Re: Proposed Title X rule

Dear Senior Advisor Huber and Deputy Assistant Secretary Foley:

As a group of academic researchers with the Texas Policy Evaluation Project (TxPEP), we describe below our grave concerns, based on extensive research, about the negative impacts that will be felt in both the provider network and among low-income women seeking subsidized family planning services if the proposed Title X rule is implemented. Based at The University of Texas at Austin’s Population Research Center, TxPEP's mission is to conduct methodologically principled research that evaluates the impact of reproductive health policies and programs in the state of Texas.

Using Texas as a case study, as well as drawing on the larger scientific literature, we show the negative impacts of the proposed rule to (1) exclude Planned Parenthood affiliates from the Title X program; (2) require that primary care be integrated with family planning services; (3) restrict information on abortion counseling and referrals; (4) emphasize natural family planning methods; and (5) weaken confidentiality protections for young people.

(1) Excluding family planning providers that also perform abortions, such as Planned Parenthood, would dramatically reduce the network of family planning providers serving women under the Title X program and would have a substantial negative impact on women’s access to highly effective contraception.

Texas provides an example of the negative impact that the exclusion of a major family planning provider can have on the health of the reproductive health safety net and on the ability of low-income women to get timely, high-quality care. Over the past several years, we have conducted and
published scientific research on the impact of Texas’s efforts to exclude Planned Parenthood clinics from providing family planning services to Texas women via two mechanisms: through extensive cuts to family planning funding and prioritizing organizations that provided primary care to receive the remaining funds, and by creating a fully state-funded program in order to exclude Planned Parenthood from a fee-for-service family planning program.

1a. Excluding Planned Parenthood by cutting family planning funds and prioritizing primary care providers for the remaining funds substantially reduced the number and health of family planning clinics.

In 2011, in an effort to restrict Planned Parenthood and other family planning providers that also provided abortion services from receiving funding, the Texas legislature cut state grant funding for family planning services by 60% (from $111 million to $38 million). Health departments and federally qualified health centers (FQHCs) that provided primary care in addition to family planning services received priority over specialized family planning providers, including but not limited to Planned Parenthood, for the remaining funds.

Following the cuts, 25% of publicly funded clinic sites closed or discontinued providing family planning services, and 54% fewer clients were served (White, Grossman, Hopkins, & Potter, 2012; White et al., 2015). Organizations also experienced difficulties providing a full range of contraceptive methods, particularly those with high up-front costs, like the IUD, implant, and sterilization (White et al., 2015). There was also evidence of women forgoing family planning care altogether because of new fees that were instituted after the cuts went into effect (Hopkins et al., 2015).

These results highlight the negative impact of excluding a large provider of family planning services on the quantity and quality of services provided by clinics in the reproductive health safety net.

1b. Excluding Planned Parenthood reduced women’s access to highly effective contraceptive methods.

On January 1, 2013, Texas replaced the Women’s Health Program (WHP), its Medicaid family planning demonstration program, with a fully state-funded program that excluded all Planned Parenthood affiliates. Before the exclusion, Planned Parenthood affiliates had provided more than 40% of all family planning services through the Medicaid program. Texas was the first state to exclude Planned Parenthood affiliates from providing care using a public healthcare funding stream.

Two aspects of Planned Parenthood’s exclusion permitted us to conduct a methodologically rigorous assessment of this policy change. First, the exclusion took place at a single point in time and affected all Planned Parenthood affiliates. Second, Planned Parenthood did not provide services all over Texas. Although they only had clinics in 23 counties, these included about half of the low-income women who were eligible for the program. Thus, by examining services provided before and after the exclusion, we could compare the change in services in the counties with Planned Parenthood clinics that were affected by the exclusion and those without such clinics that were not affected.

To assess of the impact of the exclusion, we partnered with scientists at the Texas Health and Human Services Committee (HHSC) and accessed the universe of Medicaid and WHP/replacement program medical and pharmacy claims. These claims data enabled us to determine the volume of individual methods of contraception provided in each quarter of the two years preceding and the two years following the exclusion. The volume of claims is shown below on the left-hand side in the figure on the next page (Figure 1) taken from the published report (Stevenson, Flores-Vazquez, Allgeyer, Schenkkan, & Potter, 2016).
In this figure, we distinguish between three categories of contraceptive methods: long-acting reversible contraceptives (LARC; contraceptive implants and intrauterine devices), an injectable contraceptive (depot medroxyprogesterone acetate), and short-acting hormonal methods (oral contraceptive pills, transdermal contraceptive patches, and contraceptive rings). We also separate claims according to type of county. Those that were filed in counties that had a Planned Parenthood affiliate in 2011 are represented as blue circles, and those that were filed in counties without such an affiliate at that time are represented as red triangles. **A large decline in the number of claims for LARC and injectables at the time of the exclusion is apparent in the counties with a Planned Parenthood affiliate, but not in the counties without an affiliate.** Indeed, we found a statistically significant relative reduction of 31.1% in LARC methods and a relative reduction of 35.5% in injectable contraceptives.
1c. Excluding Planned Parenthood led to fewer women continuing to use highly effective methods and to more births.

