

The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas

Kari White, PhD, MPH, Kristine Hopkins, PhD, Abigail R. A. Aiken, MD, PhD, Amanda Stevenson, MA, Celia Hubert, MA, Daniel Grossman, MD, and Joseph E. Potter, PhD

We examined the impact of legislation in Texas that dramatically cut and restricted participation in the state's family planning program in 2011 using surveys and interviews with leaders at organizations that received family planning funding.

Overall, 25% of family planning clinics in Texas closed. In 2011, 71% of organizations widely offered long-acting reversible contraception; in 2012–2013, only 46% did so. Organizations served 54% fewer clients than they had in the previous period. Specialized family planning providers, which were the targets of the legislation, experienced the largest reductions in services, but other agencies were also adversely affected.

The Texas experience provides valuable insight into the potential effects that legislation proposed in other states may have on low-income women's access to family planning services. (*Am J Public Health*. 2015; 105:851–858. doi:10.2105/AJPH.2014.302515)

PUBLICLY FUNDED FAMILY

planning clinics have been a key component of the health care safety net for low-income women in the United States and will remain essential points of access under the Affordable Care Act.^{1,2} Title X, the federal program dedicated to family

planning, provides crucial infrastructural support for a network of clinics and subsidizes the cost of family planning services for uninsured women. In many states, Medicaid family planning waivers or state plan amendments constitute another source of support, and they reimburse clinics for services provided to eligible women. These programs can help fill gaps in coverage for those who lose other insurance because of changes in income or employment or other life events.³

However, the degree to which low-income women can rely on publicly funded providers for subsidized family planning services has become increasingly dependent on policies enacted by state legislatures, which recently have taken on a large role in determining not only the amount of funding that goes to family planning but also the types of organizations that are eligible to receive it. Since 2010, several states have made significant cuts to their family planning budgets, and in 5 states, funding for family planning services was disproportionately reduced relative to other health programs.⁴ Additionally, since 2011, 16 states have proposed legislation that effectively blocks specialized family planning providers from receiving any public funding such as Title X or bars those that also provide abortion services from receiving funds, including Medicaid.^{5,6}

This legislation may be aimed at defunding entities providing abortion care, such as Planned Parenthood, even though federal dollars cannot be used to pay for abortions in almost all cases.

One of the most striking examples of legislation affecting the delivery of publicly funded family planning services took place in Texas, which in 2011 both dramatically cut and restricted participation in the state's family planning program. We examined the impact of the 2011 legislation on family planning providers in Texas. We have reported on our findings from surveys and in-depth interviews with leaders at organizations across the state that received public funding before the legislation and our analysis of state administrative data. The Texas experience provides valuable insight into the potential effects that legislation proposed in other states may have on low-income women's access to family planning services.

FAMILY PLANNING PROGRAMS IN TEXAS, FISCAL YEAR 2011

In fiscal year (FY) 2011 (September 2010 through August 2011), the Texas Department of State Health Services (DSHS) administered \$49.3 million in Title X funding and Title V (Maternal and

Child Health) and XX (Social Services) federal block grants, which funded 72 organizations throughout the state to provide family planning services to low-income populations. These organizations included public health departments, federally qualified health centers, Planned Parenthood affiliates, and other private nonprofit health centers. In FY2011, 27% of the 217 884 women served by these funds received care at Planned Parenthood health centers; an additional 13% of women obtained services from other specialized family planning agencies.

The state Health and Human Services Commission also operated the Women's Health Program (WHP), a Medicaid family planning waiver program that covered services for women aged 18 to 44 years with incomes of up to 185% of the federal poverty level, who had been legal US residents for at least 5 years. The waiver program served 119 083 women in FY2011, nearly half of whom received services at Planned Parenthood clinics.

LEGISLATIVE CHANGES, FISCAL YEARS 2012–2013

In the 2011 session, Texas state legislators passed 3 measures that expanded on initiatives carried out



in previous years to defund Planned Parenthood affiliates. First, the family planning budget was cut from \$111.0 million per biennium to \$37.9 million for the 2012–2013 budget period by diverting state and federal funds to other programs.⁷ The remaining funds, most of which were Title X because the legislature could not reallocate those funds to other services, were combined into a single program that followed Title X regulations. Title X requires organizations to provide confidential family planning services to adolescents, thereby superseding the state's parental consent requirement, and enables providers to offer services regardless of immigration status. Both of these are important exemptions in a state that has high rates of adolescent pregnancy and a large undocumented immigrant population.^{8,9} Receipt of Title X also enables organizations to participate in the 340B drug-pricing program through which they can purchase contraceptives at discounts of 50% to 80%.

