The impact of reproductive health legislation on family planning clinic services in Texas

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Abstract

We examined the impact of legislation in Texas that both dramatically cut and restricted participation in the state's family planning program in 2011. Among the 72 organizations that received family planning funding, 52 completed the first wave of a survey (February-July 2012) about changes in service delivery resulting from the legislation, and 54 completed the second wave (May-September 2013). We also conducted in-depth interviews with leaders at 28 organizations about strategies they adopted in response. Overall, 25% of family planning clinics in Texas closed and 18% reduced service hours. Only 44% of organizations widely offered long-acting reversible contraception in 2012 compared to 70% in 2011. Many organizations began charging women fixed fees for services if they did not qualify for another public program. Although Texas presents a unique case, it provides insight into the potential effects that provisions proposed elsewhere may have on low-income women's access to family planning services.

Introduction

Publicly funded family planning clinics have been a key component of the health care safety net for low-income women in the United States (US). In 2010, almost seven million women received contraception and other reproductive health services at publicly funded clinics, and 70% of these women relied on clinics that receive funds from Title X, the federal program devoted to providing contraceptive care to poor and low-income women (Frost, Zolna et al. 2013). Under the Affordable Care Act (ACA), these clinics will remain essential points of access to family planning services since there is an expected shortage of providers able to meet the demand of the newly insured (Ku, Jones et al. 2011) and not all states are participating in the Medicaid expansion. Additionally, many low-income undocumented immigrant women will remain uninsured since they are ineligible for Medicaid and subsidies for insurance purchased through state exchanges.

However, low-income women's ability to rely on these clinics for subsidized family planning services has become increasingly dependent on policies enacted by state legislatures. Since 2011, ten states have proposed legislation that includes measures which effectively block specialty family planning providers from receiving any public funding like Title X or bars those providing abortion services from receiving funds, including Medicaid (Guttmacher Institute 2013), even though federal dollars cannot be used to pay for abortion care in most cases. Furthermore, several states have made significant cuts to their family planning budgets since 2010, and in five states funding for family planning services was disproportionately reduced relative to other health programs (Gold 2013).

In this article, we examine the impact of reproductive health legislation on the delivery of publicly funded family planning services in Texas, which in 2011 both dramatically cut and

restricted participation in their family planning program. We report on our findings from a state-wide survey of organizations that received Title X or other public funding to provide family planning services prior to the legislation, as well as state administrative data. Although Texas presents a unique case, it provides insight as to the potential effects that provisions proposed elsewhere may have on low-income women's access to family planning services.

Context

Prior to 2011, an estimated 1.7 million reproductive aged women in Texas were in need of publicly funded contraceptive services (Frost, Zolna et al. 2013). In fiscal year (FY) 2011 (September 2010 – August 2011), the Department of State Health Services (DSHS) administered nearly $50 million in Title V, X, and XX federal block grants, which funded 72 organizations operating 289 clinics throughout the state. These organizations included public health departments, Federally Qualified Health Centers (FQHCs), Planned Parenthood affiliates, and other private non-profit health centers, and 40% the 215,442 women served by these funds received care at Planned Parenthood health centers and other specialty family planning agencies.

Additionally, the state Health and Human Services Commission (HHSC) operated a Medicaid family planning waiver that provided coverage for reproductive health services to women ages 18 to 44 with incomes ≤ 185% of the Federal Poverty Level (FPL) who had been legal US residents for at least five years. The Women's Health Program (WHP), which was implemented in 2007, served 106,000 women in 2010. Nearly half of these women received services at Planned Parenthood clinics.

In the 2011 session, Texas state legislators passed three measures that expanded on initiatives carried out in previous years to defund Planned Parenthood affiliates and ensure that

no public money was used for abortion. (In addition to federal regulations surrounding abortion funding, family planning and abortion services in Texas are required to be administratively separate since 2005, and agencies are subject to annual audits.) First, the family planning budget was cut from $111 million per biennium to $37.9 million for the 2012-2013 budget period. Second, the remaining funds were allocated through a three-tiered priority system in which public agencies providing family planning services (e.g. health departments) and FQHC's were in Tier 1, and specialty family planning providers were in Tier 3; the remaining agencies that provided comprehensive preventive and primary care in addition to family planning were classified as Tier 2. Third, 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; this exclusion was part of the initial five-year WHP waiver but was never enforced by HHSC.

