia	56,330	40,660	42,860	-28	5
Hawaii	4,280	5,930	2,560	39	-57
Idaho	12,890	7,510	4,340	-42	-42
Illinois	58,910	47,920	39,180	-19	-18
Indiana	43,670	26,280	15,470	-40	-41
Iowa	20,540	21,900	11,300	7	-48
Kansas	14,700	9,190	6,420	-37	-30
Kentucky	41,030	18,900	15,310	-54	-19
Louisiana	24,010	16,400	13,610	-32	-17
Maine	15,060	8,270	5,610	-45	-32
Maryland	25,570	22,680	18,600	-11	-18
Massachusetts	31,150	27,590	20,020	-11	-27
Michigan	72,830	35,560	23,910	-51	-33
Minnesota	35,850	17,930	16,520	-50	-8
Mississippi	38,550	27,190	13,620	-29	-50
Missouri	27,540	21,400	19,960	-22	-7
Montana	9,660	8,220	5,630	-15	-32
Nebraska	9,280	6,210	4,830	-33	-22
Nevada	9,840	6,980	4,740	-29	-32
New Hampshire	10,360	5,230	3,600	-50	-31
New Jersey	31,880	27,880	18,740	-13	-33
New Mexico	†	15,780	11,350	na	-28
New York	119,840	92,210	83,050	-23	-10
North Carolina	53,480	30,620	19,440	-43	-37
North Dakota	4,740	4,090	2,310	-14	-44
Ohio	67,540	37,980	34,740	-44	-9
Oklahoma	28,910	25,140	21,200	-13	-16
Oregon	34,400	28,790	19,480	-16	-32
Pennsylvania	86,880	64,650	50,280	-26	-22
Rhode Island	4,200	4,630	6,350	10	37
South Carolina	30,790	22,550	16,970	-27	-25
South Dakota	6,990	5,040	2,560	-28	-49
Tennessee	37,770	22,950	22,780	-39	-1
Texas	138,050	86,380	83,800	-37	-3
Utah	10,390	10,220	8,730	-2	-15
Vermont	6,400	3,980	3,960	-38	-1
Virginia	28,890	21,320	12,050	-26	-43
Washington	54,750	36,650	27,210	-33	-26
West Virginia	17,070	11,300	16,770	-34	48
Wisconsin	28,970	30,970	19,980	7	-35
Wyoming	5,610	3,800	2,340	-32	-38

†50–75% of patients are estimated. Note: na=not available. Source: See Table Notes box.

TABLE 10

**Number of female adolescents receiving contraceptive services from publicly supported clinics by clinic funding type, and percentage change—national summary and state detail, 2010 and 2016**

State	Adolescent patients at clinics receiving Title X funds			Adolescent patients at clinics receiving other public funds*		
	2010	2016	% change 2010–2016	2010	2016	% change 2010–2016
<b>Publicly supported clinics</b>	<b>1,054,810</b>	<b>626,970</b>	<b>–41</b>	<b>402,520</b>	<b>539,990</b>	<b>34</b>
Alabama	25,520	17,010	–33	2,880	3,290	14
Alaska	1,650	1,400	–15	2,940	3,350	14
Arizona	9,290	5,840	–37	9,490	10,650	12
Arkansas	18,170	9,400	–48	970	1,210	25
California	225,080	140,280	–38	68,880	112,560	63
Colorado	14,960	9,570	–36	12,840	14,160	10
Connecticut	7,770	5,630	–28	8,310	8,530	3
Delaware	7,870	4,180	–47	170	330	94
District of Columbia	3,930	6,350	62	1,320	1,020	–23
Florida	51,530	19,610	–62	14,920	20,440	37
Georgia	36,000	17,350	–52	4,660	25,520	448
Hawaii	5,850	2,330	–60	80	230	188
Idaho	5,410	2,360	–56	2,100	1,970	–6
Illinois	26,250	17,120	–35	21,670	22,060	2
Indiana	9,350	3,880	–59	16,930	11,600	–31
Iowa	17,870	7,310	–59	4,030	4,000	–1
Kansas	7,350	4,020	–45	1,840	2,400	30
Kentucky	16,710	9,460	–43	2,190	5,850	167
Louisiana	11,510	6,090	–47	4,890	7,520	54
Maine	6,610	3,700	–44	1,660	1,910	15
Maryland	17,840	10,170	–43	4,840	8,420	74
Massachusetts	18,990	11,480	–40	8,600	8,530	–1
Michigan	26,680	12,960	–51	8,880	10,950	23
Minnesota	8,270	9,070	10	9,660	7,450	–23
Mississippi	22,000	8,890	–60	5,190	4,730	–9
Missouri	12,790	9,370	–27	8,610	10,590	23
Montana	6,300	4,160	–34	1,920	1,460	–24
Nebraska	5,560	3,510	–37	650	1,320	103
Nevada	5,160	1,780	–66	1,820	2,960	63
New Hampshire	4,710	2,860	–39	520	730	40
New Jersey	21,420	11,860	–45	6,460	6,880	7
New Mexico	9,920	3,840	–61	5,860	7,510	28
New York	63,330	44,400	–30	28,880	38,660	34
North Carolina	24,370	12,650	–48	6,250	6,790	9
North Dakota	3,260	1,230	–62	830	1,080	30
Ohio	26,640	16,550	–38	11,340	18,190	60
Oklahoma	18,100	12,380	–32	7,040	8,810	25
Oregon	15,410	9,760	–37	13,380	9,730	–27
Pennsylvania	56,500	35,750	–37	8,150	14,530	78
Rhode Island	4,330	5,380	24	300	970	223
South Carolina	18,470	10,640	–42	4,080	6,330	55
South Dakota	3,100	1,170	–62	1,940	1,390	–28
Tennessee	18,700	15,330	–18	4,250	7,450	75
Texas	53,600	22,240	–59	32,780	61,550	88
Utah	7,820	6,870	–12	2,400	1,860	–23
Vermont	1,680	1,850	10	2,300	2,110	–8
Virginia	18,110	7,770	–57	3,210	4,280	33
Washington	25,470	18,610	–27	11,180	8,600	–23
West Virginia	10,850	13,860	28	450	2,910	547
Wisconsin	13,770	6,020	–56	17,200	13,970	–19
Wyoming	2,980	1,670	–44	820	670	–18

\*Excluding clinics that receive Title X funding. Source: See Table Notes box.

TABLE 11

**Percentage of women who likely need public support for contraceptive services who are served by publicly supported providers, all women and adolescent women—national summary and state detail, 2010 and 2016**

State	% of likely need for public support for contraceptive services that is met by publicly supported providers			
	All women		Women aged <20	
	2010	2016	2010	2016
<b>All publicly supported providers</b>	<b>49</b>	<b>45</b>	<b>41</b>	<b>40</b>
<b>Private providers serving Medicaid enrollees</b>	<b>14</b>	<b>15</b>	<b>11</b>	<b>15</b>
<b>Publicly supported clinics</b>	<b>35</b>	<b>29</b>	<b>30</b>	<b>25</b>
Alabama	36	28	36	27
Alaska	63	54	42	50
Arizona	23	19	20	17
Arkansas	42	23	40	23
California	62	64	52	48
Colorado	49	35	40	31
Connecticut	42	38	32	26
Delaware	48	30	55	33
District of Columbia	54	88	49	73
Florida	26	16	26	15
Georgia	24	26	25	26
Hawaii	35	21	33	19
Idaho	29	18	30	17
Illinois	26	24	21	21
Indiana	26	17	22	15
Iowa	46	27	39	23
Kansas	28	18	18	14
Kentucky	38	23	28	23
Louisiana	21	21	22	20
Maine	43	34	43	31
Maryland	32	32	26	22
Massachusetts	30	25	29	19
Michigan	25	16	19	16
Minnesota	32	25	20	21
Mississippi	39	23	48	28
Missouri	25	21	20	22
Montana	57	36	54	41
Nebraska	29	24	19	17
Nevada	21	14	19	13
New Hampshire	37	29	26	18
New Jersey	35	27	24	15
New Mexico	47	35	48	40
New York	37	37	32	30
North Carolina	27	16	20	13
North Dakota	44	23	33	21
Ohio	22	20	18	20
Oklahoma	45	30	43	38
Oregon	52	40	54	37
Pennsylvania	36	32	33	27
Rhode Island	35	41	27	37
South Carolina	36	26	30	23
South Dakota	46	21	33	21
Tennessee	21	22	23	24
Texas	26	21	22	20
Utah	28	18	22	17
Vermont	48	55	37	40
Virginia	23	16	18	10
Washington	40	31	39	29
West Virginia	43	66	42	68
Wisconsin	34	24	31	24
Wyoming	49	26	43	28

Source: See Table Notes box.

