



The Title X Factor:
**Why the Health of America's Women Depends
on More Funding for Family Planning**

White Paper by
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October 28, 2013

ROOSEVELT INSTITUTE

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) represents an unprecedented expansion of the nation's health care system and an historic investment in the health of American women and girls. The ACA has already improved the lives of millions and will make health care accessible for millions more as rollout continues this year and next.

Fulfilling the promise of the ACA depends on the continued support and success of existing programs – like Title X, the federal family planning program – that serve as pillars of the nation's still fragile primary health care infrastructure. Title X provides critical medical care and “wrap around” services for family planning clinics nationwide, enabling them to pay for and maintain facilities, train and hire staff, purchase equipment and supplies, and offer a host of services for specific populations.

Family planning is central to women's health and social and economic security. Given the tenuous state of the U.S. economy, the vulnerability of women's health programs in the face of unrelenting political attacks, and the fragility of the social safety net more broadly, public funding for family planning is more critical than ever. Critics may argue that because the ACA meets the needs of many women, Title X is no longer necessary. In fact, the opposite is true. Continued – indeed, increased – funding of Title X will maximize the impact and reach of the ACA and ensure continued care for those who will remain uninsured despite this landmark legislation.

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The author would like to thank the following individuals for their invaluable assistance throughout the research and writing of this paper: Ellen Chesler (Roosevelt Institute); Judy Waxman and Mara Gandal-Powers (National Women's Law Center); Clare Coleman, Jessica Marcella, Dana Thomas (National Family Planning and Reproductive Health Association); and Laura Baringer. Additional thanks to the Dobkin Family Foundation for its support of the Roosevelt Institute's Women Rising Program.

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KEY FINDINGS

- The ACA demands an unprecedented scaling up in the nation's health infrastructure, and fulfilling the promise of the law will depend on the continued support and success of Title X.
- The demand for Title X-funded clinics will only increase in coming years as more individuals seek care and those who already rely on safety net providers continue to do so.
- Despite their coverage status, women will continue to rely on Title X-funded clinics because of the clinics' experience in and commitment to providing care in a safe, confidential setting.
- For many women, particularly young women and low-income women, Title X-funded clinics are a critical entry point into the health system. These clinics will be in even greater demand in the coming months as more women obtain coverage and seek a variety of health services.
- Despite the extraordinary promise of the ACA, many will remain uninsured and for those individuals Title X providers will remain one of the only sources of quality, affordable family planning care.

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INTRODUCTION

Nearly a century ago, Margaret Sanger was jailed for establishing the country's first family planning clinic in New York City. Although the clinic was shut down by the police just a few days after opening, nearly 500 women showed up in search of reproductive care, demonstrating the enormous unmet need for family planning services among all women, but especially poor women in the United States. With birth control information and services still illegal under state and federal obscenity statutes at that time, women had few good options. They could abstain from sex, use a variety of mostly-unreliable drug store remedies, endure an illegal and often dangerous abortion, or give birth to more children than they desired or could afford (Chesler 1992).

Family planning gained in moral and social legitimacy and, by increments, in legal acceptability in the following decades, and slowly but surely services also became more available. Voluntary clinics organized by Sanger and her followers came together under the umbrella of the Planned Parenthood Federation of America, and provided the main source of reproductive health and family planning services for low-income individuals at that time. In 1960 the first oral contraceptive pill was launched, but it would be five more years until contraception was constitutionally protected for married women under a privacy doctrine established by the Supreme Court's decision in *Griswold v. Connecticut*. In 1972 the right to use contraception was extended to unmarried women in *Eisenstadt v. Baird*, and a year later, the *Roe v. Wade* decision made early abortion legal under the same privacy doctrine. Then, with the oral birth control pill widely available, the U.S. government finally integrated family planning into its social welfare programs and contracted with clinics like Planned Parenthood to provide such services (Chesler 2012).

Since the 1960s and 1970s, a number of federal programs, most notably Medicaid, have funded many health care services, including family planning for the poorest Americans who have been left behind in the absence of a comprehensive system of national health insurance. Another of the most important and impactful of these programs has been Title X, the only federal program dedicated exclusively to family planning, and one historically available to families of the working poor who often do not qualify for Medicaid. Today, Title X extends family planning and reproductive health care to more than 4.7 million individuals each year. The program prevents 1.2 million unintended pregnancies annually, thereby avoiding 590,000 unplanned births and 400,000 abortions. The Guttmacher Institute reports that without the care and services provided by Title X-funded clinics, the U.S. unintended pregnancy rate would be 35 percent higher and the rate among teens would be 42 percent higher (Frost, Zolna and Frohwirth 2013).

This white paper demonstrates the effectiveness of Title X and makes the case for its continued and increased support in the context of the ACA. Conservative politicians and activists determined to defund Title X are already arguing that mandated provisions to provide family planning under the Affordable Care Act now obviate the need for the 40-year-old family planning program. To the contrary, the author argues that Title X remains ever critical by serving American women who still need access to health services, and will continue to need it even after the ACA is implemented.

Title X will play a number of important functions in the coming years. First, it will support a network of qualified family planning and reproductive health care providers to deliver care and services to the expanded ranks of women who will now enjoy health coverage. Second, it will guarantee family planning access to those still uninsured. Third, it will continue to set a standard of care for family planning delivery, and lastly, as a primary,

trusted point of entry to care for women, it will continue to play an important role in ACA outreach and enrollment efforts to ensure that health coverage is realized by as many Americans as possible.

This paper attempts to demystify the nation's complex family planning programs and policies and elucidate their relationship to the ACA. It first contextualizes Title X by describing the historic and current political environment and showing how bipartisan support for family planning programs has changed over time. It then describes the still dismal state of women's health care and health outcomes, illustrating that the program fills critical gaps in health coverage, particularly for low-income women. It then describes the ACA's historic commitment to improving women's health and explains the mechanisms through which the legislation will make family planning accessible to millions more. This paper explains Medicaid's important relationship with Title X, family planning and women's health more broadly, and to the ACA. This analysis also addresses the significant political and legal challenges against the ACA (such as opposition to the contraceptive mandate), examines how some women will remain uninsured in the years to come, and therein demonstrates the need for increased funding of Title X for the foreseeable future.

FAMILY PLANNING: THEN AND NOW

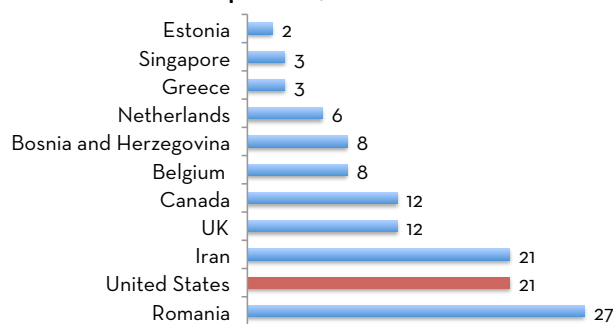
Family planning has not always evoked the partisan vitriol we see today. Title X was first enacted in 1970 as part of the Public Health Service Act under President Nixon. It was championed by then Congressman George H.W. Bush and passed with broad bipartisan support.¹ It was a unique time in U.S. history: a pervasive fear of global population growth, together with concern about the economic impact of poor women having more children than they desired or could afford, encouraged even the most socially conservative lawmakers to support federal family planning efforts. Additionally, new contraceptive technologies, especially the hormonal birth control pill and the intra-uterine device (IUD), made family planning possible for the masses. What is more, progressive social movements of the 1960s moved women's sexuality and health care into the public consciousness. Confidence that a relatively small investment in family planning would pay large dividends in the future gained widespread acceptance, a belief no longer shared by social conservatives today.

