The Provision and Funding of Contraceptive Services At Publicly Funded Family Planning Agencies: 1995–2003

CONTEXT: *Publicly funded family planning agencies face significant challenges in delivering quality services to low-income women because of the higher costs of newer contraceptive methods, changes in health care financing and a growing uninsured population.*

METHODS: *In 2003, 627 of a nationally representative sample of 956 U.S. agencies receiving public funding for family planning services responded to an eight-page survey. Responses were compared with results from similar surveys in 1995 and 1999 to describe changes in the availability of contraceptive methods, policies on method provision and funding issues. Variation was examined by agency type and Title X funding status.*

RESULTS: *Between 1995 and 2003, the number of contraceptive methods available to women increased and agencies reduced barriers to oral and emergency contraceptives by liberalizing policies for their provision. By 2003, many agencies offered the newest contraceptive methods available—the progestin-only IUD (58%), the patch (76%) and the vaginal ring (39%). However, more than half of agencies did not stock certain methods because of their cost, and some key funding sources had declined. Between 1995 and 2003, the proportion of agencies receiving Medicaid funding fell from 91% to 80%, and the proportion of clients paying full fee for their contraceptive services fell from 19% to 14%. The share of agencies waiving fees for adolescents fell from 66% in 1999 to 44% in 2003.*

CONCLUSIONS: *Continued funding challenges limit the ability of publicly funded providers to offer all available methods to all women.*

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Publicly funded family planning agencies play a critical role in delivering affordable contraceptives and related preventive health care to millions of American women each year, thereby helping them to avoid unintended pregnancy and to obtain health services that they otherwise might not receive. These agencies, which include local health departments, Planned Parenthood affiliates, community health centers, hospitals and others, are typically mandated to provide quality care to all women, regardless of ability to pay. In 2001, 6.7 million women received contraceptive services from a publicly funded clinic.[1] The women who rely on family planning agencies for their contraceptive care are disproportionately low-income, uninsured, adolescent, black and Hispanic.[2] Family planning agencies often provide these women with an entry into the health care system, delivering a range of contraceptive and reproductive health care services and, at many clinics, primary care as well.

Public funding for family planning agencies comes from various sources, such as Title X of the Public Health Service Act (the only federal program that provides categorical funding for family planning) and Medicaid. Agencies use this funding to provide women with a range of contraceptive options and a package of reproductive health services that includes contraceptive exams and counseling, method provision, gynecologic and pregnancy-related care, and testing and treatment for STDs.[3] In addition, many agencies provide other types of care, such as infertility services, primary and general preventive care, prenatal and infant care, and services to women who are beyond their reproductive years. As a result, funding for contraceptive services may make up all or just a small portion of an agency's total budget.[4]

Family planning agencies face both opportunities and challenges brought about by the introduction of new and often more effective contraceptive methods and medical technology. More methods and improved technology provide agencies the opportunity to deliver enhanced care, but first agencies must meet the challenge of rising costs.

To assess the current state of contraceptive services available through publicly funded agencies, the Guttmacher Institute conducted a survey in 2003 of a nationally representative sample of family planning agencies. The survey was designed, in part, to permit examination of changes over time, by being comparable with similar surveys conducted in 1995 and 1999.[5] In this article, we use those survey data to examine trends in the provision of contraceptive methods to women at family planning agencies and measure the extent to which agencies offer newer methods. We describe changes at family planning agencies in the availability of different types of contraceptives, policies regarding method provision and related funding issues. Our purpose is to investigate emerging issues and significant trends in the provision of contraceptive services at publicly funded family planning

agencies, with special attention to differences by agency type and by Title X funding status.

BACKGROUND

New contraceptive methods, such as the patch, the vaginal ring and the progestin-only IUD—all approved by the federal Food and Drug Administration (FDA) in 2001—give women more contraceptive choices and should improve women's success in avoiding pregnancy. However, these methods are more expensive than the ones they typically replace. For example, the patch and the vaginal ring—methods that promise levels of effectiveness similar to the pill's, but a lower likelihood of user failure—are attractive alternatives for many women seeking a reversible contraceptive method who do not wish to take a pill every day. However, the patch costs agencies $11 per cycle, and the vaginal ring $26 per cycle, whereas the most widely used oral contraceptive among clients of agencies receiving Title X support costs $2.[6] Similarly, a year's supply of the three-month injectable, which was approved by the FDA in 1993 and now is used by almost one in five clients of Title X–funded clinics,[7] costs agencies almost 50% more than a year's supply of the pill. And the progestin-only IUD, which can reduce menstrual bleeding for some women, costs clinics approximately $320 (not including the cost of insertion), compared with $175 for a nonhormonal copper IUD with a similar level of contraceptive effectiveness.

