National
Family Planning
& Reproductive Health Association

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Legislative Hearing on "Protecting Title X and Safeguarding Quality Family Planning Care"

June 19, 2019

Good morning.

Chairman Pallone, Chairwoman DeGette, Ranking Member Walden, Ranking Member Guthrie and members of the Subcommittee on Oversight and Investigations: thank you for the opportunity to testify before the subcommittee today. My name is Clare Coleman. For nearly ten years, I have served as the President & CEO of the National Family Planning & Reproductive Health Association (NFPRHA), the preeminent expert on and national advocacy organization for the Title X family planning program.

Founded the year after Title X's enactment, NFPRHA is a national, non-profit membership association that advances and elevates the importance of family planning in the nation's health care system and promotes and supports the work of family planning providers and administrators, especially those in the safety net (i.e., those providing publicly funded care). NFPRHA envisions a nation where all people can access high-quality, client-centered, affordable, and comprehensive family planning and sexual and reproductive health care from providers of their choice. With respect to Title X, NFPRHA provides education, expert resources, and technical assistance to Title X-funded entities at grantee, subrecipient and service site level.

The association represents more than 850 health care organizations in all 50 states, the District of Columbia, and the US territories, and also includes in its membership individual professionals with ties to family planning care. NFPRHA's organizational members include state, county, and local health departments; private non-profit family planning organizations (including Planned Parenthood affiliates and many others); family planning councils; hospital-based health practices; and federally qualified health centers (FQHCs).

NFPRHA's members include Title X grantees in 48 states and two territories. And when grant sub-recipients (which in a few instances are subrecipients of sub-recipients) are considered, NFPRHA's membership includes at least one Title X grantee or one grant sub-recipient in every state.

NFPRHA currently has more than 65 Title X grantee members and almost 700 Title X sub-recipient members, which translates to NFPRHA representing more than 70% of Title X grantees and more than 90% of Title X service sites. These NFPRHA member organizations operate or fund a network of more than 3,500 health centers that provide family planning services to more than 3.7 million Title X patients each year.

Title X's History and Purpose

When Title X (ten) of the Public Health Service Act created the nation's only dedicated source of family planning in 1970, it included four major sections in the statute—services, training, research, and information—plus a prohibition on funds being used for abortion. Its creation reflected a bipartisan, broadly shared imperative to leverage medical advancements to address poverty and equity and improve health outcomes, especially for women in the United States.

During the 1960s, research showed that inequitable access to modern, effective contraceptives made low-income women less able to match their actual childbearing with their desired family size, which in turn affected their ability to get an education and earn a living, and also negatively affected their own health as well as the health of their children. At the time, the two most effective contraceptives—the then-new oral contraceptive pill ("the Pill") and the copper intrauterine device ("IUD")—were available only through medical professionals and at a high cost, both for the contraceptive itself and for medical visits.

President Richard Nixon therefore called on Congress to "establish as a national goal the provision of adequate family planning services … to all those who want them but cannot afford them," stressing that

"no American woman should be denied access to family planning assistance because of her economic condition.[1]" With an unanimous vote in the Senate and an overwhelmingly bipartisan 298 to 32 vote in the House, Congress enacted Title X in December 1970.

Congress's concern was the "medically indigent" – low-income individuals who desired but could not access the contraceptive methods that more affluent members of society could, and who were forced to do without, or to rely heavily on the least effective nonmedical techniques for birth control unless they happened to live in an area where family planning services were made readily available by public health agencies or voluntary organizations. Thus, Congress created Title X to provide low-income patients with equal access to biomedical contraceptives and related medical care, and to ensure those services would be voluntary, giving patients the true freedom to make their own decisions about whether and when to have children. Those purposes remain the Title X program's central focus nearly five decades later.

Congress amended the statute in 1975 to also explicitly permit Title X projects to include natural family planning (now sometimes known as fertility awareness) in the array of methods and services they offer to patients. Likewise, Title X was amended in 1978 to explicitly cover adolescent patients, who had been using Title X care from the start, and to include infertility services among those that Title X projects offer.