In recent years, anti-choice lawmakers have targeted family planning with a zeal once reserved for anti-abortion efforts. On October 1, 2013, for the first time in two decades, the GOP shut down the federal government over its general opposition to the ACA and its demand that employers, universities, and insurers have the ability to deny women coverage for preventive health services based on any moral or religious objections. This shutdown comes on the heels of similar threats in March of 2011 and 2013, when Republicans demanded preventing Planned Parenthood from receiving federal funding and stripping the ACA of the contraceptive mandate, respectively (Culp-Ressler 2013). In 2011 and 2012, the House of Representatives passed but failed to enact legislation that would have eliminated Title X funding.

State efforts to defund family planning have only further eroded the safety net. As the Guttmacher Institute reported, since 2010 five of the 19 states that include family planning line items in their budgets have made cuts "disproportionate to those aimed at other health programs" (Gold 2013). Texas made such drastic cuts to its state program that it went from serving 212,000 patients in 2010 to 75,000 in 2012, and estimates it will only serve 61,000 in 2013. Maine, Montana and New Jersey have completely eliminated family planning funding (Gold 2013).

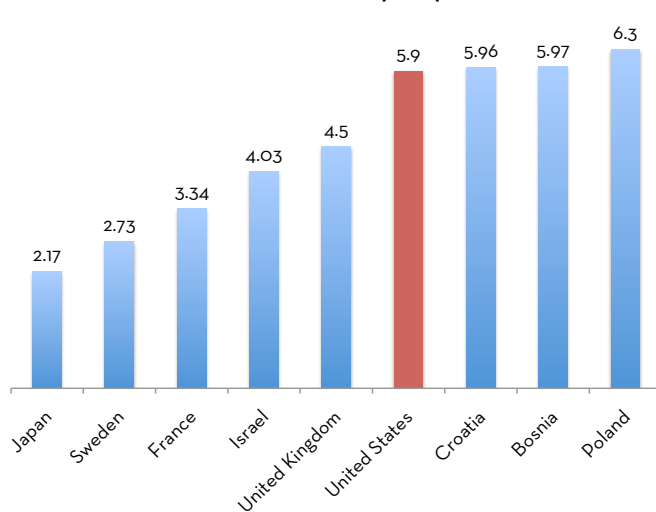
¹ The Public Health Service Act (PHSA) was originally enacted in 1944 under President Roosevelt. As part of sweeping changes ushered in the post-World War II and New Deal era, it modernized and reorganized the nearly 150-year-old Public Health Service (PHS) and drastically expanded the government's role in public health. It turned the PHS into a department focused on advancing public health by building health care facilities, training health professionals, and subsidizing biomedical research at private institutions. Family planning was not included in the original PHSA because of religious objections and its still technical illegality. Some regarded the PHSA as FDR's attempt to lay a foundation for national health insurance, a goal that was hotly debated in the early '40s and was never realized. Title X is just one of the many amendments that has been made to the PHSA since its original passage. The ACA is another such amendment.

Figure 1: Maternal Mortality Rate by Country
Deaths per 100,000 live births*



Source: CIA, Maternal Mortality Rate.
*UNICEF, WHO, UNFPA and World Bank calculations put the U.S. rate much higher than U.S. calculations.

Figure 2: Global Infant Mortality Rates
of deaths of infants under one year per 1,000 live births



source: CIA, Infant Mortality Rate

Some states have established tiered systems wherein family planning providers are given last preference for funding over a long list of health department providers and other community health centers. Others have prohibited family planning providers not affiliated with state health departments from receiving state and federal funding altogether (Guttmacher 2013). Around the country conservative lawmakers are implementing Targeted Regulations of Abortion Providers (also known as TRAP laws) in efforts to eliminate abortion access, a consequence of which is the closing of family planning clinics in areas where they are most needed. Even though abortion is most often a small fraction of the services offered at family planning clinics (if it is offered at all), being an abortion “affiliate” requires complying with these costly and hard-to-meet requirements, which force many to shut down.² Given this context, Title X and its network of providers will only become more embattled in the future.

FALLING BEHIND ON WOMEN’S HEALTH

The United States spends two and a half times more on health care per individual than other Organization for Economic Co-operation and Development (OECD) countries, yet its citizens overall have less access to care and services and worse health outcomes (see Appendix 1).³ The United States has fewer health providers per population, longer average wait times for services, and among the highest rates of teen birth, unintended pregnancy, and maternal and infant mortality (see Figures 1 and 2).⁴ The worst and most troubling outcomes exist among U.S.

² TRAP laws specifically target the practices of physicians who provide abortions, and impose on them regulations and requirements that are different and more burdensome than those required of other medical practices (Center for Reproductive Rights). Currently 27 states have such laws or regulations in place. Those include: requiring abortion facilities or their clinicians to have unnecessary and burdensome connections to a local hospital (21 states), requiring abortion facilities to meet standards for ambulatory surgical centers (26 states), specifying the size of procedure rooms and/or hallway widths (12 states), and requiring that facilities providing only medication abortion adhere to the same standards as those that also provide surgical abortion care (18 states) (Dreweke 2013).

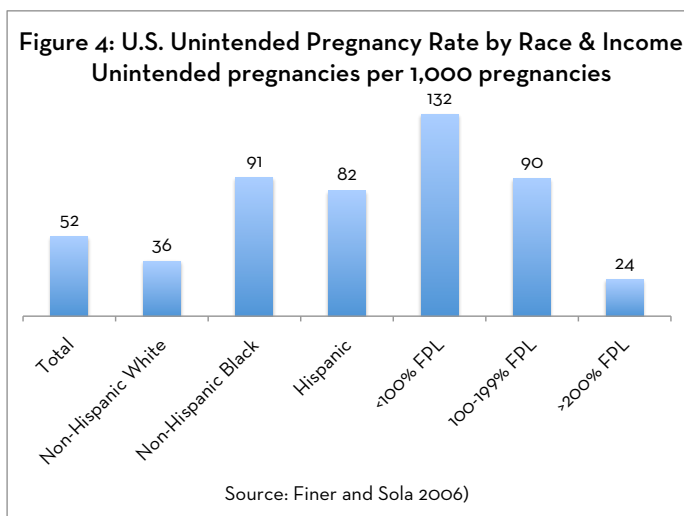
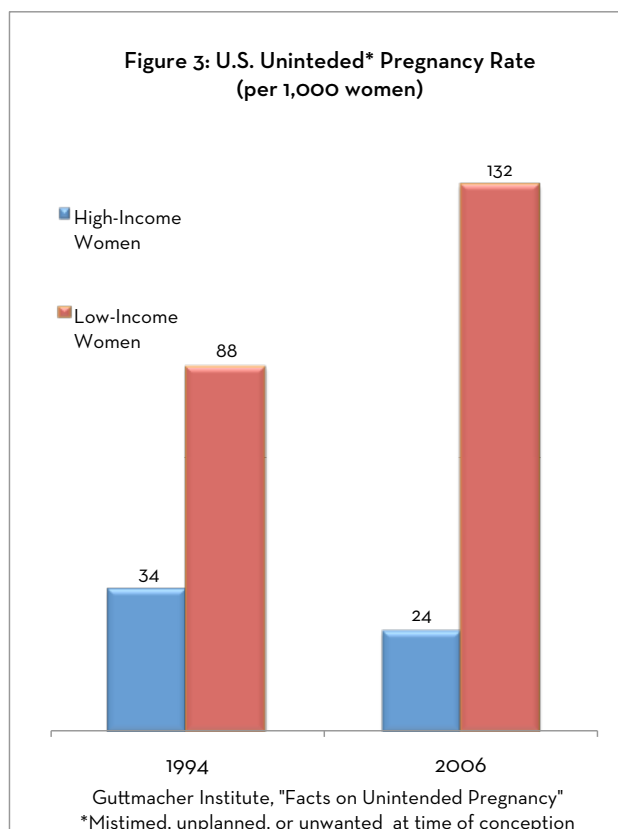
³ As of 2008, the United States spent \$7,538 per capita on health care. Health care spending by other OECD countries as of 2008 is as follows: Japan (\$2,729), Italy (\$2,870), Spain (\$2,902), United Kingdom (\$3,129), Australia (\$3,353), Sweden (\$3,470), Belgium (\$3,677), France (\$3,696), Germany (\$3,737), Austria (\$3,970), Netherlands (\$4,063), Canada (\$4,079), Switzerland (\$4,627), Norway (\$5,003) (OECD 2013).