The liberalization of agency policies regarding pelvic exam requirements and emergency contraception should improve access to methods, thereby helping to prevent unintended pregnancy. Many women's health advocates have argued that required pelvic exams may deter some sexually active women, particularly those who have never visited a clinic before, from seeking hormonal contraception. In 1993, the FDA revised package inserts for oral contraceptives, allowing women to delay a pelvic exam when seeking hormonal contraception;[8] in 2001, the federal government approved similar guidelines for the Title X program.[9] With regard to emergency contraception, past studies have documented barriers to access, such as difficulties in obtaining or filling a prescription within the necessary 72-hour time frame.[10] Providing women with an advance supply of emergency contraceptives increases use, without affecting their routine contraceptive practice.[11]

Finally, changes in public funding for family planning agencies and an evolving health insurance landscape have significant implications for agencies. Inflation-adjusted public funding for contraceptive services has increased by more than a third since the mid-1990s; however, this national trend masks changes at the state level that have left more than half of the states with fewer or stagnant resources to subsidize contraceptive services.[12] Demands for subsidized services have increased because of a growing uninsured population and a weak national economy.[13] Throughout the 1990s, moreover, managed care networks and capitated payments to health care providers largely replaced the traditional model of reimbursement for rendered services. However, because family planning agencies historically have not fully integrated into managed care networks, they lack a potentially important source of third-party reimbursement for clients with public or private insurance.

Title X–supported agencies face unique challenges because they are mandated to provide a broad range of contraceptive methods and services to poor and low-income clients for free or at a reduced fee that is based on the client's ability to pay; moreover, to ensure confidentiality, fees for teenage clients are based on their own income, rather than a parent's. Approximately two-thirds of all Title X clients have family incomes that are at or below the federal poverty level, making them eligible to receive free services.[14]

Key differences in the types, sizes and locations of family planning agencies that receive Title X funding compared with those that do not have been examined elsewhere.[15] Generally, women who visit clinics of Title X–funded family planning agencies are more likely than those who visit clinics of agencies not supported by Title X funding to go to a health department and less likely to go to a community health center or hospital. Moreover, Title X–funded clinics serve a greater average number of contraceptive clients per year than those that do not receive Title X funds, and the differential has grown over the last decade: In 2001, the average annual caseload was 1,060 for Title X–funded clinics and 628 for others; the numbers for 1994 were 1,005 and 805, respectively.

METHODS

Data

In the summer and fall of 2003, we surveyed a nationally representative sample of 1,001 agencies providing publicly funded contraceptive services and 1,875 service sites within those agencies. We drew our sample from the 2,946 agencies in the most up-to-date list of publicly funded family planning agencies available in May 2003. This list is maintained and updated by the Guttmacher Institute, using directories of Title X–supported clinics, Planned Parenthood affiliates, community and migrant health centers and Indian Health Service clinics; in addition, personal communications with Title X grantees, agency administrators and others are used to confirm clinic names, addresses, receipt of public funding and provision of contraceptive services.[16] Because the 1995 and 1999 surveys requested data only from and for agencies (not individual clinics), the analysis presented in this article focuses on the agency sample.*

We stratified the sample by agency type (community or migrant health center, health department, hospital, Planned Parenthood affiliate or "other" agency),† receipt of Title X funding (at all, some or no clinics) and geographic region of the country (Northeast, Midwest, South or West). Agencies were randomly selected within each of the strata. Because there are many more agencies of some types than of

*A forthcoming analysis will detail the results of the 2003 clinic sample, and will focus on both contraceptive and noncontraceptive services, such as HIV testing and screening for cervical cancer, as well as clinics' efforts to provide services targeted at specific client groups.

†"Other" agencies are community-based sites that do not receive federal community or migrant health center funds, Indian Health Centers and independent women's centers or primary care clinics.

others, we varied the proportion of each agency type that was sampled to ensure a sufficient number of cases to make estimates specific to each type. We sampled 100% of Planned Parenthood affiliates, 65% of hospital agencies, 43% of community and migrant health center agencies, 13% of health department agencies and 32% of other agencies.