The Title X Program Today

Today, the Title X program helps more than four million people access family planning and related health services at nearly 4,000 health centers around the country annually.[2] Title X-funded health centers include a diverse array of providers, such as state and local health departments, freestanding family planning centers, Planned Parenthood affiliates, federally qualified health centers, hospitals, school- and university-based health centers, a diversity that allows patients to seek care at a site accessible to them. While Title X networks vary substantially because they are designed by communities for communities, Title X coverage across the nation, whether urban, rural, or suburban, is wide. In 2015, as Guttmacher Institute has reported, 60% of US counties had at least one health center supported by Title X, and 90% of women in need of publicly funded family planning care lived in those counties.

Title X has successfully served as a critical pathway to care for poor, low-income, uninsured, and under-insured individuals who may otherwise forego health care access. For many of these individuals, Title X-supported sites are their main access point to obtain affordable, confidential contraception care, cancer screenings, sexually transmitted disease testing and treatment, complete and medically accurate information about their sexual health and family planning options, and other basic care. In fact, a 2017 study found six in ten women seeking contraceptive services at a Title X health center saw no other health care providers that year[3]. In 2015 alone, for example, services provided by health centers that received Title X funding helped women avert an estimated 822,300 unintended pregnancies, thus preventing 387,200 unplanned births and 277,800 abortions.[4] Without the services provided by Title X–funded sites, the US unintended pregnancy rate would have been 31% higher.[5]

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[1] Richard Nixon, Special Message to the Congress on Problems of Population Growth (July 18, 1969)

[2] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[3] Mia Zolna, Megan Kavanaugh, and Kinsey Hasstedt. "Insurance-Related Practices at Title X-Funded Family Planning Centers under the Affordable Care Act: Survey and Interview Findings." Guttmacher Institute (November 2017). https://www.guttmacher.org/article/2017/11/insurance-related-practices-title-x-funded-family-planning-centers-under-affordable.

[4] Jennifer Frost et al. "Publicly Funded Contraceptive Services at U.S. Clinics, 2015." Guttmacher Institute (April 2017). https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015

[5] Jennifer Frost et al. "Publicly Funded Contraceptive Services at U.S. Clinics, 2015." Guttmacher Institute (April 2017). https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015

In addition to contraceptive counseling and supplies, and pregnancy testing and counseling, Title X providers also play a critical role in cervical and breast cancer screening and sexually transmitted disease and HIV services. Title X providers conducted, for example, more than 650,000 Pap tests in 2017; 14% percent of those tests identified results that required further evaluation and possible treatment related to cervical cancer. Providers also performed more than 900,000 chlamydia tests, 2.4 million gonorrhea tests, and 1.2 million HIV tests; more than 2,000 of the HIV tests were positive.[6]

Title X Appropriations

Despite this compelling data, and in spite of the critical importance of equitable access to family planning services for all people, Title X has consistently been underfunded. The program has been appropriated at just over $286 million for the past six fiscal years. In 2016, researchers from the Centers for Disease Control and Prevention, the Office of Population Affairs, and George Washington University estimated that Title X would need $737 million annually to deliver family planning care to all uninsured, low-income women in the United States.[7] This estimate understates the true need for Title X, as it does not include an estimate of costs for men (who made up 12% of patients in the network in 2017[8]), does not account for Title X's trans and nonbinary patients, and does not include an estimate for insured patients who rely on Title X's confidentiality protections.

The gap between the funds appropriated and the funds needed has only grown in recent years. From 2010 to 2014 the number of women who needed publicly funded family planning services increased by one million[9] and the cost of providing services and maintaining sites increased, but Congress cut Title X's funding by $31 million over that period. That decrease unfortunately corresponds to dramatic decreases in the number of patients served at Title X-funded sites; the numbers dropped from 5.22 million in 2010[10] to just over four million in 2017.[11]

In April 2019, the House Appropriations Committee recognized these challenges and adopted NFPRHA's recommendations to strengthen the Title X program by including an appropriation of $400 million. The fiscal year (FY) 2020 appropriations bill for the Departments of Labor, Health and Human Services, and Education remains pending.

