Title X (Public Health Service Act) Family Planning Program

(name redacted)
Information Research Specialist

February 6, 2017

Congressional Research Service
7-....
www.crs.gov
RL33644

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The federal government provides grants for family planning services through the Family Planning Program, Title X of the Public Health Service Act (42 U.S.C. §§300 to 300a-6). Enacted in 1970, it is the only domestic federal program devoted solely to family planning and related preventive health services. In 2015, Title X-funded clinics served 4.0 million clients.

Title X is administered through the Office of Population Affairs (OPA) in the Department of Health and Human Services (HHS). Although the authorization of appropriations for Title X ended with FY1985, funding for the program has continued through appropriations bills for the Departments of Labor, Health and Human Services, and Education, and Related Agencies (Labor-HHS-Education).

The Consolidated Appropriations Act, 2016 (P.L. 114-113) provided $286 million for Title X, the same as the FY2015 level. The FY2016 act continued previous years' requirements that Title X funds not be spent on abortions, that all pregnancy counseling be nondirective, and that funds not be spent on promoting or opposing any legislative proposal or candidate for public office. Grantees continued to be required to certify that they encourage "family participation" when minors seek family planning services and to certify that they counsel minors on how to resist attempted coercion into sexual activity. The appropriations law also clarified that family planning providers are not exempt from state notification and reporting laws on child abuse, child molestation, sexual abuse, rape, or incest.

As of this writing, final full-year appropriations for FY2017 have not yet been enacted. In the 114th Congress, the Senate Appropriations Committee bill S. 3040, the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2017, would have provided $286 million for Title X, the same as the FY2016 level. The House Appropriations Committee bill H.R. 5926, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2017, would have provided no funding for Title X in FY2017.

In December 2016, OPA released a final rule to limit the criteria Title X grantees can use to restrict subawards: "No recipient making subawards for the provision of services as part of its Title X project may prohibit an entity from participating for reasons other than its ability to provide Title X services." The rule is effective January 18, 2017.

The law (42 U.S.C. §300a-6) prohibits the use of Title X funds in programs where abortion is a method of family planning. According to OPA, family planning projects that receive Title X funds are closely monitored to ensure that federal funds are used appropriately and that funds are not used for prohibited activities such as abortion. The prohibition on abortion does not apply to all the activities of a Title X grantee, but only to activities that are part of the Title X project. A grantee's abortion activities must be "separate and distinct" from the Title X project activities.

Contents

Figures

Tables

Contacts

Title X Program Administration and Grants

The federal government provides grants for family planning services through the Family Planning Program, Title X of the Public Health Service Act (42 U.S.C. §§300 to 300a-6). Enacted in 1970, it is the only domestic federal program devoted solely to family planning and related preventive health services. Participation in family planning services by Title X clients is, by law, voluntary.[1]

Although Title X is the only federal domestic program primarily focused on family planning, other programs also finance family planning, among their other services. These programs include Medicaid, the Health Centers program under Section 330 of the Public Health Service Act, Maternal and Child Health Block Grants, and Social Services Block Grants. In FY2010, Medicaid accounted for 75% of U.S. public family planning expenditures (including federal, state, and local government spending). In comparison, Title X accounted for 10%.[2]

Administration

Title X is administered by the Office of Population Affairs (OPA) under the Office of the Assistant Secretary for Health in the U.S. Department of Health and Human Services (HHS). Although the program is administered through OPA, funding for Title X activities is provided through the Health Resources and Services Administration (HRSA) in HHS. Authorization of appropriations expired at the end of FY1985, but the program has continued to be funded through appropriations bills for the Departments of Labor, Health and Human Services, and Education, and Related Agencies (Labor-HHS-Education).

OPA administers three types of project grants under Title X: family planning services;[3] family planning personnel training;[4] and family planning service delivery improvement research.[5]

Family Planning Services Grants

Services

Ninety percent of Title X funds are used for clinical services.[6] Grants for family planning services fund family planning and related preventive health services, such as contraceptive services; natural family planning methods; infertility services; services to adolescents; breast and cervical

[1] 42 U.S.C. §300a-5 states: "The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information."

[2] Adam Sonfield and Rachel Benson Gold, *Public Funding for Family Planning, Sterilization and Abortion Services, FY1980-2010*, Guttmacher Institute, March 2012, http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf. More background is in Institute of Medicine (IOM), "Non-Title X Family Planning Funding Sources," in *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*, ed. Adrienne Stith Butler and Ellen Wright Clayton (Washington: The National Academies Press, 2009), pp. 117-121, http://www.nap.edu/catalog/12585/a-review-of-the-hhs-family-planning-program-mission-management.

[3] *Catalog of Federal Domestic Assistance (CFDA)*, Program number 93.217, http://www.cfda.gov/programs/93.217.

[4] *CFDA*, Program number 93.260, http://www.cfda.gov/programs/93.260.

[5] *CFDA*, Program number 93.974, http://www.cfda.gov/programs/93.974.

[6] HHS, Health Resources and Services Administration, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 394, http://www.hrsa.gov/about/budget/budgetjustification2017.pdf.

cancer screening and prevention; sexually transmitted disease (STD) and HIV prevention education, counseling, testing, and referral; preconception health services; and counseling on establishing a reproductive life plan.[7] The services must be provided "without coercion and with respect for the privacy, dignity, social, and religious beliefs of the individuals being served."[8]

Title X clinics provide confidential screening, counseling, and referral for treatment. In this regard, OPA has expressed a commitment to integrating HIV-prevention services in all family planning clinics.[9] OPA has provided supplemental grants to help Title X projects implement the Centers for Disease Control and Prevention's (CDC's) "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings."[10]

Title X services offered to males include condoms, education and counseling, STD testing and treatment, HIV testing, and, in some cases, vasectomy services.[11]

Client Charges

Priority for services is given to persons from low-income families, who may not be charged for care.[12] Clients from families with income between 100% and 250% of the federal poverty guideline (FPL) are charged on a sliding scale based on their ability to pay. Clients from families with income higher than 250% FPL are charged fees designed to recover the reasonable cost of providing services. If a third party (such as a state Medicaid program or a private health insurance plan) is authorized or legally obligated to pay for a client's services, all reasonable efforts must be made to obtain the third-party payment without discounts.[13]

Client Characteristics

In 2015, Title X-funded clinics served 4.018 million clients, primarily low-income women and adolescents. Of those clients, 10% were male, 66% had incomes at or below the federal poverty level, and 86% had incomes at or below 200% of the federal poverty level.[14] One survey found

[7] Title X clinical guidelines are laid out in Loretta Gavin, Susan Moskosky, and Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), pp. 1-29, http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm; and Loretta Gavin and Karen Pazol, "Update: Providing Quality Family Planning Services—Recommendations from CDC and the U.S. Office of Population Affairs, 2015," *Morbidity and Mortality Weekly Report*, vol. 65, no. 9 (March 11, 2016), pp. 231-234, https://www.cdc.gov/mmwr/volumes/65/wr/mm6509a3.htm.

[8] *CFDA*, Program number 93.217. See also 42 C.F.R. §59.5.

[9] HHS, Office of Population Affairs (OPA), *HIV Prevention in Family Planning*, http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/hiv-prevention-and-integration/.

[10] Centers for Disease Control and Prevention (CDC), "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings," *MMWR Recommendations and Reports*, vol. 55, no. RR-14 (September 26, 2006), pp. 1-17. See also CDC, *HIV Testing in Clinical Settings*, http://www.cdc.gov/hiv/testing/clinical/index.html.

[11] HHS, OPA, *Male Services*, http://www.hhs.gov/opa/title-x-family-planning/initiatives-and-resources/male-services/.

[12] 42 C.F.R. §59.2 defines "low-income family" as having income at or below 100% of the Federal Poverty Guidelines (FPL). The regulation states that "'Low-income family' also includes members of families whose annual family income exceeds this amount, but who, as determined by the project director, are unable, for good reasons, to pay for family planning services. For example, unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources."

[13] 42 C.F.R. §59.5.

[14] Christina Fowler, Julia Gable, Jiantong Wang, and Beth Lasater, *Family Planning Annual Report: 2015 National Summary*, RTI International, Research Triangle Park, NC, August 2016, pp. 8-9, 21-22, https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2015.pdf.

that for 61% of clients, Title X clinics were their "usual" or only regular source of health care.[15] In 2015, 48% of Title X clients were uninsured.[16]

The number of Title X clients served in 2015 was 3% lower than in 2014 (when there were 4.129 million clients), 12% lower than in 2013 (when there were 4.558 million clients), and 23% lower than in 2010 (when there were 5.225 million clients).[17] The *Family Planning Annual Report* and the HRSA FY2017 *Budget Justification* suggested several reasons for grantees' decreased capacity to serve clients,[18] including

- reduced revenues for family planning projects, such as decreases in funding from state and local government programs, Title X, block grants, and other funding sources.
- staffing shortages for family planning projects, for example, due to difficulties in provider recruitment and retention.
- increased unit cost of providing services and upfront costs for infrastructure improvements (such as purchasing new health information technology and entering new contracts with insurers).

Grantees also suggested several potential reasons for a decrease in demand,[19] including

- Patient Protection and Affordable Care Act (ACA) insurance coverage expansions, because newly insured clients can choose to seek care from private practitioners and other non-Title X providers.
- increased use of long-acting reversible contraception (LARC), which could reduce the frequency of client visits in the long run, compared with some other types of contraception (such as oral contraceptives that require refills).[20]
- recent clinical guideline changes. For example, pap tests are now recommended every three years instead of annually.[21]

Grantees and Clinics

In 2015, there were 91 Title X family planning services grantees. Such grantees included 46 state, local, and territorial health departments and 45 nonprofit organizations, such as community health agencies, family planning councils, and Planned Parenthood affiliates.[22]

---

[15] Jennifer J. Frost, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010*, Guttmacher Institute, New York, 2013, p. 1, http://www.guttmacher.org/pubs/sources-of-care-2013.pdf.