We mailed an eight-page questionnaire to the family planning director of each agency in August of 2003. The questionnaire asked for basic information about the agency; the number of contraceptive clients served in the last year; the types of services offered; and staffing, funding and participation in managed care. In addition, we asked agencies to estimate the proportion of clients who received free or reduced fee care, the proportion whose care was covered by Medicaid and the proportion who paid the full fee themselves. Most survey items were closed-ended; in some cases, respondents were asked to provide additional clarifying information through open-ended responses, which were recoded to reflect the most commonly given answers.

In an attempt to identify the services women receive (as opposed to those that are offered but rarely utilized), we phrased specific questions in terms of "all or most clients" or "some clients," or asked what protocols are "typically" applied. Moreover, we restricted most questions to an agency's female contraceptive clients. (Although we collected some information on men, they accounted for a very small proportion of public agency contraceptive clients.) We defined contraceptive clients to include women who had received a medical exam related to method provision, women who had received contraceptive services and for whom a chart was maintained, and women who had received counseling on periodic abstinence or natural family planning. Clients who had received only abortion services, pregnancy tests, infertility services or counseling were not included.

To improve the response rate, we made follow-up calls, sent out reminder postcards and sent an additional mailing of the survey. We ended the survey follow-up in April 2004; however, in cases where agencies provided incomplete or unclear information, we called, e-mailed and faxed additional information requests through August 2004.

Forty-five of the sampled agencies were ineligible for the survey, mostly because they had closed, had merged with other agencies, no longer provided contraceptive services or were located in a U.S. territory rather than a state. We received completed responses from 627 of the 956 eligible agencies, for a response rate of 66% (89% for Planned Parenthood affiliates, 85% for health departments, 53% for community and migrant health centers, 52% for hospitals and 71% for other agencies). Eighty percent of agencies that received Title X funding responded, whereas 50% of agencies not receiving Title X funds did so.

Analysis

We weighted the responding agencies so that they reflected both the overall total of publicly funded agencies providing contraceptive services in 2003 and the distribution of these agencies by type, Title X–funding status and region.* We calculated a second set of weights for the proportions of clients in each payment category (i.e., free or reduced fee, Medicaid or full fee), by multiplying the agency weights by the number of contraceptive clients per agency.†

We analyzed variation in service provision according to two key agency characteristics: type and Title X funding status. To best identify key variations across the major agency types, we condensed agency type into three categories: health department, Planned Parenthood affiliate or other agency. We defined funding by whether an agency received federal Title X funding at any of its clinics. Standard errors and significant differences were calculated using the svy series of commands in Stata 8.2, to account for the stratified survey design.

RESULTS

Publicly Funded Family Planning Agencies

In 2003, 43% of publicly funded family planning agencies were health departments, 5% Planned Parenthood affiliates and 52% other agencies; these proportions are similar to those for 1999 (46%, 4% and 50%, respectively) and 1995 (45%, 5% and 50%, respectively). Overall, 58% of agencies received Title X funding; this proportion was basically unchanged from that of 1995 (61%) or 1999 (60%). Whereas 84% of health departments and 87% of Planned Parenthood affiliates received Title X funding in 2003, only 34% of other agencies did; again, these proportions are similar to those for 1995 (87%, 78% and 33%, respectively) and 1999 (87%, 82% and 35%, respectively).

The average number of clients served per agency in 2003 varied widely according to agency type. Twenty percent of all contraceptive clients were served at Planned Parenthood affiliates (even though Planned Parenthood affiliates made up only 5% of the agency pool); health departments served 37% and other agencies served the remaining 43%.

Contraceptive Services

•*Methods offered.* In 2003, agencies offered 14 contraceptive methods, compared with 12 in 1995 and 1999 (Table 1, page 40).‡ This increase resulted from the introduction of the contraceptive patch and the vaginal ring, as well as the renewed availability of the sponge. The implant, which was available in 1995 and 1999, was no longer in the marketplace by 2003.

Fewer than 1% of family planning agencies in 2003 offered all 14 contraceptive methods that were available that year (not shown). Overall, agencies offered an average of 8.0 methods in 2003, significantly more than the 7.5 of-

*Weighted number equals 2,943 agencies: 1,256 health departments, 149 Parenthood affiliates and 1,538 other agencies.

†For 180 agencies, no total number of clients was reported. In these cases, we imputed the number of clients using information collected by The Alan Guttmacher Institute (AGI) in its 2001 census of family planning clinics (source: Frost JJ, Frohwirth L and Purcell A, *Expanded Methodology for the 2001 Census of Publicly Funded Family Planning Clinics,* New York: AGI, 2004).

‡These numbers are slightly different from those published previously because they do not include emergency contraception in the mean number of contraceptive methods.