Title X is a Unique and Essential Safety-Net Resource that Attracts Highly Qualified Providers

Of the $286.5 million that has been annually appropriated to the program in recent years, approximately $260 million supports family planning service delivery. Each Title X project supplements its federal funding with service reimbursement payments, such as from Medicaid or private insurance, patient-paid fees—from those with incomes between 101% and 250% of the annual federal poverty level (FPL) who are thus eligible for Title X's sliding fee scale, instead of no-cost care (as Title X ensures for those with

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[6] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[7] Euna August, et al, "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," *American Journal of Public Health* (February 2016): 334-341.

[8] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[9] Jennifer Frost, Lori Frohwirth and Mia Zolna, "Contraceptive Needs and Services, 2014 Update," Guttmacher Institute (September 2016). https://www.guttmacher.org/report/contraceptive-needs-and-services-2014-update.

[10] Christina Fowler et al, "Family Planning Annual Report: 2017 National Summary," RTI International (August 2018). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2017-national-summary.pdf.

[11] Fowler et al, "Family Planning Annual Report: 2016 National Summary."

incomes below the FPL), as well as from patients paying full fee for their care—and/or state, local or private sources.

To be clear, while the federal Title X grants may not serve as the largest source of revenue to support a family planning project, they are the essential backbone of this national program. All care within any Title X project, even though the Title X grant is only a part of the project's budget, is bound by the federal law, regulations, and clinical and administrative standards of the Title X program. Specifically, Title X requires the critical feature of no-cost care for low-income patients, supports staff and infrastructure expenses that are not reimbursable under insurance, arises out of merit-based selection of grantees, and requires providers to comply with all of the Title X program's comprehensive requirements.

As a result, Title X-funded family planning organizations typically have deep expertise in the care they provide and the federally regulated framework in which they provide it. And they are highly responsive to patient concerns and needs. Many current grantees and sub-recipients have been part of the Title X network for decades. A number have been part of Title X care from the very beginning of the program. The experience and intense dedication of current Title X providers to their patients' family planning and sexual health is reflected in the quality of care they deliver.

Title X providers are Title X family planning providers, for example, typically offer a greater number of contraceptive method options to their patients than do non-Title X health care providers and are more likely to offer those options onsite rather than requiring a patient to go to a pharmacy or to another provider for insertion of an IUD or implant.[12] And Title X providers spend more time with patients during an initial contraceptive visit and other counseling than do clinicians at non-Title X sites.[13]

Equally important, Title X providers strive to create a welcoming, non-judgmental atmosphere and openness to Title X patients' own stated needs, and respect each individual patient's values and autonomy. That kind of respectful and professional atmosphere allows providers to build and maintain trust, whether with a new patient or a returning one. This has been as important to Title X's longtime effectiveness as the scope and expertise of its clinical care.

Title X is the Gold Standard for Quality Family Planning Care

Because Title X aims to provide poor and low-income patients equal access to quality, up-to-date family planning methods and services, HHS has periodically adopted and revised clinical standards and other program guidance toward that end. These HHS directives govern grantees and their provider networks to help ensure that Title X programs are offering evidence-based clinical care consistent with current nationally recognized standards.

In 2009, in a memorandum distributed to Title X grantees, OPA acknowledged that its directives had in some respects fallen behind then-currently recognized clinical standards; subsequently, the agency initiated an extensive updating process. The process culminated in April 2014 with the publication of two documents that currently comprise OPA's main Title X program guidance: (1) OPA's Title X Program Requirements; and (2) the *Quality Family Planning* guidelines (QFP) – the joint CDC and OPA publication on clinical standards for providing quality family planning services, as updated periodically. The CDC has since published updates on additional research related to the QFP, including as recently as

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[12] Kinsey Hasstedt. "Why We Cannot Afford to Undercut the Title X National Family Planning Program." *Guttmacher Policy Review* 20 (2017). https://www.guttmacher.org/sites/default/files/article_files/gpr2002017.pdf

[13] Kinsey Hasstedt. "Why We Cannot Afford to Undercut the Title X National Family Planning Program." *Guttmacher Policy Review* 20 (2017). https://www.guttmacher.org/sites/default/files/article_files/gpr2002017.pdf

December 2017, which have continued to reinforce the validity of the QFP standards. OPA has explicitly incorporated the QFP into its current requirements for and monitoring of all Title X projects.