[16] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, pp. 21 and 23.

[17] Ibid., p. A-6.

[18] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, pp. ES-3 and C-2. HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 391.

[19] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, pp. ES-3 and C-2. HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 392.

[20] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, pp. A-20 to A-22.

[21] Loretta Gavin, Susan Moskosky, and Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), p. 20. Fowler et al., *Family Planning Annual Report: 2015 National Summary*, p. A-23.

[22] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, p. 7. A directory of Title X grantees is at HHS, OPA, *Title X Grantees*, https://www.hhs.gov/opa/title-x-family-planning/title-x-grantees/index.html. A searchable directory of Title X clinics is at https://www.opa-fpclinicdb.com/.

Title X grantees can provide family planning services directly or they can subaward Title X monies to other public or nonprofit entities to provide services. Although there is no fixed matching amount required for grants, regulations specify that no Title X projects may be fully supported by Title X funds.[23] In 2015, Title X provided services through 3,951 clinics located in the 50 states, the District of Columbia, and the U.S. territories and Freely Associated States.[24]

Family Planning Training and Research Grants

Family planning training grants are used to train staff and to improve the use and career development of paraprofessionals.[25] Staff are trained through a National Training Center for Service Delivery Improvement and a National Clinical Training Center.[26] These programs have produced provider education resources, training tools, podcasts, and webinars on topics such as ACA implementation, the Zika virus, mandated child abuse reporting, and clinical efficiency, among other topics.[27] Family planning service delivery improvement research grants are used for studies to enhance effectiveness and efficiency of the service delivery system.[28]

For more information on the Title X program, see https://www.hhs.gov/opa/title-x-family-planning.

Funding

Title X is a discretionary program, meaning its funding is provided in and controlled by annual appropriations acts. The Consolidated Appropriations Act, 2016 (P.L. 114-113) provided $286.479 million for Title X in FY2016, the same as the FY2015 enacted level. As of this writing, final full-year appropriations for FY2017 have not yet been enacted. In the 114th Congress, the Senate Appropriations Committee bill S. 3040, the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2017, would have provided $286 million for Title X, the same as the FY2016 level. The House Appropriations Committee bill H.R. 5926, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2017, would have provided no funding for Title X in FY2017.

FY2016 Funding

As mentioned previously, P.L. 114-113 provided $286.479 million for Title X in FY2016, the same as the FY2015 enacted level.[29] The FY2016 act continued previous years' requirements that Title X funds not be spent on abortions, among other requirements (see text box "Requirements on the Use of Title X Funds in P.L. 114-113, Consolidated Appropriations Act, 2016").

FY2016 appropriations were subject to a clause, known as the Weldon amendment, stating that "None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any

[23] 42 C.F.R. §59.7(c).

[24] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, p. 7.

[25] *CFDA*, Program number 93.260.

[26] HHS, OPA, *National Training Centers*, http://www.hhs.gov/opa/title-x-family-planning/training/national-training-centers/.

[27] Family Planning National Training Center, http://fpntc.org/.

[28] OPA, *Research*, https://www.hhs.gov/opa/title-x-family-planning/title-x-research-grants/index.html.

[29] P.L. 114-113, Division H, Title II; P.L. 113-235, Division G, Title II.

institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."[30] Some have argued that the Weldon amendment conflicts with regulations that require Title X family planning services projects to give pregnant women the opportunity to receive information, counseling, and referral upon request for several options, including "pregnancy termination."[31] In the February 23, 2011, *Federal Register*, HHS stated that potential conflicts would be handled on a case-by-case basis: "The approach of a case by case investigation and, if necessary, enforcement will best enable the Department to deal with any perceived conflicts within concrete situations."[32]

[30] P.L. 114-113, Division H, Title V, §507(d). The Weldon Amendment was originally adopted as part of the FY2005 Labor-HHS-Education appropriations law, and has been attached to each subsequent Labor-HHS-Education appropriations law: P.L. 108-447, Division F, §508(d), 118 Stat. 3163 (FY2005); P.L. 109-149, §508(d), 119 Stat. 2879 (FY2006). Under P.L. 110-5, §2, 121 Stat. 8, FY2007 appropriations were subject to the same conditions as during FY2006. P.L. 110-161, Division G, §508(d), 121 Stat. 1844 (FY2008). P.L. 111-8, Division F, §508(d), 123 Stat. 803 (FY2009). P.L. 111-117, Division D, §508(d), 123 Stat. 3280 (FY2010). Under P.L. 112-10, Division B, §§1101 and 1104, FY2011 appropriations were subject to the same conditions as during FY2010. P.L. 112-74, Division F, §507(d), 125 Stat. 111 (FY2012). Under P.L. 113-6 §§1101 and 1105, FY2013 appropriations are subject to the same conditions as during FY2012 under P.L. 112-74. P.L. 113-76, Division H, Title V, §507(d), 128 Stat. 409 (FY2014). P.L. 113-235, Division G, Title V, §506(d), 128 Stat. 2515 (FY2015).

[31] 42 C.F.R. §59.5(a)(5). Examples of this argument appear in "Weldon Amendment," *Congressional Record*, daily edition, vol. 151, no. 51 (April 25, 2005), p. S4222; and "Federal Refusal Clause," *Congressional Record*, daily edition, vol. 151, no. 52 (April 26, 2005), p. S425. The National Family Planning and Reproductive Health Association (NFPRHA), many of whose members provide Title X services, filed a lawsuit challenging the Weldon Amendment in the U.S. District Court for the District of Columbia. The court found that "While Weldon may not provide the level of guidance that NFPRHA or its members would prefer, may create a conflict with pre-existing agency regulations, and may impose conditions that NFPRHA members find unacceptable, none of these reasons provides a sufficient basis for the court to invalidate an act of Congress in its entirety." Upon appeal, the U.S. Court of Appeals for the District of Columbia Circuit found that the plaintiff lacked the standing to challenge the Weldon Amendment. See *National Family Planning and Reproductive Health Association, Inc., v. Alberto Gonzales, et al*., 468 F.3d 826 (D.C. Cir. 2006), and 391 F. Supp. 2d 200, 209 (D.D.C. 2005).

[32] HHS, "Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws," 76 *Federal Register* 9973, February 23, 2011.

Requirements on the Use of Title X Funds in P.L. 114-113, Consolidated Appropriations Act, 2016

P.L. 114-113 continues previous years' requirements regarding the use of Title X funds:

- Title X funds shall not be spent on abortions.
- All pregnancy counseling shall be nondirective.[33]
- Funds shall not be spent on promoting or opposing any legislative proposal or candidate for public office.
- Grantees must certify that they encourage "family participation" when minors decide to seek family planning services and that they counsel minors on how to resist attempted coercion into sexual activity.
- Family planning providers are not exempt from state notification and reporting laws on child abuse, child molestation, sexual abuse, rape, or incest.

Sources: P.L. 114-113, Division H, Title II, and §207 and §208. (HHS, HRSA, *Fiscal Year 2017, Justification of Estimates for Appropriations Committees*, p.25.)

FY2017 Budget Request

As of this writing, final full-year appropriations for FY2017 have not yet been enacted. President Obama's FY2017 budget, submitted February 9, 2016, requested $300 million for Title X, 5% higher than the FY2016 enacted level.[34] This budget reflected the Obama Administration's priorities; its proposals may differ from what may be enacted by the current Congress and Administration. This budget would have continued previous years' provisions in appropriations laws prohibiting the use of Title X funds for abortion, among other requirements (see text box "Requirements on the Use of Title X Funds in P.L. 114-113, Consolidated Appropriations Act, 2016").

According to the HRSA *Justification*, the proposed FY2017 funding level would have supported family planning services for 4.26 million clients. The program's FY2017 goals included preventing 1,278 cases of infertility through *Chlamydia* screening and preventing 977,400 unintended pregnancies.[35] The FY2017 target for cost per client served was $328.41, with the goal of maintaining the cost per client below the medical care inflation rate.[36]

OPA also planned to use FY2017 funds to train and support providers in adopting the standards in "Providing Quality Family Planning Services, Recommendations of CDC and the U.S. Office of Populations Affairs."[37] OPA planned to use FY2017 funds to develop a Family Planning Delivery System Improvement Center "that will use evidence based principles to support the delivery of quality family planning services within a sustainable system of care." OPA also planned to create

[33] OPA has explained that "grantees may provide as much factual, neutral information about any option, including abortion, as they consider warranted by the circumstances, but may not steer or direct clients toward selecting any option, including abortion, in providing options counseling." (65 *Federal Register* 41273).

[34] HHS, HRSA, *Fiscal Year 2017, Justification of Estimates for Appropriations Committees*, p.389.

[35] Outcome measures for the Title X program are described in "Enclosure II: Department of Health and Human Services' Evaluations of Title X Family Planning Program Outcomes," in U.S. Government Accountability Office (GAO), *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010–2012*, GAO-15-270R, March 20, 2015, pp. 16-18, http://www.gao.gov/products/GAO-15-270R.

[36] HHS, HRSA, *Fiscal Year 2017, Justification of Estimates for Appropriations Committees*, pp. 389-397.

[37] Loretta Gavin, Susan Moskosky, and Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), pp. 1-29. These guidelines are also discussed in "Institute of Medicine Evaluation."

a centralized data center for Family Planning Annual Report (FPAR) data, supporting a shift from grantee-level aggregate reporting to de-identified encounter-level reporting.[38]

As more clients have gained health insurance through the ACA, the Title X program has encouraged clinics to increase their number of contracts with insurance plans and to recover more costs through reimbursements and billing third-party payers. OPA expected that clinics' additional investment in third-party billing, along with improved electronic health records adoption, would increase revenue and allow the Title X program to serve more clients.[39]

FY2017 Senate Appropriations Bill

On June 9, 2016, the Senate Appropriations Committee reported S. 3040. It would have provided $286 million for Title X, the same as the FY2016 level. It would also have continued to contain the Weldon amendment and would have continued previous years' requirements that Title X funds not be spent on abortions, among other requirements (see text box "Requirements on the Use of Title X Funds in P.L. 114-113, Consolidated Appropriations Act, 2016").