TABLE 1. Mean number of contraceptive methods offered by family planning agencies, and percentage of agencies offering various methods, by agency type, funding status and year

Method	All			Type of agency						Title X funding			
				Health department		Planned Parenthood		Other		Yes		No	
	2003 (N=624)	1999 (N=636)	1995 (N=603)	2003 (N=141)	1995 (N=241)	2003 (N=117)	1995 (N=138)	2003 (N=366)	1995 (N=224)	2003 (N=394)	1995 (N=428)	2003 (N=230)	1995 (N=175)
Mean no. offered	8.0	7.7	7.5*	7.9	7.3*	10.0†	9.5*	7.9‡	7.6	8.4	7.7*	7.4§	7.3
Pill	100	99	100	100	100	100	100	100	100	100	100	100	100
Injectable	97	98	96	96	98	100†	100	97‡	93*	98	99	96	91
Male condom	93	94	94	98	100	99	100	88†,‡	89	98	100	85§	86
Tubal sterilization	39	24*	28*	40	18*	18†	17	40‡	38	40	22*	38	37
Vasectomy	31	24*	23*	43	19*	29†	30	20†	25	39	19*	19§	28*
Spermicide	69	89*	91*	75	98*	77	99*	64†,‡	83*	77	99*	58§	79*
Diaphragm	74	87*	90*	82	94*	96†	99	65†,‡	85*	83	96*	61§	81*
Natural family planning	57	79*	78*	67	80*	67	83*	48†,‡	76*	67	82*	43§	73*
Female condom	44	55*	30*	41	22*	79†	80	43‡	31*	45	28*	42	32
Cervical cap	17	30*	20	10	11	52†	59	20†,‡	25	17	17	18	25
Patch	76	na	na	62	na	98†	na	85†,‡	na	74	na	78	na
Vaginal ring	39	na	na	22	na	83†	na	48†,‡	na	34	na	45§	na
Sponge	9	na	na	6	na	12	na	12†	na	7	na	12	na
IUD	58	51	47*	53	36*	87†	88	58‡	52	63	46*	50§	48
Implant	na	47	59	na	51	na	91	na	62	na	63	na	52

*Significantly different from 2003 at p<.05. †Significantly different from health department for 2003 at p<.05. ‡Significantly different from Planned Parenthood for 2003 at p<.05. §Significantly different from Title X–funded for 2003 at p<.05. *Note:* na=not applicable because the method was not offered.

fered in 1995 (Table 1). In addition, the number of methods offered differed significantly by agency type: In 2003, Planned Parenthood affiliates offered an average of 10.0 methods, whereas health departments and other agencies offered 7.9. Furthermore, Title X–funded agencies offered more methods, on average, than did others (8.4 vs. 7.4). The mean number of methods offered by Title X–funded agencies increased between 1995 and 2003; agencies not supported by Title X offered the same average number of methods throughout the period.

The reversible contraceptive methods most commonly used by American women and their sexual partners—the pill, the injectable and the male condom[17]—were nearly universally offered between 1995 and 2003. These three methods were available at 93–100% of agencies during the study period, except for the male condom, which was available at only 88–89% of other agencies and 85–86% of agencies not funded by Title X. In contrast, there were substantial declines between 1999 and 2003 in the availability of several less commonly used reversible methods—spermicides (from 89% to 69%), the diaphragm (from 87% to 74%), natural family planning (from 79% to 57%), the female condom (from 55% to 44%) and the cervical cap (from 30% to 17%).

Significant increases occurred in the availability of both tubal sterilization and vasectomy over the study period; most or all of the increase occurred in health departments and Title X–funded agencies after 1999. The provision of vasectomy declined at agencies not funded by Title X.

A greater proportion of agencies offered the IUD in 2003 than in 1995 (58% vs. 47%), partly because of the introduction of the progestin-only device. A greater proportion of Title X agencies than of others offered the IUD in 2003 (63% vs. 50%). Health departments were the only agency type to experience a significant increase in availability of the IUD from 1995 to 2003.

Overall, the proportions of agencies offering the contraceptive patch, the vaginal ring and the sponge were 76%, 39% and 9%, respectively. The proportions offering these newer methods were highest among Planned Parenthood affiliates, with 98% offering the patch, 83% offering the ring and 12% offering the sponge. Compared with Title X–funded agencies, a greater proportion of other agencies offered the vaginal ring (45% vs. 34%).