TABLE 12

**Percentage of women who likely need public support for contraceptive services who are served by clinics, according to clinic funding type, all women and adolescent women, by state—2010 and 2016**

State	% of likely need for public support for contraceptive services that is met by publicly supported clinics							
	All women				Women aged <20			
	Clinics receiving Title X funds		Clinics receiving other public funds*		Clinics receiving Title X funds		Clinics receiving other public funds*	
	2010	2016	2010	2016	2010	2016	2010	2016
<b>Publicly supported clinics</b>	<b>25</b>	<b>17</b>	<b>10</b>	<b>12</b>	<b>22</b>	<b>14</b>	<b>8</b>	<b>12</b>
Alabama	32	24	4	3	32	23	4	4
Alaska	18	18	45	36	15	15	27	36
Arizona	10	7	13	12	10	6	10	11
Arkansas	39	21	3	2	38	20	2	3
California	45	36	17	28	40	27	12	21
Colorado	19	12	30	22	21	12	18	18
Connecticut	22	19	20	19	15	10	16	16
Delaware	47	28	1	2	54	30	1	2
District of Columbia	47	76	7	12	36	63	12	10
Florida	20	9	6	7	20	8	6	8
Georgia	20	12	3	14	22	11	3	16
Hawaii	35	19	1	2	33	17	0	2
Idaho	20	9	9	9	21	9	8	8
Illinois	15	13	11	12	12	9	10	12
Indiana	9	5	17	11	8	4	14	11
Iowa	36	18	9	9	32	15	7	8
Kansas	22	13	6	5	14	9	4	5
Kentucky	35	15	3	7	25	14	3	9
Louisiana	15	12	6	9	15	9	6	11
Maine	33	25	10	10	35	20	9	11
Maryland	27	21	5	11	20	12	6	10
Massachusetts	18	16	12	9	20	11	9	8
Michigan	19	9	6	7	14	9	5	7
Minnesota	18	16	14	10	9	12	11	9
Mississippi	31	15	8	7	39	18	9	10
Missouri	16	10	9	11	12	10	8	12
Montana	40	26	17	10	41	31	13	11
Nebraska	26	20	3	5	17	12	2	5
Nevada	14	5	7	8	14	5	5	8
New Hampshire	34	25	3	4	23	15	3	4
New Jersey	30	21	6	6	18	10	5	6
New Mexico	25	10	22	25	30	13	18	26
New York	27	23	10	13	22	16	10	14
North Carolina	21	12	5	4	16	8	4	4
North Dakota	32	14	12	9	26	11	7	10
Ohio	14	11	8	10	13	10	5	11
Oklahoma	30	18	16	13	31	22	12	16
Oregon	27	17	25	23	29	18	25	18
Pennsylvania	32	24	4	8	29	19	4	8
Rhode Island	32	33	3	8	25	32	2	6
South Carolina	30	18	6	7	24	14	5	9
South Dakota	20	9	25	12	20	9	13	11
Tennessee	18	16	4	6	19	16	4	8
Texas	15	8	11	14	14	5	8	15
Utah	19	13	9	5	17	13	5	4
Vermont	18	24	30	31	16	19	22	21
Virginia	18	11	5	5	15	6	3	3
Washington	27	20	14	12	27	20	12	9
West Virginia	42	56	1	9	40	57	2	12
Wisconsin	16	9	18	15	14	7	17	16
Wyoming	37	19	12	7	33	20	9	8

\*Excluding clinics that receive Title X funding. Source: See Table Notes box.

TABLE 13

### Health benefits from contraceptive and related noncontraceptive services received during publicly funded family planning visits, according to provider type, national summary, 2016

Outcomes prevented	All publicly supported providers				
	Publicly supported clinics			Private providers serving Medicaid recipients	All publicly supported providers
	All	Clinics receiving Title X funds	Clinics receiving other public funds*		
<b>From contraception:</b>					
Pregnancies	1,305,570	755,300	550,280	682,900	1,988,470
Births	614,760	355,650	259,110	321,560	936,320
Abortions	441,730	255,550	186,180	231,050	672,780
Miscarriages	249,080	144,100	104,990	130,290	379,370
<b>From STI testing:</b>					
Chlamydia infections among partners	75,950	43,980	31,970	30,750	106,710
Gonorrhea infections among partners	12,590	7,230	5,360	5,610	18,200
HIV infections among partners	700	370	330	100	810
PID cases	7,920	4,590	3,330	4,140	12,060
Ectopic pregnancies	710	410	300	370	1,090
Infertility cases	1,350	780	570	700	2,050
<b>From Pap and HPV testing:</b>					
Cervical cancer cases	1,210	720	500	650	1,860
Cervical cancer deaths	550	330	230	290	850
<b>From HPV vaccination:</b>					
Abnormal cervical cell cases	3,020	1,750	1,270	1,580	4,590
Precancer cases	600	350	250	320	920
Cervical cancer cases	30	20	10	20	50
Cervical cancer deaths	10	6	5	6	20
Other HPV-attributable cancer cases	30	20	10	20	40
<b>Cost savings (in 000s of dollars) from:</b>					
Maternity and birth-related costs to 60 months	\$9,081.4	\$5,281.7	\$3,799.8	\$5,214.9	\$14,296.3
Miscarriage and ectopic pregnancy costs	\$265.1	\$153.8	\$111.3	\$153.3	\$418.4
Chlamydia and gonorrhea testing	\$35.7	\$20.8	\$14.9	\$16.4	\$52.1
HIV testing	\$192.8	\$101.5	\$91.3	\$28.4	\$221.2
Pap and HPV testing	\$8.1	\$4.8	\$3.3	\$4.4	\$12.4
HPV vaccination	\$1.4	\$0.8	\$0.6	\$0.7	\$2.0
Total gross savings	\$9,584.6	\$5,563.4	\$4,021.2	\$5,418.0	\$15,002.5
Family planning costs	\$1,930.6	\$1,113.5	\$817.1	\$1,174.0	\$3,104.6
Total net savings	\$7,654.0	\$4,449.8	\$3,204.1	\$4,244.0	\$11,897.9

\*Excluding clinics that receive Title X funding. Source: See Table Notes box.

TABLE 14

### Health benefits from contraceptive and related noncontraceptive services received during publicly supported family planning visits at all provider types, national summary and by state for publicly supported clinics, 2016

Provider type and state	Contraceptive services			STI and HIV testing			Pap and HPV testing and vaccination	
	Events prevented among patients			Infections prevented among partners		PID cases prevented among patients	Abnormal cell cases averted among patients*	Cervical cancer cases averted among patients
	Pregnancies	Births	Abortions	Chlamydia	Gonorrhea			
<b>All publicly supported providers</b>	<b>1,988,470</b>	<b>936,320</b>	<b>672,780</b>	<b>106,710</b>	<b>18,200</b>	<b>12,060</b>	<b>4,590</b>	<b>1,910</b>
<b>Private providers serving Medicaid recipients</b>	<b>682,900</b>	<b>321,560</b>	<b>231,050</b>	<b>30,750</b>	<b>5,610</b>	<b>4,140</b>	<b>1,580</b>	<b>670</b>
<b>Publicly supported clinics</b>	<b>1,305,570</b>	<b>614,760</b>	<b>441,730</b>	<b>75,950</b>	<b>12,590</b>	<b>7,920</b>	<b>3,020</b>	<b>1,250</b>
Alabama	20,930	9,850	7,080	1,800	390	240	50	30
Alaska	4,640	2,190	1,570	370	70	40	10	5
Arizona	18,900	8,900	6,390	1,500	220	160	40	10
Arkansas	10,930	5,150	3,700	900	200	120	30	20
California	346,970	163,380	117,390	16,600	2,390	1,650	800	280
Colorado	24,770	11,660	8,380	1,950	220	190	60	20
Connecticut	14,610	6,880	4,940	830	50	60	30	10
Delaware	3,450	1,620	1,170	350	40	20	8	3
District of Columbia	9,350	4,400	3,160	1,040	190	80	20	10
Florida	45,990	21,650	15,560	1,560	280	210	110	30
Georgia	41,800	19,680	14,140	1,900	370	180	100	50
Hawaii	2,970	1,400	1,000	160	20	20	7	2
Idaho	4,480	2,110	1,510	170	10	20	10	4
Illinois	40,790	19,210	13,800	2,530	560	240	90	30
Indiana	16,320	7,680	5,520	1,040	270	130	40	20
Iowa	11,180	5,270	3,780	710	90	80	30	10
Kansas	7,370	3,470	2,490	280	50	30	20	8
Kentucky	14,930	7,030	5,050	680	120	60	30	7
Louisiana	15,240	7,170	5,150	2,460	530	200	40	20
Maine	5,470	2,580	1,850	310	10	30	10	4
Maryland	21,010	9,890	7,110	920	180	100	50	20
Massachusetts	19,480	9,170	6,590	940	50	80	50	20
Michigan	22,660	10,670	7,670	1,640	250	150	50	20
Minnesota	16,410	7,730	5,550	1,210	180	130	40	10
Mississippi	11,340	5,340	3,840	1,070	250	150	30	20
Missouri	18,210	8,580	6,160	1,040	240	120	40	20
Montana	5,160	2,430	1,740	290	20	30	10	7
Nebraska	6,430	3,030	2,170	420	90	50	10	10
Nevada	5,670	2,670	1,920	330	50	40	10	6
New Hampshire	4,060	1,910	1,380	160	10	20	9	3
New Jersey	25,290	11,910	8,560	1,710	190	160	60	20
New Mexico	11,280	5,310	3,820	740	110	90	30	4
New York	93,060	43,820	31,490	4,750	610	480	220	100
North Carolina	25,010	11,780	8,460	1,080	190	140	60	50
North Dakota	2,310	1,090	780	150	50	20	5	3
Ohio	32,830	15,460	11,110	3,310	860	320	80	20
Oklahoma	18,170	8,550	6,150	1,000	260	140	40	20
Oregon	22,970	10,810	7,770	900	110	110	50	20
Pennsylvania	50,090	23,580	16,950	2,730	530	250	120	30
Rhode Island	5,810	2,730	1,960	260	10	30	10	4
South Carolina	19,240	9,060	6,510	2,450	420	230	40	20
South Dakota	2,400	1,130	810	150	10	20	6	3
Tennessee	22,340	10,520	7,560	1,090	240	150	50	20
Texas	88,960	41,890	30,100	5,780	890	640	210	90
Utah	8,240	3,880	2,790	680	70	70	20	6
Vermont	4,230	1,990	1,430	150	0	10	10	3
Virginia	16,410	7,730	5,550	850	210	120	40	30
Washington	29,040	13,670	9,820	1,640	220	200	70	30
West Virginia	16,650	7,840	5,630	270	50	30	40	20
Wisconsin	17,820	8,390	6,030	1,000	150	90	40	10
Wyoming	1,920	910	650	140	10	10	4	2

\*Based on HPV vaccination only, not testing. Source: See Table Notes box.