The first two pieces of legislation went into effect on September 1, 2011. DSHS initially funded all Tier 1 organizations, and lower tier organizations only received funding if there were no other providers in their service area. Funds were immediately issued to organizations in a series of temporary extensions, and later through competitive applications for formal contracts covering the period between January 15, 2012 and March 31, 2013; DSHS also solicited grant applications from several new Tier 1 organizations during this period. The vast majority of the family planning funding came from the Title X block grant, which legislatures could not divert to other programs. This funding stream allows organizations to provide confidential family planning services to teens, thereby superseding the state's parental consent requirement, and does not require proof of US citizenship or legal residency to obtain services; both of these are important exemptions in a state that has high rates of teen pregnancy and a large undocumented

immigrant population (Passel and Cohn 2011; Kost and Henshaw 2013). Receipt of Title X also enables organizations to participate in the 340B drug-pricing program where they can purchase contraceptives at discounts of 50 to 80%.

In March 2012, the Centers for Medicare and Medicaid Services (CMS) 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. 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 $40 million of annual federal funding that had previously supported the program.

Study data and methods

Data sources. Data for this study come from two waves of interviews conducted with leaders of state-funded family planning organizations, collected as part of a comprehensive three-year evaluation of the impact of the 2011 reproductive health legislation. In February 2012, we mailed a letter inviting executive directors of all 72 organizations that received DSHS family planning funding in FY2011 to complete a self-administered structured survey about services provided at their organization, including clinic hours and staffing, the total number of clinic sites and sites offering confidential teen services, the availability of specific contraceptive methods and preventive screening services such as Pap smears and testing for sexually transmitted infections (STIs), and participation in discount pricing programs and the WHP. Leaders at a sub-sample of organizations also were asked to participate in an in-depth interview to obtain detailed information about changes in service delivery resulting from the legislation and strategies to adapt to these changes. Organizations in the sub-sample were selected by stratifying across

Texas' eight health service regions and then, within each region, sampling based on probability proportional to size, where size was the number of clients the organization served in FY2010 – the most recent year available at the time.

Between February and July 2012, 52 organizations completed the first wave of the survey; participating organizations served 91% of clients obtaining DSHS-funded family planning services in FY2011. Leaders at 28 organizations also completed the first in-depth interview. The second wave of the survey took place between May and September 2013. Of the 66 organizations that were still providing family planning services (including new contractors), 54 completed the survey, 42 of which also completed the first wave; leaders at 29 organizations took part in the second in-depth interview. Survey and interview respondents provided their oral consent to participate and were not compensated for completing the survey or in-depth interviews. Self-administered surveys were submitted electronically through a secure on-line system. In-depth interviews were recorded and transcribed.

To supplement our interview findings, we also used DSHS administrative data as a third data source. Specifically, we obtained data on funding allocations and the number of clients obtaining family planning services in FY2011 and FY2012 (September 1, 2011 – March 31, 2013). This study was approved by the appropriate Institutional Review Boards.

Methods. Based on the expected impacts of the 2011 legislation and adaptive strategies undertaken by Title X funded organizations in response to political challenges elsewhere (Dalton, Jacobson et al. 2005; Jacobson, Dalton et al. 2005), we examined four key categories of change: financial, operational, clinical services, and client volume. Using both DSHS administrative data and information from the two waves of the structured survey, we determined

the number of organizations that lost state funding for family planning services during FY2012, the total percent change in funding over this period, changes in participation in the WHP and discount drug pricing programs, and implementation of new fees for services for uninsured clients. For operational changes, we assessed the number of clinics that closed or stopped offering family planning services, reduced service hours and no longer provided confidential teen services during FY2012. In addition to the structured survey, information on clinic closures between waves was obtained through updates provided by organizations and project consultants. We focused on variation in the proportion of organizations that widely offered specific contraceptive methods to their clients and had cervical cancer and STI screening available on-site as indicators of changes in clinical services provided. Finally, we used the structured survey and DSHS administrative data to examine changes in the volume of clients that organizations served following the funding cuts. For all outcomes, we examined differences according to funding tier (Tiers 1 and 2 versus Tier 3). We combined Tiers 1 and 2 since there were few Tier 2 organizations.

We also reviewed the in-depth interview transcripts for common themes in changes to service delivery and found a high level of convergence between these themes and responses to the surveys. Here, we use quotations from the in-depth interviews that are representative of these themes to highlight our main survey findings, as well as organizations' adaptive strategies to respond to these changes.

