



Family Planning: An Essential, Cost Effective Part of Health Care Reform

“The Democratic Party also strongly supports access to comprehensive affordable family planning services and age-appropriate sex education which empower people to make informed choices and live healthy lives. We also recognize that such health care and education help reduce the number of unintended pregnancies and thereby also reduce the need for abortions.”

- 2008 Democratic Party Platform¹

With these words, the Democratic Party signaled its commitment to providing all Americans with access to comprehensive family planning services and to the reduction of unintended pregnancies in the United States. This effort is critical – the United States has one of the highest rates of unintended pregnancy among Western nations. Each year, half of the more than 6 million pregnancies in this country are unintended, and nearly half of those end in abortion.² However, publicly funded contraceptive services help to prevent at least 1.4 million unintended pregnancies every year, thus reducing the need for abortion.³

To make this commitment a reality, the next administration must incorporate common-sense, effective family planning services and policies into health care reform, including:

- **Expanding Contraceptive Coverage**
- **Investing in Evidence-Based, Comprehensive Community- and Faith-Based Interventions**
- **Creating National Standards of Care for Family Planning**
- **Expanding Access to Family Planning Through Medicaid**
- **Making a Significant Investment in Title X**
- **Addressing the High Cost of Pharmaceuticals**

Today family planning health centers are relied upon by millions of Americans for their basic health services, providing everything from contraceptive services and education to breast and cervical cancer screenings and a vast array of other, preventive health services. The reach of these publicly funded health centers is expansive – 85 percent of U.S. counties have at least one health center providing subsidized family planning services.⁴ Successful health care reform, therefore, must build upon the existing network of family planning providers and utilize this effective infrastructure to reach the most vulnerable populations: the low-income, uninsured and underinsured.

Family planning services are a fundamental part of preventive health care that results in improved health outcomes while simultaneously reducing the cost of health care. The following recommendations will help to expand coverage of and access to family planning services, ensure the quality of those services, maintain a focus on prevention, reduce health care costs, decrease disparities, and ultimately improve the health of American families.



Health Care Reform Must Include Comprehensive Family Planning Services

Any meaningful health care reform must incorporate comprehensive family planning services. Family planning, including contraceptive services and supplies, education, counseling, and other preventive health services, is a critical element of basic public health care that helps women and men build strong, socially responsible families. Contraception improves the health of women and children by enabling women to plan and space their births. Women with unintended pregnancies are less likely to obtain timely or adequate prenatal care,⁵ and unintended pregnancy increases the likelihood of low birth-weight babies and infant mortality.⁶ Contraception is also the key to preventing unintended pregnancies. The 11 percent of American women at risk for unintended pregnancy who do not use contraception account for half of all unintended pregnancies.⁷

There are an estimated 66 million women of reproductive age (13–44) in the United States, and more than half (36 million) are in need of contraceptive services and supplies (i.e. they are sexually active and able to become pregnant, but do not wish to become pregnant).⁸ Of the 31 million adult women in need, 4.5 million in 2006 were poor (<100% of poverty) and 7.9 million were low-income (100–249%).⁹ According to the Guttmacher Institute, 17.5 million women were in need of publicly funded contraceptive services and supplies in 2006, a number that has increased by more than one million since 2000.¹⁰ However, publicly funded sources of family planning reach fewer than seven million women per year.¹¹

Women in need of publicly supported contraceptive services are disproportionately of color, and their numbers are increasing. In 2006, 5.1 million of the adult women in need were non-Hispanic black and 5.9 million were Hispanic.¹² Between 2000 and 2006, the number of Hispanic women in need increased by 24 percent and the number who were black increased by 11 percent, while the number of women in need who were white increased by only 1 percent.¹³

- **Expanding Contraceptive Coverage:** The latest census data show that 46 million Americans – over 21 million of which are women – are uninsured. Even for women with insurance, there are barriers to accessing contraception. For those Americans who are insured, private insurance often does not include comprehensive contraceptive coverage.¹⁴ In an effort to remedy this inequality, twenty-seven states currently require insurers that cover prescription drugs to provide coverage of the full range of FDA-approved contraceptive drugs and devices. However, even among the states that require contraceptive coverage, inadequacies remain: nineteen of those states allow certain employers and insurers to refuse to comply with state mandates.