⁴ The United States has fewer clinicians routinely providing contraceptive care (3.9 per 10,000) than many other developed nations. The Netherlands has 4.7, Sweden 7, and Belgium 12.7 per 10,000. Americans wait on average 20 days to see a provider, while women in Germany and Sweden wait 7 days, in Belgium 5 days, and in Netherlands 2. days (Bachrach, et al.).

communities of color and poor communities, and the health status of women of color in U.S. urban centers is comparable to that of women in developing countries.⁵

America's high rates of unplanned pregnancies, adolescent births, pre-term deliveries, and its lack of comprehensive pre- and post-natal care, have especially adverse consequences for the health and wellness of women and children. Almost half of all U.S. pregnancies – approximately 3.2 million each year – remain unintended, and 43 percent of those pregnancies end in abortion (Finer and Zolna 2011). Low-income women have an unintended pregnancy rate nearly four times that of high-income women, and women of color have significantly higher rates of unintended pregnancy rates than white women in the United States. This disparity has grown only greater over the past two decades (see Figures 3 and 4).

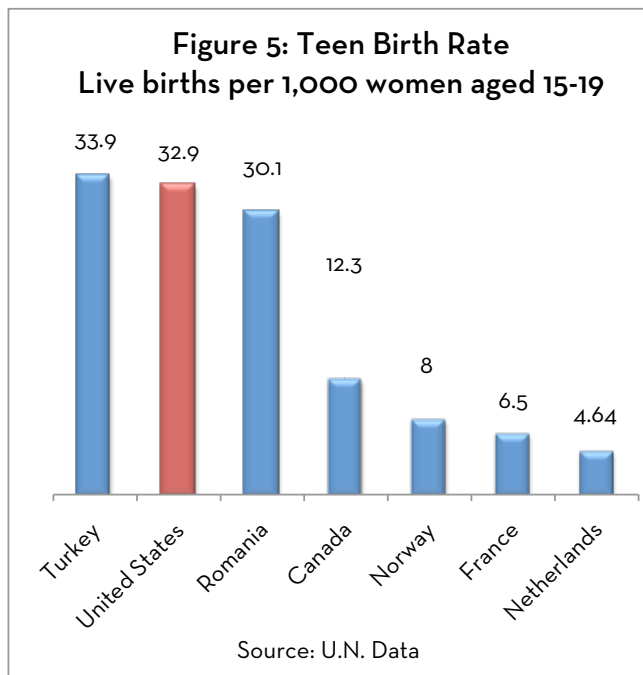
Adolescent pregnancies are a leading factor in infant mortality, and the United States has a higher adolescent pregnancy rate than any other industrialized country (see Figure 5). Additionally, babies born to teen mothers are more likely to have low-birth weight, be born pre-term, and die within their first month of life. According to a recent Save the Children report (2012), they are also more likely to “suffer chronic medical conditions, do poorly in school, and give birth during their teen years (continuing the cycle of teen pregnancy).” In 2008, nearly 30 percent of pregnant women in the United States did not receive prenatal care in their first trimester, and before the ACA, 62 percent of women enrolled in insurance plans on the individual market did not have maternity coverage (Cuellar, Simmons, and Finegold 2012). These statistics tragically reflect the country's continued failure to provide quality care for women and girls and for their families and communities more broadly.



TITLE X: BRIDGING THE GAP

Title X bridges a critical gap in family planning services for individuals around the country, and without it the state of women's health would be even more troubling. The U.S. Department of Health and Human Services' Office of Population Affairs (OPA) oversees Title X by funding a network of 4,189 of the nation's nearly 7,000 community-based family planning clinics, providing critical services to 4.76 million individuals in nearly three-quarters of all counties in the United States (Frost, Zolna and

⁵ See "Pregnancy Associated Mortality: New York City, 2001-2005."



Frohwirth 2013). In fiscal year 2012, the Title X budget totaled \$294 million and the program served 4.76 million clients, 71 percent of whom had incomes below the poverty line, and 21 percent of whom had incomes between 100 and 250 percent of the federal poverty level. In 2012, 64 percent of Title X clients were uninsured (Fowler 2013).

Title X is vital to women's health in a number of ways. Not only does it enable clinics to serve uninsured family planning clients, but it also helps clients obtain the contraceptive method of their choice quickly and easily. It provides financial resources that allow clinics to devote time and expertise to specific populations, such as adolescents and immigrants (Gold 2012). Title X requires all clinics that receive funding to meet a rigorous set of requirements, and as such sets standards for family planning care nationwide.

Title X funding also supports comprehensive family planning health care services at no charge to individuals at or below the poverty line, and on a sliding fee scale for those above the poverty line, ensuring that every woman is able to access services for a price within her means. In addition to contraception, Title X-supported clinics offer other important services such as pregnancy testing and counseling, breast and pelvic exams, cervical cancer screening, testing for HIV and other sexually transmitted infections, and screening for diabetes, high blood pressure and cholesterol (NFPRHA "Title X"). Despite commonly held beliefs, the Title X statute explicitly prohibits the use of federal dollars to pay for abortions and demands that any organizations that do provide abortions prove that no Title X funds pay for those services.⁶ Observing U.S. protections of free speech, the program does require that pregnant women be offered information and counseling about all options, "including prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination," and referrals upon request (Gold 2001).

Clinics that receive Title X funds are considered highly effective. A 2005 government review of Title X by the White House Office of Management and Budget (OMB) found that the program serves a unique and valuable purpose and is cost-effective and well managed. Over two decades, services provided at Title X-funded health centers prevented an estimated 20 million unintended pregnancies and nine million abortions, and helped to prevent 5.5 million adolescent pregnancies (Gold 2001). Between 1980 and 2000, these health centers also provided 54.4 million breast exams and 57.3 million Pap tests, resulting in the early detection of as many as 55,000 cases of invasive cervical cancer (Gold 2001). In 2011 alone, family planning services at Title X-funded health centers helped prevent an estimated 996,000 unintended pregnancies, 200,000 of which were among teens (HRSA 2013). These figures do not account for the significant maternal health complications that result every year from unintended pregnancies and births.

⁶ Federal law states: A Title X project may not provide pregnancy options counseling which promotes abortion or encourages persons to obtain abortion, although the project may provide patients with complete factual information about all medical options and the accompanying risks and benefits. While a Title X project may provide a referral for abortion, which may include providing a patient with the name, address, telephone number, and other relevant factual information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider, the project may not take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the patient (Office of Population Affairs 2000).

In addition to the positive health outcomes related to Title X funding, research has found a significant cost benefit as well. A report examining the impact of federally funded family planning programs found that services provided at Title X-supported clinics accounted for an estimated \$3.4 billion in savings in 2008 alone (Frost, Finer, and Tapales 2008).

Title X is perhaps equally important for its role in upholding a comprehensive standard of care that no other federal program requires. A clinic that receives even \$1 of Title X funding must meet all of the requirements set forth by the federal government, including providing necessary services regardless of ability to pay. There are no other federal programs that require the level of comprehensive care and services Title X guarantees. While this is great news for patients, being required to serve and provide care to all uninsured patients, regardless of ability to pay, is a financial burden for many health providers. An increase in federal funding would enable them to meet this level of comprehensive care in a more sustainable way.