FY2017 House Appropriations Bill

On July 22, 2016, the House Appropriations Committee reported H.R. 5926. It would have provided no funding for Title X in FY2017. Section 228 of the bill stated that "None of the funds appropriated in this Act may be used to carry out title X of the PHS Act."

FY2017 Continuing Resolutions

As of this writing, final full-year appropriations for FY2017 have not yet been enacted. On September 29, 2016, President Obama signed into law the Continuing Appropriations Act, 2017 (P.L. 114-223, Division C). It funded most discretionary programs through December 9, 2016, at the rate they were funded in the Consolidated Appropriations Act, 2016 (P.L. 114-113), minus an across-the-board reduction of about one-half of one percent (0.496%). On December 10, 2016, President Obama signed P.L. 114-254, Further Continuing and Security Assistance Appropriations Act, 2017. It funds most discretionary programs through April 28, 2017 (or until full-year appropriations are enacted), at the rate they were funded in the Consolidated Appropriations Act, 2016 (P.L. 114-113), minus an across-the-board reduction of about one-fifth of one percent (0.1901%). In general, the temporary funding provided by both continuing resolutions (CRs) is subject to the same authority and conditions as was the case in the FY2016 Consolidated Appropriations Act.[40] The CR also directs that the act be "implemented so that only the most limited funding action of that permitted in the Act shall be taken in order to provide for continuation of projects and activities."[41] The purpose of these limits on the use of funds is to preserve flexibility in subsequent appropriations decisionmaking.

[38] Title X grantees will be asked to leverage electronic health records (EHR) technology to securely transmit FPAR data on each client encounter, including data on client demographics, services provided, and health outcomes. The information will be de-identified to protect patient privacy. HHS, HRSA, *Fiscal Year 2017, Justification of Estimates for Appropriations Committee*, pp. 394-395.

[39] Ibid., pp. 391 and 394.

[40] P.L. 114-223, Division C, Sections 101 and 104. P.L. 114-254, Section 101.

[41] P.L. 114-223, Division C, Section 110.

Funding provided by the CR is not available until it is apportioned by the Office of Management and Budget (OMB). OMB has released instructions to federal agencies on how to calculate automatic apportionments under FY2017 continuing resolutions. OMB notes that automatic apportionments do not apply to accounts for which the House or Senate had passed or reported a bill with zero funding. OMB explains that "This restrictive funding action is to ensure that the agency does not impinge on final funding prerogatives of the Congress." As noted above, on July 22, 2016, the House reported H.R. 5926, which would provide zero funding for the Title X family planning account in FY2017. Thus, OMB instructions exclude the Title X program from the automatic apportionment under the continuing resolutions. [42]

History of Funding

Table 1 shows Title X appropriations amounts since FY1971, when the program was created. **Figure 1** shows Title X appropriations amounts since FY1978, in current dollars (not adjusted for inflation) and constant FY2016 dollars (adjusted for medical care inflation).

[42] This OMB guidance does allow for an agency to request an account-specific apportionment in such cases, along with a justification for why funds should be provided. OMB, *Circular A-11*, Section 123.3, "What do I do if my account receives no funding in the House or Senate bill?," 2016, https://obamawhitehouse.archives.gov/sites/default/files/omb/assets/a11_current_year/s123.pdf. "Apportionment of the Continuing Resolution(s) for Fiscal Year 2017," Letter from Shaun Donovan, Director, OMB, to the Heads of Executive Departments and Establishments, September 29, 2016, p. 2, https://obamawhitehouse.archives.gov/sites/default/files/omb/bulletins/2016/16-01.pdf. As of January 17, 2017, no FY2017 Title X grant funds had yet been distributed (Email from HHS Office of the Assistant Secretary for Legislation, January 17, 2017).

Table 1. Title X Family Planning Program Appropriations, FY1971-FY2016

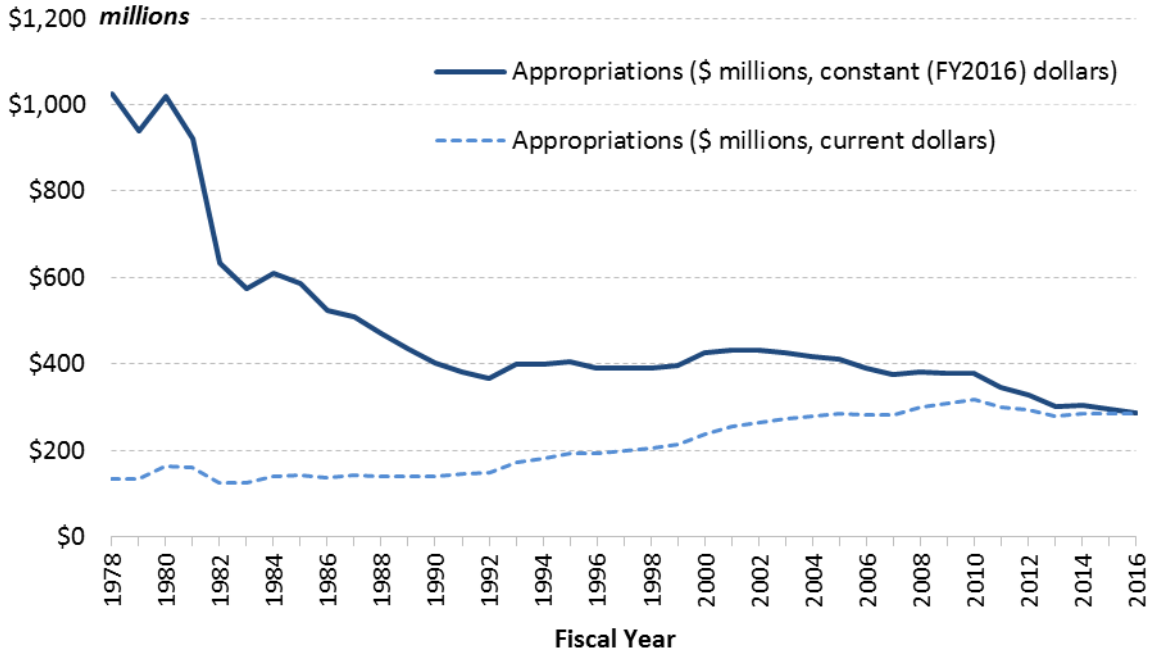
(in millions, current dollars, not adjusted for inflation)

FY	Appropriation	FY	Appropriation	FY	Appropriation
1971	$6.0	1987	$142.5	2003	$273.4
1972	$61.8	1988	$139.7	2004	$278.3
1973	$100.6	1989	$138.3	2005	$286.0
1974	$100.6	1990	$139.1	2006	$282.9
1975	$100.6	1991	$144.3	2007	$283.1
1976	$100.6	1992	$149.6	2008	$300.0
1977	$113.0	1993	$173.4	2009	$307.5
1978	$135.0	1994	$180.9	2010	$317.5
1979	$135.0	1995	$193.3	2011	$299.4
1980	$162.0	1996	$192.6	2012	$293.9
1981	$161.7	1997	$198.5	2013	$278.3
1982	$124.2	1998	$203.5	2014	$286.5
1983	$124.1	1999	$215.0	2015	$286.5
1984	$140.0	2000	$238.9	2016	$286.5
1985	$142.5	2001	$253.9	2017	[a]
1986	$136.4	2002	$265.0		

Sources: FY1971-FY2005: Department of Health and Human Services, Office of Population Affairs, *Title X Funding History*, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html; FY2006: Senate Appropriations Committee, S.Rept. 109-287, p. 325; FY2007: *Consolidated Appropriations Act, 2008 Committee Print of the House Committee on Appropriations on* H.R. 2764/P.L. 110-161, Division G, p. 1793, http://www.gpo.gov/fdsys/pkg/CPRT-110HPRT39564; FY2008-FY2009: "Explanatory Statement Submitted by Mr. Obey, Chairman of the House Committee on Appropriations, Regarding H.R. 1105, Omnibus Appropriations Act, 2009," *Congressional Record*, daily edition, vol. 155, no. 31 (February 23, 2009), p. H2378. FY2010: P.L. 111-117, 123 Stat. 3239. FY2011: P.L. 112-10, §1810 and §1119. FY2012: HHS, HRSA, *Fiscal Year 2013 Justification of Estimates for Appropriations Committees*, p. 347. FY2013: HHS, HRSA, *Sequestration Operating Plan for FY2013,* http://www.hrsa.gov/about/budget/operatingplan2013.pdf. FY2014: P.L. 113-76, Division H, Title II. FY2015: P.L. 113-235, Division G, Title II. FY2016: P.L. 114-113, Division H, Title II.

a. As of this writing, final full-year appropriations for FY2017 have not yet been enacted.

Figure 1. Title X Family Planning Program Appropriations, FY1978-FY2016



Sources: Current dollars, see **Table 1**. Constant (FY2016) dollars, calculated by CRS using a fiscal year inflation adjustment based on monthly data for the Consumer Price Index All - Urban Consumers for Medical Care published by the Bureau of Labor Statistics, http://data.bls.gov/timeseries/CUUR0000SAM/.

Institute of Medicine Evaluation

At the request of OPA's Office of Family Planning, the Institute of Medicine (IOM) of the National Academy of Sciences independently evaluated the Title X program and made recommendations in *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results* (2009).[43]

IOM found that family planning—"helping people have children when they want to and avoid conception when they do not—is a critical social and public health goal," and that the "federal government has a responsibility to support the attainment of this goal." IOM noted, for example, that family planning can prevent unintended and high-risk pregnancies, thereby reducing fetal, infant, and maternal mortality and morbidity. IOM also stated that the appropriate use of contraception can reduce abortion rates and cited "ample evidence that family planning services are cost-effective."[44] IOM made specific recommendations to increase program funding and to improve program management, administration, and evaluation.