•*Difficulties providing methods.* More than half of agencies (57%) reported that they did not stock certain methods because of cost (not shown). Most often, the methods that agencies reported being unable to offer because of cost were the IUD, the vaginal ring and the patch. Significantly greater proportions of health departments (74%) than of Planned Parenthood affiliates (46%) or other agencies (45%), and of Title X agencies (66%) than of other agencies (45%), reported such cost constraints.

Contraceptive Provision Policies

•*Emergency contraception.* From 1995 to 2003, there was a broad expansion of the availability of emergency contraception from publicly funded family planning agencies. Overall, the proportion of agencies that dispensed or prescribed the method increased from 38% in 1995 to 80% in 1999 (Table 2); this proportion remained stable between

1999 and 2003. In 2003, 71% of health departments offered the method, compared with 100% of Planned Parenthood affiliates and 83% of other agencies. A greater proportion of Title X–funded agencies than of others provided the method (84% vs. 73%).

Although the overall proportion of agencies providing emergency contraception did not change significantly after 1999, agencies generally adopted policies that made the method easier to obtain. In 2003, 47% of agencies that provided emergency contraception did so ahead of time, and 36% prescribed the method over the phone—proportions that are significantly greater than those from 1999 (21% and 16%, respectively). A greater proportion of agencies prescribed emergency contraception over the phone to returning clients than to new clients, regardless of agency type. In 2003, a greater proportion of Planned Parenthood affiliates than of health departments or other agencies reported prescribing emergency contraception ahead of time (85% vs. 40% and 46%, respectively) or over the phone (60% vs. 12% and 51%, respectively). A greater proportion of agencies that did not receive Title X funding than of those that did prescribed emergency contraception over the phone (58% vs. 25%) or without a prescription (12% vs. 4%); however, a greater proportion of Title X–funded agencies dispensed the method on-site (98% vs. 53%).

•*Pelvic exams.* Agencies have improved access to the pill by changing policies that require women to undergo a pelvic exam when obtaining oral contraceptives. The overall proportion of agencies that adopted policies that allow women to delay a pelvic exam increased from 45% in 1995 to 70% in 2003 (Table 2). The adoption of such policies differed significantly by agency type and funding status. In 2003, only 7% of Planned Parenthood affiliates required a pelvic exam at an initial contraceptive visit, compared with 23% of health department and 33% of other types of agencies; 82% of Title X–funded agencies allowed women to delay, compared with 54% of agencies not funded by the program. Furthermore, in 2003, 2% of agencies overall (10% of Planned Parenthood affiliates and 4% of other agencies) reported for the first time not requiring women to undergo a pelvic exam at all when obtaining oral contraceptives.

Funding and Payments

•*Contraceptive clients by payment type.* In 2003, 56% of all agencies' clients received free or reduced-fee services, 29% received care paid for by Medicaid or the State Children's Health Insurance Program (SCHIP) and 14% paid the full fee, either through private insurance or out of pocket (Table 3, page 42). The proportion of women who paid the full fee represents a significant decline from 19% in 1999. Other agencies had the greatest proportion of clients who received care paid by Medicaid or SCHIP (40%), health department had the greatest proportion of clients who received free or reduced-fee services (70%) and Planned Parenthood affiliates had the greatest proportion of clients who paid full fee (27%). Among clients of agencies not funded by Title X, the greatest proportion received care paid by Medicaid or SCHIP (45%), whereas among clients of Title X–funded agencies, the majority (63%) received free or reduced-fee services. The share of female clients in Title X agencies paying full fee decreased significantly from 17% in 1999 to 13% in 2003.

•*Sources of agency funding.* The patterns of federal funding received by family planning agencies remained relatively stable between 1995 and 2003 (not shown). Although the proportion of agencies that received Medicaid funding de-

TABLE 2. Percentage of family planning agencies, by selected policies or procedures for providing various contraceptive methods, according to agency type, funding status and year