TABLE 15

### Health benefits from contraceptive and related noncontraceptive services received during publicly supported family planning visits at clinics receiving Title X funds, by state, 2016

Provider type and state	Contraceptive services			STI and HIV testing			Pap and HPV testing and vaccination	
	Events prevented among patients			Infections prevented among partners		PID cases prevented among patients	Abnormal cell cases averted among patients*	Cervical cancer cases averted among patients
	Pregnancies	Births	Abortions	Chlamydia	Gonorrhea			
<b>Total at clinics receiving Title X funds</b>	<b>755,300</b>	<b>355,650</b>	<b>255,550</b>	<b>43,980</b>	<b>7,230</b>	<b>4,590</b>	<b>1,750</b>	<b>740</b>
Alabama	18,330	8,630	6,200	1,570	340	210	40	30
Alaska	1,560	740	530	120	20	10	4	2
Arizona	6,570	3,090	2,220	520	80	60	20	5
Arkansas	10,040	4,730	3,400	820	180	110	20	20
California	194,280	91,480	65,730	9,300	1,320	930	450	160
Colorado	8,940	4,210	3,020	700	80	70	20	8
Connecticut	7,420	3,500	2,510	420	20	30	20	7
Delaware	3,220	1,510	1,090	320	40	20	7	2
District of Columbia	8,070	3,800	2,730	900	160	70	20	10
Florida	25,470	11,990	8,620	860	150	110	60	20
Georgia	19,450	9,160	6,580	880	180	80	40	20
Hawaii	2,720	1,280	920	140	20	20	6	2
Idaho	2,280	1,070	770	80	10	10	5	2
Illinois	21,500	10,120	7,270	1,340	280	130	50	20
Indiana	5,350	2,520	1,810	340	90	40	10	6
Iowa	7,450	3,510	2,520	470	60	50	20	10
Kansas	5,270	2,480	1,780	200	30	20	10	6
Kentucky	10,100	4,760	3,420	460	80	40	20	5
Louisiana	8,760	4,130	2,960	1,420	300	120	20	10
Maine	3,920	1,850	1,330	230	10	20	10	3
Maryland	13,730	6,460	4,640	600	120	60	30	10
Massachusetts	12,230	5,760	4,140	590	30	50	30	10
Michigan	12,980	6,110	4,390	940	140	90	30	10
Minnesota	10,180	4,800	3,450	750	110	80	20	6
Mississippi	7,590	3,570	2,570	720	170	100	20	10
Missouri	8,690	4,090	2,940	500	110	60	20	10
Montana	3,750	1,760	1,270	210	20	20	9	5
Nebraska	5,230	2,460	1,770	350	70	40	10	9
Nevada	2,270	1,070	770	130	20	20	5	2
New Hampshire	3,450	1,630	1,170	130	10	10	8	3
New Jersey	19,360	9,120	6,550	1,310	150	120	40	20
New Mexico	3,180	1,500	1,080	210	30	30	7	1
New York	59,210	27,880	20,030	3,020	380	300	140	60
North Carolina	19,020	8,950	6,430	820	140	110	40	40
North Dakota	1,380	650	470	90	20	10	3	2
Ohio	16,950	7,980	5,740	1,710	430	170	40	10
Oklahoma	10,580	4,980	3,580	580	150	80	20	10
Oregon	9,770	4,600	3,310	380	50	50	20	10
Pennsylvania	37,510	17,660	12,690	2,050	380	180	90	20
Rhode Island	4,730	2,230	1,600	220	10	20	10	4
South Carolina	13,880	6,540	4,700	1,770	300	170	30	20
South Dakota	1,060	500	360	70	0	10	2	1
Tennessee	16,070	7,570	5,440	780	170	110	40	20
Texas	32,240	15,180	10,910	2,090	320	230	70	30
Utah	5,850	2,750	1,980	480	50	50	10	4
Vermont	1,870	880	630	60	0	10	4	1
Virginia	11,260	5,300	3,810	580	150	80	30	20
Washington	18,130	8,540	6,130	1,020	140	130	40	20
West Virginia	14,260	6,720	4,830	240	40	30	30	10
Wisconsin	6,790	3,200	2,300	380	60	30	20	4
Wyoming	1,390	660	470	100	10	10	3	1

\*Based on HPV vaccination only, not testing. Source: See Table Notes box.



TABLE 16

**Health benefits from contraceptive and related noncontraceptive services received during publicly supported family planning visits at clinics receiving other (non-Title X) public funds, by state, 2016**

Provider type and state	Contraceptive services			STI and HIV testing			Pap and HPV testing and vaccination	
	Events prevented among patients			Infections prevented among partners		PID cases prevented among patients	Abnormal cell cases averted among patients†	Cervical cancer cases averted among patients
	Pregnancies	Births	Abortions	Chlamydia	Gonorrhea			
<b>Total at clinics receiving other public funds*</b>	<b>550,280</b>	<b>259,110</b>	<b>186,180</b>	<b>31,970</b>	<b>5,360</b>	<b>3,330</b>	<b>1,270</b>	<b>510</b>
Alabama	2,600	1,220	880	220	50	30	6	4
Alaska	3,080	1,450	1,040	240	50	30	7	3
Arizona	12,330	5,810	4,170	980	140	110	30	10
Arkansas	880	410	300	70	20	10	2	2
California	152,700	71,900	51,660	7,310	1,070	730	350	120
Colorado	15,830	7,450	5,360	1,250	140	120	40	10
Connecticut	7,190	3,390	2,430	410	20	30	20	7
Delaware	230	110	80	20	0	0	1	0
District of Columbia	1,280	600	430	140	30	10	3	2
Florida	20,520	9,660	6,940	690	120	90	50	10
Georgia	22,350	10,520	7,560	1,010	190	100	50	30
Hawaii	240	110	80	10	0	0	1	0
Idaho	2,200	1,040	740	80	10	10	5	2
Illinois	19,290	9,080	6,530	1,200	280	110	40	20
Indiana	10,970	5,170	3,710	700	180	80	30	10
Iowa	3,740	1,760	1,270	240	30	30	9	5
Kansas	2,100	990	710	80	10	10	5	2
Kentucky	4,830	2,270	1,630	220	40	20	10	2
Louisiana	6,470	3,050	2,190	1,050	240	90	10	9
Maine	1,550	730	520	90	0	10	4	1
Maryland	7,290	3,430	2,470	320	60	30	20	7
Massachusetts	7,250	3,410	2,450	350	20	30	20	6
Michigan	9,670	4,550	3,270	700	110	70	20	8
Minnesota	6,230	2,930	2,110	460	70	50	10	4
Mississippi	3,750	1,770	1,270	350	80	50	9	7
Missouri	9,520	4,480	3,220	540	130	60	20	10
Montana	1,410	660	480	80	0	10	3	2
Nebraska	1,190	560	400	80	20	10	3	2
Nevada	3,390	1,600	1,150	200	30	20	8	4
New Hampshire	610	290	210	20	0	0	1	0
New Jersey	5,930	2,790	2,010	400	40	40	10	5
New Mexico	8,100	3,810	2,740	530	80	70	20	3
New York	33,850	15,940	11,450	1,730	230	170	80	40
North Carolina	6,000	2,830	2,030	260	40	30	10	10
North Dakota	940	440	320	60	20	10	2	1
Ohio	15,870	7,470	5,370	1,600	430	160	40	10
Oklahoma	7,580	3,570	2,560	420	110	60	20	10
Oregon	13,200	6,220	4,470	520	60	60	30	10
Pennsylvania	12,570	5,920	4,250	690	140	60	30	8
Rhode Island	1,070	500	360	50	0	0	2	1
South Carolina	5,350	2,520	1,810	680	120	70	10	6
South Dakota	1,340	630	450	90	10	10	3	2
Tennessee	6,270	2,950	2,120	310	70	40	10	7
Texas	56,720	26,710	19,190	3,680	570	410	130	60
Utah	2,390	1,130	810	200	20	20	6	2
Vermont	2,370	1,120	800	80	0	10	5	2
Virginia	5,150	2,420	1,740	270	70	40	10	8
Washington	10,900	5,130	3,690	620	80	80	30	10
West Virginia	2,390	1,130	810	40	10	0	6	2
Wisconsin	11,030	5,190	3,730	620	100	50	30	6
Wyoming	530	250	180	40	0	0	1	1

\*Excluding clinics that receive Title X funding. †Based on HPV vaccination only, not testing. Source: See Table Notes box.