We also measured the impact of the exclusion on contraceptive continuation and subsequent births, by identifying a population of women who were using a contraceptive method requiring regular provider visits and for which the length of contraceptive efficacy was consistent and short enough to allow for pregnancies within the timeframe between the exclusion and the 18 months of complete Medicaid births data available at the time of our analysis. Injectable contraceptives met both of these requirements. We constructed two cohorts of injectable contraceptive users. The first cohort received an injection in the fourth quarter of 2011 and thus had a year to continue receiving services before the exclusion of Planned Parenthood affiliates took effect. The second cohort received an injection in the fourth quarter of 2012 and thus was subject to the influence of the exclusion before the due date for the next injection. For each cohort and county group, we computed the proportions of women who received an on-time injection in the next quarter and who had a Medicaid-paid delivery in the following 18 months. For continuation and births, we calculated the difference in differences between the two cohorts and groups of counties.

The proportion of women returning for a subsequent on-time contraceptive injection in counties with Planned Parenthood affiliates was lower after the exclusion. Specifically, the percentage of women decreased from 56.9% to 37.7% in counties with Planned Parenthood affiliates but increased from 54.9% to 58.5% in counties without such affiliates (estimated difference in differences for counties with Planned Parenthood affiliates as compared with those without affiliates, −22.9%; P<0.001). This represents a relative decrease in continuation of 40.2% (−22.9% divided by 56.9%).

The percentage of women who had a birth covered by Medicaid within 18 months increased from 7.0% to 8.4% in the counties with Planned Parenthood affiliates and decreased from 6.4% to 5.9% in the counties without Planned Parenthood affiliates (estimated difference in differences, 1.9%; P=0.01). This change represents a relative increase of 27.1% from baseline (1.9% divided by 7.0%) in the proportion of women using injectable contraceptives who had a birth by Medicaid within 18 months after the claim.

These findings show that among women using injectable contraceptives, fewer women who received an injection in the quarter preceding the exclusion continued to receive an injection through the program than did those in an earlier cohort. In addition, there was a disproportionate increase in the rate of childbirth covered by Medicaid.

1d. Women enrolled in the Women’s Health Program (WHP) at Planned Parenthood had difficulty finding replacement services after Planned Parenthood’s exclusion.

To find out how easy it was for women who were receiving services through WHP at Planned Parenthood to find a new provider after the exclusion, we conducted a study of women who had received a dose of injectable contraception from the Planned Parenthood affiliates in Houston and Midland in the last quarter of 2012 (Woo, Alamgir, & Potter, 2016). We interviewed 224 of these women by telephone between April and October 2014 and asked them about their current method of contraception and any difficulty obtaining the method before May 2013, pregnancy occurrence in 2013, and demographic characteristics. The experiences captured in these interviews pointed to challenges and barriers women may face when seeking a new provider of contraception including unnecessary physical exams, multiple visits and unauthorized copayments.

Of the 148 interviewees who remained enrolled in WHP when the next injection was due and also sought another injection, 80% obtained the dose, but only 56.8% did so at no cost and on time. By comparison, in the corresponding months of 2012 in Houston, 92% of all injectable contraception patients obtained their doses at no cost and on time. While WHP was intended to provide
contraception without cost, 9.5% of interviewees with WHP reported paying because they chose a nonparticipating provider; bought the medicine themselves at a pharmacy because it was unavailable at the health provider's office; or were charged an “injection fee” or “co-pay”. Among all women who successfully obtained a repeat dose, regardless of WHP enrollment status (n = 129), more than 85% reported no barriers. Among those who experienced barriers, the most common were difficulty making an appointment and affording the injection. In addition, more than half of women were required to have a physical exam first, 17.0% needed more than one visit, and 11.0% said the injection was out of stock at their initial visit. Of the 148 women with WHP, 30 missed their next dose. They gave multiple reasons for doing so, most commonly: difficulty finding a provider, the cost of the injection and trouble getting an appointment.