THE AFFORDABLE CARE ACT: A BOON FOR WOMEN'S HEALTH

The ACA aims to reverse many of the United States' negative reproductive health trends, and is particularly revolutionary for women and girls:

- It mandates that private insurers cover without cost-sharing all FDA-approved contraceptive methods, sterilization procedures, patient education, and counseling for all women of reproductive age, along with a host of other preventive health services (Cuellar, Simmons, and Finegold 2012).⁷ Previously, patients were usually required to pay a percentage of the cost of contraception, which made many methods, especially long-acting methods such as the IUD and the implant – often the most desirable and effective – inaccessible to most women.
- It prohibits private plans from charging women higher premiums than men and prohibits all forms of gender discrimination in any program or activity that receives federal financial assistance (hospitals, clinics, employers, insurance companies, Medicare, Medicaid, etc). This is the first time that federal law has prohibited sex discrimination in health care (National Women's Law Center 2013).
- It prohibits denying coverage because of existing or pre-existing conditions.
- It enables young people to stay on their family's health plan until they are 26. The Commonwealth Fund estimates that 7.8 million of the 15 million young adults who were enrolled in a parent's health plan in 2012 would likely not have been eligible for this coverage without this provision of the ACA (2013).
- It invests \$75 million annually in a state grant program to fund comprehensive approaches to sex education, including but not limited to sexual abstinence (U.S. Department of Health and Human Services).

In addition to these important contraceptive benefits, the ACA also mandates coverage for preventive health services that will contribute to overall improvements in women's sexual and reproductive health. Per the recommendation of a group of independent experts at the U.S. Department of Health's Health Resources and Services Administration (HRSA), the ACA mandates coverage of eight preventive services for women with no cost-sharing requirement, including (HRSA "Women's Health and Wellbeing"):

- Coverage of Pap tests, testing for high-risk strains of HPV, and the HPV vaccination.
- Coverage of counseling on HIV and other sexually transmitted infections (STIs) for all sexually active women, and the coverage of screenings for four specific STIs: HIV, chlamydia, gonorrhea, and syphilis.

⁷ Some plans that existed before March 2010 qualify for "grandfathered" status and they are not required to cover preventive services without cost sharing as long as their status is maintained. The majority of those plans will lose their grandfathered status within the next few years and will then have to provide coverage without cost sharing. Today 36 percent of individuals with employer-based health insurance are enrolled in a grandfathered health plan, down from 48 percent in 2012 and 56 percent in 2011 (Barr 2013).

- Coverage of preconception and prenatal care visits (more than a dozen over the course of a pregnancy), including a daily folic acid supplement (Cuellar, Simmons, and Finegold 2012).⁸
- Coverage of postpartum counseling and education and support for breastfeeding, including the cost of renting or purchasing breastfeeding equipment such as a breast pump (Sonfield 2012).
- Coverage of at least one well-visit per year so that women can gain access to the abovementioned services.

Millions of women who are not currently covered by private insurance will also enjoy these benefits, thanks to the drastic expansion of public and private health coverage mandated by the ACA. The expansion of Medicaid will represent the largest growth in coverage since the program's creation. Beyond Medicaid expansion, the ACA will extend care to millions of Americans by providing insurance subsidies through the new state health exchanges (operational as of October 1, 2013) and by investing in a national network of community health centers that provide critical care and services to low-income communities.

Health Exchanges

ACA-created health exchanges or marketplaces target people who are not covered by their employers but whose incomes are above the Medicaid threshold. These new marketplaces will enable individuals and small businesses to shop for insurance coverage in a competitive online marketplace, where they can choose among plans of varying costs and coverage benefits. The federal government is making health insurance more affordable by providing subsidies to enrollees and families with incomes between 100 and 400 percent of the federal poverty level. Those who are currently uninsured and opt not to purchase health insurance through the exchanges will face a tax penalty. Every state should have a marketplace as of October 1, 2013 through one of three mechanisms:

1. A partnership exchange, a hybrid model in which a state operates designated functions related to plan management, consumer assistance and outreach, etc. while the federal government coordinates all other critical logistics among patients, employers, insurance plans, and the Treasury (such as verifying identification).⁹
2. A declared state-based exchange, in which the state will be responsible for all duties related to managing enrollment of individuals into plans on the marketplace.¹⁰
3. A default to federal exchange, wherein a state does not create its own marketplace and the federal government manages the entire process.¹¹

Community Health Centers

Community Health Centers (CHCs) have for decades formed the backbone of the U.S. health care system and are critical to the implementation of the ACA. CHCs are one type of organization that falls under the umbrella of Federally Qualified Health Centers (FQHCs).¹² They operate as non-profit organizations that receive federal

⁸ It is estimated that beginning in 2014, 8.7 million more women who currently buy coverage in the individual market will gain maternity coverage, along with millions more who currently have employer-based coverage.

⁹ Seven states will have "Planning for Partnership Exchanges." In these partnerships the federal government is responsible for: maintaining a website that provides standardized plan information; operating a toll-free hotline; providing employers and the Treasury lists of employees eligible for a tax credit; providing a calculator to determine actual after-subsidy cost of coverage; issuing to individuals, employers, and the Treasury certifications of exemption for individuals not required to meet the individual responsibility requirement; and creating grant-making programs that provide funds for organizations that assist consumers.

¹⁰ Seventeen states will have declared state-based exchanges. In this model the state will perform all of the above tasks.

¹¹ Twenty-seven states will have "Default to Federal Exchange" programs. These states have refused to set up their own exchanges and the federal government will manage all aspects of the exchanges.

¹² FQHCs are health centers that deliver primary health services to medically underserved populations, including migratory and seasonal agricultural workers, the homeless, and residents of public housing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements, as defined by Section 330 of the Public Health Service Act.

funding and must meet comprehensive federal standards as they provide primary care services to the nation's underserved communities.

CHCs play an important role in the delivery of reproductive health and family planning services. As of 2011, 8,500 delivery sites operated by CHCs served more than 20 million patients across the country. Sixty percent of patients served by CHCs are women – 25 percent of childbearing age (Wood, Susan et al 2013). Almost all CHCs deliver family planning care, with 87 percent of all sites providing a “typical” package of care, including testing and treatment for STIs and prescription and/or delivery of oral contraceptives and one additional method (IUD, injectables, emergency contraception, condoms, implants, etc). Some of these sites receive Title X funding.

Over the next five years, federal funding under the ACA will invest an estimated \$11 billion in the operations, expansion, and construction of these important safety net health centers, as we heavily depend on them to meet the needs of the ranks of newly insured individuals around the country (U.S. Department of Health and Human Services 2012). Since the beginning of 2009 – before the passage of the ACA – CHCs had already increased their patient load by more than 3 million annually. That number is likely to increase dramatically as the ACA is fully implemented. It is important to note, however, that many family planning providers are not classified as FQHCs – either because they did not apply for such status or because they do not provide the full range of required primary care services (eye, ear, dental, radiologic services, etc.) – and therefore will be not be eligible to receive the additional funding available through the ACA. They will continue to rely on Title X funding.

Lessons from Massachusetts, where a state version of the ACA was implemented in 2006, tell us that even though the uninsured patient population will shrink in the coming years, and patients will have the option to receive care at a host of different providers, many will likely continue to visit CHCs. A 2011 study looking at the impact of Massachusetts' health reform concluded that patients who use safety net providers do so not only as a last resort, but because they prefer the care that is offered there.