The second legislative measure allocated the remaining funds through a 3-tiered priority system in which public agencies providing family planning services (e.g., health departments) and federally qualified health centers were in the highest priority tier, tier 1, and specialized family planning providers were in the lowest tier, tier 3; the remaining agencies that provided comprehensive preventive and primary care in addition to family planning were classified as tier 2.¹⁰ Finally, the legislature's renewal of the WHP, which was to expire on December 31, 2011,

reauthorized the exclusion of organizations affiliated with abortion providers from the program and prompted the Health and Human Services Commission to adopt rules that would enforce the ban, which had not been implemented previously.¹¹

The first 2 measures went into effect on September 1, 2011. The DSHS immediately issued temporary funding extensions to all tier 1 organizations and temporarily funded other organizations only if no other providers were in their service area. The DSHS issued formal contracts for the period from January 15, 2012, through March 31, 2013, when the state's contract for Title X ended. Later, in March 2012, the Centers for Medicare and Medicaid Services declined the state's WHP renewal application because the exclusion criteria restricted women's abilities to choose qualified providers, which is not permitted under federal law.¹² Federal funding for the WHP, which covered 90% of the program's costs, was discontinued on December 31, 2012. On January 1, 2013, the state began administering the Texas Women's Health Program, using state revenue to cover the \$30 million of annual federal funding that had previously supported the program.

METHODS

This mixed methods study included 2 waves of surveys and in-depth interviews with leaders at organizations that received DSHS family planning funding in FY2011. The first wave of data collection took place between February and July 2012, and the

second wave took place between May and September 2013.

Survey of Family Planning Organizations

In February 2012, we mailed a letter inviting executive directors of all 72 family planning organizations to complete a survey about services provided at their organization. After sending the invitation letter, we made follow-up phone calls and sent emails reminding them to complete the survey. We used the same approach for the second wave.

Executive directors, medical directors, or program administrators who were knowledgeable about the organization's family planning program completed the self-administered structured surveys on clinic operations and services in FY2011 and FY2012–2013. Questions included the number of clinics and sites offering confidential adolescent services at the organization; clinic hours; availability of specific contraceptive methods and preventive services, such as cervical cancer screening and testing for sexually transmitted infections, at the organization; and participation in discount drug-pricing programs and the WHP. The majority of the surveys were submitted electronically through a secure online system, but a few organizations returned the surveys by mail or fax.

In-Depth Interviews With Organizational Leaders

We also asked leaders at a subsample of organizations to participate in 2 in-depth interviews, which corresponded to each wave of the survey, to obtain detailed information about the strategies

used to adapt to changes resulting from the legislation. We selected organizations for the subsample by stratifying across Texas's 8 health service regions and then, within each region, sampling on the basis of probability proportional to size, where size was the number of family planning clients the organization served in FY2010. We recorded and transcribed the in-depth interviews.

Survey and interview respondents were not compensated.

State Administrative Data

From the DSHS, we obtained data on family planning funding allocations and the number of unduplicated clients obtaining family planning services in FY2011 and FY2012–2013 (September 1, 2011, through March 31, 2013). The end date for FY2012–2013 corresponds to the end of the Title X award period and DSHS-administered family planning funding for the legislative biennium.

At the time of this study, claims for family planning services in the WHP and Texas Women's Health Program were not available to assess the impact of excluding Planned Parenthood affiliates.

Data Analysis

From the survey data, we assessed the number of clinics that closed or stopped offering family planning services, reduced service hours, and no longer provided confidential adolescent services during FY2012–2013. Project consultants provided information on clinic closures from organizations that did not respond to the survey; in addition, some



organizations notified us of closures that occurred between survey waves. For nonrespondents, we estimated the number of confidential adolescent clinics from state administrative data on organizations receiving Title X funding in each period.

We also examined the percentage of organizations charging uninsured clients new fees for services, participating in discount drug-pricing programs, and widely offering specific contraceptive methods and cervical cancer and sexually transmitted infection screening on site in FY2011 and FY2012–2013. Such changes were among the adaptive strategies Title X-funded organizations in other states undertook when facing political challenges.^{13,14} For all outcomes, we examined differences according to funding tier (tiers 1 and 2 vs tier 3). We combined tiers 1 and 2 because there were only 6 tier 2 organizations.