The QFP describes clinical standards for any family planning provider, whether funded by Title X or not, and incorporates other national standards such as the CDC preconception care and STD treatment guidelines and the US Medical Eligibility Criteria for Contraceptive Use. The QFP was the result of a lengthy process involving dozens of technical experts and the Expert Working Group of which I was a part. It drew on the CDC's "longstanding history of developing evidence-based recommendations for clinical care" and the fact that "OPA's Title X Family Planning Program has served as the national leader in direct family planning service delivery" since 1970.

The QFP's recommendations "outline how to provide quality family planning services, which include contraceptive services, pregnancy testing and counseling, helping clients achieve pregnancy, basic infertility services, preconception health services, and sexually transmitted disease services."[14] The QFP standard is to provide equitable, evidence-based care consistent with current professional knowledge, so that family planning does not vary in quality because of the personal characteristics of clients.

The Trump Administration Has Sought to Undermine Title X's Program Integrity

Unfortunately, as partisanship has intensified in Washington and family planning has been politicized, Title X has become a target. The current administration has sought to reshape the Title X network and divert its essential resources away from the core purposes of the program.

In the 2018 funding opportunity announcement (FOA) that outlines how applicants can apply for service delivery grants, for example, HHS sought to require grantees to emphasize education and counseling programs that would encourage "sexual risk avoidance" i.e., abstinence—or "returning to a sexually risk-free status" for unmarried patients, including adults.[15] The FOA also sought to impose a "meaningful emphasis" on abstinence[16], even though the clear, motivating purpose behind Title X was to help sexually active individuals manage their fertility through modern contraception, and more than 95% of adult Title X patients are or wish to be sexually active.

Strikingly, nowhere in the 60-page 2018 FOA appeared the words contraceptive or contraception.[17] Similarly, the 2018 FOA nowhere mentioned the QFP or required compliance with these standards of care. The 2018 FOA also failed to draw upon OPA's own Program Requirements and Policy Notices, or otherwise required prospective grantees to comply with them. Instead, the 2018 FOA encouraged applications for projects that use methods that are "historically underrepresented in the Title X program." Because Title X providers have been in the forefront of offering all methods of family planning, including the most effective and up-to-date ones, for ultimate choice by patients, this preference for "underrepresented" methods represented a step backward from current clinical standards and data documenting which methods are most acceptable to patients.

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[14] Loretta Gavin et a. "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs." *Morbidity and Mortality Weekly Report* 63.4 (April 25, 2014).

[15] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

[16] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

[17] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

For example, the FOA repeatedly reiterated the need for Title X projects to include natural family planning methods, which are offered by Title X providers but are one of the least effective methods (according to HHS) and chosen by less than 0.5% of users. Thus, despite the fact that Title X's longstanding regulations require projects to offer a broad range of "acceptable and effective medically approved family planning methods and services," the 2018 FOA named only natural family planning, one of the least effective and acceptable methods (as demonstrated by its low demand), and ignored the regulations' specific requirements that Title X projects, for example, "provide for the effective use of contraceptive devices and practices" by their patients.
The 2018 FOA also sought to give priority to providers interested in "a holistic vision of health" in the Title X program.[18] These were code words for bringing certain providers' values—against sex outside marriage and against abortion—into Title X and efforts to direct grants to those providers. When HHS did not get the number and kind of grant applications from such providers in the FY 2018 grant competition that it sought, it imposed a very short grant period (seven months as opposed to the usual three years) to trigger another competition of the entire national network. It also moved to publish current grantees' in-depth and proprietary applications on the HHS website to give potential new entrants material to assist in their application efforts. Both the 2018 FOA and the HHS efforts to publicly post current grantees' applications resulted in litigation.

On March 4, 2019, the administration finalized the Title X rule "Compliance With Statutory Program Integrity Requirements," in the *Federal Register*. The rule builds on previous efforts by the Trump administration to divert Title X funds, direct them toward uses that are not properly part of the Title X program, and remove this federal funding from any entities that also provide abortions outside Title X.