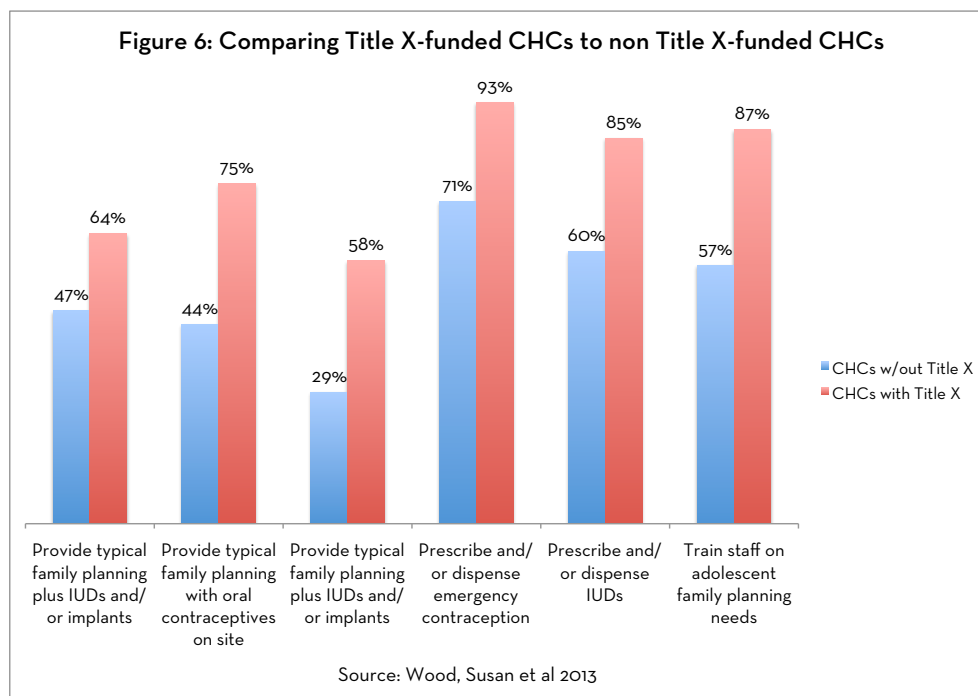
In the four years following Massachusetts' health care reform, CHCs there experienced a 31 percent increase in patients, even though the number of uninsured visiting those facilities fell from 35.5 percent to under 20 percent. Most safety-net patients reported using CHCs because they were convenient (79.3 percent) and affordable (73.8 percent), while only 25.2 percent reported having had problems getting appointments elsewhere (Ku, et al. 2011). This suggests that the need for CHCs and other safety-net providers will actually increase when the ACA is fully implemented, precisely why the ACA provides for such a significant investment in them.

Title X clinics and CHCs have for years worked hand in hand. As a study by George Washington University (2013) explained:

Both programs are joined through the Public Health Service Act. Both are administered by HHS, and they share mission, overall operational structures, and a great reliance on Medicaid payment policy. Both programs stand to be transformed by the Affordable Care Act's insurance expansions, innovations in coverage design for family planning, and emphasis on payment reform. (Wood, Susan et al 2013)

While nearly a quarter of all CHCs do receive Title X funds, the majority do not. Many communities are home to both Title X clinics and CHCs that often have loose partnerships but effectively function completely independent of one another. The organizations typically have a strong reciprocal referral relationship so that CHC patients who need family planning services, or who prefer to receive family planning care separately, will be referred to a Title X clinic, and visa versa (Wood, Susan et al 2013).

CHCs that receive Title X funds offer more comprehensive family planning and reproductive health services and generally serve a larger population of patients who do not, and cannot, receive care elsewhere. According to the George Washington study, Title X-funded CHCs have “higher proportions of patients who are uninsured, Medicaid eligible, adolescents, and women of childbearing age, and a lower proportion of non-Hispanic white



patients, suggesting that their services are of particular importance to minority women” (Wood, Susan et al 2013).

Title X-funded clinics offer staff specially trained to serve more client groups and provide a broader range of contraceptives on site, including emergency contraception and long-acting reversible contraceptive methods (LARCs) (see figure 6). Title X providers, for example, serve an average of eight different client groups

and host special programs and outreach efforts for an average of five client groups (such as adolescents, non-English speaking patients, patients experiencing partner violence, and patients with substance abuse problems, as well as men, immigrants, LGBTQ individuals, and sex workers). Meeting the needs of adolescents is a particular hallmark of Title X funding, and 91 percent of clinics retain staff that are specially trained in addressing the needs of this younger population. As the Guttmacher Institute has argued:

Title X funding enables a clinic to go beyond the provision of bare-bones clinical care to craft a multi-faceted effort in which clinicians and counselors with specialized training can take extra time with clients needing extra effort, and resources are invested in community outreach to identify the agency as a source of high-quality, culturally appropriate, affordable and confidential care. (Gold 2012)

Title X is a critical program even for individuals who have private insurance. Because of confidentiality concerns such as intimate partner violence, religious beliefs of employers, family, and partners, among a host of other issues, many women may choose to circumvent their insurance plans when accessing family planning services and rely on public providers. A study conducted by the Guttmacher Institute found that more than 60 percent of clinics reported that clients choose their facility because of the availability of confidential services (Frost, et al. 2012). Protecting the confidentiality of patients will be an ongoing issue as ACA implementation occurs, one that Title X-funded sites are experienced in managing.

MEDICAID & WOMEN’S HEALTH

It is difficult to describe the importance of Title X without explaining its symbiotic relationship to Medicaid. While Title X provides medical services and the wrap-around funding that enables clinics to keep their doors open, their shelves stocked, and their staff trained and gainfully employed, Medicaid operates as an insurance plan that pays for qualified low-income patients to receive care at those facilities. This section will describe the contours of Medicaid’s family planning program, the intersections of Title X and Medicaid, and the expected impact of Medicaid under the ACA.

The Role of Medicaid in Family Planning

Medicaid plays a critical role in enabling low-income Americans to access family planning services. Seventy percent of Medicaid's enrollees are women, and the program covers 4 out of ten births in the United States annually, with the federal government compensating states for 90 percent of costs of all pregnancy-related programs (Sonfield, Frost, and Gold 2011). Family planning programs funded through Medicaid result in improved contraceptive use, fewer unintended pregnancies, and longer intervals between births. These programs improve public health and save taxpayer dollars. Research has shown that every \$1.00 spent on publicly funded family planning saves \$5.68 in Medicaid expenditures (Frost, Zolna and Frohworth 2013).

Medicaid coverage of family planning has gradually expanded over its almost 40 year history, and represents nearly all the growth in public family planning spending over the last two decades (Gold 2012). When Medicaid was originally established in 1965, it provided coverage only for single mothers and their children. In 1972, Congress required states to provide Medicaid coverage for family planning services and supplies, a benefit matched 9-to-1 by the federal government. In 1980, Congress again modified the program and eventually required states to extend prenatal, delivery and post-partum care to all women with incomes up to 133 percent of the poverty level. And in 1987, Congress gave states the option to expand family planning eligibility to women with incomes up to 185 percent of the poverty level. As of November 2010, 22 states had already expanded Medicaid programs that extended family planning services to individuals on the basis of income alone. Some states are providing services to individuals at 133 percent of the federal poverty threshold (\$21,256 for an individual) and others up to 300 percent (\$34,470 for an individual), regardless of other qualifications required for traditional Medicaid benefits.¹³

Medicaid enrollees are exempt from cost-sharing requirements like deductibles and co-pays, and federal law demands that those individuals must have the freedom to visit a family planning provider of their choosing, even ones outside their care network (NFPRHA, "Medicaid"). Some states have attempted to challenge this requirement by excluding Planned Parenthood and other providers "affiliated" with abortion from the program.

Last year, Texas forfeited federal family planning funds so the state could prevent Planned Parenthood from receiving Medicaid dollars. Other states have attempted to make such providers ineligible from receiving federal family planning funding, but Texas is the only one thus far willing to forfeit federal funding to achieve its goal, much to the detriment of low-income women there.