Results

Financial changes

In September 2011, 14 organizations lost all Title V, X, and XX funding, including five of the state's eight Planned Parenthood affiliates, four of seven other specialty family planning providers (Tier 3), and five Tier 2 organizations. Once competitive contracts were issued and extension funding expired, 39 organizations that were funded in FY2011 continued to receive DSHS family planning funds as of July 1, 2012. None of these were Planned Parenthood affiliates and only two were specialty family planning providers. Seventy one percent of organizations in all tiers had ≥33% decrease in funding, but the percentage of organizations with ≥33% decrease in funding was larger in Tier 3 compared with Tiers 1 and 2 (94% versus 64%, respectively) (Table 1). Twelve Tier 1 and 2 organizations (22%) received more DSHS funding in FY2012 compared to FY2011.

Organizations that lost Title X funding and were not FQHCs also lost their eligibility to participate in the 340B discount pricing program. This was more common for Tier 3 organizations than those in Tiers 1 and 2. At the end of FY2012 (March 2013), only 33% of Tier 3 organizations remained eligible for 340B pricing, compared to 85% for organizations in Tiers 1 & 2. As indicated in the following comment by an administrator at a Tier 3 organization, this 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 as well. . . 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."*

Some Tier 3 organizations (n=4, 33%) were able to purchase contraceptives at a reduced cost through other discount programs, but one-third did not participate in any discount program.

The reduction in DSHS family planning funding meant enrolling potentially eligible women in the WHP became a key survival strategy, and the majority of qualified organizations continued to participate in the program after January 2013. In the in-depth interviews, many organizations reported that they were now more stringent about women presenting appropriate documentation of their eligibility, such as proof of income and residence, before providing services since DSHS funding was insufficient to cover the cost of care for otherwise eligible women's services. This was reported more often by other specialty family planning providers in Tier 3 organizations that were not Planned Parenthood affiliates.

Reductions in funding also led organizations in all tiers to implement or expand systems requiring women to pay fixed fees for services if they did not qualify for the WHP, instead of using a sliding fee scale. During FY2012, 58% of Tier 1 and 2 organizations and 75% of Tier 3 organizations reported that a larger percentage of their clients paid for services relative to FY2011; after January 1, 2013, all Planned Parenthood affiliate clients who lacked insurance coverage for contraception were required to pay fixed fees for services since these organizations could no longer participate in the WHP. Some organizations developed a fee schedule in which physicals, Pap tests and other services were provided at a fixed-cost, while other organizations charged fees for individual services; the cost of a contraceptive method was often an additional charge. Prices for services and contraception varied across organizations and, as noted by a CEO at a Tier 1 organization, took several factors into consideration:

> *"What we're trying to do now is find a way to provide as much as we can for an amount that the women can afford. So we're going through … a real strict cost analysis on what it costs us to provide a women's health exam, what it costs to do this, this, this…Then once we get how much it costs, we'll come up with a reduced fee and say, 'Listen, if you want to come to us, this is what you need, this is what it's going to cost you.'"*

Operational changes

In response to decreases in funding, many organizations closed clinic sites or stopped offering family planning services. Of the 88 clinics administered by Tier 3 organizations, 37 (42%) closed, and organizations in Tiers 1 and 2 closed 39 (18%) of their 213 clinic sites (Figure 1). Additionally, service hours were reduced at 33 (38%) Tier 3 clinics and 22 (10%) Tier 1 and 2 locations. Some organizations eliminated evening or weekend hours, while others reduced service hours more significantly to only one or two days per week. In some communities, this resulted in longer waiting times to get an appointment, as noted by a program administrator at a Tier 1 organization:

> *"At certain clinics … there's a backlog of patients that are waiting for appointments, [and that's] our clinic located on the north side of town … because you can get on the bus and go to [that] clinic, whereas the other … clinics, you have to have transportation."*

Additionally, 25% of organizations in all funding tiers reported fewer clinic sites where teens could access contraceptive services without parental consent in FY2012 compared to FY2011. This was due to reductions in Title X funding. Various approaches were used to assure services were accessible to teen clients, which were considered a priority group. Teens were given preference for grant-funded appointments at some organizations, while at others funds were channeled into clinics where there was a high volume of teen clients. Although teens unable to obtain parental consent were referred to Title X-funded locations, a few leaders admitted not all teens in need may be reaching these sites.