There has only been one previous attempt by the executive branch to remake the program from one intended to ensure equal access to quality clinical family planning services so that poor and low-income individuals can freely determine their own childbearing, into a coercive ideological program that imposes choices and limits information when Title X patients find themselves pregnant. At the end of the Reagan administration in 1988, HHS promulgated a rule with similarities to the one issued by the Trump administration this year, though it was not nearly as expansive. Those 1988 rules were enjoined immediately, remained blocked through years of litigation and were ultimately rescinded in January 1993.

Under the new rule, HHS seeks to prioritize the beliefs and values of hypothesized, potential Title X providers over the needs and wishes of the patients who might seek care at sites operated by them. Specifically, the rule would allow potential new Title X providers to use their religious beliefs to limit the methods of family planning they might offer to patients within the Title X program, without informing patients or ensuring that they can access the care appropriate for them elsewhere.

The new rule also subverts the voluntariness and patient-centeredness that is central to Title X care, and would leave poor and low-income patients inadequate, second-class care. In so doing, the new rule fundamentally undermines universal access for low-income patients to the national standard of care to which the Title X program is now held.

The rule forces a Hobson's Choice, each of which harm patients as well as the providers: it forces all current, effective providers to either (1) attempt to stay in the Title X program out of a commitment to low-income individuals' access to family planning care, despite the compromised care newly mandated

[18] Office of the Assistant Secretary for Health, Population Affairs. "Announcement of Anticipated Availability of Funds for Family Planning Services Grants: PA-FPH-18-001." Department of Health and Human Services (Feb. 23, 2018). https://www.hhs.gov/opa/sites/default/files/FY18-Title-X-Services-FOA-Final-Signed.pdf

by the rule, or (2) leave Title X because the rule requires providers to depart from standards of care and medical ethics principles -- thereby shrinking the Title X network, reducing patients' access to family planning and related care, and triggering cascading harms.

If implemented, the final rule would damage the nation's family planning program and severely diminish, rather than increase, the public health benefits realized from the limited funding available to the program. It would have far-reaching implications for all Title X-funded entities, the services they provide, and the ability of patients to receive the confidential family planning and related sexual health care they seek. NFPRHA is actively engaged in litigation to prevent this rule from taking effect, and the rule is currently enjoined by the courts.

Aspiring to a Better Outcome

While the Title X network struggles with stagnant resources and under seemingly endless attack, our country and this Congress are missing critical opportunities to improve outcomes related to sexual and reproductive health and advance needed health reforms. I'm grateful that this hearing today gives me a chance to raise just one idea.

When Title X was envisioned and created nearly a half a century ago, it was meant to reduce inequity. It did so in part by requiring that services be offered for free to people with incomes under 100% FPL and on a schedule of discounts, or sliding fee scale, to those with incomes between 101-250% FPL (roughly $12,500 to $31,225 a person). Today, because the health care landscape has evolved, that cost-sharing approach is now contributing to inequity.

Since 2014, more and more Americans have gained access to private insurance, through which contraceptive coverage is offered at no cost-sharing, and it has long been the case that those who access health care through Medicaid have family planning as a required service with no cost-sharing. That leaves a troubling, unjustifiable gap: uninsured, low-income people with incomes between roughly $12,500 and $31,225 are expected to share the costs of their family planning and sexual health care in a way that other populations are no longer required to do.

Addressing that cost gap would be an essential element of our nation's next health reforms, and perhaps it would lead the way to other needed improvements in our system of care, especially for those with the least among us. To do right by all Americans, we should ensure that different types of insurance, which often correlates with income, do not mean different breadth and depth of health care. This is especially important when it comes to family planning and sexual health, which is deeply sensitive and involves the most intimate aspects of our lives.

If we could expend less energy trying to maintain the integrity of the public health success story that is Title X, we could together align using a public health lens: work to advance more access points, equity across the board, and high-quality care across all provider settings. Only then can we fulfill President Nixon's vision for the "provision of adequate family planning services … to all those who want them but cannot afford them."

Conclusion

In conclusion, thank you for this opportunity to offer testimony on the unique value of our nation's family planning program, and I welcome continued dialogue on Title X and ways to bolster the family planning safety net nationwide. I am happy to answer any questions that you may have.