Medicaid and Title X

Medicaid fills a critical need among low-income women in the United States, but it could not do so as effectively without Title X. While Medicaid functions as a form of insurance individuals can use to access care and services, it does not support the health infrastructure many of those services rely on. In addition to subsidizing medical care, Title X funds staff trainings, counseling, outreach and community education for specialized populations, new technology, expanded hours and locations, and provider infrastructure. It also provides coverage for individuals who do not qualify for Medicaid (such as immigrants who have been in the country for less than five years and undocumented immigrants), those who do not have private health insurance, and those who for a variety of reasons may choose not to rely on their insurance plans for family planning services.

Without Title X funding, there would be fewer clinics, fewer skilled clinicians, and fewer contraceptive options available to Medicaid patients. As the Guttmacher Institute has noted:

The availability of Medicaid, or any form of insurance, would quickly become meaningless absent a healthy network of providers to care for low-income clients. Although private providers have a critical role to play, they are increasingly unlikely to accept Medicaid clients. (Gold, et al. 2009)

¹³ Previously adults had to fall under at least one of a series of categories to qualify for Medicaid, such as being pregnant women, having children, or being disabled.

Medicaid and the ACA

The ACA includes money for each state to cover more individuals through Medicaid, and when it was originally passed into law in 2010, it required that by 2014 every state expand Medicaid to all individuals who fall below 138 percent of the federal poverty level (\$15,415 for an individual or \$26,344 for a family of three) (Kaiser 2012 “Medicaid Expansion”). The law also struck down previous categorical requirements that excluded many low-income adults in need of care (such as requiring that adults be pregnant, disabled, have children, etc.).

In a high profile decision last year, the Supreme Court upheld the constitutionality of the ACA’s individual mandate – the requirement that individuals be insured or otherwise pay a penalty. But the court ruled that requiring states to participate in Medicaid expansion is unconstitutionally coercive, essentially giving them the ability to opt out (Kaiser 2012 “A Guide to...”). Under the ACA, the federal government will reimburse states that participate in Medicaid expansion for 100 percent of the program’s cost during the first three years, and then for a minimum of 90 percent of the cost in the years to follow. It is estimated that if the proposed Medicaid expansions were fully implemented in all states, an estimated additional 21.3 million people would enroll in Medicaid by 2022, a 41 percent increase compared to projected levels without the ACA (Kaiser 2012 “Medicaid Analysis”).

The ACA also enables states to expand Medicaid eligibility for family planning services to individuals who would not have previously qualified, and requires the coverage of adolescents and men, who were exempt under prior rules. Until 2010, states had to obtain a waiver from the federal Medicaid rules to establish these expanded family planning programs, through a process so complex and cumbersome it often took up to two years.

ACA IS NOT UNIVERSAL COVERAGE

As originally envisioned, the ACA provided a path to health insurance for all Americans. However, because of the Supreme Court’s decision to allow states to opt-out of Medicaid expansion, fewer uninsured Americans will be covered than intended. Even if the ACA were fully implemented, however, the Congressional Budget Office (CBO) now estimates that nearly 30 million individuals would still remain uninsured as of 2016, and into the foreseeable future. This is surely a vast improvement from the nearly 57 million who would be uninsured without it, but still a significant number (CBO 2013). Despite the immense progress expected under the ACA, the law’s loopholes and exceptions will necessitate sustained and perhaps increased funding of Title X and other such federal programs.

Refusing Medicaid Expansion

As of October 2013, 22 states have determined they will not yet participate in Medicaid expansion and another four are still debating the issue (Kaiser 2013 “Status of State Action”).¹⁴ Lawmakers in those states argue that Medicaid is already too costly, and they don’t trust Washington to honor its promise of guaranteed funding. This creates an unanticipated conundrum. In states that refuse expanded Medicaid funding, individuals on the edge of poverty will fall into a coverage gap. They will not qualify for subsidies for the marketplaces and they will also not qualify for Medicaid coverage.

If the four states currently debating expansion decide to participate, an additional 680,000 women will gain coverage, and if the 22 states that have rejected federal funding decide to instead expand Medicaid an additional 3.7 million women would gain access to care (Kaiser 2013, Rosenthal 2013) (see Appendix 2). Many of those states also have the highest uninsured populations of women in the nation (Kaiser 2012 “Nonelderly”).

¹⁴ States not moving forward with expansion include: Alabama; Alaska; Florida; Georgia; Idaho; Indiana; Kansas; Louisiana; Maine; Mississippi; Missouri; Montana; Nebraska; North Carolina; Oklahoma; South Carolina; South Dakota; Texas; Utah; Virginia; Wisconsin; and Wyoming. States still debating expansion include: New Hampshire; Ohio; Pennsylvania; and Tennessee.

Even in states that participate in Medicaid expansion, however, many low-income individuals may still remain uninsured. Educating individuals about their eligibility for Medicaid and then assisting them in the enrollment process is no small task, and it is estimated that between roughly 25 and 35 percent of those who are newly eligible for full coverage will not actually enroll in the short term (Holahan and Headen 2010).

Many immigrants will also remain uninsured, as federal law mandates that new arrivals must wait five years before qualifying for coverage, and undocumented immigrants are not eligible for assistance at all (Kaiser 2012 “Medicaid ... Lifespan”). These communities – low-income people who qualify but do not enroll in Medicaid, and immigrants who are not eligible – are populations that will remain in need of Title X-funded services. Publicly funded clinics will be the only place that they can turn to for care.

Grandfathered Plans

Some individuals with private health insurance will not immediately see the benefits of the ACA’s women’s health provisions. Most plans that existed before the ACA was passed in March 2010 qualify for “grandfathered” status. These plans are not required to cover preventive services without cost sharing as long as they maintain grandfathered status (Collins 2010). Although still required to cover children up to the age of 26 and still prevented from having lifetime limits and from having waiting periods of more than 90 days, plans with grandfathered status are not required to guarantee access to emergency, pediatric, and ob-gyn services and do not have to eliminate cost sharing for preventive services, among other benefits (Collins 2010).¹⁵

In 2013, 36 percent of individuals who received health insurance through their employers were enrolled in a grandfathered health plan (Barr 2013). Women who are covered under grandfathered plans will have to wait until their plans lose such status before they can access the full range of benefits provided by the ACA. Within the next couple of years, the majority of plans will lose their grandfathered status and have to comply with all of the ACA’s requirements. In the meantime, potential delays in family planning coverage will leave an important gap to be filled by Title X-funded clinics.

Churning

It is anticipated that large numbers of people will cycle on and off insurance coverage (or between different types of coverage) as the ACA is implemented. This process, known as “churning,” results from fluxes in life circumstances, such as changes in income, employment status, and marital status, all of which can alter an individual’s insurance status. Data from Massachusetts shows that such churning patterns are especially common among young and low-income women (NFPRHA 2012 “Medicaid Family Planning”).

A recent study conducted by the Urban Institute found that unless measures are taken to prevent churning, more than 29 million people under age 65 will be forced to change coverage systems from one year to the next, representing approximately one third of all individuals who will receive either Medicaid or exchange subsidies during any given year (Buettgens, Nichols, and Dorn 2012). The study found that:

- 6.9 million individuals will move from Medicaid to subsidized coverage (or vice versa)
- 19.5 million individuals will shift between Medicaid and ineligibility for all insurance subsidy programs (typically individuals will have incomes that are too high for Medicaid and are eligible for health coverage through their employers) and
- 3 million individuals will no longer qualify for subsidized coverage in the exchanges and will also not qualify for Medicaid.