During FY2012, some organizations also reported that they were providing family planning services at new locations. This was often a result of increases in funding, but also restructuring of clinical sites in their service area. Tier 1 and 2 organizations, including new

contractors, reported 18 new sites offering family planning, and Tier 3 organizations reported 2 new clinics.

Clinical services changes

In FY2011, a larger percentage of Tier 3 organizations widely offered long-acting reversible contraceptive (LARC) methods, such as implants and IUDs, than organizations in Tiers 1 and 2 (Figure 2). In FY2012, all organizations reported that many methods were less widely provided to their clients. Seventy percent of organizations still widely provided injectables, but 40% or fewer widely provided implants and IUDs. The decrease was particularly pronounced among Tier 3 organizations.

In the in-depth interviews, organizational leaders commented that LARCs and female sterilization were less widely offered because of their high cost. For many organizations in FY2012, LARCs were often reserved for women with medical contraindications to other methods. Several leaders also stated that they had begun waiting lists of women who wanted LARCs and female sterilization should funds still be available at the end of the contract period. 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. The following statement, by the Medical Director at a Tier 1 organization, highlights this differential pattern of access taking place at organizations in all tiers:

> *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 three women for their annual exam and birth control. And so, I mean, if there is a woman who has tried everything else and nothing, you know, 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; that's not it … We just tell them, there's not funding for that at this time.*

In contrast to contraceptive methods, organizations reported few changes in the availability of other reproductive health services. In both FY2011 and FY2012, organizations in all funding tiers provided Pap tests, annual chlamydia and gonorrhea screening to women ≤25 years old and HIV testing on-site for their clients. Approximately 60% of organizations in all funding tiers offered colposcopies, and 33% of organizations in Tiers 1 and 2 and 58% of Tier 3 organizations offered loop electrosurgical excision procedure (LEEP) on-site for women with abnormal Pap smear results. There was no change in the availability of these services in any funding tier between FY2011 and FY2012. However, as the executive director at a Tier 3 organization commented, self-pay clients 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.*

Changes in client volume

In FY2012, 75,160 women were served with DSHS funds, compared to 215,442 in FY2011. Although the decrease in the number of women served is not unexpected given the large funding cuts, the overall number of women obtaining family planning services from FY2011 DSHS contractors also declined. The vast majority (83%) of Tier 3 organizations reported that their total client volume decreased between FY2011 and FY2012, compared to 48% of organizations in Tiers 1 and 2. Thirty-two percent of organizations in Tiers 1 and 2 reported they were seeing more clients and 20% stated their client volume had not changed since FY2011.

For Planned Parenthood affiliates, the loss of the WHP was a key reason for the reduced number of clients served.

In the in-depth interviews, many organizational leaders reported that they did not know what had happened to their clients, but suspected that they were simply not seeking reproductive health care. For organizations in large Latino communities, program administrators frequently noted that undocumented women were "*really [falling] through the cracks*" in the current funding environment. Not only are they ineligible for the WHP, but they also are behind teens and other women in line for grant-funded appointments and less able to pay fixed fees for services. 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.*

Discussion

The 2011 funding cuts and tiered distribution system adversely affected many publicly funded family planning organizations in Texas. Specialty family planning providers were particularly hard hit, but public agencies, FQHCs, and other organizations which were not the targets of the legislation also experienced significant funding losses that impacted their delivery of reproductive health services. Clinic closures, reduced hours, and requiring a larger percentage of their clients to pay higher fixed (versus sliding) fees for services have likely contributed to the

smaller number of low-income women seeking family planning and reproductive health care in FY2012.

Additionally, many women who continue to seek services have reduced access to the most effective methods, like IUDs and implants, which are considered first-line contraceptive options for preventing unintended pregnancy (Blumenthal, Voedisch et al. 2011; American College of Obstetricians and Gynecologists 2012). The tiered funding system placed providers that had the greatest amount of experience providing these methods at a disadvantage, and instead favored organizations 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 constrained by the specific funding source for their care. Not only is this contrary to the original premise of Title X, but restricted access is coming at a time when many other states in the US have experienced significant increases in LARC use (Secura, Allsworth et al. 2010; White, Potter et al. 2012). Together the reduced numbers of women obtaining care and limited access to highly effective contraception are likely to increase the rate of unintended pregnancies in Texas and increase costs to the state in the form of Medicaid-paid births.