Policy/procedure	All			Type of agency						Title X funding			
				Health department		Planned Parenthood		Other		Yes		No	
	2003 (N=624)	1999 (N=636)	1995 (N=597)	2003 (N=141)	1999 (N=256)	2003 (N=117)	1999 (N=114)	2003 (N=366)	1999 (N=266)	2003 (N=394)	1999 (N=440)	2003 (N=230)	1999 (N=196)
Emergency contraception													
Dispenses/prescribes	79	80	38*	71	78	100†	100	83†,‡	80	84	84	73§	73
Dispenses/prescribes ahead of time††	47	21*	u	40	8*	85†	83	46‡	24*	48	19*	44	23*
Dispenses on-site††	82	81	u	97	92	99	100	69†,‡	69	98	92*	53§	61
Prescribes over the phone††	36	16*	u	12	3*	60†	38*	51†	25*	25	11*	58§	26*
To new clients††	12	u	u	6	u	33†	u	14†,‡	u	10	u	15	u
To returning clients††	35**	u	u	10**	u	59†,**	u	51†,**	u	24**	u	56§,**	u
Dispenses without a prescription††	7	u	u	3	u	12	u	9	u	4	u	12§	u
Pelvic exam for pill use													
Can be delayed‡‡	70	55*	45*	77	62*	83	84	64†,‡	46*	82	65*	54§	41*
Required at initial visit	27	45*	u	23	38*	7†	12	33‡	54*	16	35*	43§	59*
Not required	2	0*	u	0	0	10†	4	4†,‡	0*	2	0*	4	0*

*Significantly different from 2003 at p<.05. †Significantly different from health department for 2003 at p<.05. ‡Significantly different from Planned Parenthood for 2003 at p<.05. §Significantly different from Title X–funded for 2003 at p<.05. **Significantly different from new clients for 2003 at p<.05. ††Among agencies that dispense/prescribe. ‡‡Includes "differing requirements." *Note:* u=unavailable.

TABLE 3. Percentage distribution of clients, by payment category, according to agency type, funding status and year

Payment category	All		Type of agency						Title X funding			
			Health department		Planned Parenthood		Other		Yes		No	
	2003 (N=480)	1999 (N=516)	2003 (N=117)	1999 (N=193)	2003 (N=106)	1999 (N=103)	2003 (N=257)	1999 (N=220)	2003 (N=325)	1999 (N=354)	2003 (N=155)	1999 (N=162)
Medicaid/SCHIP	29	25	24	23	22	18	40†,‡	32	24	21	45§	41
Reduced/no fee	56	56	70	65	51†	55	45†	51	63	62	35§	34
Full fee	14	19*	7	12*	27†	28	15†,‡	16	13	17*	20§	25
Total	100	100	100	100	100	100	100	100	100	100	100	100

*Significantly different from 2003 at p<.05. †Significantly different from health department for 2003 at p<.05. ‡Significantly different from Planned Parenthood for 2003 at p<.05. §Significantly different from Title X–funded for 2003 at p<.05. *Note:* SCHIP=State Children's Health Insurance Program.

clined significantly from 91% to 80%, Medicaid remained the most common form of federal funding among these agencies, and rates were similar across all agency types. Fifty-eight percent of agencies received Title X funds in 2003, 32% received funds from the maternal and child health block grant and 11% received social services block-grant funding; these proportions were not significantly different from those in 1995. A greater proportion of Title X–funded agencies than of other agencies received funding from block grants (15% vs. 4%).

Agencies use Title X funding, as well as block-grant funding, to provide free or reduced-fee services and to fund information, counseling and outreach services that are not reimbursable by Medicaid or private insurance. Overall, 89% of agencies reported that they offer clients not eligible for Medicaid free or reduced-fee services or that they determine charges using a sliding scale on the basis of income. Nearly all Title X–funded agencies (96%) reported providing free or reduced fee services to clients not eligible for Medicaid, compared with 79% of other agencies. In addition, 44% of all agencies waive charges for teenagers, a significant decline from the 66% that did so in 1999. Furthermore, a significantly greater proportion of Title X–funded agencies than of agencies not funded by the program waive fees for adolescents (61% vs. 18%).

•*Role of managed care.* Between 1995 and 1999, the proportion of agencies with at least one managed care contract more than doubled, from 24% to 54% (Table 4). This trend stabilized after 1999; the proportion was 59% in 2003. Similarly, the proportion of agencies with private managed care contracts almost doubled between 1995 and 2003 (from 15% to 28%). Overall, 42% of agencies in 2003 had contracts to provide primary care (including contraceptive or STD services), 17% to provide contraceptive services only and 10% to provide STD services only. Planned Parenthood affiliates had the greatest proportion of agencies with contracts for contraceptive services only and STD services only (35% and 32%, respectively), whereas other agencies had the greatest proportion with contracts for primary care (63%). A significantly greater proportion of agencies that did not receive Title X funding than of those that did had private managed care contracts (36% vs. 21%) and had contracts for primary care (59% vs. 30%); a greater proportion of Title X–funded agencies had contracts for contraceptive services only (28% vs. 2%) or STD services only (16% vs. 2%).