We analyzed the in-depth interview transcripts using open coding of text segments on changes in service delivery. K.W. organized coded segments into common themes and discussed these with other members of the research team, who conducted the interviews to confirm coherence within each theme. Finally, we compared the themes and survey results to identify convergence between these data. We have presented quotations from the in-depth interviews that are representative of these themes to highlight our main survey findings.

Using the DSHS administrative data, we calculated the total family planning funding award received in FY2011 and FY2012–2013 and the percentage of organizations funded through March 31, 2013, according to funding tier.

We also calculated the total percentage change in funding and number of unduplicated clients served between FY2011 and FY2012–2013. Because FY2012–2013 included 19 calendar months, funding and client totals were not comparable to FY2011. To address this difference, we computed 12-month equivalent totals for any organization that received more than 12 months of funding by dividing the total amount of funding (or number of clients served) by the total months of funding received in FY2012–2013 and multiplying this value by 12 months.

RESULTS

Between February and July 2012, 52 organizations (72%) completed the first wave of the survey; many of the nonrespondents were smaller organizations, and those that participated served 91% of clients obtaining DSHS family planning services in FY2011. Of the 64 organizations that were still providing family planning services in May 2013, 52 completed the second survey, 42 of which also completed the first wave. Leaders at 27 organizations participated in each wave of in-depth interviews, and we interviewed leaders at 17 organizations in both waves.

Funding Cuts

DSHS administrative data showed that in FY2011 40% of Texas's family planning funds went to 5 organizations; 3 were tier 1 public agencies and 2 were tier 3 specialized family planning providers (Table 1). The majority

of organizations (66%) providing family planning services in FY2011 received less than \$500 000, and very few of these were tier 3 organizations. In FY2012–2013, organizations had less funding overall to provide services for a longer period, but reductions in funding were substantially greater for tier 3 organizations than for those in tiers 1 and 2. Additionally, fewer tier 3 organizations received any funding during this period.

At the start of FY2012–2013 (September 1, 2011), 9 of the 17 tier 3 organizations, including 4 of the state's 7 Planned Parenthood affiliates, lost all their state family planning funding, but only 5 of the 55 tier 1 and 2 organizations lost all funding. By the end of FY2012–2013 (March 31, 2013), only 4 (23%) tier 3 organizations remained funded; none were Planned Parenthood affiliates. By contrast, 37 (67%) tier 1 and 2 organizations continued to receive family planning funds.

Clinic Closures and Reduced Hours

According to the survey and project consultants, 6 organizations in tiers 1 and 2 and 3 tier 3 organizations discontinued family planning services at all their 22 clinics because of decreased funding. Many other organizations also stopped offering family planning services at some locations or closed select clinics in their network. Overall, 38 (40%) of the 96 clinics administered by tier 3 organizations closed, and organizations in tiers 1 and 2 closed 44 (19%) of their 237 clinic sites (Figure 1). Additionally, service hours were reduced at 30 (31%) tier 3 clinics

and 19 (8%) tier 1 and 2 locations. In the in-depth interviews, leaders at some organizations commented that they had eliminated evening or weekend hours, whereas others reported reducing service hours more significantly to only 1 or 2 days per week. In some communities, this resulted in longer waiting times to get an appointment.

There also were fewer sites where minors could access contraceptive services without parental consent in FY2012–2013, according to survey and administrative data. Organizations in tiers 1 and 2 operated 127 clinics in FY2011 that offered confidential services to minors. In FY2012–2013, 14 of these sites no longer offered confidential services, but such services were available at 15 new sites because Title X funding was awarded to some organizations that had not previously received it. Among tier 3 organizations, adolescents could obtain confidential services at 45 clinics in FY2011, but by the end of FY2012–2013, there were only 13 clinics where these services were available. In-depth interview respondents said this was because they no longer received Title X funding or allocated funds to clinics serving a large number of clients ineligible for the WHP. They also commented that fewer Title X clinics made it difficult for adolescents, who were considered a priority population, to access services:

If they came in to the clinic and they didn't have a parent and they didn't get consent, we would refer those patients to [the Title X clinic], but they weren't always able to make the arrangement to get over there. (program administrator, tier 1)