Another lesson may be drawn from the large difference we found between clients at the Midland and Houston sites in the proportion returning to Planned Parenthood after the exclusion to get another dose of injectable contraception and having to pay nearly $100 for the injection. This proportion was much greater in Midland than Houston. This finding corresponds with the greater number of alternative providers in Houston, the fourth largest city in the US. Finally, at 18 or more months after the exclusion, the former Planned Parenthood clients we interviewed used an ineffective mix of contraceptive methods in comparison with a nationally representative cohort of injectable contraceptive users.

In summary, excluding Planned Parenthood from participating in family planning program funding in Texas reduced the number of clinics providing contraceptive services, which in turn reduced women’s access to highly effective contraceptive methods, led to fewer women continuing to use highly effective methods and to more births, and resulted in women having difficulty finding replacement family planning services.

(2) The proposed Title X rule that requires primary care services on-site or in close physical proximity will likely lead to lower quality care.

During the 2013 legislative session, the state legislature allocated $100 million to a new Expanded Primary Health Care (EPHC) program in an effort to repair the reproductive health care safety net and expand the network of family planning providers that had been reduced as a result of state budget cuts and the exclusion of Planned Parenthood in 2011. Organizations participating in the EPHC program were required to integrate family planning with existing primary care services and provide contraceptive counseling and on-site access to reversible contraceptive methods for the majority of women they served through the program. The majority of EPHC-funded organizations were Federal Qualified Health Centers (FQHCs) and public health departments and hospitals; specialized family planning organizations also received funding from the program, but agencies affiliated with an organization that provides abortion were ineligible, which effectively excluded Planned Parenthood.

We conducted interviews with 72 program administrators and clinicians at 30 EPHC-funded organizations about their experiences implementing or expanding family planning services during the program’s first year; these organizations received more than 80% of the initial funding allocations for the program. We found that many primary care organizations initially lacked capacity to provide evidence-based family planning services, and therefore, did not immediately offer the same level of services that women’s health contractors already provided (White, Hopkins, Grossman, & Potter, 2018). In particular, primary care organizations, such as FQHCs and public health departments, which were first-time recipients of family planning contracts, reported numerous operational challenges to launching a family planning program. These agencies often had a delayed start because they needed to establish contracts with vendors to purchase contraceptive
methods and other supplies to offer routine reproductive health services to the new clients they expected to serve. They also had to hire new staff or train existing staff about the sexual and reproductive health issues that need to be addressed when women presented at their clinics. Additionally, clinicians who were already employed at both established and new primary care contractors often lacked training to provide IUDs and implants.

Even after hiring and training staff, respondents stated it was difficult to accommodate the EPHC program’s focus on family planning because of their existing patient population’s extensive primary care needs and the time constraints during a single visit to address a range of health concerns; therefore, clinicians only addressed health issues that women raised. We also found that some clinicians who received training to provide IUDs and implants did not feel competent and comfortable enough to insert the methods, which limited their availability to women who wanted them. Furthermore, clinicians at some of these organizations described protocols for providing IUDs and implants that did not follow the US Medical Eligibility Criteria (Centers for Disease Control and Prevention, 2010) (Centers for Disease Control and Prevention, 2010), and instead restricted provision to adult women with children and required them to make multiple visits for medically unnecessary services.

These results indicate that primary care organizations with limited expertise in family planning will not be able to immediately offer women evidence-based family planning services, and therefore will be unable to fulfill the guidelines to make rapid and effective use of Title X funds. However, the current network of publicly funded women’s health organizations already provides this type of care and can offer low-income women wanting to prevent pregnancy services when they need them.

(3) The proposed rule restricting information on abortion counseling and referrals will adversely affect care at publicly funded family planning organizations for women with unplanned pregnancies.

In the study with family planning program administrations described above, we also asked about counseling and referrals for women with unplanned pregnancies after Texas began enforcing a requirement that organizations and providers receiving state family planning funds must not provide or promote elective abortions and could not facilitate a woman’s access to abortion care. We found that all 15 of the Title X-funded organizations but only nine of 22 state-only-funded organizations reported offering non-directive pregnancy options counseling (White, Adams, & Hopkins, n.d.).

Staff at Title X-funded organizations described tailoring the information offered to women’s particular wants and needs, such that women who were unsure about their decision were provided information on parenting, abortion and adoption, but counseling for those who explicitly mentioned that they planned to continue their pregnancy focused on pregnancy-related care. In contrast, respondents at state-only-funded organizations often described directing pregnant women exclusively to prenatal care, without considering women’s preferences. This practice is inconsistent with women’s desires for unbiased information about their pregnancy options (French, Steinauer, & Kimport, 2017) and national professional medical associations’ guidelines that providers offer pregnant women options counseling so they can receive accurate information and access appropriate care (American Academy of Physician Assistants, 2013; American College of Obstetricians and Gynecologists, 2014; Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), 2016; Committee on Adolescence, American Academy of Pediatrics, 1998).