TABLE 17

### Number of pregnancies, births and abortions averted among patients younger than 20 at all provider types, national summary, and by state for publicly supported clinics, 2016

Provider type and state	All publicly funded providers			Title X–funded clinics			Other publicly funded clinics*		
	Events averted			Events averted			Events averted		
	Total pregnancies	Births	Abortions	Total pregnancies	Births	Abortions	Total pregnancies	Births	Abortions
<b>All publicly supported providers</b>	<b>508,090</b>	<b>264,180</b>	<b>146,870</b>	na	na	na	na	na	na
<b>Private doctors serving Medicaid enrollees</b>	<b>187,040</b>	<b>97,250</b>	<b>54,070</b>	na	na	na	na	na	na
<b>Publicly funded clinics</b>	<b>321,050</b>	<b>166,930</b>	<b>92,800</b>	<b>172,490</b>	<b>89,680</b>	<b>49,860</b>	<b>148,560</b>	<b>77,250</b>	<b>42,940</b>
Alabama	5,580	2,900	1,610	4,680	2,430	1,350	900	470	260
Alaska	1,310	680	380	390	200	110	920	480	270
Arizona	4,540	2,360	1,310	1,610	840	470	2,930	1,520	840
Arkansas	2,920	1,520	840	2,590	1,350	750	330	170	90
California	69,560	36,170	20,110	38,590	20,060	11,150	30,970	16,110	8,960
Colorado	6,530	3,400	1,890	2,630	1,370	760	3,900	2,030	1,130
Connecticut	3,900	2,030	1,130	1,550	810	450	2,350	1,220	680
Delaware	1,240	640	360	1,150	600	330	90	40	30
District of Columbia	2,030	1,060	590	1,750	910	510	280	150	80
Florida	11,020	5,730	3,190	5,400	2,810	1,560	5,620	2,920	1,630
Georgia	11,790	6,130	3,410	4,770	2,480	1,380	7,020	3,650	2,030
Hawaii	700	360	200	640	330	190	60	30	10
Idaho	1,190	620	340	650	340	190	540	280	150
Illinois	10,780	5,600	3,120	4,710	2,450	1,360	6,070	3,150	1,760
Indiana	4,260	2,210	1,230	1,070	560	310	3,190	1,650	920
Iowa	3,110	1,620	900	2,010	1,050	580	1,100	570	320
Kansas	1,770	920	510	1,110	580	320	660	340	190
Kentucky	4,210	2,190	1,220	2,600	1,350	750	1,610	840	470
Louisiana	3,740	1,940	1,080	1,680	870	490	2,060	1,070	590
Maine	1,540	800	450	1,020	530	290	520	270	160
Maryland	5,120	2,660	1,480	2,800	1,460	810	2,320	1,200	670
Massachusetts	5,510	2,860	1,590	3,160	1,640	910	2,350	1,220	680
Michigan	6,580	3,420	1,900	3,570	1,860	1,030	3,010	1,560	870
Minnesota	4,550	2,370	1,320	2,490	1,290	720	2,060	1,080	600
Mississippi	3,750	1,950	1,080	2,450	1,270	710	1,300	680	370
Missouri	5,490	2,850	1,590	2,580	1,340	750	2,910	1,510	840
Montana	1,550	810	450	1,150	600	330	400	210	120
Nebraska	1,330	690	380	960	500	280	370	190	100
Nevada	1,300	680	380	490	250	140	810	430	240
New Hampshire	990	510	290	790	410	230	200	100	60
New Jersey	5,160	2,680	1,490	3,260	1,690	940	1,900	990	550
New Mexico	3,120	1,620	900	1,060	550	310	2,060	1,070	590
New York	22,850	11,880	6,610	12,210	6,350	3,530	10,640	5,530	3,080
North Carolina	5,350	2,780	1,550	3,480	1,810	1,010	1,870	970	540
North Dakota	630	330	180	340	180	100	290	150	80
Ohio	9,560	4,970	2,760	4,550	2,370	1,320	5,010	2,600	1,440
Oklahoma	5,830	3,030	1,690	3,410	1,770	990	2,420	1,260	700
Oregon	5,360	2,790	1,550	2,680	1,390	770	2,680	1,400	780
Pennsylvania	13,830	7,190	4,000	9,840	5,120	2,840	3,990	2,070	1,160
Rhode Island	1,750	910	510	1,480	770	430	270	140	80
South Carolina	4,670	2,430	1,350	2,930	1,520	850	1,740	910	500
South Dakota	700	360	200	320	170	90	380	190	110
Tennessee	6,270	3,260	1,810	4,220	2,190	1,220	2,050	1,070	590
Texas	23,050	11,980	6,660	6,120	3,180	1,770	16,930	8,800	4,890
Utah	2,400	1,250	690	1,890	980	550	510	270	140
Vermont	1,090	570	320	510	270	150	580	300	170
Virginia	3,310	1,720	960	2,140	1,110	620	1,170	610	340
Washington	7,490	3,890	2,170	5,120	2,660	1,480	2,370	1,230	690
West Virginia	4,610	2,400	1,330	3,810	1,980	1,100	800	420	230
Wisconsin	5,500	2,860	1,590	1,660	860	480	3,840	2,000	1,110
Wyoming	640	330	190	460	240	130	180	90	60

\*Excluding clinics that receive Title X funding. Note: na=not applicable. Source: See Table Notes box.

TABLE 18

**Public cost savings from contraceptive and related noncontraceptive services received during publicly supported family planning visits at all providers, including savings from averted pregnancies, STI sequelae and cancers, national summary, and by state for publicly supported clinics, 2016**

Provider type and state	Cost savings from specific components (in 000s of dollars)					Overall cost savings (in 000s of dollars)		
	Maternity and birth-related costs to 60 months	Miscarriage and ectopic pregnancy costs	Chlamydia, gonorrhea and HIV testing	Pap and HPV testing	HPV vaccination*	Total gross savings	Family planning costs	Total net savings
<b>All publicly supported providers</b>	<b>14,296,307</b>	<b>418,433</b>	<b>273,297</b>	<b>12,449</b>	<b>2,034</b>	<b>15,002,520</b>	<b>3,104,598</b>	<b>11,897,922</b>
<b>Private doctors serving Medicaid recipients</b>	<b>5,214,876</b>	<b>153,342</b>	<b>44,744</b>	<b>4,354</b>	<b>654</b>	<b>5,417,970</b>	<b>1,174,012</b>	<b>4,243,958</b>
<b>Publicly supported clinics</b>	<b>9,081,432</b>	<b>265,090</b>	<b>228,553</b>	<b>8,095</b>	<b>1,380</b>	<b>9,584,550</b>	<b>1,930,586</b>	<b>7,653,965</b>
Alabama	127,478	3,604	1,807	216	11	133,116	50,167	82,949
Alaska	64,100	2,128	376	37	3	66,645	9,500	57,145
Arizona	179,296	5,248	1,093	113	10	185,761	23,068	162,693
Arkansas	103,077	2,780	736	146	7	106,746	10,954	95,792
California	1,840,414	51,892	49,454	1,830	515	1,944,107	572,350	1,371,756
Colorado	146,788	4,384	3,447	148	42	154,810	43,214	111,595
Connecticut	130,798	3,905	1,172	99	13	135,987	15,998	119,989
Delaware	34,504	956	1,015	20	4	36,500	4,768	31,732
District of Columbia	95,741	2,907	12,358	77	8	111,091	15,979	95,112
Florida	283,594	9,076	1,312	187	16	294,185	76,283	217,902
Georgia	281,291	9,892	7,336	322	39	298,880	21,835	277,045
Hawaii	19,588	546	112	13	4	20,263	4,109	16,154
Idaho	18,762	745	57	28	5	19,597	8,377	11,220
Illinois	269,071	9,608	4,100	208	47	283,033	67,956	215,078
Indiana	104,658	3,511	920	118	17	109,224	26,444	82,780
Iowa	79,408	2,564	332	80	10	82,395	11,403	70,992
Kansas	45,415	1,346	240	70	5	47,077	4,268	42,809
Kentucky	121,736	3,334	368	47	14	125,499	19,357	106,142
Louisiana	107,868	3,200	17,486	139	15	128,708	39,529	89,179
Maine	29,193	907	167	27	4	30,299	6,655	23,644
Maryland	183,043	5,270	1,792	146	17	190,267	16,495	173,772
Massachusetts	185,134	4,926	2,394	124	21	192,599	29,181	163,418
Michigan	171,357	5,363	806	117	24	177,667	33,828	143,840
Minnesota	144,720	3,256	2,814	66	9	150,866	30,676	120,190
Mississippi	82,256	2,589	1,722	131	11	86,709	12,999	73,710
Missouri	127,598	3,406	684	140	13	131,842	17,612	114,229
Montana	33,669	1,258	117	36	4	35,083	5,526	29,557
Nebraska	48,873	1,729	678	70	3	51,352	7,268	44,084
Nevada	34,324	1,155	151	34	3	35,666	9,593	26,073
New Hampshire	20,556	576	236	19	11	21,398	3,653	17,744
New Jersey	134,250	2,838	2,419	193	18	139,718	30,794	108,924
New Mexico	112,712	3,427	497	33	5	116,675	22,637	94,038
New York	739,235	19,379	13,007	614	101	772,336	202,716	569,620
North Carolina	154,288	4,441	842	288	19	159,878	56,836	103,042
North Dakota	11,487	393	44	21	2	11,947	3,222	8,725
Ohio	207,223	6,231	4,376	152	33	218,016	32,600	185,416
Oklahoma	127,656	4,192	751	166	14	132,779	22,783	109,995
Oregon	183,630	6,360	2,952	148	20	193,110	46,068	147,043
Pennsylvania	521,886	15,107	10,537	242	89	547,861	46,954	500,907
Rhode Island	48,536	1,258	607	29	16	50,446	2,425	48,022
South Carolina	167,575	5,704	2,024	125	19	175,448	19,700	155,748
South Dakota	14,844	502	50	21	1	15,418	3,688	11,729
Tennessee	194,733	4,929	808	131	14	200,617	16,433	184,184
Texas	717,387	18,242	69,076	473	48	805,227	97,050	708,178
Utah	47,330	1,791	1,192	42	3	50,359	4,074	46,285
Vermont	29,771	860	75	18	3	30,728	5,475	25,253
Virginia	125,114	3,684	816	185	8	129,807	33,463	96,344
Washington	192,906	6,128	1,396	227	22	200,679	46,575	154,104
West Virginia	115,298	3,678	467	108	15	119,565	3,489	116,076
Wisconsin	107,384	3,403	1,191	57	22	112,057	31,779	80,278
Wyoming	13,873	481	143	12	1	14,510	2,784	11,727

\*Includes savings from other HPV-attributable cancer cases averted in addition to cervical cancer. *Source:* See Table Notes box.