In 2013, the state legislature attempted to repair the damage to the health care safety net for low-income women by allocating more than $140 million to the budget for women's health services. Approximately $40 million from state general revenue was included to replace lost federal block grant funding. An additional $100 million was appropriated from state general revenue for 'expanded primary health care services' for women 18 and older with incomes ≤200% FPL. This funding allows organizations to pay for wrap-around women's health services such as immunizations, nutritional counseling, and prenatal dental services, in addition to family

planning and reproductive health services; 60% of services provided should be for contraceptive care. The extent to which this funding will reinstate access to services is unclear. Many specialty family planning providers remain ineligible for the funding (i.e., Planned Parenthood affiliates), may be unable to provide the range of non-reproductive health services required, or meet other administrative mandates. Furthermore, these funds may not be sufficient to allow organizations that stopped providing family planning to begin serving women again. Some organizations have closed entirely or lost essential staff and infrastructure. Given that this funding is from state general revenue, it is also unclear how sustainable this initiative will be.

The new state funding also does not allow teens 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 one of the 121 clinic sites run by 34 organizations that received Title X funding through the Women's Health and Family Planning Association of Texas. In April 2013, this coalition was awarded the Title X contract for Texas and, as a non-state agency, is not subjected to the legislated tiering system for allocating funds. Yet, these organizations may continue to face challenges meeting the needs of low-income populations in their communities. Many are specialty family planning providers and, as noted above, may not be able to secure other state funding that is essential to subsidize care for women ineligible for other programs. In a state as big as Texas, multiple sources of funding are necessary to meet the needs of the large number of uninsured and underserved.

Although this study focuses on the unique case of family planning services in Texas, it highlights challenges about how health care will be provided to US women in the future, particularly those with low incomes. The ACA has emphasized a community health center

model of care where patients will have a 'medical home.' This model, which emphasizes primary health care, may not be one that is best suited to women's health needs (Weisman, Chuang et al. 2010). Routine reproductive health needs for women, such as Pap tests, risk of being triaged in favor of patients requiring management of chronic diseases. Additionally primary health care providers may lack training and experience with LARC methods, managing contraceptive side effects and have limited awareness of recent evidence-based protocols for providing reproductive health care – areas where specialty family planning providers excel (Frost, Zolna et al. 2013; Wood, Goldberg et al. 2013). Finally, the fact that 21 states are not planning to participate in the Medicaid expansion (Kaiser Family Foundation 2013) and that undocumented immigrants are left out of the ACA entirely raises questions about how to meet the health care needs for the most vulnerable segments of the population.

The findings from this study should be interpreted within the context of its 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 on service delivery may have been different for non-responders, which were typically smaller and served fewer clients. However, we believe our findings are largely representative of most organizations since those that did respond served the vast majority of women seeking publicly funded services. Also, at this time, we do not know the extent to which the changes in service delivery have affected women's reproductive health outcomes, such as the rates of unintended pregnancy, Medicaid births and STIs. Additional research is needed to measure any impact of the legislation on these outcomes, and we plan to examine some of these in future analyses.

Despite these limitations, the experience in Texas provides insight into the impact of legislative initiatives aimed at marginalizing specialty family planning organizations from

publicly funded programs that support access to reproductive health care for low-income women. Not only do broad-sweeping measures exclude organizations that typically provide women a broader range of family planning services, they also have the potential to damage the larger health care safety net. Given that publicly funded family planning clinics are likely to remain a key source of health care for low-income women, it is essential to identify strategies to ensure they can access comprehensive reproductive health care.

Note: The findings and conclusions in this paper are those of the authors and do not necessarily represent the views of Planned Parenthood Federation of America, Inc.

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Table 1. Changes in grant funding and program participation between Fiscal Years 2011 and 2012, by Department of State Health Services (DSHS) funding tier

	Tier 1 & 2 n (%)	**Tier 3** n (%)
DSHS grant funding relative to FY11*		
Increased, no change	12 (22)	0 (0)
Decreased 1-32%	8 (15)	1 (6)
Decreased 33-66%	20 (36)	3 (18)
Decreased 67-99%	10 (18)	5 (29)
Decreased 100%	5 (9)	8 (47)
Participation in discount drug pricing†1		
340B discount pricing program	34 (85)	4 (33)
Other discount pricing program		4 (33)
None	6 (15)	4 (33)
Participation in TWHP†2		
Yes	39 (97)	6 (50)
No	1 (3)	6 (50)
Charging clients fixed fees for services†		
Larger percentage relative to FY11	23 (58)	9 (75)
Smaller percentage relative to FY11	4 (10)	3 (25)
No change	13 (32)	0 (0)