TABLE 4. Percentage of family planning agencies with managed care plans, by type of plan and care covered, according to agency type, funding status and year

Plan and coverage	All			Type of agency						Title X funding			
				Health department		Planned Parenthood		Other		Yes		No	
	2003 (N=591)	1999 (N=636)	1995 (N=525)	2003 (N=135)	1995 (N=212)	2003 (N=115)	1995 (N=127)	2003 (N=341)	1995 (N=186)	2003 (N=376)	1995 (N=378)	2003 (N=215)	1995 (N=148)
Any	**59**	**54**	**24***	**44**	**10***	**73†**	**34***	**70†**	**37***	**58**	**19***	**61**	**33***
Type													
Private	28	30	15*	5	4	55†	17*	44†	26*	21	9*	36§	24*
Medicaid	58	51	21*	44	9*	68†	25*	67†	31*	57	16*	59	29*
Care covered													
Primary care**	42	44	20*	18	8*	37†	5*	63†,‡	33*	30	13*	59§	30*
Contraceptive services only	17	10*	5*	27	3*	35	29	7†,‡	4	28	6*	2§	3
STD services only	10	7*	u	14	u	32†	u	6†,‡	u	16	u	2§	u

*Significantly different from 2003 at p<.05. †Significantly different from health department for 2003 at p<.05. ‡Significantly different from Planned Parenthood for 2003 at p<.05. §Significantly different from Title X–funded for 2003 at p<.05. **Includes contraceptive or STD services. *Note:* u=unavailable.

DISCUSSION

Publicly funded family planning agencies offer women a broader choice of contraceptive methods now than they did in the past. Many also bring women newer, highly effective methods, even though these methods typically cost clinics more than comparable methods. However, the shift toward the provision of newer contraceptive methods appears to come at a price: the decreased availability at some agencies of certain less popular methods. And by phasing out certain methods, such as female condoms and diaphragms, because demand is low, agencies limit the availability of nonhormonal, female-controlled options in clinics. Nonetheless, the broader choice of methods and the increasing availability of newer, long-lasting and highly effective methods should enable women to better select the method that they can use most successfully, which should help them better control their fertility and help the nation reduce its high rate of unintended pregnancy.

Although the contraceptive patch and the vaginal ring both were approved by the FDA in late 2001, 76% of agencies in 2003 offered the patch, whereas 39% offered the ring. In part, this may be because the ring is more expensive than the patch. But to what extent do pharmaceutical marketing and promotion influence this decision at the agency level? The patch is marketed by Ortho-McNeil, a pharmaceutical company far larger than Organon, the company that makes the vaginal ring. And unlike Organon, Ortho-McNeil has significant direct-to-consumer marketing efforts to promote its new product. Title X–funded agencies may be particularly sensitive to these marketing efforts, especially to the extent that companies offer agencies access to free or subsidized products. Further monitoring is needed to see whether use of new, more expensive, long-lasting methods ultimately replaces pill use, as this would have significant cost implications for agencies.

In addition, further investigation is needed to better understand the increased availability of female sterilization and vasectomy between 1999 and 2003. Does this represent a shift in family planning agencies' ability to provide surgical care, or is it due, in part, to the consolidation of more clinics into fewer agencies, with at least one performing sterilizations? Alternately, it may be related to changes in insurance reimbursement or may indicate a response to greater demand for permanent contraceptive methods. Analyses of data from the National Survey of Family Growth could examine whether there have been any increases in the use of sterilization among low-income men and women paralleling the broader availability of this method.

The adoption of policies that reduce barriers to oral contraceptives and emergency contraception should expand women's contraceptive options. A significantly greater proportion of family planning agencies in 2003 than in 1999 allowed clients to delay pelvic exams when first receiving hormonal contraceptives, a practice the FDA approved more than a decade ago. Title X guidelines issued in 2001 promote the delay of pelvic exams for up to six months, helping to explain why more than eight in 10 Title X–funded agencies in 2003 permitted the practice, and why a considerably greater proportion of Title X–funded agencies than of other agencies do so. However, these delays make client follow-up and continuity of care all the more important, and it would be useful to know if and how agencies are addressing these issues.