TABLE 19

**Public cost savings from contraceptive and related noncontraceptive services received during family planning visits at Title X-funded clinics, including savings from averted pregnancies, STI sequelae and cancers, by state, 2016**

Provider type and state	Cost savings from specific components (in 000s of dollars)					Overall cost savings (in 000s of dollars)		
	Maternity and birth-related costs to 60 months	Miscarriage and ectopic pregnancy costs	Chlamydia, gonorrhea and HIV testing	Pap and HPV testing	HPV vaccination*	Total gross savings	Family planning costs	Total net savings
<b>Clinics receiving Title X funds</b>	<b>5,281,660</b>	<b>153,752</b>	<b>122,332</b>	<b>4,804</b>	<b>805</b>	<b>5,563,353</b>	<b>1,113,524</b>	<b>4,449,829</b>
Alabama	111,630	3,156	1,582	189	10	116,566	43,930	72,636
Alaska	21,564	716	126	13	1	22,420	3,196	19,224
Arizona	62,284	1,823	380	39	4	64,529	8,013	56,516
Arkansas	94,741	2,555	676	134	7	98,113	10,068	88,045
California	1,030,480	29,055	27,683	1,022	289	1,088,528	320,469	768,060
Colorado	52,980	1,582	1,244	53	15	55,875	15,597	40,278
Connecticut	66,462	1,984	596	50	7	69,098	8,129	60,969
Delaware	32,175	892	946	19	4	34,036	4,446	29,590
District of Columbia	82,669	2,510	10,670	66	7	95,922	13,798	82,125
Florida	157,046	5,026	727	103	9	162,911	42,243	120,667
Georgia	130,895	4,603	3,414	149	18	139,080	10,161	128,919
Hawaii	17,970	501	103	12	3	18,589	3,769	14,819
Idaho	9,535	379	29	14	2	9,959	4,257	5,702
Illinois	141,815	5,064	2,158	109	25	149,171	35,816	113,354
Indiana	34,285	1,150	301	39	6	35,781	8,663	27,118
Iowa	52,891	1,708	221	53	7	54,880	7,595	47,285
Kansas	32,454	962	171	50	4	33,641	3,050	30,591
Kentucky	82,369	2,256	249	31	9	84,914	13,097	71,817
Louisiana	62,041	1,841	10,053	80	8	74,023	22,735	51,288
Maine	20,931	651	120	19	3	21,723	4,772	16,952
Maryland	119,569	3,442	1,170	95	11	124,287	10,775	113,512
Massachusetts	116,234	3,093	1,503	78	13	120,920	18,321	102,600
Michigan	98,193	3,073	462	67	14	101,808	19,384	82,424
Minnesota	89,793	2,020	1,745	41	6	93,606	19,033	74,573
Mississippi	55,048	1,732	1,152	87	7	58,027	8,699	49,328
Missouri	60,883	1,625	326	66	6	62,907	8,404	54,503
Montana	24,456	913	86	26	3	25,484	4,014	21,471
Nebraska	39,794	1,408	552	57	2	41,813	5,918	35,895
Nevada	13,772	463	60	14	1	14,310	3,849	10,461
New Hampshire	17,469	490	200	16	9	18,185	3,105	15,080
New Jersey	102,800	2,173	1,852	147	14	106,986	23,580	83,406
New Mexico	31,759	966	140	9	1	32,876	6,378	26,497
New York	470,350	12,330	8,273	389	64	491,407	128,981	362,426
North Carolina	117,300	3,376	640	218	15	121,550	43,210	78,339
North Dakota	6,838	234	26	13	1	7,111	1,918	5,193
Ohio	107,023	3,218	2,256	78	17	112,592	16,836	95,756
Oklahoma	74,380	2,443	438	97	8	77,365	13,275	64,090
Oregon	78,109	2,705	1,256	63	9	82,142	19,595	62,546
Pennsylvania	390,859	11,314	7,888	181	67	410,308	35,166	375,143
Rhode Island	39,547	1,025	495	23	13	41,104	1,976	39,128
South Carolina	120,940	4,117	1,460	90	14	126,621	14,218	112,403
South Dakota	6,554	222	22	9	0	6,808	1,629	5,179
Tennessee	140,060	3,545	581	94	10	144,292	11,819	132,472
Texas	259,971	6,611	25,032	171	17	291,802	35,169	256,633
Utah	33,600	1,272	846	30	2	35,750	2,892	32,858
Vermont	13,118	379	33	8	2	13,539	2,412	11,127
Virginia	85,874	2,529	560	127	6	89,095	22,968	66,127
Washington	120,460	3,827	871	141	14	125,314	29,084	96,230
West Virginia	98,730	3,149	399	92	13	102,384	2,988	99,396
Wisconsin	40,920	1,297	454	21	8	42,700	12,110	30,590
Wyoming	10,040	348	104	9	1	10,501	2,015	8,487

\*Includes savings from other HPV-attributable cancer cases averted in addition to cervical cancer. Source: See Table Notes box.

TABLE 20

**Public cost savings from contraceptive and related noncontraceptive services received during family planning visits at clinics receiving other (non-Title X) public funds, including savings from averted pregnancies, STI sequelae and cancers, by state, 2016**

Provider type and state	Cost savings from specific components (in 000s of dollars)					Overall cost savings (in 000s of dollars)		
	Maternity and birth-related costs to 60 months	Miscarriage and ectopic pregnancy costs	Chlamydia, gonorrhea and HIV testing	Pap and HPV testing	HPV vaccination†	Total gross savings	Family planning costs	Total net savings
<b>Clinics receiving other public funds*</b>	<b>3,799,771</b>	<b>111,338</b>	<b>106,221</b>	<b>3,292</b>	<b>575</b>	<b>4,021,197</b>	<b>817,061</b>	<b>3,204,136</b>
Alabama	15,848	448	225	27	1	16,550	6,237	10,313
Alaska	42,537	1,412	249	25	2	44,225	6,304	37,921
Arizona	117,013	3,425	714	74	7	121,232	15,054	106,177
Arkansas	8,335	225	60	12	1	8,632	886	7,746
California	809,935	22,837	21,771	808	227	855,578	251,882	603,697
Colorado	93,808	2,802	2,203	95	27	98,935	27,617	71,318
Connecticut	64,336	1,921	576	49	6	66,889	7,869	59,020
Delaware	2,329	65	68	1	0	2,464	322	2,142
District of Columbia	13,072	397	1,688	11	1	15,169	2,182	12,987
Florida	126,548	4,050	586	84	7	131,274	34,040	97,234
Georgia	150,396	5,289	3,922	172	21	159,800	11,674	148,126
Hawaii	1,618	45	9	1	0	1,674	339	1,334
Idaho	9,228	367	28	14	2	9,638	4,120	5,518
Illinois	127,255	4,544	1,943	99	22	133,863	32,139	101,723
Indiana	70,373	2,360	619	80	11	73,443	17,781	55,662
Iowa	26,517	856	111	27	3	27,515	3,808	23,707
Kansas	12,961	384	68	20	2	13,435	1,218	12,218
Kentucky	39,368	1,078	119	15	4	40,585	6,260	34,325
Louisiana	45,827	1,360	7,433	59	6	54,685	16,793	37,891
Maine	8,263	257	47	8	1	8,576	1,884	6,692
Maryland	63,474	1,827	622	51	6	65,980	5,720	60,260
Massachusetts	68,900	1,833	891	46	8	71,678	10,860	60,818
Michigan	73,164	2,290	345	50	10	75,859	14,443	61,416
Minnesota	54,927	1,236	1,069	25	3	57,260	11,642	45,617
Mississippi	27,208	856	570	44	4	28,682	4,300	24,382
Missouri	66,716	1,781	358	73	7	68,935	9,209	59,726
Montana	9,212	344	31	10	1	9,598	1,512	8,087
Nebraska	9,079	321	126	13	1	9,539	1,350	8,189
Nevada	20,552	691	90	21	2	21,356	5,744	15,612
New Hampshire	3,087	87	35	3	2	3,213	549	2,665
New Jersey	31,451	665	567	46	4	32,732	7,214	25,518
New Mexico	80,953	2,461	357	24	4	83,799	16,258	67,541
New York	268,885	7,049	4,734	224	37	280,929	73,735	207,194
North Carolina	36,988	1,065	202	70	5	38,329	13,625	24,703
North Dakota	4,649	159	18	9	1	4,836	1,304	3,532
Ohio	100,201	3,013	2,120	74	16	105,423	15,763	89,660
Oklahoma	53,276	1,749	313	70	6	55,414	9,508	45,906
Oregon	105,521	3,655	1,696	85	12	110,968	26,472	84,496
Pennsylvania	131,027	3,793	2,649	61	22	137,553	11,788	125,764
Rhode Island	8,989	233	112	5	3	9,343	449	8,894
South Carolina	46,635	1,588	564	35	5	48,827	5,482	43,344
South Dakota	8,289	280	28	12	1	8,610	2,060	6,550
Tennessee	54,673	1,384	227	37	4	56,325	4,614	51,712
Texas	457,417	11,631	44,044	302	31	513,425	61,880	451,545
Utah	13,730	520	346	12	1	14,609	1,182	13,427
Vermont	16,653	481	42	10	2	17,189	3,063	14,126
Virginia	39,240	1,156	256	58	3	40,712	10,495	30,217
Washington	72,446	2,301	524	86	8	75,366	17,491	57,875
West Virginia	16,567	528	68	16	2	17,182	501	16,680
Wisconsin	66,465	2,106	738	35	14	69,357	19,670	49,688
Wyoming	3,833	133	40	3	0	4,009	769	3,240