Though many states now ensure that health insurance plans that cover prescription drugs provide equitable coverage for contraceptives, many women still lack contraception coverage and thus have to pay more for their contraceptives than for other medications. Since 1999, the federal government has also required that the Federal Employees Health Benefits Program, which provides insurance for millions of federal employees, include contraceptive coverage. Any health care reform plan should at least match the standard set by the federal government for its employees, and therefore must include provisions to ensure quality, nationwide, private health insurance coverage for prescription contraceptives and related medical services.



- **Investing in Evidence-Based, Comprehensive Community- and Faith-Based Interventions:** Community- and faith-based programs can be key partners in improving the sexual and reproductive health of local communities, partners who, by nature, take into account the unique contours of ethnic, political and religious diversity of the populations they serve. Community- and faith-based interventions can improve the health of low-income and uninsured Americans by meeting them where they are, providing services in unconventional places if necessary. It is vital, however, that these interventions be scientifically sound and comprehensive and meet the fundamental standards of sound public health.
- **Creating National Standards of Care for Family Planning:** It is critical that federally funded family planning services be more than just family planning in name only. All federal programs that provide funding for family planning services need one set of unified standards to ensure that patients receive high-quality care, including a broad range of safe and effective contraceptive methods and accurate information about their sexual health. These standards should be evidence-based and consistent with the current standards of care recommended by leading medical organizations, such as the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the U.S. Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), American Cancer Society and the Sexuality Information and Education Council of the United States (SIECUS).
- **Expanding Access to Family Planning Through Medicaid:** Since the early 1990s, many states have been granted waivers by the Department of Health and Human Services (HHS) to expand Medicaid coverage of family planning services. Recognizing the cost-effectiveness of helping women avoid unintended pregnancies, 27 states currently have waivers to expand Medicaid eligibility. Of those, 20 states expand Medicaid coverage of family planning services based on income.¹⁵ States seeking to expand access to family planning services, however, must navigate a burdensome bureaucratic process of waiver approval, which lasts an average of 15 months, involves a significant investment of staff time and resources, and requires states to renew their family planning waivers on a regular basis.

Medicaid coverage of family planning services is proven effective in helping low-income women avoid unintended pregnancy, thereby saving money to the state and federal governments. A 2003 U.S. Department of Health and Human Services (HHS)-funded evaluation of six states that expanded access to Medicaid-funded family planning services found that each state realized substantial net savings. States as diverse as Arkansas, Oregon, and South Carolina each saved at least \$15 million a year as a result of their family planning waivers. Other states saved much more, such as California, which has realized more than \$400 million a year in net federal savings.¹⁶ Illinois' Medicaid waiver was expected to save a total of \$59 million over the five-year period of the waiver, which expires in March 2009.¹⁷

The next administration must work to expand access to family planning by requiring states to provide coverage of Medicaid family planning services to women up to the same income level used to determine eligibility for pregnancy related care (states are required to provide coverage of pregnancy related care to women with incomes up to 133 percent of the federal poverty level, and many states go up to 185 percent of poverty and beyond).



The Guttmacher Institute estimates that requiring states to provide coverage of Medicaid family planning services to women up to the same income level used to determine eligibility for pregnancy related care (up to 200% FPL) would expand eligibility to more than 3.5 million women a year, prevent more than 500,000 unintended pregnancies, and save the federal government and states approximately \$1.5 billion. In 2007, a Congressional Budget Office evaluation found that an optional version of the income-based expansion of Medicaid family planning services would save the federal government \$200 million over 5 years and \$400 million over 10 years.¹⁸ This federal savings is in addition to the money states would save by expanding family planning services.

A Significant Investment in Title X is a Necessary Component of Health Care Reform

In its nearly four decades of operation, Title X,¹⁹ the only federal program devoted specifically to supporting family planning services, has become a critical component of the nation's public health infrastructure and a true public health success story.²⁰ Title X currently provides service delivery grants to 87 public and private, nonprofit grantees located in every state and U.S. territory, whom then determine which local providers receive funding. State, county, and local health departments make up the majority (57 percent) of Title X service providers. Hospitals, family planning councils and other private, nonprofit organizations make up the rest of Title X providers.