TABLE 1—Changes in Organizations’ Family Planning Funding in Texas Between Fiscal Year 2011 and Fiscal Years 2012–2013, by Fiscal Year 2011 Funding Allocation and Funding Tier

FY2011 Funding Allocation for Each Organization	No. Organizations	Total Funding, FY2011	Total Funding, FY2012–2013	Percentage Decrease ^a	Organizations Funded Through March 31, 2013
\$4 000 000–\$6 999 999					
Tiers 1 and 2	2	10 976 992	7 087 364	59.2	2
Tier 3	0
\$2 000 000–\$3 999 999					
Tiers 1 and 2	1	2 148 103	1 463 955	57.0	1
Tier 3	2	6 763 612	1 992 104	70.5	0
\$1 000 000–\$1 999 999					
Tiers 1 and 2	4	6 273 991	5 095 390	48.7	4
Tier 3	5	6 350 875	1 202 654	85.6	2
\$500 000–\$999 999					
Tiers 1 and 2	7	4 599 125	2 595 096	62.7	5
Tier 3	3	1 694 050	496 529	81.5	1
\$300 000–\$499 999					
Tiers 1 and 2	10	3 723 473	3 731 914	32.6	5
Tier 3	5	2 009 362	534 722	73.4	0
\$100 000–\$299 999					
Tiers 1 and 2	16	3 481 491	3 281 607	37.0	12
Tier 3	2	399 194	458 265	27.5	1
< \$100 000					
Tiers 1 and 2	15	840 793	1 157 933	6.4	8
Tier 3	0
Total	72	49 261 061	29 097 533	59.7	41
Tiers 1 and 2	55	32 043 968	24 413 259	50.6	37
Tier 3	17	17 217 093	4 684 274	76.5	4

Note. FY = fiscal year. Fiscal year 2011: September 1, 2010, through August 31, 2011; fiscal years 2012–2013: September 1, 2011, through March 31, 2013. Tier 1 and 2 organizations include public agencies (e.g., county health departments) providing family planning services and nonpublic agencies providing family planning services in addition to comprehensive primary care. Tier 3 organizations include nonpublic agencies providing family planning services only.

Source. Texas Department of State Health Services data for Titles V, X, and XX family planning program funding.

^aThe percentage decrease relative to fiscal year 2011 reflects the 12-mo equivalent funding total in fiscal years 2012–2013. The 12-mo equivalent total was calculated by dividing the total amount of funding by the total months of funding received in fiscal years 2012–2013 and multiplying this value by 12 mo for any organization that received more than 12 mo of funding.

Changes in Cost of Services for Providers and Women

Although nearly all organizations reported in the survey that they participated in the WHP in FY2011, in-depth interview respondents commented that enrolling potentially eligible women in the program became a key

survival strategy following reduced DSHS funding in FY2012–2013. Moreover, they were now more stringent about women presenting documentation of their WHP eligibility, such as proof of income and residence, before providing grant-funded services because funding was insufficient

to cover the costs for all clients. This was reported more often by tier 3 specialized family planning providers that were not Planned Parenthood affiliates.

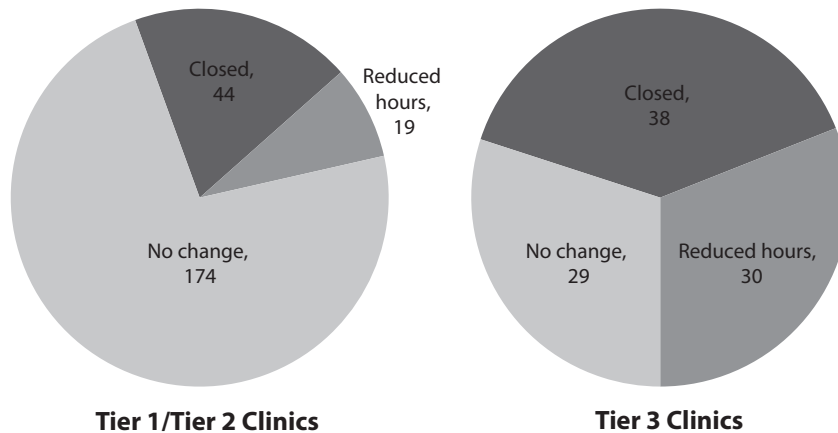
Reduced funding also led organizations in all tiers to implement or expand systems requiring women to pay fixed fees for services, instead of

using a sliding fee scale. These fixed fees applied to clients who did not qualify for the WHP and either received care at a clinic that did not have Title X funding or were unable to get one of the limited number of monthly appointments at a Title X-funded clinic.