\*Excluding clinics that receive Title X funding. †Includes savings from other HPV-attributable cancer cases averted in addition to cervical cancer. Source: See Table Notes box.

**Number of women aged 13–44 and the number with potential demand for contraceptive services and supplies, by age-group, income level, and race and ethnicity—2000, 2010 and 2016**

Year	Total	By age-group			By income level, % of FPL (among those aged 20–44)			By race and ethnicity			
		<20	20–29	30–44	<100%	100–249%	≥250%	Non-Hispanic white	Non-Hispanic black	Hispanic	Other
<b>All women aged 13–44 (in 000s)</b>											
<b>2000</b>	65,507	13,758	18,859	32,889	7,418	13,831	30,500	42,951	8,844	9,100	4,612
<b>2010</b>	66,418	14,780	21,038	30,600	9,245	14,328	28,066	38,668	9,167	12,655	5,927
<b>2016</b>	67,631	14,346	22,149	31,135	9,875	14,974	28,436	37,474	9,444	13,991	6,723
<b>% change 2000–2010</b>	1	7	12	–7	25	4	–8	–10	4	39	29
<b>% change 2010–2016</b>	2	–3	5	2	7	5	1	–3	3	11	13
<b>Women with potential demand for contraceptive services and supplies (in 000s)*</b>											
<b>2000</b>	33,983	4,850	14,233	14,899	4,076	7,470	17,587	22,205	4,580	4,741	2,457
<b>2010</b>	37,401	4,881	16,484	16,036	5,576	8,688	18,257	21,562	5,199	6,944	3,695
<b>2016</b>	40,201	4,636	18,425	17,140	6,245	9,766	19,554	22,403	5,761	7,912	4,125
<b>% change 2000–2010</b>	10	1	16	8	37	16	4	–3	14	46	50
<b>% change 2010–2016</b>	7	–5	12	7	12	12	7	4	11	14	12

\*Women with potential demand for contraceptive services and supplies during the year include those who have ever had voluntary sex, believe they could conceive, and are not pregnant nor trying to get pregnant during the entire year. *Note:* FPL=federal poverty level. *Source:* See Table Notes box.

### Number of women aged 13–44 by age-group, income level, and race and ethnicity—2010 and 2016 national summary, and 2016 state detail

State	All women aged 13–44												
	Total	By age-group				By income level, % of FPL (among those aged 20–44)					By race and ethnicity*		
		<18	18–19	20–29	30–44	<100%	100–137%	138–199%	200–249%	≥250%	Non-Hispanic white	Non-Hispanic black	Hispanic
<b>2010 total</b>	<b>66,419,460</b>	<b>10,341,910</b>	<b>4,438,100</b>	<b>21,038,200</b>	<b>30,600,560</b>	<b>9,244,600</b>	<b>3,823,410</b>	<b>5,964,340</b>	<b>4,540,200</b>	<b>28,066,210</b>	<b>38,669,250</b>	<b>9,166,350</b>	<b>12,655,790</b>
<b>2016 total</b>	<b>67,630,630</b>	<b>10,113,770</b>	<b>4,232,010</b>	<b>22,149,370</b>	<b>31,135,490</b>	<b>9,874,990</b>	<b>3,915,980</b>	<b>6,230,800</b>	<b>4,827,460</b>	<b>28,435,630</b>	<b>37,473,830</b>	<b>9,443,530</b>	<b>13,990,760</b>
<b>% change 2010–2016</b>	<b>2</b>	<b>-2</b>	<b>-5</b>	<b>5</b>	<b>2</b>	<b>7</b>	<b>2</b>	<b>5</b>	<b>6</b>	<b>1</b>	<b>11</b>	<b>-3</b>	<b>3</b>
Alabama	1,014,030	154,470	64,780	333,040	461,740	188,840	67,570	98,390	75,350	364,630	616,480	310,440	47,130
Alaska	155,560	21,750	9,050	53,690	71,070	15,450	7,760	12,110	11,170	78,270	88,990	5,210	12,310
Arizona	1,418,140	222,570	92,620	465,790	637,160	233,020	92,760	138,610	108,020	530,540	660,020	66,320	532,320
Arkansas	614,890	92,290	43,200	200,330	279,060	108,700	49,650	69,390	50,360	201,300	420,020	110,190	53,670
California	8,557,280	1,249,910	506,920	2,843,020	3,957,430	1,221,730	513,050	799,790	595,630	3,670,250	2,667,430	484,870	3,777,590
Colorado	1,193,540	172,800	69,570	389,840	561,340	138,870	64,220	104,690	88,240	555,170	765,930	47,760	291,660
Connecticut	717,880	112,730	51,780	226,280	327,090	73,750	31,820	49,290	41,310	357,210	428,890	84,690	143,190
Delaware	191,040	28,760	12,470	63,540	86,270	25,790	7,980	15,040	12,890	88,110	106,960	47,300	21,690
District of Columbia	189,250	13,650	11,390	74,640	89,570	28,180	7,340	12,180	9,070	107,440	79,170	74,120	19,790
Florida	3,988,320	561,290	235,680	1,304,690	1,886,650	605,930	277,440	441,980	330,330	1,535,650	1,832,170	765,500	1,162,520
Georgia	2,269,490	346,170	144,680	721,730	1,056,910	373,080	134,500	223,980	166,590	880,510	1,080,040	795,620	237,010
Hawaii	282,230	38,510	14,390	92,910	136,420	28,020	9,620	21,880	20,480	149,330	54,730	6,120	34,910
Idaho	347,340	61,400	21,990	108,300	155,640	50,130	24,140	38,740	27,560	123,380	275,060	2,470	51,230
Illinois	2,714,910	414,650	163,120	876,140	1,261,010	376,850	141,530	223,960	181,050	1,213,750	1,517,790	423,550	545,510
Indiana	1,378,790	217,980	90,740	452,780	617,290	221,660	81,130	134,840	108,650	523,790	1,047,950	147,310	111,170
Iowa	628,320	98,440	45,590	205,790	278,500	88,470	35,850	55,970	46,000	258,000	520,760	26,370	44,620
Kansas	598,530	96,180	40,740	194,980	266,640	79,930	34,940	56,320	47,240	243,190	431,580	37,170	82,580
Kentucky	904,980	137,370	59,480	293,820	414,310	165,450	57,310	90,150	66,080	329,130	751,500	80,750	35,690
Louisiana	999,480	147,830	59,750	334,970	456,930	191,730	70,300	93,480	68,360	368,040	547,940	356,640	51,880
Maine	246,030	36,980	16,650	77,110	115,290	36,150	14,800	20,590	18,650	102,210	224,890	4,330	5,350
Maryland	1,267,280	187,200	75,830	403,300	600,950	123,110	49,390	87,340	77,580	666,830	582,490	411,490	140,670
Massachusetts	1,450,360	201,390	103,150	491,430	654,400	166,100	56,700	91,270	78,530	753,220	970,040	116,040	202,620
Michigan	1,995,800	320,540	128,120	667,940	879,190	328,600	117,780	180,360	140,510	779,890	1,411,290	316,410	122,690
Minnesota	1,126,630	176,690	69,590	357,500	522,850	120,510	53,150	88,220	76,060	542,410	851,580	82,490	72,440
Mississippi	634,120	95,600	44,980	208,140	285,400	130,350	45,320	65,890	48,260	203,730	325,950	269,410	19,910
Missouri	1,249,490	189,170	81,800	411,040	567,480	192,750	70,510	124,520	96,560	494,190	952,460	167,360	61,240
Montana	200,170	30,350	12,230	67,030	90,560	31,760	14,420	20,010	16,970	74,430	167,000	1,030	9,300
Nebraska	391,620	60,260	26,730	127,800	176,830	54,870	21,100	38,560	30,520	159,590	297,030	20,530	48,960
Nevada	618,720	93,570	31,470	199,090	294,590	86,700	40,060	67,350	53,420	246,140	257,750	59,310	211,260
New Hampshire	255,340	38,390	18,160	83,660	115,130	25,510	9,300	18,220	16,400	129,340	224,970	3,650	11,820
New Jersey	1,819,070	282,650	106,280	561,120	869,010	182,840	81,730	125,620	101,030	938,910	883,660	264,790	423,770
New Mexico	422,790	68,380	28,070	138,230	188,110	81,100	32,160	46,110	32,730	134,220	126,270	7,170	230,720
New York	4,227,140	576,580	256,830	1,445,270	1,948,460	611,200	217,010	334,390	255,640	1,975,490	2,124,030	666,930	900,170