¹⁵ Eventually, most plans will lose their grandfathered status and will be subject to the ACA’s regulations. Any of the following actions would result in a loss of the grandfathered status: a significant reduction in benefits; an increase in co-insurance above March 2010 levels; a designated increase in co-payments; an increase in deductibles, out-of-pocket limits, or other cost-sharing amounts by more than a set amount; changing annual limits that did not exist before March 2010 or adding annual limits that results in a reduction of coverage.

As people churn from one type of coverage to another, they will experience disruptions in care: some plans may be grandfathered and not include certain types of coverage; physicians covered by one plan may not be covered by another; and individuals simply may not want to navigate the complex system of health care to determine how to use a new plan. Having access to Title X clinics will ensure that women can maintain a continuity of care throughout these changes.

TITLE X: A PROGRAM FACING CONSTANT THREATS

Funding for Title X has consistently remained below what is required to meet the needs of women across the country. For fiscal year 2013 the program's budget was \$278.3 million – \$39.2 million below the amount budgeted for 2010. In inflation-adjusted dollars, Title X funding is 65 percent below what it was in 1980 (Gold 2012). President Obama requested \$327 million for fiscal year 2014, and while this amount represents a \$49 million increase from the current budget, it would simply bring the program back to where it started before the round of cuts in 2010 (Office of Management and Budget 2013) (see Appendix 3).

The National Family Planning and Reproductive Health Association (NFPRHA) – a nonprofit organization comprising a spectrum of family planning administrators and clinicians who serve the nation's low-income and uninsured women and men – estimates that Title X is currently only meeting 35 percent of the population in need, and that in order to function at full capacity, the program would require funding in the ballpark of \$800 million (Coleman 2013). Millions of women would benefit from even greater increases to this program, especially in these early and important years of ACA implementation. Despite this unmet need for Title X services, the budgeting process is rooted in a tug-of-war between the service delivery-driven realities of program needs and the political feasibility of successfully advancing a budget in the current political climate.

Since the 2008 financial crisis and the proceeding recession, the need for Title X has grown dramatically, while funding levels have declined or remained flat. In 2009 and 2010, the Title X system saw 173,000 new patients, which constituted the largest increase in the program's patient population in a decade (Office of Population Affairs 2012). Clare Coleman, President and CEO of NFPRHA says, "The increased patient load absolutely reflects patients falling out of subsidized care and a larger transient population of people who are out of work for longer and transitioning between insurance coverage." While the ACA will significantly expand women's health coverage, there remains a great need for publicly funded health services and the current funding levels simply cannot meet the demand.

The anti-family planning and overall austerity sentiments that swept the nation as many conservatives were elected to office in 2010 impacted family planning budgets across the country and nearly eliminated Title X. This means that there are fewer funds from state and federal coffers for women's health, at the very time that women are also losing jobs, and with them, insurance and other benefits on which their physical, social, and economic well-being depends. When centers lose funding, they are forced to make cuts in three places: services and supplies, hours, and staff, all of which impact their ability to serve the population in need. Directly after the first year of funding reductions, the Title X network immediately experienced a decline in patients served. Most recent data estimates between 2010-2012 show that the total number of Title X users went from 5.22 million to 4.76 million, a decrease of 440,000 (Office of Population Affairs 2012, Fowler 2013). This decline is unfortunately only expected to increase as funding sources continue to shrink.

The Guttmacher Institute reports that six in 10 Title X-supported sites are unable to stock some contraceptive methods, particularly long-acting reversible contraceptives (LARCs) such as the IUD and implant, because of the cost (Gold 2012). LARCs are a critical component of family planning programs, and it is more important than ever that Title X clinics have the supplies and expertise required to insert and manage them. They are highly desirable because they are among the most effective methods of birth control on the market. LARCs carry a higher up-front cost than other methods but save money for providers and users in the long run. They are effective for three to 10 years and eliminate the need for women to make multiple trips to a clinic, which is especially

important for low-income women and women who live in rural areas, who might not be able to take time off or travel for health and family planning care. Recent studies have confirmed that when given the choice, the majority of women prefer an IUD or hormonal implant because they are more effective and are simpler than birth control pills.¹⁶

Title X-funded clinics have already had profound impact, and would greatly benefit from increased funding, as they struggle to meet the needs of the expanding populations they now must serve. Given the program's effectiveness to date, despite meager and inconsistent funding, it's not hard to predict the scaled up impact of the program with expanded funding.

CONTINUED CHALLENGES

President Obama's 2014 budget proposal includes a request for \$327 million for Title X – the amount recommended by many advocates and service providers across the country including the national Family Planning Coalition, a broad-based group of health and legal experts and religious and secular activists, including NFPRHA and Planned Parenthood (Office of Management and Budget 2013). However, the past few years have seen historic challenges to Title X and family planning more broadly. The current anti-choice and anti-family planning sentiments at the state level are clear indications of the federal program's continued vulnerability.

When President Obama initially introduced the ACA, it was expected to pave a path for all Americans to receive health care in the coming years. As a result of intense efforts to derail the law, certain components have been modified or scaled back, and the ACA – at least for now – will not be as comprehensive as originally planned.

Contraceptive Mandate

In addition to the contraction of the originally planned Medicaid expansions, legal challenges to the contraceptive mandate further complicate the ACA's reach. The mandate has been under fire since the legislation was first signed into law, with religious organizations arguing the provision is a violation of their religious freedom.

In response to this opposition, President Obama proposed a new rule that makes houses of worship completely exempt from the contraceptive mandate and provides an accommodation that allows employees of, or students at, nonprofit organizations that hold themselves out as religious, such as hospitals and universities, to access contraceptives at no cost to her or her employer.

Religious employers have not been the only ones to protest the contraceptive coverage requirement. More than 40 lawsuits have been filed against the mandate by for-profit businesses opposed to providing this coverage to their employees. A split in the circuit courts of appeals exists on the novel question of whether a for-profit company can exercise religious beliefs. This issue may reach the Supreme Court this term. Twenty-eight states already had "contraceptive equity" laws that require coverage of contraceptives if plans provide other prescription drug coverage, and the highest courts in both California and New York rejected challenges to such laws on the grounds that they advance governmental interests in women's health and gender equity (*Domino's Farms Corp., et al v. Kathleen Sebelius* 2013).

As the National Women's Law Center has argued, the contraceptive mandate does not represent a substantial burden to the "exercise of religion" and, even if it did, the provision of contraceptive services to all women furthers:

¹⁶ The Contraceptive CHOICE Project, directed by researchers at Washington University in St. Louis (2012), enrolled some 10,000 women ages 14 to 45 (with a mean age of 25) identified as being at risk of unintended pregnancy and wanting contraception. Each was given the reversible contraceptive method of her choice, at no cost, for two or three years. Seventy-five percent of project participants selected an IUD or hormonal implant.

the compelling governmental interests of safeguarding public health and promoting gender equality in the least restrictive means possible. The regulations further ensure that women will have complete control over their reproductive lives by guaranteeing women's ability to access medically recommended preventive services free from employer interference. (Domino's Farms Corp., et al)

Other legal challenges

An initial pillar of the ACA was the employer mandate – a requirement that all businesses with more than 50 full-time employees offer “affordable” coverage for their workers, including children up to age 26. In response to business lobbyists who argued that meeting the requirements of the ACA would prove too complex and time consuming to achieve the 2014 deadline, President Obama delayed the employer mandate until 2015. This unfortunately means that employees of these businesses (and their children) may be forced to go without care for another year.

Small businesses – those employing fewer than 50 full-time employees – are not obligated to provide insurance for their employees and will not face a tax penalty if they decide not to. However, small businesses will qualify for subsidies to make the cost of coverage more affordable should they choose to offer it. For the employees of small businesses that do not provide coverage, Title X-funded clinics will remain ever important.