[43] Institute of Medicine (IOM), Committee on a Comprehensive Review of the HHS Office of Family Planning Title X Program, *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*, ed. Adrienne Stith Butler and Ellen Wright Clayton (Washington, DC: The National Academies Press, 2009), http://www.nap.edu/catalog/12585/a-review-of-the-hhs-family-planning-program-mission-management.

[44] Ibid., pp. 4, 70. See also Jennifer J. Frost, Adam Sonfield, and Mia Zolna, et al., "Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program," *Milbank Quarterly*, vol. 92, no. 4 (December 2014), pp. 696-749, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4266172/pdf/milq0092-0667.pdf.

Among IOM's recommendations was that OPA's Office of Family Planning "review and update the Program Guidelines to ensure that they are evidence-based." IOM noted, for example, that the guidelines required female Title X clients, including adolescents, to have pelvic and breast examinations within six months of their initial visit, though "relevant abnormalities are rarely found in adolescents." At the time of the IOM report, Title X Program Guidelines had not been updated since 2001.[45]

In response to the IOM recommendations, OPA released new program guidelines in April 2014.[46] The new guidelines draw on systematic literature reviews and existing recommendations from organizations, such as the CDC, the U.S. Preventive Services Task Force, the American Congress of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Society for Reproductive Medicine, and the American Urological Association. For example, the new guidelines state that pelvic exams and clinical breast exams are "not needed routinely to provide contraception safely to a healthy client" (though they may be recommended for some cases, such as inserting an intrauterine device, fitting a diaphragm, cancer screening for non-adolescents, assessing gestational age after a positive pregnancy test, if the client has certain STD symptoms, as part of infertility care, or to address other non-contraceptive health needs). OPA states that the new guidelines have "a foundation of empirical evidence and information supporting clinical practice."[47] Also in response to the IOM report, HHS contracted with IOM to convene a Standing Committee to advise the Title X program on issues raised by the 2009 report, as well as other emerging family planning issues.[48]

The Patient Protection and Affordable Care Act and Title X

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) has numerous provisions impacting Title X clinics. Notably, ACA increases access to health insurance.[49] (In 2015, 48% of Title X clients were uninsured, down from 63% in 2013.)[50] Federal ACA regulations and guidance also require most health plans and health insurers to cover contraceptive services without cost-sharing.

[45] IOM, *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*, pp. 13, 15, 240; the 2001 guidelines are reprinted in Appendix D.

[46] HHS, OPA, *Program Guidelines*, http://www.hhs.gov/opa/program-guidelines/. The new guidelines are comprised of two documents: HHS, OPA, *Program Requirements for Title X Funded Family Planning Projects*, April 2014, https://www.hhs.gov/opa/sites/default/files/ogc-cleared-final-april.pdf; and Loretta Gavin, Susan Moskosky, and Marion Carter, et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," *Morbidity and Mortality Weekly Report*, vol. 63, no. RR-4 (April 25, 2014), pp. 1-29.

[47] HHS, HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 394.

[48] IOM, Standing Committee on Family Planning, http://www.nationalacademies.org/hmd/Activities/Women/FamilyPlanning.aspx.

[49] The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimate that 22 million more nonelderly people will have health insurance in 2016 than would have without the ACA. CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 24, 2016, Table 4, "Effects of the Affordable Care Act on Health Insurance Coverage for People Under Age 65" https://www.cbo.gov/publication/51385. One study found that uninsurance rates among reproductive age women declined by almost 40% between 2012 and 2015. Rachel K. Jones and Adam Sonfield, "Health Insurance Coverage Among Women of Reproductive Age Before and After Implementation of the Affordable Care Act," *Contraception*, vol. 93, no. 5 (May 2016), pp. 386-391, http://dx.doi.org/10.1016/j.contraception.2016.01.003.

[50] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, p. A-19.

ACA has several provisions that may increase health insurance coverage in the populations served by Title X. These provisions could help free up funds that Title X clinics have historically spent on serving the uninsured. For example,

- States can expand Medicaid eligibility to include most nonelderly, nonpregnant individuals with income at or below 133% of FPL, effectively 138% FPL with the 5% income disregard.[51] (In 2015, 66% of Title X clients had incomes under 101% of FPL; another 14% had incomes between 101% and 150% of FPL.)[52]
- ACA gives states the option, through a Medicaid state plan amendment, of providing targeted Medicaid family planning services and supplies to certain individuals who would otherwise be ineligible for Medicaid.[53]
- ACA requires most private health plans that offer dependent coverage for children to continue to make such coverage available for young adult children under the age of 26.[54] (In 2015, 45% of Title X clients were younger than 25 years old; another 22% were aged 25 to 29.)[55]
- ACA provides certain individuals and small businesses with access to private health plans through new health insurance exchanges and subsidizes the premium costs for certain individuals. To ensure access for low-income individuals, exchange plans are required to have a sufficient number and geographic distribution of "essential community providers," which include Title X projects.[56]

[51] P.L. 111-148, §2001 as modified by §10201; P.L. 111-152, §1004 and §1201. This provision is summarized in CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*, by (name re dacted)is jointly financed by federal and state governments. All state Medicaid programs are mandated to include family planning services and supplies in their benefit packages, with no cost-sharing. In states that choose to expand Medicaid eligibility, the federal government pays 100% of Medicaid expenditures for those in the new eligibility group in 2014 through 2016, including family planning expenditures, gradually declining to 90% in 2020 and thereafter. For all other Medicaid enrollees, the federal government pays 90% of Medicaid family planning expenditures.

[52] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, p. 22.

[53] P.L. 111-148, §2303. This provision was effective upon enactment. Prior to ACA, states could provide these Medicaid family planning expansions only by obtaining special waivers. This provision is summarized in CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by (name redacted) et al. As of September 1, 2016, 14 states have had state plan amendments approved under this new authority. Guttmacher Institute, *State Policies in Brief as of January 1, 2017: Medicaid Family Planning Eligibility Expansions*, https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions. Federal guidance is provided in Cindy Mann, director, Center for Medicaid, CHIP and Survey & Certification, *State Medicaid Directors Letter #10-013, Family Planning Services Option and New Benefit Rules for Benchmark Plans*, July 2, 2010, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf, and *State Medicaid Directors Letter #14-003, Family Planning and Family Planning Related Services Clarification*, April 16, 2014, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-14-003.pdf.

[54] P.L. 111-148, §1001, as amended by P.L. 111-152, §2301. This dependent coverage provision is effective for plan years beginning on or after September 23, 2010. The provision is summarized in CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by (name redacted) and (name redac ted) .

[55] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, pp. 10-11.

[56] U.S. Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), *2018 Letter to Issuers in the Federally-facilitated Marketplaces*, December 16, 2016, p. 31, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf. 45 C.F.R. §156.235.

- ACA's individual mandate provision requires most individuals to have health insurance or pay a penalty.[57]

OPA has established FY2017 Program Priorities to guide the project plans of family planning services grantees. In response to ACA, one of these priorities is demonstrating Title X clinics' ability to bill Medicaid and private health insurance. Project plans should have "Evidence of contracts with insurance plans and systems for third party billing as well as the ability to facilitate the enrollment of clients into private insurance and Medicaid, optimally onsite; and to report on numbers of clients assisted and enrolled."[58] A survey of publicly funded family planning clinics found that in 2015, 79% of Title X clinics had contracts to bill Medicaid plans (compared with 35% in 2010) and 69% had contracts to bill private health insurance plans (compared with 26% in 2010).[59]

According to the FY2017 HRSA *Justification,* the Administration expects that Title X clinics will increase revenue, in part by raising the proportion of clients who have health insurance and by billing third parties.[60] Title X clinics also provide enrollment assistance to clients eligible for Medicaid or exchange plans under ACA.[61] OPA awarded one-year grants in FY2014 and FY2015 to help Title X clinics enroll uninsured clients in health coverage.[62]

Title X supporters state that, although clinics funded by Title X could see increased revenues from Medicaid and private insurance, the Title X program is still necessary under the ACA:

> In addition to medical care, Title X supports activities that are not reimbursable under Medicaid and commercial insurance plans… Title X has made a major contribution to the training of clinicians; that need remains today… Title X helps to support staff salaries, not just for clinicians but for front-desk staff, educators and finance and administrative staff. Title X provides for individual patient education as well as community-level outreach and public education about family planning and women's health issues. Title X also helps to support the infrastructure necessary to keep the doors open—subsidizing rent, utilities and infrastructure needs like health information technology.[63]

---

[57] P.L. 111-148, §1501 and §10106, as amended by P.L. 111-152, §1002. This provision is summarized in CRS Report R44438, *The Individual Mandate for Health Insurance Coverage: In Brief*, by (name redacted).

[58] HHS, OPA, *Program Priorities*, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/program-priorities/index.html.

[59] Mia R. Zolna and Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, Guttmacher Institute, November 2016, Table 11, p. 44, https://www.guttmacher.org/sites/default/files/report_pdf/publicly-funded-family-planning-clinic-survey-2015_1.pdf. Jennifer J. Frost, Rachel Benson Gold, and Lori Frohwirth, et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, Guttmacher Institute, May 2012, Table 8, p. 37, https://www.guttmacher.org/sites/default/files/report_pdf/clinic-survey-2010.pdf.

[60] HHS, HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 394.

[61] "Connecting Clients to Coverage," in Adam Sonfield, Kinsey Hasstedt, and Rachel Benson Gold, *Moving Forward: Family Planning in the Era of Health Reform*, Guttmacher Institute, March 2014, pp. 34-35, http://www.guttmacher.org/pubs/family-planning-and-health-reform.pdf.

[62] HHS, OPA, *FY14 Announcement of Availability of Funds to Enroll Family Planning Clients into Health Insurance Programs*, April 3, 2014, http://www.grants.gov/web/grants/view-opportunity.html?oppId=253413. HHS, OPA, *FY15 Announcement of Availability of Funds to Enroll Family Planning Clients into Health Insurance Programs*, May 13, 2015, http://www.grants.gov/web/grants/view-opportunity.html?oppId=275157. HHS, HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 393.