**Number of women aged 13–44 by age-group, income level, and race and ethnicity—2010 and 2016 national summary, and 2016 state detail**

State	All women aged 13–44												
	Total	By age-group				By income level, % of FPL (among those aged 20–44)					By race and ethnicity*		
		<18	18–19	20–29	30–44	<100%	100–137%	138–199%	200–249%	≥250%	Non-Hispanic white	Non-Hispanic black	Hispanic
North Carolina	2,129,250	317,610	138,640	683,990	989,020	352,440	140,870	220,300	163,520	795,880	1,240,310	508,850	229,360
North Dakota	155,910	20,450	11,240	58,620	65,600	20,480	7,100	13,130	12,570	70,930	128,050	5,100	6,640
Ohio	2,341,960	371,190	148,000	765,520	1,057,260	378,450	131,420	214,850	164,010	934,040	1,778,890	330,730	103,190
Oklahoma	821,370	127,850	52,210	270,780	370,530	135,060	55,850	89,070	64,800	296,530	503,060	67,780	97,860
Oregon	844,060	117,700	48,330	273,920	404,110	135,050	53,190	83,230	65,930	340,630	600,370	16,650	132,550
Pennsylvania	2,529,940	378,010	171,740	837,540	1,142,650	341,210	130,140	204,720	178,660	1,125,460	1,819,090	315,920	224,090
Rhode Island	220,100	30,740	17,600	76,160	95,600	30,620	10,600	17,350	16,250	96,930	146,850	14,990	40,390
South Carolina	1,014,470	145,210	67,060	337,550	464,660	170,970	65,650	111,120	76,320	378,160	600,920	307,430	63,450
South Dakota	169,460	26,670	11,860	56,040	74,890	25,000	8,760	14,830	14,150	68,190	134,150	3,320	7,040
Tennessee	1,389,170	209,380	82,890	459,310	637,600	233,080	88,970	145,540	106,640	522,680	975,230	269,620	83,270
Texas	6,196,090	969,200	381,640	1,983,740	2,861,500	926,050	394,980	621,150	450,580	2,452,490	2,301,880	801,200	2,642,400
Utah	709,650	118,430	45,660	234,440	311,120	79,390	37,410	70,430	61,180	297,140	546,890	7,050	104,630
Vermont	120,920	17,460	9,810	40,460	53,190	13,540	6,800	10,510	8,810	53,980	109,630	1,880	3,200
Virginia	1,781,400	254,180	116,120	573,800	837,310	209,920	80,010	137,570	123,280	860,330	1,026,500	365,960	191,000
Washington	1,525,860	217,970	85,880	498,890	723,110	197,810	81,470	135,780	107,330	699,620	972,750	61,330	228,200
West Virginia	347,170	51,190	21,350	112,200	162,440	69,600	20,590	33,590	25,940	124,920	317,230	12,590	6,510
Wisconsin	1,148,350	177,010	76,540	372,970	521,840	153,530	63,660	107,970	80,810	488,840	883,610	88,670	96,070
Wyoming	116,940	17,040	7,620	38,510	53,760	15,660	6,160	10,430	9,430	50,610	95,590	1,150	13,520

\*Women of other or multiple races are excluded here. *Note:* FPL=federal poverty level. *Source:* See Table Notes box.



### Number of women with potential demand for contraceptive services and supplies during the year, by age-group, income level, and race and ethnicity—2010 and 2016 national summary, and 2016 state detail

State	Women with potential demand for contraceptive services and supplies*												
	Total	By age-group				By income level, % of FPL (among those aged 20–44)					By race and ethnicity†		
		<18	18–19	20–29	30–44	<100%	100–137%	138–199%	200–249%	≥250%	Non-Hispanic white	Non-Hispanic black	Hispanic
<b>2010 total</b>	<b>37,400,340</b>	<b>2,075,640</b>	<b>2,805,240</b>	<b>16,484,000</b>	<b>16,036,170</b>	<b>5,575,570</b>	<b>2,229,050</b>	<b>3,686,590</b>	<b>2,772,220</b>	<b>18,256,530</b>	<b>21,562,220</b>	<b>5,198,410</b>	<b>6,944,440</b>
<b>2016 total</b>	<b>40,201,280</b>	<b>2,027,010</b>	<b>2,609,180</b>	<b>18,424,690</b>	<b>17,140,410</b>	<b>6,244,630</b>	<b>2,583,990</b>	<b>4,069,970</b>	<b>3,112,490</b>	<b>19,554,010</b>	<b>22,403,410</b>	<b>5,760,870</b>	<b>7,912,110</b>
<b>% change 2010–2016</b>	<b>8</b>	<b>-2</b>	<b>-7</b>	<b>12</b>	<b>7</b>	<b>12</b>	<b>16</b>	<b>10</b>	<b>12</b>	<b>7</b>	<b>4</b>	<b>11</b>	<b>14</b>
Alabama	594,750	33,810	40,390	275,560	244,980	120,940	44,460	63,250	48,360	243,530	358,610	187,760	25,090
Alaska	94,820	3,900	5,530	44,850	40,540	9,310	5,420	8,370	7,240	55,050	55,320	3,380	7,350
Arizona	837,910	41,630	56,640	384,110	355,520	143,500	61,450	91,650	70,870	372,160	401,280	39,990	301,230
Arkansas	356,370	19,370	27,340	165,720	143,940	68,970	32,560	44,420	31,160	132,550	243,470	65,850	28,650
California	5,140,940	221,670	305,760	2,353,390	2,260,110	748,320	334,600	524,850	390,800	2,614,920	1,651,180	296,780	2,165,430
Colorado	718,860	33,540	43,140	324,780	317,400	87,270	42,250	69,350	58,600	384,710	470,810	28,820	165,030
Connecticut	432,220	23,050	31,950	188,550	188,680	45,270	21,210	32,370	26,820	251,560	260,800	51,450	82,110
Delaware	115,360	6,060	7,660	53,490	48,150	16,480	5,580	9,890	8,380	61,300	65,190	28,910	12,070
District of Columbia	126,290	2,980	7,060	62,390	53,860	18,800	5,290	8,650	6,610	76,900	54,420	48,260	12,420
Florida	2,380,920	114,480	145,780	1,087,330	1,033,330	382,530	181,490	290,520	214,500	1,051,610	1,108,110	468,910	666,400
Georgia	1,336,470	73,520	90,040	600,550	572,370	236,740	88,630	146,250	106,770	594,530	632,710	482,610	127,230
Hawaii	175,230	5,440	8,050	78,370	83,380	17,400	6,710	14,910	13,610	109,110	35,060	4,180	20,710
Idaho	201,320	12,350	13,790	90,320	84,860	32,020	15,690	24,770	17,550	85,140	160,770	1,500	28,120
Illinois	1,603,800	83,910	100,420	733,050	686,420	241,460	92,490	144,640	116,560	824,310	900,170	260,610	303,120
Indiana	806,440	46,050	56,450	377,200	326,740	143,580	54,160	88,060	68,840	349,290	614,470	89,510	60,060
Iowa	362,760	20,510	28,430	170,590	143,230	58,720	24,080	35,440	28,300	167,280	301,180	15,770	24,350
Kansas	347,330	19,190	25,570	162,920	139,650	52,410	22,970	36,320	29,700	161,180	251,310	22,630	45,190
Kentucky	522,610	28,860	37,570	243,020	213,160	104,450	37,990	57,660	40,490	215,600	433,390	48,840	19,100
Louisiana	596,060	32,530	37,250	277,810	248,460	123,170	47,380	61,750	43,670	250,300	325,520	215,260	29,640
Maine	143,710	7,820	10,340	63,240	62,310	21,930	9,390	12,880	11,700	69,650	131,750	2,370	3,020
Maryland	767,330	39,530	46,560	340,120	341,120	80,480	32,830	58,080	51,120	458,740	350,050	256,690	80,270
Massachusetts	892,510	41,180	63,120	407,940	380,270	104,860	37,730	60,850	52,020	532,740	602,130	71,030	117,310
Michigan	1,174,860	68,420	79,030	555,300	472,110	214,680	79,790	117,860	89,540	525,550	827,320	194,290	67,440
Minnesota	659,730	35,910	42,760	300,080	280,970	78,910	36,170	58,030	49,020	358,920	499,960	48,850	39,110
Mississippi	369,850	21,270	28,080	171,240	149,270	82,150	29,650	42,380	29,740	136,590	188,360	159,740	10,840
Missouri	731,710	39,610	50,830	341,850	299,410	125,560	46,660	80,230	60,900	327,920	555,260	102,410	33,760
Montana	116,870	6,100	7,520	54,860	48,400	19,500	9,670	13,130	10,690	50,270	98,450	640	5,230
Nebraska	227,120	12,470	16,520	106,480	91,650	35,720	14,160	24,820	19,370	104,040	173,270	12,380	26,610
Nevada	366,790	17,120	19,160	164,760	165,750	52,550	26,030	43,770	34,400	173,770	156,580	35,810	118,810
New Hampshire	155,410	8,310	11,260	69,820	66,030	16,330	6,120	12,060	10,900	90,440	137,240	2,120	6,980
New Jersey	1,094,690	56,130	64,850	468,830	504,880	110,070	53,270	81,510	65,340	663,520	535,010	160,500	242,790
New Mexico	245,010	11,650	17,060	113,360	102,950	49,810	21,160	30,200	21,250	93,890	75,930	4,330	130,560
New York	2,584,290	115,720	157,140	1,196,120	1,115,320	376,850	142,090	219,100	168,180	1,405,220	1,309,270	410,040	526,050