Low-income individuals may be caught in a bind

Even in states that participate in Medicaid expansion and with the newly formed health insurance marketplaces in all states, a number of low-income individuals will likely be left off insurance rolls. Roosevelt Institute Senior Fellow Richard Kirsch has noted that even though many companies will have to offer new coverage to their employees under the ACA, the cost of that coverage may still be prohibitive for some. “Many low-wage workers will be forced to choose between paying huge chunks of their income on premiums or on a penalty that leaves them with no coverage at all,” he claims (Kirsch 2013). Even though improved health coverage will provide substantial savings in the long run, the upfront cost may simply be too great for many people. Low-wage workers will be caught in a bind, either choosing to pay a significant percentage of their meager wages for sub-par health insurance that would still require out-of-pocket costs, or simply pay a fine for remaining uninsured (Kirsch 2013). For these individuals, a robust and reliable safety net will continue to be key for ensuring continuous, quality health care.

CONCLUSION

Family planning is not simply an issue of women's health and rights. It is an issue central to the nation's greater public health and economy. Given the current fragility of the U.S. economy – and the recession's devastating impact on low-income families – family planning is an economic issue, not just a social one, and a necessity, particularly at a time when so many families face enormous challenges as a result of stagnant wages, the contraction of manufacturing and other well-paid jobs and continued high unemployment (National Employment Law Project 2012). Access to affordable contraception and reproductive health care services enables women to pursue educational and professional opportunities that strengthen their families and their communities. Today more than ever, many American families, especially in female-headed households, rely on the social safety net to access this critical health care. The ACA is a historic step in meeting the needs of many of those women and families, and Title X will help the new law meet its potential, while also serving those who remain uninsured in the years to come.

This paper has investigated the pivotal role that Title X has played in women's health care for more than 40 years since its inception. It has also analyzed the continued importance of this unique family planning program as the ACA is rolled out. In order to most effectively meet the complex health needs of women around the country as we scale up the nation's health system under the ACA, lawmakers should:

- Continue Title X funding through the full implementation of the ACA, using the 2014 budget amount as a floor, as a means to ensure that the safety net is equipped to support and achieve the goals of the ACA.
- Facilitate formalized partnerships and collaborations between Title X facilities and CHCs, which will enable more CHCs to provide and access the comprehensive family planning services offered at Title X facilities. As the researchers at George Washington argued, both models are critical pillars in our current health infrastructure, and the government should provide mandates, guidance, and funding to enable the sharing of best-practices and more effective, sustainable partnerships, which will help secure the foundation of CHCs as they are expanded under the nation's new healthcare system.
- Conduct a thorough assessment to determine remaining unmet need for family planning care as various provisions of the ACA are implemented.
- Use this assessment as the basis for future Title X funding, so the funding process is data-driven and need-based.

When fully implemented, the ACA will vastly increase health care coverage in this country and ultimately will result in a greatly strengthened and expanded health infrastructure. However, in the short term, without clinics to serve the growing insured population, the promise of coverage will be meaningless. Title X will remain a last line of defense for the low-income uninsured. The variability of Medicaid eligibility thresholds in various states (due to the number of states that have rejected federal funding for Medicaid expansion) will only compound the demand for Title X services.

The ACA will provide a foundation upon which quality and comprehensive family planning care can be made readily available at all primary care facilities, but that day is not yet upon us, and given the significant political and logistical challenges facing the law it is unlikely to become a reality for a number of years. For now and for the foreseeable future Title X remains necessary to provide patient care, to open clinic doors and maintain facilities, to hire and train staff, and to fund programs that meet the unique needs of specific populations, including adolescents.

As the Guttmacher Institute wisely observes, the contribution made by Title X “will be no less important even if the Affordable Care Act is fully implemented, Medicaid is expanded as projected and the nation over time approaches something close to universal health insurance coverage” (Gold 2012). The ACA should be celebrated as an enormous achievement for women, and especially for low-income women. However, we must acknowledge that gaps remain in its immediate reach, and we must continue to fund programs such as Title X, that raise the standard of quality care and protect those in greatest need.

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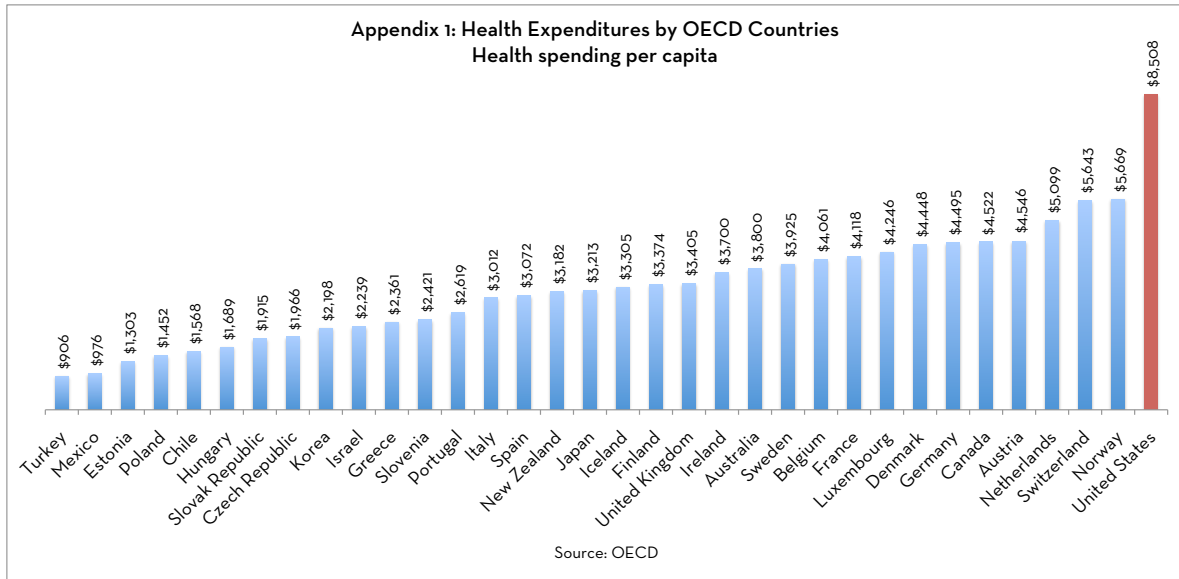
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APPENDICES



Appendix 2: Number of Women Who Would Become Eligible for Medicaid Under the ACA Expansion
As of October 22, 2013

Participating in Medicaid Expansion		States Still Debating	
Arizona	45,000	New Hampshire	24,000
Arkansas	106,000	Ohio	256,000
California	856,000	Pennsylvania	241,000
Colorado	98,000	Tennessee	159,000
Connecticut	37,000		
Delaware	4,000	States Not Participating	
District of Columbia	7,000	Alabama	156,000
Hawaii	14,000	Alaska	19,000
Illinois	219,000	Florida	613,000
Iowa	48,000	Georgia	342,000
Kentucky	139,000	Idaho	51,000
Maryland	70,000	Indiana	177,000
Massachusetts	34,000	Kansas	67,000
Michigan	247,000	Louisiana	176,000
Minnesota	51,000	Maine	20,000
Nevada	78,000	Mississippi	114,000
New Jersey	140,000	Missouri	173,000
New Mexico	61,000	Montana	29,000
New York	80,000	Nebraska	36,000
North Dakota	12,000	North Carolina	277,000
Oregon	119,000	Oklahoma	108,000
Rhode Island	16,000	South Carolina	140,000
Vermont	n/a	South Dakota	20,000
Washington	134,000	Texas	903,000
West Virginia	66,000	Utah	46,000
		Virginia	169,000
		Wisconsin	70,000
		Wyoming	13,000
Total	2,681,000	Total	4,399,000

Sources: Rosenthal 2013, Kaiser Family Foundation 2013