Currently, nearly 5 million women and men receive services at more than 4,400 health centers funded through the Title X program.²¹ In 2006, Title X-funded clinics provided 2.5 million Pap tests, 2.4 million breast exams, 5.2 million STD tests, and 652,426 confidential HIV tests.²² Between 1980 and 1999, Title X-supported clinics prevented almost 20 million unintended pregnancies, 9 million of which would have ended in abortion; conducted an estimated 54.4 million breast examinations and an estimated 57.3 million Pap tests, which have resulted in the early detection of as many as 55,000 cases of invasive cervical cancer.²³

In keeping with established medical ethics, a woman facing an unintended pregnancy is entitled to nondirective counseling and referrals upon request regarding all of her available options, including: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. By statute, no Title X funds may be used to pay for pregnancy termination.

- **Investing in Family Planning Saves Money:** Increasing access to family planning services for men and women in need reduces social costs, and creates stronger families, healthier children, a stronger society and better quality of life for all. Increased funding for family planning is not only a critical component of preventive health care, but also fiscally responsible – every dollar spent to increase funding for family planning would save \$4.02 in pregnancy-related and newborn care costs to Medicaid.²⁴ Research has also demonstrated that Medicaid family planning waivers are cost-effective policy options that save both state and federal government money.^{25,26}

In total, publicly funded family planning services save federal and state governments \$4.3 billion annually due to their impact on preventing unintended pregnancies. This does not even include the health or fiscal effects of the other services provided, such as STD and HIV screening and breast and cervical cancer screening. It also does not include the impact of Medicaid family planning services provided by providers outside of the public health center setting.²⁷



- **Title X Health Centers Are Ideally Situated to Provide Expanded Services Under Health Care Reform:** Title X-funded family planning centers are the entry point into the health care system for millions of Americans. These centers often serve as the only health care provider for many of the women and men they serve, primarily low-income, uninsured and underinsured Americans. Thus, federally funded family planning providers are ideally positioned to provide comprehensive health care services, including family planning, especially to the key target populations of any health care reform effort: the low-income, the uninsured and the underinsured.

Nearly 75 percent of U.S. counties have a Title X-funded health center.²⁸ Title X's expansive reach, combined with its focus on vulnerable and underserved populations, places Title X health centers in an ideal position to reduce disparities. Patients served by Title X are disproportionately women of color,²⁹ and the majority of those receiving family planning services through Title X are low-income.³⁰ These populations all are at higher risk of an unintended pregnancy and for being uninsured. A low-income woman (a woman below 250% of the federal poverty level) is four times as likely to have an unintended pregnancy, five times as likely to have an unintended birth, and more than four times as likely to have an abortion as her higher-income counterpart.³¹

Besides contraceptive and gynecological services, Title X family planning health centers have already been used effectively to provide screenings for STDs, including HIV; cervical and breast cancers; high blood pressure; anemia; and diabetes, in addition to health education and referrals for other health and social services. Title X should include additional services to maximize the public health benefit, including: preconception and interconception care; expanded services to men; availability of the HPV vaccine; and services to address a range of behavioral risk factors facing the target populations including depression, anxiety, intimate partner violence, alcohol, tobacco and other drugs that may impact effective family planning. In addition, many Title X-funded health care centers are currently working to implement cutting-edge practices for outreach and enrollment. Many of them are partnering with states to provide point-of-service eligibility determinations for Medicaid and other programs for which patients receiving services may be eligible, making these providers well-placed to capitalize on their extensive reach to solve one of the most difficult problems of any health care reform effort: recruiting and enrolling individuals with limited connections to the health care system as a whole.

- **Investing in Title X is Critical to Public Health:** Despite the incredible success of the Title X program and the critical services it provides, Title X has been chronically underfunded, posing a significant challenge to the program's survival. If appropriations had kept up with inflation since FY 1980, the program would be funded at \$759 million rather than the FY 2007 funding level of \$283 million.³² This underfunding has led to a number of negative consequences, including: constraints on the ability to offer the most effective contraceptives, limited staffing to address the educational and counseling services needed, difficulties in conducting outreach to the most vulnerable of the priority populations, and insufficient capacity to meet all of the demand for services.