The proportion of agencies offering emergency contraception was relatively stable between 1999 (the year that the FDA approved Plan B, the second dedicated emergency contraceptive product) and 2003. During that period, however, agencies took significant steps to improve access to emergency contraception, by providing or prescribing it ahead of time and by prescribing it over the phone. More research is needed to determine whether increased availability of emergency contraception in publicly funded agencies leads to increased use and fewer unintended pregnancies. In addition, it is not clear why a smaller proportion of Title X–funded agencies (nearly all of which dispense emergency contraception on-site) than of other agencies prescribe the method over the phone. Further work should investigate if this barrier to access is driven by staffing constraints or other factors amenable to change. Given the federal government's August 2005 announcement that it would indefinitely postpone its decision regarding a proposal to make Plan B available over the counter for women 16 and older, family planning agencies will continue to play a vital role in ensuring that women of all ages and income levels have a means to access the method in a timely way.[18]

Although the overall funding and payment patterns were fairly stable between 1999 and 2003, two important shifts stand out. First, the proportion of female clients paying full fee for services declined significantly (from 19% to 14%), a trend likely resulting from the rising proportion of women of reproductive age who are uninsured. In 2003, one in five women of reproductive age were uninsured—a 10% increase from 2001—in part because state welfare reform has made it more difficult to qualify for Medicaid.[19] Moreover, between 2000 and 2002, the number of women in need of publicly subsidized services grew by nearly 400,000.[20] Many of these women, particularly those who visit Title X–funded clinics, may require free care because they are young, low-income or poor, but are ineligible for Medicaid. How clinics are coping with this increased burden, given the stagnant Title X–funding levels and declining state contributions, and what it means for patient care, is worth further investigation.

The second shift of note is the substantial decline in the share of agencies waiving fees for adolescents, from 66% in 1999 to 44% in 2003. Given this decline, how are adolescents paying for their contraceptive services? Has the number of adolescent clients served increased at agencies that waive fees? Unfortunately, our data do not permit such examination. The availability of SCHIP may influence some of the decline in free care. However, it is important to determine whether this decline creates a service barrier for teenagers who wish not to involve their parents but do not have the resources to pay for care. In fact, the confidentiality

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protections in the Title X program likely are responsible for the fact that the proportion of clinics that waive fees for adolescent clients is three times as high among those receiving Title X support as among others.

Between 1999 and 2003, Medicaid remained an important source of funding and payment for more than a quarter of all clients of publicly funding clinics. However, federal legislation pending before Congress includes changes to Medicaid that could affect both family planning clients and agencies. Traditionally, contraceptives have been exempt from Medicaid cost-sharing requirements, but under the new legislation, states would be allowed to impose cost-sharing requirements on some brand-name contraceptive drugs. Also, states would be allowed to reshape and reduce the benefits provided to many recipients, and family planning services would not be mandated in these stripped-down benefit packages. These changes may make family planning less affordable for many low-income Americans and may deny agencies a vital source of third-party reimbursement for some clients, while increasing the demand for uncompensated care.

It appears that the growth in managed care contracts among family planning agencies that occurred in the late 1990s plateaued by 2003. However, four in 10 family planning agencies still do not participate in managed care networks, despite the relative pervasiveness of managed care in both the public and the private insurance sectors. This likely reflects not a lack of interest or sophistication on the part of family planning agencies, but rather a decision by insurers to exclude family planning agencies from their panels of authorized providers. Nonparticipation in managed care plans has significant financial implications for family planning agencies. It means that women who have a third-party source of reimbursement are likely to seek services elsewhere, denying agencies revenue that could help them recover their costs and subsidize services to low-income, uninsured clients. Moreover, when women who are enrolled in managed care go out of network to make a clinic visit, the clinic often receives no reimbursement for the services provided.[21]

Our findings suggest that Title X funding directly benefits clients. Compared with other agencies, Title X–funded agencies offer a broader range of methods, and greater proportions have adopted policies to increase access, offer free or reduced-fee services and waive charges for adolescents. Yet, Title X–funded agencies face unique cost pressures because of exactly those services and policies that benefit clients. Moreover, federal funding for Title X has remained stagnant over the past several years, which helps explain why, when adjusted for medical inflation, funding is 59% lower today than it was in 1980.[22] Title X–funded agencies have a long and impressive history of doing more with less. However, given the enormity of these funding challenges and constraints, it is unclear how long they will be able to fulfill their mission.

This article provides only the broadest outline of how agencies are balancing competing demands in the face of limited funding. Significant and ongoing challenges remain to ensure that all poor and low-income women who wish to avoid an unintended pregnancy have access to high-quality contraceptive services. Many of our findings suggest that increased funding for family planning services at both the state and the federal levels are not only warranted, but greatly needed. Moreover, they suggest that although program administrators and providers are adopting policies designed to facilitate access to contraceptive services at publicly funded family planning agencies, more can be done in this regard.

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