In the survey, 58% of tier 1 and 2 organizations and 75% of tier 3 organizations reported that a larger percentage of their clients paid for services in FY2012–2013 than in FY2011. Some organizational leaders stated in the interviews that they developed a fee schedule by which physicals, cervical cancer screening, and other services were provided at a fixed cost, whereas other organizations charged fees for each service; contraceptive methods often incurred an additional charge. Prices varied across organizations, as administrators factored in both their cost to provide the service and what women could afford. However, this did not guarantee clients would be able to pay the new fees:

The day before, this person didn't have a dime to put towards their health care and now they're suddenly expected to cough up 50, 60 bucks. . . . So it has caused a lot of anxiety at the clinics. (executive director, tier 1)

Organizations that lost Title X funding and were not federally qualified health centers lost their eligibility for 340B discount drug pricing. The survey and administrative data showed that only 4 organizations (33%) in tier 3 that continued to provide family planning services had 340B pricing at the end of FY2012–2013 compared with 27 (81%) tier 1 and 2



Note. Tier 1 and 2 organizations include public agencies (e.g., county health departments) providing family planning services and nonpublic agencies providing family planning services in addition to primary care. Tier 3 organizations include nonpublic agencies providing family planning services only.

Source. Survey of Family Planning Organizations.

FIGURE 1—Number of Texas clinics that reduced service hours and stopped offering family planning services between September 2011 and September 2013, by funding tier.

organizations that were not federally qualified health centers. Four tier 3 organizations (33%) were able to purchase contraceptives at a reduced cost through other discount programs, but one third did not participate in any discount program. Loss of 340B pricing resulted in substantially higher costs for contraception:

The fee for us is . . . significantly higher, and so that also has to be transferred to the client . . . for example, I could buy a patch for \$12 . . . but now, I mean the patch to us is like \$60 . . . and it's not affordable. (program administrator, tier 3)

Changes in Contraceptive and Clinical Services

Funding reductions and reallocations also affected organizations' ability to provide women the full range of contraceptive methods. In FY2011, 86% of organizations in tier 1 and 2 responding to the

survey widely offered contraceptive injections (e.g., Depo-Provera) and fewer than half widely offered long-acting reversible contraceptives (LARCs), such as implants and intrauterine devices (IUDs; Figure 2). During the same period, all tier 3 organizations widely offered contraceptive injections and more than 80% widely offered LARCs. Female sterilization was widely offered by approximately 25% of organizations in all tiers.

In FY2012–2013, organizations reported that many methods were not as widely available to their clients. Almost 70% of organizations in all tiers still widely provided contraceptive injections, but 42% or fewer widely provided implants and IUDs and fewer than 15% offered female sterilization. The decrease in the availability of contraceptive injections and LARC was particularly pronounced among tier 3 organizations.

In-depth interview respondents commented that LARCs and female sterilization were less widely offered because of their high cost. At many organizations, LARCs were reserved for women with medical contraindications to other methods. However, more limited access to these methods primarily affected women whose services were covered by DSHS funding, and not those who received contraception through the WHP:

We're doing IUD's right and left on Women's Health Program. . . . If we did an IUD for a Title X client, that's \$700-plus that will come out of that big pot of money. And for that \$700, we can actually see 3 women for their annual exam and birth control. And so, I mean, if there is a woman who has tried everything else and . . . this is the only option for her, then we'll do that. So it's not like we say we absolutely refuse to do that. . . . We just tell them there's not funding