The current funding level for Title X does not adequately support the services provided by the program, which are essential to public health. A significant investment in Title X is an essential part of successful health care reform. Based on a 2006 analysis by the Guttmacher Institute, it is estimated that each \$100 million increment in new funding for Title X could



allow Title X providers to serve 491,700 new patients, prevent 86,100 unplanned pregnancies (which would otherwise result in 34,700 abortions and 41,100 unplanned births), and save Medicaid \$380 million.³³

The next administration must increase funding for the Title X program to \$700 million. This critical commitment to Title X would ensure the most effective methods of contraception are available to patients, and make available more accurate cervical cancer and human papillomavirus screening tools that have become the standard of care in the private sector. A significant investment in Title X would also allow for new STD testing and treatment technology and the ability to expand the availability of HIV testing and better integrate HIV counseling, testing, and referral services into the family planning system. Moreover, new and expanded services essential to addressing the needs of the program's priority populations and reflecting a truly comprehensive set of services that support prevention cannot be accomplished without significantly increased funding.

Health Care Reform Must Address the High Cost of Pharmaceuticals

The high price of prescription medications has been a major factor in escalating health care costs and has had a devastating impact on Americans' health. Spending on prescription drugs in the U.S. reached \$216.7 billion in 2006, five times more than the \$40.3 billion spent in 1990. While spending on prescriptions has been a relatively small proportion of overall national health care spending, it has been one of the fastest growing components. Drug spending overall is projected to increase over the next decade, and annual increases of around 8% are expected to occur, putting increased pressure on government-funded programs and uninsured individuals to purchase prescription medications.³⁴

Recent, dramatic increases in the cost of contraceptive supplies have become a major obstacle to health centers struggling to use limited federal funds to provide services to as many low-income and uninsured women and men as possible. Title X expenditures on contraceptive supplies increased by an average of 26 percent over three years, while the Title X grants over the same period increased by an average of 11 percent.³⁵

The federal 340B program cite, which exists to provide certain federally funded health care providers (including Title X providers) with access to low-cost drugs, has been limited in its ability to impact the high cost of contraceptives. Under the current system, pharmaceutical companies are able to change the price of the drugs they offer through 340B on a quarterly basis and without notice, often leading Title X providers scrambling to cover new, unplanned for price increases. At a time when Title X providers are already strapped as a result of new and expensive contraceptive technologies and STD and HIV screening and treatment, the expense of training and retaining qualified health care personnel in an era of nursing shortages, the increased cost of contraceptives and the last-minute price fluctuations under 340B has put Title X providers in the untenable position of having to chose between offering fewer contraceptive choices, cutting services, or even reducing staff or closing health centers in some cases.

Further hindering family planning providers are changes made through the Deficit Reduction Act of 2005 that inadvertently eliminated incentives for pharmaceutical companies to extend a "nominal price" to non-340B eligible family planning providers. Nearly four million women who depend on college health centers and safety-net providers for their birth control have seen prices increase



dramatically as an unintended consequence of a change in the DRA, going from an average \$5 to \$10 per month up to as much as \$40 or \$50 a month.

As part of successful health care reform efforts, the next administration must consider a variety of solutions to combat the increased cost of prescription drugs and ways to help family planning providers offset those costs. The next administration must consider the development of a national prescription-drug purchasing consortium for all federally-funded health care programs, to better harness the combined purchasing power of federal health grantees to provide low-cost drugs to patients in need. Non-340B eligible family planning providers, who operate as part of the health-care safety net, must also be allowed to once again access low-cost contraceptives.

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¹ Democratic National Convention Committee. (2008). *The 2008 Democratic national platform: renewing America's promise*. Washington, DC: Democratic National Committee.

² Boonstra, H.D, Gold, R.B., Richards, C.L., & Finer, L.B. (2006). *Abortion in Women's Lives*, New York: Guttmacher Institute.

³ Frost, J.J., Finer, L.B., & Tapales, A. (2008, August). "The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings," *Journal of Health Care for the Poor and Underserved*, 19: 778-796.

⁴ Frost, J., Frohwirth, L., & Purcell, A. (2004, September/October). "The availability and use of publicly funded family planning clinics: U.S. trends, 1994-2001," *Perspectives on Sexual and Reproductive Health*, 36(5): 206-215.

⁵ Dailard, C. (1999, July). "U.S. policy can reduce cost barriers to contraception," *Issues in Brief*, New York: Guttmacher Institute.

⁶ Singh, S., Darroch, J.E., Vlassoff, M., & Nadeau, J. (2003) *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care*. New York: Guttmacher Institute and United Nations Population Fund.

⁷ Boonstra, et al. *Abortion in Women's Lives*, Guttmacher Institute.

⁸ Guttmacher Institute. (2008). "Women in need of contraceptive services and supplies, 2006." Retrieved October 19, 2008 from <http://www.guttmacher.org/pubs/win/WIN2006.pdf>

⁹ Ibid.