[63] Clare Coleman and Kirtly Parker Jones, "Title X: A Proud Past, An Uncertain Future," *Contraception*, vol. 84 (September 2011), pp. 209-211, http://www.arhp.org/publications-and-resources/contraception-journal/september-2011. See also "The Ongoing Need for Title X," in Sonfield, Hasstedt, and Gold, *Moving Forward: Family Planning in the Era of Health Reform*, Guttmacher Institute, March 2014, pp. 29-30.

Some Title X supporters argue that Medicaid and private health insurance reimbursements do not cover the full cost of providing care.[64] Some advocates also note that even with ACA's health coverage expansions, family planning services will still be sought by uninsured persons[65] and dependents who, for confidentiality reasons, might not wish to bill reproductive health services to their parent's or spouse's health insurance.[66] Advocates maintain that even with the ACA, there is still strong demand for safety net providers, such as many Title X clinics, that provide health care to underserved populations.[67]

ACA requires most private health plans to cover certain preventive services for women without cost-sharing.[68] HHS commissioned the Institute of Medicine to recommend preventive services to be included in this requirement.[69] Adopting the IOM recommendations, federal rules and guidelines require that most health plans cover, without cost-sharing, "All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity," as prescribed.[70] Some have noted that

[64] Adam Sonfield, Andrea Rowan, and Joseph L. Alifante, et al., *Assessing the Gap Between the Cost of Care for Title X Family Planning Providers and Reimbursement from Medicaid and Private Insurance*, Guttmacher Institute, New York, NY, January 2016, https://www.guttmacher.org/pubs/Title-X-reimbursement-gaps.pdf.

[65] CBO and JCT estimate that about 28 million people will be uninsured in 2026. CBO, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*, March 24, 2016, Table 1. One study found that as of 2015, uninsurance rates had not declined significantly for Latinas and low-income women in states that did not expand Medicaid. Rachel K. Jones and Adam Sonfield, "Health Insurance Coverage Among Women of Reproductive Age Before and After Implementation of the Affordable Care Act," *Contraception*, vol. 93, no. 5 (May 2016), pp. 386-391, http://dx.doi.org/10.1016/j.contraception.2016.01.003. See also Euna M. August, Erika Steinmetz, and Lorrie Gavin, et al., "Projecting the Unmet Need and Costs for Contraception Services After the Affordable Care Act," *American Journal of Public Health*, vol. 106, no. 2 (February 2016), pp. 334-341, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4985850/.

[66] Confidentiality issues are discussed in Kathleen P. Tibb, Erica Sedlander, and Gingi Pica, et al., *Protecting Adolescent Confidentiality Under Health Care Reform: The Special Case Regarding Explanation of Benefits (EOBs)*, Philip R. Lee Institute for Health Policy Studies and Division of Adolescent and Young Adult Medicine, Department of Pediatrics, University of California, San Francisco, June 2014, http://nahic.ucsf.edu/download/protecting-adolescent-confidentiality-under-health-care-reform-the-special-case-regarding-explanation-of-benefits-eobs/; and Adam Sonfield, Kinsey Hasstedt, and Rachel Benson Gold, *Moving Forward: Family Planning in the Era of Health Reform*, Guttmacher Institute, March 2014, p. 16. Tibb et al. note that as of March 2013, an estimated 15 million young adults aged 15 to 25 were on their parents' health plans, in part due to ACA's dependent coverage provisions.

[67] Kinsey Hasstedt, Yana Vierboom, and Rachel Benson Gold, "Still Needed: The Family Planning Safety Net Under Health Reform," *Guttmacher Policy Review*, vol. 18, no. 3 (Summer 2015), pp. 56-61, http://www.guttmacher.org/pubs/gpr/18/3/gpr1805615.html. See also Marion Carter, Kathleen Desilets, and Lorrie Gavin, et al., "Trends in Uninsured Clients Visiting Health Centers Funded by the Title X Family Planning Program—Massachusetts, 2005–2012," *Morbidity and Mortality Weekly Report*, vol. 63, no. 3 (January 24, 2014), pp. 59-62, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6303a3.htm. In 2006, Massachusetts passed its health reform law; subsequently the state's uninsurance rate decreased, to 3% in 2011. The authors found that "Title X program data from 2005–2012 indicate that client volume remained high throughout the period," though the percentage of the state's Title X clients who were uninsured declined from 59% in 2005 to 36% in 2012. In Massachusetts, Title X client volume in 2012 was 90% of what it was in 2005.

[68] P.L. 111-148, §1101. This requirement does not apply to grandfathered plans. Grandfathered plans are those that existed on March 23, 2010, and have not made certain specified changes (for example, to benefits and cost-sharing).

[69] IOM, *Clinical Preventive Services for Women: Closing the Gaps* (Washington, DC: The National Academies Press, 2011), http://www.nap.edu/catalog/13181/clinical-preventive-services-for-women-closing-the-gaps.

[70] The requirement is effective for plan years beginning on or after August 1, 2012, with some exceptions and accommodations for religious objections. Condoms and vasectomies are not included. HHS, HRSA, *Women's Preventive Services: Required Health Plan Coverage Guidelines*, http://www.hrsa.gov/womensguidelines/. For health insurance plan/policy years beginning on or after December 20, 2017, updated guidelines are at HHS, HRSA, *Women's Preventive Services Guidelines*, https://www.hrsa.gov/womensguidelines2016/index.html. HHS, Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, *Fact Sheet: Women's Preventive*
(continued...)

this requirement, by removing up-front cost barriers, could result in more women switching to longer-acting contraceptive methods, such as hormonal implants and intrauterine devices.[71] OPA has identified "Patient access to a broad range of contraceptive options, including long acting reversible contraceptives (LARC)" as one of the key Title X issues in FY2017.[72] HHS has also added Title X clients' rate of LARC use to the list of outcome measures for assessing program performance.[73]

The *Family Planning Annual Report: 2015 National Summary* contains Title X program data from 2015, the second year that ACA's major coverage provisions were in effect. Clients' insurance coverage rates have risen: 50% of Title X clients had health insurance in 2015, compared with 43% in 2014, 35% in 2013 and 31% in 2010.[74] Projects that received Title X funds also reported increased revenues from private third-party payers such as private health insurance plans: $104.0 million in 2015, compared with $95.1 million in 2014, $69.2 million in 2013, and $50.4 million in 2010.[75] Projects that received Title X funds had Medicaid revenues of $501.4 million in 2015, compared with $481.3 million in 2010.[76]

The number of Title X clients served in 2015 (4.018 million) was 3% lower than in 2014 (when there were 4.129 million clients), 12% lower than in 2013 (when there were 4.558 million clients), and 23% lower than in 2010 (when there were 5.225 million clients).[77] As noted above in "Client Characteristics," a decrease in demand might be explained in part by ACA coverage expansions, because newly insured clients can now seek care from private practitioners and other providers. Increased LARC use could also affect demand by reducing the frequency of client visits in the long run, compared with some other contraceptive methods (such as oral contraceptives that require refills). The number of female Title X clients using hormonal implants or intrauterine devices in 2015 was 11% higher than in 2014, 16% higher than in 2013, and 50% higher than in 2010.[78]

(...continued)

Services Coverage, Non-Profit Religious Organizations, and Closely-Held For-Profit Entities, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html. CRS In Focus IF10169, *The Affordable Care Act's Contraceptive Coverage Requirement: History of Regulations for Religious Objections*, by (name redacted)

[71] Michelle Andrews, "Insurance Coverage Might Steer Women To Costlier—But More Effective—Birth Control," *Kaiser Health News*, February 20, 2012, http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/2012/contraceptives-coverage-022112.aspx. Jonathan M. Bearak, Lawrence B. Finer, and Jenna Jerman, et al., "Changes in out-of-pocket costs for hormonal IUDs after implementation of the Affordable Care Act: an analysis of insurance benefit inquiries," *Contraception*, February 2016, http://dx.doi.org/10.1016/j.contraception.2015.08.018. Nora Becker and Daniel Polsky, "Women Saw Large Decrease In Out-Of-Pocket Spending For Contraceptives After ACA Mandate Removed Cost Sharing," *Health Affairs*, vol. 34, no. 7 (July 2015), pp. 1204-1211.

[72] HHS, OPA, *Program Priorities*, https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/program-priorities/index.html.

[73] In FY2014, 13% of female clients used LARC as their primary contraception method; the FY2017 target is 11%. HHS, HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 396.

[74] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, p. A-19.

[75] Ibid., p. A-32. Actual dollars.

[76] Ibid., p. A-32. Actual dollars.

[77] Ibid., p. A-6.

[78] Ibid., p. A-20. 451,625 female Title X clients used the LARC methods of hormonal implants or intrauterine devices in 2015, compared to 405,310 in 2014, 387,875 in 2013, and 300,136 in 2010. A separate CDC study found that among teens seeking contraceptive services at Title X clinics, 7.1% used long-acting reversible contraception in 2013, compared with 0.4% in 2005. Lisa Romero, Karen Pazol, and Lee Warner, et al., "Vital Signs: Trends in Use of Long-Acting Reversible Contraception Among Teens Aged 15–19 Years Seeking Contraceptive Services—United States, 2005-2013," *Morbidity and Mortality Weekly Report*, vol. 64 (April 10, 2015), pp. 363-369. Title X guidelines (continued...)