FY11: Fiscal Year 2011; TWHP: Texas Women's Health Program

* Among all DSHS FY2011 contractors (n=72)

† Among all organizations completing Wave II that were DSHS FY2011 contractors (n=52)

1. Participation on March 31, 2013
2. Participation after January 1, 2013

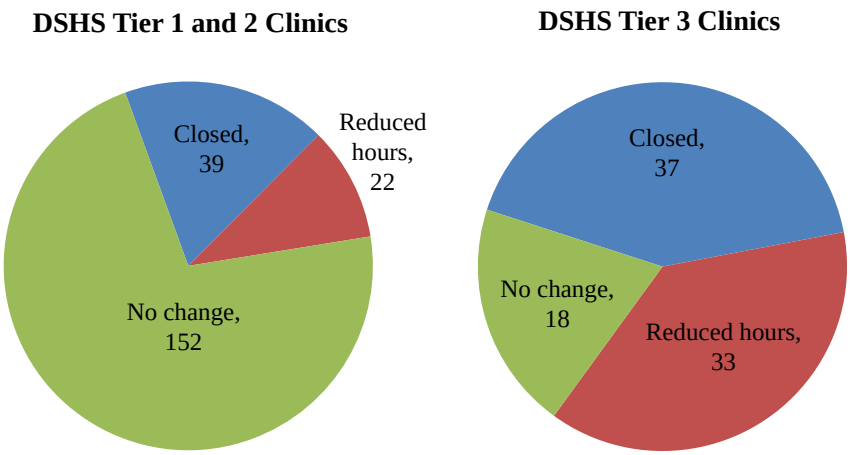

Figure 1: Number of clinics that closed or reduced service hours between September 2011- September 2012, by DSHS funding tier

DSHS – Department of State Health Services

Tier 1: public agencies (e.g., health departments) that provide family planning services
Tier 2: non-public agencies that provide family planning as part of comprehensive primary and preventive care
Tier 3: non-public agencies that provide family planning only

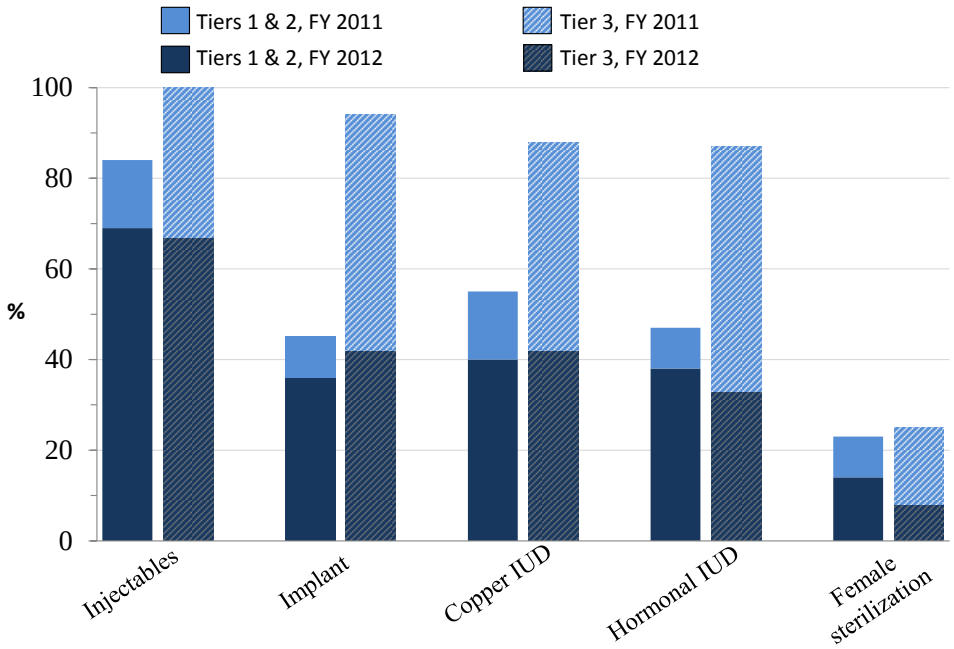

Figure 2. Percentage of organizations widely offering select contraceptive methods in FY2011 and FY2012, by Department of State Health Services funding tier

FY: Fiscal Year