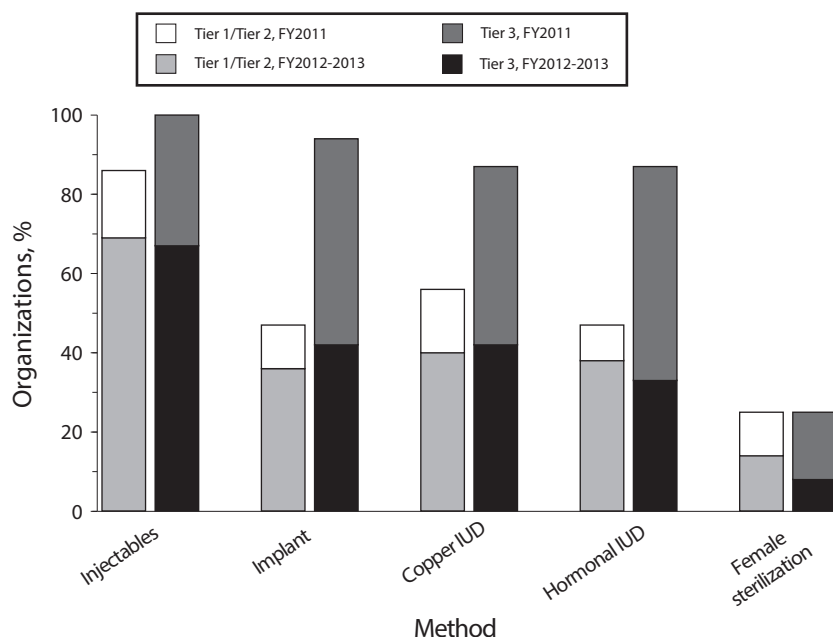
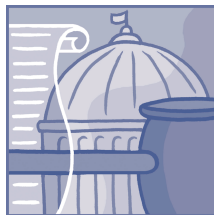
for that at this time. (program administrator, tier 1)

In contrast to contraception, there was no change in the availability of cervical cancer screening, annual chlamydia and gonorrhea screening for women aged 25 years and younger, and HIV testing between FY2011 and FY2012–2013, and all organizations responding to the survey offered these services on site (data not shown). However, clients paying fixed fees for services were less likely to opt for reproductive health screenings:

[We are charging] \$60 for a Pap smear and an exam, and then the birth control pills [are] like \$20 a pack, and even then, they just couldn't afford it. Most of the time they would just take the pills [because] we could offer the pills without an exam. (executive director, tier 3)

Changes in Client Volume

Administrative data for FY2012–2013 showed that 151 719 clients received DSHS-funded family planning services. This is a 54% decrease from FY2011 after adjusting for the longer period of funding in FY2012–2013 (data available as a supplement to the online version of this article at <http://www.ajph.org>). Most organizations in all tiers served a smaller number of clients than they did in FY2011, and changes were correlated with decreases in funding (Figure 3). Organizations serving the largest numbers of clients in FY2011 reported a 41%–92% decrease in clients during FY2012–2013, and very few organizations were able to serve a similar number of clients with less funding. Although



Note. FY = fiscal year; IUD = intrauterine device. Tier 1 and 2 organizations include public agencies (e.g., county health departments) providing family planning services and nonpublic agencies providing family planning services in addition to primary care. Tier 3 organizations include nonpublic agencies providing family planning services only. The total height of each bar is the percentage of organizations widely offering each method in fiscal year 2011. The height of the lower portion is the percentage of organizations widely offering each method in fiscal years 2012–2013.

Source. Survey of Family Planning Organizations.

FIGURE 2—Methods widely offered at family planning organizations in Texas in fiscal years 2011 and 2012–2013, by funding tier.

7 tier 1 and 2 organizations receiving greater levels of funding in FY2012–2013 reported serving more clients than they did in FY2011, this increase was not proportional. In addition, these organizations served fewer clients in FY2011 than did other organizations and, therefore, the impact of the overall increase in clients served in FY2012–2013 was small.

In-depth interview respondents reported that they did not know what had happened to their former clients but suspected that they simply were not seeking reproductive health care. Those at

organizations serving Latino communities frequently noted that undocumented women were “really [falling] through the cracks” after the funding cuts. Not only were they ineligible for the WHP, but they also were typically a lower priority than were other ineligible women (e.g., adolescents and those with incomes > 185% federal poverty level) for grant-funded appointments. The reduced client volume, overall, prompted a variety of concerns:

The women [that] are not [coming in] I also worry about. . . . The long waiting [for] appointments,