ACA has also impacted the Title X program in other ways. For example, because ACA increased the Medicaid rebate percentage paid by drug makers, Title X clinics receive larger discounts on drugs purchased through the 340B drug pricing program. As a result of receiving larger drug discounts through the 340B program, Title X clinics receive more revenue on drugs dispensed to clients.[79]

ACA also increased funding for teen pregnancy prevention efforts, expanded health care workforce programs, and increased funding for community health centers (many of which are Title X providers).[80] HHS contracted with IOM to convene a Standing Committee to advise the Title X program. Among other topics, the IOM Standing Committee was tasked with examining the roles of family planning, reproductive health, and Title X in health reform.[81] OPA also awarded FY2014 research funding to "conduct data analysis and related research and evaluation on the impact of the Affordable Care Act on Title X funded family planning centers."[82] For Title X grantees and clinics, the Title X Family Planning National Training Centers have compiled resources and provided training on how ACA may affect Title X.[83]

Legislation has been introduced to amend, repeal, or replace some or all of the ACA.[84] President Trump's Administration may also use the executive branch to change ACA regulations, guidance, and/or enforcement activities.[85] Such legislative and executive branch actions could further impact Title X in the future. Depending on what these actions are, and because many of ACA's effects on Title X are indirect, the potential consequences for Title X are unclear at this point.

(...continued)

encourage providers to explain to clients that LARC methods are "safe and effective for most women, including those who have never given birth and adolescents." (Gavin et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," p. 8.)

[79] P.L. 111-148, §2501. Title X clinics are among the entities eligible to receive discounts on certain drugs' prices under §340B of the Public Health Service Act. The maximum prices that drug manufacturers can charge 340B entities are calculated using the Medicaid rebate formula. The ACA provision is summarized in CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by (name redacted) et al. The 340B program website is http://www.hrsa.gov/opa. A 340B program overview is in Medicare Payment Advisory Commission, *Overview of the 340B Drug Pricing Program: Report to Congress*, May 2015, p. viii, http://www.medpac.gov/docs/default-source/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf. It states: "Covered entities can purchase 340B drugs for all eligible patients, including patients with Medicare or private insurance, and generate revenue if the reimbursements for the drugs from payers exceed the discounted prices they pay for the drugs. Because the 340B statute does not restrict how covered entities can use this revenue, entities can use these funds to expand the number of patients served, increase the scope of services offered to low-income and other patients, invest in capital, cover administrative costs, or for any other purpose."

[80] These and other ACA provisions that could potentially impact Title X clinics are summarized in CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in ACA: Summary and Timeline*, coordinated by (name redacted) and (name redacted) , and CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by (name redacted) et al.

[81] IOM, *Standing Committee on Family Planning*, http://iom.nationalacademies.org/Activities/Women/FamilyPlanning.aspx. HHS, HRSA, *Fiscal Year 2013 Justification of Estimates for Appropriations Committees*, p. 351, http://www.hrsa.gov/about/budget/budgetjustification2013.pdf.

[82] HHS, OPA, *FY14 Announcement of Availability of Funds for Family Planning Affordable Care Act (ACA) Impact Analysis Research Cooperative Agreements*, March 7, 2014, http://www.grants.gov/web/grants/view-opportunity.html?oppId=252304.

[83] National Family Planning Training Centers, *Affordable Care Act*, http://fpntc.org/topics/affordable-care-act.

[84] Examples of such legislation can be found in the Legislative Information System (access for congressional offices only), http://lis.gov. From the Topics pull-down menu, choose PPACA (Patient Protection and Affordable Care Act) (111th-) to generate a list of bills with titles or summaries mentioning ACA.

[85] See, for example, Executive Order 13765, "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal," 82 *Federal Register* 8351, January 24, 2017.

Final Rule on Selecting Subrecipients

As mentioned earlier, Title X grantees can provide family planning services directly or they can subaward Title X funds to other government or nonprofit entities (subrecipients) to provide services. In December 2016, OPA promulgated the final rule "Compliance With Title X Requirements by Project Recipients in Selecting Subrecipients."[86] It is effective January 18, 2017. The rule applies to grantees that make subawards; it does not affect grantees that provide all their Title X services directly. It adds the following language to Title X Family Planning Services grant program regulations:

> No recipient making subawards for the provision of services as part of its Title X project may prohibit an entity from participating for reasons other than its ability to provide Title X services.[87]

In the rule's preamble, OPA explained that some states have taken actions to limit Title X participation by certain types of providers. For example, some states have enacted laws to prohibit state and local agencies from giving Title X subawards to abortion providers.[88] Some other states have established a priority system for allocating Title X subawards, for example by giving preference to state health departments, primary care providers, and community health centers over specialized family planning clinics.[89] OPA argued that "These policies, and varying court decisions on their legality, have led to uncertainty among recipients, inconsistency in program administration, and reduced access to services for Title X priority populations."[90]

The final rule limits the criteria a grantee can use to restrict entities from Title X subawards, disallowing "reasons other than [the entity's] ability to provide Title X services." The preamble explains that under this rule, applicants for new and continuing[91] Title X grants will be required to describe their criteria for choosing subrecipients. The preamble notes that HHS will review these submissions for rule compliance, and that "the Department will make every effort to help entities

---

[86] Office of Population Affairs, Office of the Secretary, U.S. Department of Health and Human Services, "Compliance With Title X Requirements by Project Recipients in Selecting Subrecipients," 81 *Federal Register* 91852-91860, December 19, 2016, https://www.federalregister.gov/d/2016-30276. It was preceded by a proposed rule and public comment period, see 81 *Federal Register* 61639-61646, September 7, 2016, https://www.federalregister.gov/d/2016-21359.

[87] The rule amends 42 C.F.R. §59.3, and also revises the section's heading to read "Who is eligible to apply for a family planning services grant or to participate as a subrecipient as part of a family planning project?" The section's current heading is "Who is eligible to apply for a family planning services grant?"

[88] OPA notes the example of Florida law H.B. 1411, 2016 Leg., Reg. Sess. (Fla. 2016). According to OPA, this law was permanently enjoined on August 18, 2016, in an unpublished court order. (81 *Federal Register* 91853, footnote 8).

[89] OPA discusses the example of the Texas state government's "tiered" system for Title X subaward competition in 2011. (81 *Federal Register* 91853; Texas General Appropriations Act, 82nd Leg., R.S., ch. 1355, art. II, rider 77, at II-71, http://www.lrl.state.tx.us/scanned/ApproBills/82_0/82_R_ALL.pdf#page=179.) In FY2013, the Women's Health and Family Planning Association of Texas became the state's Title X grantee; previously it had been the Texas Department of State Health Services.

[90] 81 *Federal Register* 91858.

[91] Title X family planning services projects have "project periods," typically up to three years, during which HHS does not require the grantee to recompete for funds. Within these project periods, continuing awards are generally funded in annual increments (one-year budget periods). Continuing awards are contingent on factors such as appropriations, program priorities, and grantees' compliance with federal requirements. See HHS, OPA, *Announcement of Anticipated Availability of Funds for Family Planning Services Grants, FY2017*, p. 11, https://www.hhs.gov/opa/sites/default/files/FY-17-Title-X-FOA-New-Competitions.pdf; HHS, OPA, *Program Requirements for Title X Funded Family Planning Projects*, April 2014, p. 10.

come into compliance, and will award replacement grants to other providers when necessary to minimize any disruption of services."[92]

Supporters of the rule have argued that it protects funding to specialized family planning providers, such as Planned Parenthood,[93] and that it protects vulnerable individuals' access to family planning services.[94] Critics of the rule have argued that states should have the discretion to administer Title X funds consistently with state policy,[95] and that the rule violates the conscience rights of voters and states that object to public funding of abortion providers.[96]

Abortion and Title X

The law prohibits the use of Title X funds in programs where abortion is a method of family planning.[97] On July 3, 2000, OPA released a final rule with respect to abortion services in family planning projects.[98] The rule updated and revised regulations that had been promulgated in 1988.[99] The major revision revoked the "gag rule," which restricted family planning grantees from providing abortion-related information. The regulation at 42 C.F.R. §59.5 had required, and continues to require, that abortion not be provided as a method of family planning. The July 3,

[92] 81 *Federal Register* 91853-91854.

[93] See, for example, The Times Editorial Board, "One Obama rule that Trump should keep: Making sure family planning funds reach everyone who needs them," *Los Angeles Times*, December 27, 2016, http://www.latimes.com/opinion/editorials/la-ed-titlex-new-rule-20161221-story.html; and The New York Times Editorial Board, "A Way to Protect Planned Parenthood Services," *New York Times*, September 10, 2016, p. A18, New York edition, http://www.nytimes.com/2016/09/10/opinion/a-way-to-protect-planned-parenthood-services.html.

[94] See, for example, Letter from 34 U.S. Senators to President-Elect Donald J. Trump, December 22, 2016, http://www.help.senate.gov/download/title-x-trump; and Letter from 41 U.S. Senators to the Honorable Sylvia Mathews Burwell, Secretary, Department of Health and Human Services, October 7, 2016, https://www.regulations.gov/document?D=HHS-OS-2016-0014-14254.

[95] See, for example, U.S. House of Representatives, Select Investigative Panel of the Energy and Commerce Committee, *Final Report*, December 30, 2016, pp. xlii and 408, https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/114/Analysis/20161230Select_Panel_Final_Report.pdf.

[96] See, for example, Bradford Richardson, "Obama administration 'stunt' would force states to fund Planned Parenthood," *Washington Times*, September 7, 2016, http://washingtontimes.com/news/2016/sep/7/obama-administration-stunt-would-force-states-to-f/; and Robert King, "Conservative chides feds over protecting Planned Parenthood," *Washington Examiner*, September 6, 2016, http://www.washingtonexaminer.com/conservative-chides-feds-over-protecting-planned-parenthood/article/2601071. Legislation has been introduced to nullify the rule under the Congressional Review Act; see, for example, H.J.Res. 39, H.J.Res. 43, and S.J.Res. 13. For more on the Congressional Review Act, see CRS In Focus IF10023, *The Congressional Review Act (CRA)*, by (name redacted), (name redacted), and (name redacted) . See also CRS Insight IN10611, *Can a New Administration Undo a Previous Administration's Regulations?*, by (name redacted).

[97] 42 U.S.C. §300a-6. In addition, language in annual Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations bills have also prohibited the use of Title X funds for abortions. (In FY2016, this provision appeared in P.L. 114-113, Division H, Title II.) For background on abortion funding restrictions in general, see CRS Report RL33467, *Abortion: Judicial History and Legislative Response*, by (name redacted) .