¹⁰ Ibid.

¹¹ Frost, et al. "The availability and use of publicly funded family planning clinics: U.S. trends, 1994-2001."

¹² "Women in need of contraceptive services and supplies, 2006."

¹³ Ibid.

¹⁴ Guttmacher Institute (2008, October) "State policies in brief: insurance coverage of contraceptives." Retrieved October 19, 2008 from http://www.guttmacher.org/statecenter/spibs/spib_ICC.pdf.

¹⁵ The 20 states that currently have a waiver to expand Medicaid coverage of family planning services based on income are: AL, AR, CA, IL, IA, LA, MI, MN, MS, NM, NY, NC, OK, OR, PA, SC, TX, VA, WA, and WI.

¹⁶ Letter from Governor Arnold Schwarzenegger to Michael Leavitt, Secretary of Health and Human Services, September 11, 2008.

¹⁷ Illinois Department of Healthcare and Family Services, "Illinois Family Planning Expansion Initiative under Medicaid," and CMS, Special Terms and Conditions for the Illinois Family Planning Medicaid Expansion Project 1115 Demonstration, Attachment A.

¹⁸ Congressional Budget Office. (2007, August). "Estimated effect on direct spending and revenues of H.R. 3162, the Children's Health and Medicare Protection Act, for the Rules Committee." Retrieved October 19, 2008 from <http://www.cbo.gov/ftpdocs/85xx/doc8519/HR3162.pdf>

¹⁹ Title X of the Public Health Service Act, 42 U.S.C. 300.

²⁰ A 2005 government review of the Title X family planning program confirms that the program serves a unique and valuable purpose, is cost-effective, and is effectively managed. ExpectMore.gov. (2008, January) "Detailed information on the family planning assessment." Retrieved October 19, 2008 from <http://www.whitehouse.gov/omb/expectmore/summary/10003513.2005.html>.

²¹ Fowler, CI, Gable, J, and Wang, J. (2008, February). *Family Planning Annual Report: 2006 National Summary*. Research Triangle Park, NC: RTI International.

²² Ibid.

²³ The Alan Guttmacher Institute. (2000). *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics*. New York: The Alan Guttmacher Institute.

²⁴ Frost, et al. "The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings."

²⁵ Kaiser Family Foundation. (2007, October). "Medicaid's role in family planning." Retrieved October 19, 2008 from http://www.kff.org/womenshealth/upload/7064_03.pdf

²⁶ Kearney, M. & Levine, P.B. (2008, July). "Reducing unplanned pregnancies through Medicaid family planning services." Washington, DC: Brookings Institute.

²⁷ Sonfield, A. (2008). "Family planning clinics prevent 1.4 million unplanned pregnancies annually, save billions of government dollars," *Guttmacher Policy Review*, 2008, 11(3).

²⁸ Frost, et al. "The availability and use of publicly funded family planning clinics: U.S. trends, 1994-2001."



²⁹ Nineteen percent of all Title X clients identify themselves as Black and 25 percent as Hispanic or Latino. Fowler, CI, Gable, J, and Wang, J. (2008, February). *Family Planning Annual Report: 2006 national summary*. Research Triangle Park, NC: RTI International. This is disproportionate to their representation in the general population, which stands at 13.4 percent and 14.8 percent respectively. U.S. Census Bureau. (2007, December) “Black History Month, February 2008.” *Facts for Features*.: U.S. Census Bureau. (2007, July). “Hispanic Heritage Month 2007, September 15-October 15.” *Facts for Features*.

³⁰ *Family Planning Annual Report: 2006 National Summary*.

³¹ Boonstra, et al. *Abortion in Women's Lives*, Guttmacher Institute.

³² Guttmacher Institute. Internal Memo, February 5, 2008.

³³ Frost, J. et al, “Estimating the Impacts of Serving New Clients by Expanding Funding for Title X.” Guttmacher Institute, Occasional Report No. 33, November 2006.

³⁴ Kaiser Family Foundation. (2008, September). “Prescription drug trends.” Retrieved October 19, 2008 from http://www.kff.org/rxdrugs/upload/3057_07.pdf.

³⁵ Sonfield, A., Gold, R.B., Frost., J.J., Aldrich, C. (2006) “Cost pressures on Title X family planning grantees, FY 2001-2004,” New York: Guttmacher Institute.