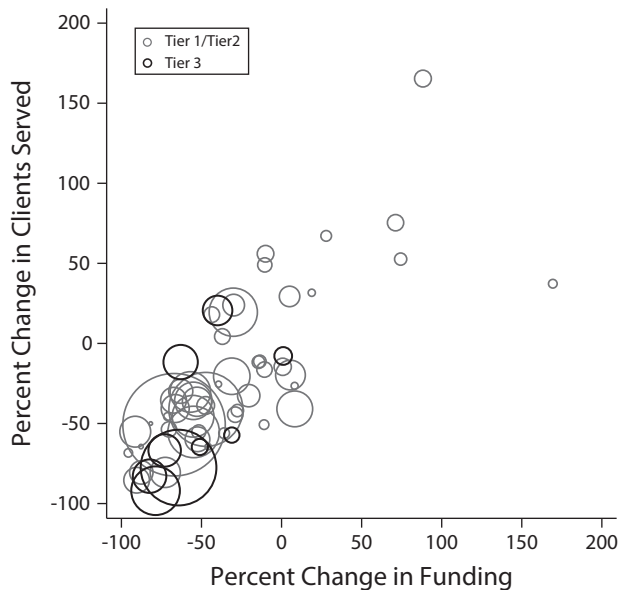
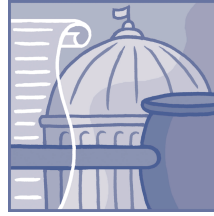
the payments that they have to pay. They’re saying, “Forget it, I can’t afford it.” So they’re kind of letting things go. Forgoing the birth control, their Pap test, their basic health care. So it’s really very tragic because you are not going to see the impact of all of that until maybe about a year from now with a lot of Medicaid births. . . . We won’t be able to tell about the undetected disease but there will be some; because we were catching some. (executive director, tier 3)

DISCUSSION

The 2011 funding cuts, tiered distribution system, and provider eligibility criteria for the WHP

were designed to prevent Planned Parenthood from receiving family planning funding from the state.¹⁰ Our results indicate that the legislative measures reduced or eliminated Planned Parenthood affiliates’ participation in Texas’s family planning programs, leading to several adverse consequences for these organizations. Tier 3 specialized family planning providers that were not affiliated with Planned Parenthood were also hard hit. Moreover, public agencies, federally qualified health centers, and other organizations, which were not the targets of the legislation and were in the top funding tiers, also experienced significant funding losses that limited their delivery of reproductive health services. Clinic closures, reduced hours, and requiring a larger percentage of their clients to pay higher fixed (vs sliding) fees for services have likely contributed to the smaller number of low-income women receiving family planning and reproductive health care in FY2012–2013.

Additionally, many women who continued to receive services had reduced access to the most highly effective methods, such as IUDs and implants, which are considered first-line contraceptive options for preventing unintended pregnancy.^{15,16} The tiered funding system placed organizations that had the greatest amount of experience providing these methods at a disadvantage and instead favored those that did not offer these methods as widely to their clients. Furthermore, low-income women’s access to these methods is increasingly uneven because their choice of contraception is



Note. Tier 1 and 2 organizations include public agencies (e.g., county health departments) providing family planning services and nonpublic agencies providing family planning services in addition to primary care. Tier 3 organizations include nonpublic agencies providing family planning services only. The percentage change relative to fiscal year 2011 reflects the 12-mo equivalent funding and unduplicated client totals in fiscal years 2012–2013 for all organizations that received Texas Department of State Health Services-administered family planning funds. The 12-mo equivalent total was calculated by dividing the total amount of funding or unduplicated clients served by the total months of funding received in fiscal years 2012–2013 and multiplying this value by 12 mo for any organization that received more than 12 mo of funding. Symbol size reflects the number of clients served by Texas Department of State Health Services-administered family planning grants in fiscal year 2011.

Source. Texas Department of State Health Services data for family planning program funding.

FIGURE 3—Percent change in unduplicated clients served and funding received at family planning organizations in Texas in fiscal years 2012–2013, by funding tier.

constrained by the specific funding source for their care. This is contrary to the original premise of Title X and has put clinicians and program administrators in the difficult position of deciding which low-income clients have the greatest need for these methods.¹⁷ This restricted access also is coming at a time when many other places in the United States have

experienced significant increases in LARC use.^{18,19}

Although Texas’s family planning programs covered only 26% of women in need of subsidized family planning services before the 2011 legislation,²⁰ the reduced numbers of women obtaining care and limited access to highly effective contraception are likely to increase unintended

pregnancy and costs to the state in the form of Medicaid-paid births. The Texas Legislative Budget Board estimated that the 2011 legislation would result in an additional 20 511 Medicaid births.²¹ Data are not yet available to measure the actual change in Medicaid births, but we plan to assess this impact as well as economic costs to the state in future analyses.