[98] HHS, OPA, "Standards of Compliance for Abortion-Related Services in Family Planning Services Projects," 65 *Federal Register* 41270–41280, July 3, 2000, https://federalregister.gov/a/00-16758; and HHS, OPA, "Provision of Abortion-Related Services in Family Planning Services Projects, " 65 *Federal Register* 41281-41282, July 3, 2000, https://federalregister.gov/a/00-16759.

[99] HHS, Public Health Service, "Statutory Prohibition on Use of Appropriated Funds in Programs Where Abortion is a Method of Family Planning; Standard of Compliance for Family Planning Services Projects," 53 *Federal Register* 2922, February 2, 1988. The 1988 rule was subsequently challenged in court, and in 1993, the HHS Secretary suspended the rule (HHS, Public Health Service, "Standards of Compliance for Abortion-Related Services in Family Planning Service Projects," 58 *Federal Register* 7462, February 5, 1993).

2000, rule amended the section to add the requirement that a project must give pregnant women the opportunity to receive information and counseling on each of the following options: prenatal care and delivery; infant care, foster care, or adoption; and pregnancy termination. If the woman requests such information and counseling, the project must give "neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling."[100]

According to OPA, family planning projects that receive Title X funds are closely monitored to ensure that federal funds are used appropriately and that funds are not used for prohibited activities such as abortion. The prohibition on abortion does not apply to all the activities of a Title X grantee, but only to activities that are part of the Title X project. The grantee's abortion activities must be "separate and distinct" from the Title X project activities.[101] Safeguards to maintain this separation include (1) careful review of grant applications to ensure that the applicant understands the requirements and has the capacity to comply with all requirements; (2) independent financial audits to examine whether there is a system to account for program-funded activities and non-allowable program activities; (3) yearly comprehensive reviews of the grantees' financial status and budget report; and (4) periodic and comprehensive program reviews and site visits by OPA regional offices.[102]

It is unclear precisely how many Title X clinics also provide abortions through their non-Title X activities. In 2015, the Guttmacher Institute surveyed a nationally representative sample of publicly funded family planning clinics. Respondents included 535 clinics that received Title X funds. Based on that survey, an estimated 10% of clinics that received any Title X funding reported offering abortions separately from their Title X project.[103]

In 2004, following appropriations conference report directions, HHS surveyed its Title X grantees on whether their clinic sites also provided abortions with nonfederal funds.[104] Grantees were informed that responses were voluntary and "without consequence, or threat of consequence, to non-responsiveness." The survey did not request any identifying information. HHS mailed surveys to 86 grantees and received 46 responses. Of these, 9 indicated that at least one of their clinic sites (17 clinic sites in all) also provided abortions with nonfederal funds, and 34 indicated that none of their clinic sites provided abortions with nonfederal funds; 3 responses had no numerical data or said the information was unknown.

[100] On December 19, 2008, HHS published a provider conscience rule which, according to HHS at the time, was "inconsistent" with the requirement that Title X grantees provide clients with abortion referrals upon request (73 *Federal Register* 78087). The rule was later rescinded in 2011 (76 *Federal Register* 9968).

[101] 65 *Federal Register* 41281-41282, July 3, 2000.

[102] Email from Barbara Clark, HHS, Office of the Assistant Secretary for Legislation, August 24, 2006. Site visits and comprehensive program reviews are described in IOM, *A Review of the HHS Family Planning Program: Mission, Management, and Measurement of Results*, pp. 349-354.

[103] Guttmacher Institute, unpublished tabulations from a 2015 Survey of Publicly Funded Family Planning Clinics. The survey methodology is described in Mia R. Zolna and Jennifer J. Frost, *Publicly Funded Family Planning Clinics in 2015: Patterns and Trends in Service Delivery Practices and Protocols*, Guttmacher Institute, November 2016, https://www.guttmacher.org/sites/default/files/report_pdf/publicly-funded-family-planning-clinic-survey-2015_1.pdf. For details by abortion type, see Appendix Table A, Questions Q11ee and Q11ii, p. 54.

[104] HHS, Report to Congress Regarding the Number of Family Planning Sites Funded Under Title X of the Public Health Service Act That Also Provide Abortions with Non-Federal Funds, 2004. HHS was directed to conduct the survey by FY2004 appropriations conference report H.Rept. 108-401, pp. 800-801.

Title X supporters argue that family planning reduces unintended pregnancies, thereby reducing abortion.[105] HHS and the Guttmacher Institute estimate that Title X family planning services helped avert more than 900,000 unintended pregnancies in 2014.[106] It is unclear exactly how many unintended pregnancies would have ended in abortion; however the Guttmacher Institute estimates that in 2014, clinics receiving Title X funds helped avert 326,000 abortions, including 54,000 abortions among teens.[107]

On the other hand, Title X critics argue that federal funds should be withheld from any organization that performs abortions, such as the Planned Parenthood Federation of America. These critics argue that federal funding for non-abortion activities frees up Planned Parenthood's other resources for its abortion activities.[108] Some critics also argue that if a family planning program is operated by an organization that also performs abortions, the implicit assumption and the message to clients is that abortion is a method of family planning.[109]

Teenage Pregnancy and Title X

In 2015, 18% of Title X clients were aged 19 or younger.[110] Critics argue that by funding Title X, the federal government is implicitly sanctioning nonmarital sexual activity among teens. These critics argue that a reduced teenage pregnancy rate could be achieved if family planning programs emphasized efforts to convince teens to delay sexual activity, rather than efforts to decrease the percentage of sexually active teens who become pregnant.[111] (See CRS Report RS20301, *Teenage Pregnancy Prevention: Statistics and Programs*.)

[105] Examples of this argument can be found in Rachel Benson Gold, Adam Sonfield, and Cory L. Richards, et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, Guttmacher Institute, New York, 2009, pp. 16-17, http://www.guttmacher.org/pubs/NextSteps.pdf, and in U.S. Congress, Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, *Threat to Title X and Other Women's Health Services*, 104th Cong., 1st sess., August 10, 1995, S.Hrg. 104-416 (Washington: GPO, 1996), pp. 16-21.

[106] Title X services helped avert an estimated 941,000 unintended pregnancies in 2014, according to HHS, HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 391. Title X clinics' services averted an estimated 904,000 unintended pregnancies in 2014, according to Jennifer J. Frost, Lori Frohwirth, and Mia R. Zolna, *Contraceptive Needs and Services, 2014 Update*, Guttmacher Institute, September 2016, p. 13, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[107] The Guttmacher Institute estimates that in the absence of Title X-funded clinics, the 2014 abortion rate would have been 33% higher than it actually was. Jennifer J. Frost, Lori Frohwirth, and Mia R. Zolna, *Contraceptive Needs and Services, 2014 Update*, Guttmacher Institute, September 2016, pp. 1, 13, 14, 16, and 32.

[108] Examples of this argument can be found in House debate, *Congressional Record*, daily edition, vol. 154, no. 112 (July 9, 2008), pp. H6320-H6326. According to the Planned Parenthood Federation of America's most recent *Annual Report*, abortions accounted for 3% of Planned Parenthood services. 323,999 abortion procedures were performed by Planned Parenthood health centers from October 1, 2013 through September 30, 2014. During that period, Planned Parenthood health centers provided 9.5 million services to 2.5 million patients during 4 million clinical visits. Planned Parenthood Federation of America, *Planned Parenthood 2014-2015 Annual Report*, 2015, pp. 29-30, http://www.plannedparenthood.org/about-us/annual-report.

[109] An example of these arguments can be found in U.S. Congress, Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, *Threat to Title X and Other Women's Health Services*, pp. 22-35.

[110] Fowler et al., *Family Planning Annual Report: 2015 National Summary*, p. 9.

[111] An example of these arguments can be found in U.S. Congress, Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, *Threat to Title X and Other Women's Health Services*, pp. 22-35.

The program's supporters, on the other hand, argue that the Title X program should be expanded to serve more people in order to reduce the rate of unintended pregnancies. According to HHS, in 2014, Title X family planning services helped avert an estimated 171,800 unintended teen pregnancies.[112] The Guttmacher Institute estimates that without Title X clinics' services, the 2014 U.S. teen pregnancy rate would have been 30% higher.[113] Supporters of expanding family planning services argue that the United States has a higher teen pregnancy rate than some countries (such as Sweden) where a similar percentage of teens are sexually active, in part because U.S. teens use contraception less consistently. Some also argue that recent declines in U.S. teen birth rates can be explained in part by changes in teen contraceptive use.[114]

Confidentiality for Minors and Title X

By law, Title X providers are required to "encourage" family participation when minors seek family planning services.[115] However, confidentiality is required for personal information about Title X services provided to individuals, including adolescents.[116] OPA instructs grantees on confidentiality for minors:

> It continues to be the case that Title X projects may not require written consent of parents or guardians for the provision of services to minors. Nor can any Title X project staff notify a parent or guardian before or after a minor has requested and/or received Title X family planning services.[117]

[112] HHS, HRSA, *Fiscal Year 2017 Justification of Estimates for Appropriations Committees*, p. 391. See also the discussion of publicly funded family planning services in "Programs to Reduce Unintended Pregnancy," in The Institute of Medicine, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families* (Washington: National Academy Press, 1995), p. 220, http://www.nap.edu/catalog/4903/the-best-intentions-unintended-pregnancy-and-the-well-being-of.

[113] The Guttmacher Institute estimates that in the absence of Title X-funded clinics, the 2014 teen pregnancy rate would have been 69 pregnancies per 1,000 teens rather than the actual 2014 rate of 53 pregnancies per 1,000 teens. Jennifer J. Frost, Lori Frohwirth, and Mia R. Zolna, *Contraceptive Needs and Services, 2014 Update*, Guttmacher Institute, September 2016, Figure 5, p. 14, https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.