**Number of women with potential demand for contraceptive services and supplies during the year, by age-group, income level, and race and ethnicity—2010 and 2016 national summary, and 2016 state detail**

State	Women with potential demand for contraceptive services and supplies*												
	Total	By age-group				By income level, % of FPL (among those aged 20–44)					By race and ethnicity†		
		<18	18–19	20–29	30–44	<100%	100–137%	138–199%	200–249%	≥250%	Non-Hispanic white	Non-Hispanic black	Hispanic
North Carolina	1,252,110	66,720	86,400	568,850	530,150	225,810	92,660	143,540	105,320	531,660	731,400	309,310	122,310
North Dakota	93,850	4,130	6,890	48,950	33,890	13,750	5,030	8,990	8,350	46,710	77,420	3,220	3,790
Ohio	1,377,180	79,600	92,010	638,100	567,470	245,580	88,990	141,410	103,760	625,840	1,043,950	200,260	57,650
Oklahoma	477,730	24,200	31,640	225,600	196,290	87,230	36,910	57,840	41,050	198,870	294,430	41,380	53,230
Oregon	506,140	23,420	29,710	225,880	227,130	84,490	35,400	55,090	42,430	235,610	364,250	9,850	73,900
Pennsylvania	1,525,670	79,870	106,100	694,050	645,650	213,310	86,520	133,850	115,520	790,500	1,102,810	191,160	127,240
Rhode Island	134,390	6,290	10,770	62,870	54,450	19,300	7,030	11,660	10,930	68,400	90,770	9,160	23,500
South Carolina	604,860	31,800	41,780	280,140	251,160	110,700	44,140	73,560	49,570	253,320	357,650	187,740	34,610
South Dakota	97,810	5,150	7,240	46,520	38,900	16,460	6,060	9,570	9,030	44,300	78,360	1,930	3,940
Tennessee	815,510	44,400	51,950	382,290	336,860	148,900	58,740	94,610	67,750	349,160	570,460	164,660	44,570
Texas	3,607,970	184,090	237,280	1,658,290	1,528,310	582,510	256,600	402,250	288,270	1,656,980	1,368,860	489,870	1,473,680
Utah	423,010	24,010	28,600	198,420	171,970	51,670	24,710	45,360	38,930	209,730	328,460	4,280	58,980
Vermont	72,620	3,760	6,170	33,310	29,380	8,460	4,440	6,910	5,900	36,970	65,920	1,130	1,910
Virginia	1,064,640	51,810	71,660	481,900	459,260	135,390	52,980	89,320	79,770	583,710	611,480	225,160	108,210
Washington	924,830	41,660	52,300	416,360	414,510	125,110	54,110	89,500	70,260	491,890	594,930	37,120	128,370
West Virginia	200,340	11,130	13,360	92,530	83,310	43,960	13,520	20,440	15,570	82,350	182,950	7,530	3,630
Wisconsin	672,910	37,450	47,500	310,710	277,250	101,110	42,980	71,430	51,100	321,330	517,970	54,240	52,800
Wyoming	69,370	3,440	4,780	31,910	29,240	10,130	4,030	6,620	5,950	34,410	56,980	690	7,690

\*Women with potential demand for contraceptive services and supplies during the year include those who have ever had voluntary sex, believe they could conceive, and are not pregnant nor trying to get pregnant during the entire year. †Women of other or multiple races are excluded here. *Note:* FPL=federal poverty level. *Source:* See Table Notes box.

**Number of women aged 13–44, number with potential demand for contraceptive services and supplies during the year, and percentage change between 2010 and 2016—national summary and state detail, 2000, 2010 and 2016**

State	All women aged 13–44				Women with potential demand for contraceptive services and supplies*			
	2000	2010	2016	% change 2010–2016	2000	2010	2016	% change 2010–2016
<b>Total</b>	<b>65,506,530</b>	<b>66,419,460</b>	<b>67,630,630</b>	<b>2</b>	<b>33,982,660</b>	<b>37,400,340</b>	<b>40,201,280</b>	<b>7</b>
Alabama	1,032,010	1,022,450	1,014,030	–1	496,250	542,770	594,750	10
Alaska	152,150	153,090	155,560	2	71,620	88,790	94,820	7
Arizona	1,156,640	1,349,610	1,418,140	5	606,160	788,050	837,910	6
Arkansas	599,970	607,900	614,890	1	279,870	317,720	356,370	12
California	8,050,740	8,393,180	8,557,280	2	4,281,480	4,998,920	5,140,940	3
Colorado	1,030,440	1,088,870	1,193,540	10	536,670	642,480	718,860	12
Connecticut	768,970	738,970	717,880	–3	438,450	435,540	432,220	–1
Delaware	184,230	190,320	191,040	0	92,530	104,560	115,360	10
District of Columbia	149,480	167,470	189,250	13	84,830	105,240	126,290	20
Florida	3,425,830	3,782,800	3,988,320	5	1,699,100	2,061,580	2,380,920	15
Georgia	2,013,930	2,205,910	2,269,490	3	988,200	1,189,220	1,336,470	12
Hawaii	269,590	278,220	282,230	1	137,950	165,700	175,230	6
Idaho	298,020	328,770	347,340	6	140,820	183,710	201,320	10
Illinois	2,916,860	2,805,470	2,714,910	–3	1,568,370	1,556,970	1,603,800	3
Indiana	1,409,540	1,375,360	1,378,790	0	735,070	744,300	806,440	8
Iowa	651,850	615,300	628,320	2	324,810	330,620	362,760	10
Kansas	612,840	592,910	598,530	1	308,670	322,990	347,330	8
Kentucky	941,850	909,390	904,980	–0	442,320	472,160	522,610	11
Louisiana	1,073,590	987,600	999,480	1	519,690	534,580	596,060	12
Maine	285,450	257,550	246,030	–4	152,170	143,950	143,710	–0
Maryland	1,265,140	1,268,630	1,267,280	–0	637,240	712,160	767,330	8
Massachusetts	1,505,400	1,430,910	1,450,360	1	879,720	873,940	892,510	2
Michigan	2,298,840	2,051,780	1,995,800	–3	1,214,580	1,113,390	1,174,860	6
Minnesota	1,155,060	1,114,610	1,126,630	1	598,050	614,320	659,730	7
Mississippi	676,790	644,200	634,120	–2	309,680	335,430	369,850	10
Missouri	1,285,750	1,254,060	1,249,490	–0	664,690	684,240	731,710	7
Montana	198,720	191,690	200,170	4	89,240	104,700	116,870	12
Nebraska	389,980	378,850	391,620	3	196,620	204,690	227,120	11
Nevada	450,350	585,730	618,720	6	238,580	346,920	366,790	6
New Hampshire	287,360	267,020	255,340	–4	157,610	151,140	155,410	3
New Jersey	1,926,570	1,854,510	1,819,070	–2	1,100,840	1,112,140	1,094,690	–2
New Mexico	419,340	426,120	422,790	–1	206,600	240,530	245,010	2
New York	4,468,370	4,289,390	4,227,140	–1	2,556,730	2,601,230	2,584,290	–1
North Carolina	1,888,920	2,070,090	2,129,250	3	924,450	1,105,570	1,252,110	13
North Dakota	144,480	137,050	155,910	14	71,530	75,590	93,850	24
Ohio	2,603,250	2,386,230	2,341,960	–2	1,368,970	1,295,830	1,377,180	6
Oklahoma	783,120	784,610	821,370	5	371,710	420,260	477,730	14
Oregon	768,730	801,580	844,060	5	389,810	465,570	506,140	9
Pennsylvania	2,727,140	2,599,600	2,529,940	–3	1,527,500	1,530,470	1,525,670	–0
Rhode Island	245,870	227,270	220,100	–3	142,760	137,750	134,390	–2
South Carolina	940,110	985,250	1,014,470	3	458,220	530,550	604,860	14
South Dakota	169,310	162,990	169,460	4	81,890	87,060	97,810	12
Tennessee	1,326,530	1,354,890	1,389,170	3	645,820	718,420	815,510	14
Texas	5,050,370	5,689,320	6,196,090	9	2,469,310	3,051,530	3,607,970	18
Utah	563,610	644,840	709,650	10	292,430	377,360	423,010	12
Vermont	139,280	125,680	120,920	–4	72,340	69,620	72,620	4
Virginia	1,684,420	1,752,430	1,781,400	2	834,890	971,730	1,064,640	10
Washington	1,376,280	1,441,110	1,525,860	6	708,340	853,190	924,830	8
West Virginia	396,210	363,430	347,170	–4	181,800	186,970	200,340	7
Wisconsin	1,235,200	1,170,950	1,148,350	–2	634,220	636,030	672,910	6
Wyoming	112,040	113,500	116,940	3	51,470	62,160	69,370	12

\*Women with potential demand for contraceptive services and supplies during the year include those who have ever had voluntary sex, believe they could conceive, and are not pregnant nor trying to get pregnant during the entire year. *Source:* See Table Notes box.



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