Our study also found that most organizations, regardless of funding source, provided women a list of agencies offering abortion, adoption and prenatal care; however, respondents often made it clear that their practice did not extend to making an abortion referral. Moreover, some respondents
expressed concern that providing other information about abortion would threaten their funding. In contrast, respondents indicated staff would make appointments for prenatal care, assist with Medicaid applications and enrollment in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and, in some instances, directly connect women with adoption-related services.

Approximately four million clients received care from Title X-funded organizations in 2016, and many rely on these organizations for pregnancy testing (Fowler, Gable, Wang, & Lasater, 2017; Frost, 2013). Therefore, the proposed Title X guidelines that permit but do not require providers to offer options counseling would prevent many women from receiving unbiased information that honors their choices about their pregnancy and helps them make the decision that is right for them and their families. In addition, recommendations for quality care include providing women with comprehensive information about facility locations and services, cost, and funding support because women frequently report difficulty locating a provider and navigating other obstacles to care (Baum, White, Hopkins, Potter, & Grossman, 2016; Fuentes et al., 2016; White, deMartelly, Grossman, & Turan, 2016; Zurek, O'Donnell, Hart, & Rogow, 2015).

(4) The proposed rule’s emphasis on natural family planning methods undermines the core mission of Title X—to help women (and men) plan their families by providing the full range of birth control methods that women want.

In a prospective study we conducted about low-income women’s contraceptive preferences (Potter et al., 2017), we found that less than 1% of the 1,469 women we interviewed three months after delivering a baby said that they wanted to be using natural family planning methods by the time their baby was six months old (Strandberg & Hopkins, 2018). Nearly all the other women in the study wanted to use more effective birth control. For example, 34% of women wanted to use an implant or IUD, birth control methods that are more than 99% effective. But the high costs of these methods put them out of reach for many women.

The vast majority of Title X providers (93%) already ensure that women who prefer natural family planning methods can effectively use them to prevent pregnancy by offering them counseling and support (Hasstedt, 2018). Additionally, clinics that specialize in reproductive health, such as Planned Parenthood, also do better supporting natural family planning than primary care clinics that offer family planning (91% versus 75%) (Zolna & Frost, 2016).

Title X funds should be used to help all women get the effective methods of birth control that they want. The proposed Title X rule that does not include a requirement to provide the full range of contraceptive methods will make highly effective methods even more difficult for low-income women to access.

(5) The proposed rule weakens confidentiality protections for young people, which could lead to higher birthrates through reduced use of family planning services and contraceptives among minor teens.

Texas state law requires parental consent for unmarried minors seeking contraceptive services in facilities that do not receive Title X funds. This parental consent requirement extends to minors who are already mothers; while these young women can consent to the medical care for their children, they cannot consent to their own medical care.

In a focus group study that we conducted, we found that teenagers considered the need for parental consent a barrier to obtaining family planning services because it required them to reveal to their
parents that they were, or were contemplating becoming, sexually active (Hopkins et al., 2015). This finding is supported by studies documenting that a majority of teenagers believe their parents disapprove of their having sex (Jones, Singh, & Purcell, 2005). In a recent nationally representative study of reproductive aged women, sexually active teens ages 15-17 with concerns about parental consent and lack of confidentiality were less likely to have received contraceptive services in the last 12 months than those who did not have such concerns (Fuentes, Ingerick, Jones, & Lindberg, 2018). Moreover, a large body of evidence finds that parental consent or notification laws are associated with reduced use of family planning services (Girma & Paton, 2013) and contraceptives (Jones, Purcell, Singh, & Finer, 2005; Reddy, Fleming, & Swain, 2002) and increased birthrates (Zavodny, 2004) and among teenagers.

We at the Texas Policy Evaluation Project urge HHS to modify the proposed rule to take into account the substantial scientific evidence to: (1) allow the inclusion of providers that use other funds to offer abortion care; (2) not require on-site or nearby primary care; (3) mandate options counseling and permit referrals for abortion care as well as for adoption services and prenatal care; (4) require counseling and provision about the full range of contraceptive options; and (5) ensure minor teens can access confidential reproductive health services.

If you would like additional information, please contact Dr. Joseph Potter at joe@prc.utexas.edu or at 512-471-8341.

Sincerely,

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References


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