[114] An example of these arguments can be found in U.S. Congress, Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, *Threat to Title X and Other Women's Health Services*, pp. 16-21. See also Jacqueline E. Darroch, et al., "Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use," *Family Planning Perspectives*, vol. 33, no. 6 (November/December 2001), pp. 244-251; John S. Santelli and Andrea J. Melnikas, "Teen Fertility in Transition: Recent and Historic Trends in the United States," *Annual Review of Public Health*, vol. 31 (2010), pp. 371-383; Heather D. Boonstra, "What Is Behind the Declines in Teen Pregnancy Rates?" *Guttmacher Policy Review*, vol. 17, no. 3 (Summer 2014), pp. 15-21; and Laura Lindberg, John Santelli, and Sheila Desai, "Understanding the Recent Decline in Adolescent Fertility in the United States, 2007-2013," *Journal of Adolescent Health*, vol. 58, no. 2, Supplement (February 2016), p. S100–S101.

[115] 42 U.S.C. 300(a) states that Title X grantees shall encourage family participation "to the extent practical." P.L. 114-113, Division H, §207 requires Title X grantees to certify that they encourage family participation in minors' decisions to seek family planning services.

[116] 42 C.F.R. §59.11. Also, several court cases have interpreted Title X statute as supporting confidentiality for minors; see Glenn A. Guarino, "Provision of family planning services under Title X of Public Health Service Act (42 U.S.C.A. §300-300a-8) and implementing regulations," *American Law Reports Federal*, 1985, 71 A.L.R. Fed. 961.

[117] HHS, OPA, *Clarification regarding "Program Requirements for Title X Family Planning Projects": Confidential Services to Adolescents*, OPA Program Policy Notice 2014-1, June 5, 2014, https://www.hhs.gov/opa/sites/default/files/ppn2014-01-001.pdf.

The April 2014 Title X guidelines state,

> Providers of family planning services should offer confidential services to adolescents and observe all relevant state laws and any legal obligations, such as notification or reporting of child abuse, child molestation, sexual abuse, rape, or incest, as well as human trafficking. Confidentiality is critical for adolescents and can greatly influence their willingness to access and use services. As a result, multiple professional medical associations have emphasized the importance of providing confidential services to adolescents.
>
> Providers should encourage and promote communication between the adolescent and his or her parent(s) or guardian(s) about sexual and reproductive health. Adolescents who come to the service site alone should be encouraged to talk to their parents or guardians. Educational materials and programs can be provided to parents or guardians that help them talk about sex and share their values with their child. When both parent or guardian and child have agreed, joint discussions can address family values and expectations about dating, relationships, and sexual behavior.[118]

Although minors are to receive confidential services, Title X providers are not exempt from state notification and reporting laws on child abuse, child molestation, sexual abuse, rape, or incest.[119]

Some minors who use Title X clinics have dependent health coverage through a parent's private health insurance policy. However, for confidentiality reasons, they may not wish to bill family planning or STD services to their parent's health insurance. According to OPA, Title X clinics "commonly forgo billing" health insurers in order to maintain confidentiality.[120]

As for payment of services provided to minors, Title X regulations indicate that "unemancipated minors who wish to receive services on a confidential basis must be considered on the basis of their own resources."[121] Program requirements instruct that "Eligibility for discounts for unemancipated minors who receive confidential services must be based on the income of the minor."[122]

---

[118] Gavin et al., "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs," p. 13. For an overview of Title X efforts to encourage family participation, see RTI International, *An Assessment of Parent Involvement Strategies in Programs Serving Adolescents: Final Report*, 2007, http://web.archive.org/web/20160830233907/http://www.hhs.gov/opa/pdfs/parent-involvement-final-report.pdf. The report found that parent involvement is associated with several positive outcomes, such as delayed sexual initiation and lower rates of pregnancy and sexually transmitted infections.

[119] P.L. 114-113, Division H, Title II, §208. HHS, OPA, *Clarification regarding "Program Requirements for Title X Family Planning Projects": Confidential Services to Adolescents*, OPA Program Policy Notice 2014-1, June 5, 2014.

[120] Private health insurance policy holders often receive "explanations of benefits" that describe services charged to their insurance policy. Often policy holders may also view a history of claims made under their policies. These common health insurance practices may inadvertently breach the confidentiality of dependents who receive care through those policies. OPA has awarded research funding to study these practices' effects on Title X clinics' revenues. HHS, OPA, *FY14 Announcement of Availability of Funds for Family Planning Affordable Care Act (ACA) Impact Analysis Research Cooperative Agreements*, March 7, 2014, pp. 5-6, 10-11, https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=49223. See also Abigail English, Rachel Benson Gold, and Elizabeth Nash, et al., *Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies*, Guttmacher Institute, July 2012, http://www.guttmacher.org/pubs/confidentiality-review.pdf; and Guttmacher Institute, *State Policies in Brief as of September 1, 2016: Protecting Confidentiality for Individuals Insured as Dependents*, http://www.guttmacher.org/statecenter/spibs/spib_CMII.pdf.

[121] 42 C.F.R. §59.2.

[122] HHS, OPA, *Program Requirements for Title X Funded Family Planning Projects*, April 2014, p. 13, https://www.hhs.gov/opa/sites/default/files/ogc-cleared-final-april.pdf.

Supporters of confidentiality argue that parental notification or parental consent requirements would lead some sexually active adolescents to delay or forgo family planning services, thereby increasing their risk of pregnancy or sexually transmitted diseases.[123]

Critics argue that confidentiality requirements can interfere with parents' right to know of and to guide their children's health care. Some critics also disagree with discounts for minors without regard to parents' income, because the Title X program was intended to serve "low-income families."[124]

Planned Parenthood and Title X

The Planned Parenthood Federation of America (PPFA) operates through a national office and 57 affiliates, which operate approximately 650 local health centers.[125] Affiliates participating in Title X can receive funds directly from HHS or indirectly from other Title X grantees, such as their state or local health departments.[126] The Guttmacher Institute found that in 2010, Planned Parenthood clinics made up 13% of Title X clinics, but served 37% of Title X clients.[127]

In March 2015, the Government Accountability Office (GAO) released a report with data on the obligations, disbursements, and expenditures of federal funds for several nonprofit organizations, including PPFA and its affiliates.[128]

According to the GAO report, in FY2012, HHS reported obligating $18.67 million, and disbursing $19.08 million, to PPFA affiliates through the Title X program.[129] These figures reflected funds that HHS provided directly to these organizations. They did not include Title X funds that reached Planned Parenthood or its affiliates indirectly through subgrants or that passed through from state agencies or other organizations.

The GAO report also showed PPFA affiliates' expenditures of Title X funds. Most of these expenditures were identified through audit reports that PPFA affiliates submitted to comply with

[123] An example of this argument is in Rachel K. Jones, Alison Purcell, and Susheela Singh et al., "Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception," *JAMA*, vol. 293, no. 3 (January 19, 2005), pp. 340-348. See also the staff quotations in RTI International, *An Assessment of Parent Involvement Strategies in Programs Serving Adolescents: Final Report*, 2007, pp. 5-10.

[124] Examples of these arguments appear in *Congressional Record*, daily edition, vol. 142 (July 11, 1996), pp. H7348-H 7349, and U.S. Congress, Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, *Threat to Title X and Other Women's Health Services*, pp. 22-23. See also the discussion in RTI International, *An Assessment of Parent Involvement Strategies in Programs Serving Adolescents: Final Report*, 2007, pp. 5-9.

[125] Planned Parenthood Federation of America, *Planned Parenthood at a Glance*, http://www.plannedparenthood.org/about-us/who-we-are/planned-parenthood-at-a-glance.

[126] The Title X Family Planning Service Site Database currently includes more than 300 Planned Parenthood sites, https://www.opa-fpclinicdb.com/.

[127] Jennifer J. Frost, Mia R. Zolna, and Lori Frohwirth, *Contraceptive Needs and Services, 2010*, Guttmacher Institute, July 2013, Figure 3 and Table 3, http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf#page=13.

[128] U.S. Government Accountability Office (GAO), *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010–2012*, GAO-15-270R, March 20, 2015, http://www.gao.gov/products/GAO-15-270R.

[129] According to GAO, the term obligation refers to "a definite commitment by a federal agency that creates a legal liability to make payments immediately or in the future," while the term disbursement refers to "amounts paid by federal agencies, in cash or cash equivalents, to satisfy government obligations." GAO, *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010–2012*, pp. 30, 32.

Office of Management and Budget (OMB) audit requirements.[130] Expenditures included federal funds provided directly or indirectly to these organizations. The most recent expenditure data were from FY2012, when Planned Parenthood and its affiliates reported spending $64.35 million from the Title X Family Planning Services program.[131]

On September 22, 2015, the Congressional Budget Office estimated that PPFA and its affiliates receive approximately $60 million annually through the Title X program.[132]

Author Contact Information

(name redacted)
Information Research Specialist
[redacted]@crs.loc.gov, 7-....

[130] Organizations with annual expenditures of federal funds of $500,000 or more are required to have an audit. For several PPFA affiliates that did not meet the expenditure threshold for audits, GAO obtained data directly from the affiliates. GAO, *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010–2012*, pp. 2, 39, 40.

[131] Tables 24 and 25, GAO, *Health Care Funding: Federal Obligations to and Expenditures by Selected Entities Involved in Health-Related Activities, 2010–2012*, pp 39, 40. In their single audits to the Federal Audit Clearinghouse, PPFA affiliates reported spending $58.03 million in Title X funds in FY2012 (Table 24). According to data GAO obtained directly from PPFA, affiliates spent an additional $6.32 million in Title X funds in FY2012 that they were not required to report to the Federal Audit Clearinghouse because the amounts did not meet the reporting threshold (Table 25). These two dollar amounts total $64.35 million. However, the total is approximate, because expenditure data were reported using affiliates' 12-month fiscal years, which vary.

[132] Congressional Budget Office, *Budgetary Effects of Legislation That Would Permanently Prohibit the Availability of Federal Funds to Planned Parenthood*, September 22, 2015, p. 2, https://www.cbo.gov/publication/50833.