Four fundamental principles drive public funding for family planning. First, unintended pregnancy is associated with negative health consequences, including reduced use of prenatal care, lower breast-feeding rates, and poor maternal and neonatal outcomes. Second, governments realize substantial cost savings by investing in family planning, which reduces the rate of unintended pregnancies and the costs of prenatal, delivery, postpartum, and infant care. Third, all Americans have the right to choose the timing and number of their children. And fourth, family planning enables women to attain their educational and career goals and families to provide for their children. These principles led to the bipartisan passage of Title X in 1970 and later to other federal- and state-funded programs supporting family planning services for low-income women.

Despite the demonstrated positive effects of these programs, political support and funding for them have begun to erode. Recently, efforts to expand access to contraception through the Affordable Care Act ignited a broad debate regarding the proper role of government in this sphere, and proposals have been put forth to eliminate Title X.

Several states have already taken substantial steps to reduce public funding for family planning and other reproductive health services. In 2011, Texas enacted the most radical legislation to date, cutting funding for family planning services by two thirds — from $111 million to $37.9 million for the 2-year period. The remaining funds were allocated through a three-tiered priority system, with organizations that provide comprehensive primary care taking precedence over those providing only family planning services (see pie charts). The Texas legislature also imposed new restrictions on abortion care and reauthorized the exclusion of organizations affiliated with abortion providers from participation in the state Medicaid waiver program, the Women’s Health Program (WHP), which was due for renewal in January 2012. Although the exclusion had not previously been enforced by the state Health and Human Services Commission, it runs contrary to federal policy, and the renewal of the WHP was declined by the Centers for Medicare and Medicaid Services. In 2010, the WHP provided services to nearly 106,000 women 18 years of age or older with incomes below 185% of the federal poverty level who had been legal residents of Texas for at least 5 years. Almost half of these women were served at Planned Parenthood clinics.

To implement the legislation and funding cuts, the Texas Department of State Health Services reduced the number of funded family planning organizations
Effects on Clinics in Texas of Cuts in Family Planning Funding.

The Department of State Health Services (DSHS) Tier 1 clinics are public entities (e.g., health departments) that provide family planning services, Tier 2 clinics are nonpublic entities that provide family planning as part of comprehensive primary and preventive care, and Tier 3 clinics are nonpublic entities that provide family planning only. Although clinics in Tier 3 account for a smaller number of total sites, they served approximately 41% of women seeking publicly funded family planning services.

From 76 to 41. Some of the largest organizations that continue to receive funding lost up to 75% of their budgets. The WHP remains in place as of mid-September 2012, because Planned Parenthood providers obtained a preliminary injunction order on April 30, 2012, against enforcement of the rule banning abortion provider affiliates. The U.S. Court of Appeals for the Fifth Circuit held that the order should be vacated, but it remains in effect pending the ruling on a petition for rehearing.

Texas has a very high teen birth rate, many undocumented migrants, and the second-largest number of Medicaid births (after California). For demographically and socioeconomically similar states, Texas’s experience may be a harbinger of the broader impact of eliminating public funding for family planning.

As part of a comprehensive 3-year evaluation of the legislative changes to family planning policy in Texas, we have interviewed 56 leaders of organizations throughout the state that provided reproductive health services using Title X and other public funding before the cuts went into effect. From these interviews, we have identified the likely channels through which the legislation will influence reproductive outcomes and the women who are most likely to be affected.

Facing severe budget cuts, most clinics have restricted access to the most effective contraceptive methods because of their higher up-front costs. Even with the 340B drug-pricing program, which offers discounts of 50 to 80%, a clinic may pay $250 or more for an intrauterine device (IUD) or subdermal implant, whereas a pack of pills costs about $5. To continue serving as many clients as possible, clinics now rarely offer IUDs or implants, reserving these methods for women with medical contraindications to other contraceptives. Some providers have started waiting lists for IUDs and implants in the unlikely event that they can purchase them with money left over at the end of a funding period. In addition, as more women are steered toward contraceptive pills, they are being provided with fewer pill packs per visit, a practice that has been shown to result in lower rates of continuation with the method and that may increase the likelihood of unintended pregnancy — and therefore that of abortion.

Many organizations have also implemented or expanded systems that require clients to pay for services if they don’t qualify for the WHP. Though the fees for well-woman exams and a pack of pills are lower than in the private sector, they vary widely among clinics and within communities and remain out of reach for some of the poorest women. Those who cannot pay are turned away, whereas previously their visit would have been covered by public funds. The organizational leaders we spoke to reported that women who can pay the newly instated fees are choosing less-effective methods, purchasing fewer pill packs, and opting out of testing for sexually transmitted infections to save money.

The 35 organizations that lost all funding are facing two additional repercussions. They are no longer eligible to buy contraceptives through the 340B discount program and must pay higher prices, which are passed on to patients. And they are no longer exempt from Texas’s law requiring parental consent for teens younger than 18 years of age who seek contraceptive services. Under a federal exemption to such state laws, providers receiving Title X funds are required to provide services to teens without parental consent. As a result of the cuts, teens seeking confidential services are already having to travel farther to obtain them.

Finally, there is considerable variation across Texas in terms of the willingness and ability of communities to cover the shortfall in public funding for family
Cutting Family Planning in Texas

John A. Graves, Ph.D., and Katherine Swartz, Ph.D.

Health Care Reform and the Dynamics of Insurance Coverage — Lessons from Massachusetts

John A. Graves, Ph.D., and Katherine Swartz, Ph.D.

As the blueprint for the Affordable Care Act (ACA), the 2006 Massachusetts health care reforms are useful for projecting the potential effect of national health care reform on insurance coverage throughout the United States. In Massachusetts, reforms have yielded gains in insurance coverage. It is estimated that between 2006 and 2009, the proportion of low-income Massachusetts adults who lacked insurance coverage decreased by one sixth, while the proportion in similar states barely changed — a substantial achievement by any measure.¹

One aspect of the Massachusetts reforms that has not been evaluated, however, is their effect on various groups of uninsured people — in particular, those who have short spells without insurance versus those who remain uninsured longer. This distinction is important: since 2007, Massachusetts and the federal government have together spent more than $700 million annually...