In 2013, the state legislature attempted to repair the damage to the reproductive health care safety net by allocating more than \$140 million to the budget for women’s health services, administered through 3 separate programs. The extent to which this funding will reinstate access to care is unclear because these programs had not been implemented at the time of our study. The family planning landscape has been drastically altered over the past 2 years, and the new program guidelines will likely continue to shift the composition of providers and scope of services. Planned Parenthood affiliates remain ineligible for state-administered family planning funds, and other specialized family planning providers may be unable to provide the range of nonreproductive health services required by some of these programs.

Small organizations that are otherwise eligible for funding may not participate because they cannot comply with the new administrative mandates for the separate programs. Also, because many of the organizations that are currently funded through the new programs are not experienced family planning providers, they may lack training and experience with LARC methods and may be

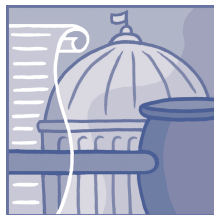
less likely to use evidence-based protocols that facilitate contraceptive access and continuation.^{22–24} Furthermore, the funds may not allow organizations that stopped providing family planning to begin serving women again because some have closed entirely or have lost essential staff and infrastructure.

The new state funding also does not allow adolescents to obtain family planning services without parental consent nor guarantee eligibility for undocumented immigrants, who have been particularly affected by the funding cuts. These groups may regain access to services at 1 of the 92 clinic sites run by 27 organizations that received Title X funding through a nonprofit women’s health association.

In April 2013, this association was awarded the Title X contract for Texas and, as a nonstate agency, is not subject to the legislated tiering system for allocating funds. However, there are currently only half as many of Title X-funded clinics in Texas than there were in FY2011, and Title X-funded organizations are likely to face challenges meeting the needs of low-income populations in their communities. Many are specialized family planning providers and may not be able to secure other state funding that is essential to subsidize care for women ineligible for other programs.

Limitations

This study has several limitations. Although we contacted all organizations providing DSHS-funded family planning services in FY2011, not all of them responded to our survey. The impact of the legislation may have been different for nonresponders, which were typically smaller and served fewer clients.



However, our findings are representative of the service environment encountered by most Texas women receiving publicly funded family planning services, because those organizations that did respond served the vast majority of these women.

Also, we may have overestimated the number of unduplicated family planning clients served in FY2012–2013 for those organizations that received both funding extensions and contracts, because organizations had to report the number of clients separately for each funding period. Finally, we do not know the extent to which changes in service delivery have affected women’s reproductive health outcomes, such as rates of unintended pregnancy, Medicaid births, and sexually transmitted infections, because these data are not yet available.

Conclusions

Although this study focuses on the unique case of Texas, it highlights how the patchwork of programs that have supported low-income women’s access to reproductive health services can come apart at the seams when specialized family planning providers are marginalized or systematically excluded from public programs. Whether this stems from political motivations, as in Texas and other states, or results from investing health resources in organizations that focus on primary care, women will lose access to essential preventive services.

Because many women are likely to remain in need of publicly funded family planning clinics under the Affordable Care Act,^{1,2} it is

essential to continue funding these clinics and identify or correct policy strategies to ensure those in need can access comprehensive reproductive health care. ■

About the Authors

Kari White is with the Department of Health Care Organization & Policy, University of Alabama, Birmingham. At the time of the study, Kristine Hopkins, Abigail R. A. Aiken, Amanda Stevenson, Celia Hubert, and Joseph E. Potter were with the Population Research Center, University of Texas, Austin. Daniel Grossman is with Ibis Reproductive Health, Oakland, CA.

Correspondence should be sent to Kari White, Department of Health Care Organization & Policy, University of Alabama at Birmingham, RPHB 320, 1720 2nd Ave S, Birmingham, AL 35294 (e-mail: kariwhite@uab.edu). Reprints can be ordered at <http://www.ajph.org> by clicking the “Reprints” link.

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Contributors

K. White led the writing and analysis. K. White, K. Hopkins, D. Grossman, and J. E. Potter designed the study. A. R. A. Aiken, A. Stevenson, and C. Hubert assisted with data collection. All authors helped to interpret findings and reviewed and edited drafts of the article.

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Human Participant Protection

This study was approved by the institutional review boards at the University of Alabama, Birmingham, and University of Texas, Austin. All participants provided oral informed consent.

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