National
Family Planning
& Reproductive Health Association

February 21, 2017

Director Mick Mulvaney
Office of Management and Budget
725 17th Street NW
Washington, DC 20503

Dear Director Mulvaney:

I am writing on behalf of the National Family Planning & Reproductive Health Association (NFPRHA), a membership organization representing providers and administrators committed to helping people get the family planning education and care they need. As President George H.W. Bush stated:

> We need to make population and family planning household words. We need to take sensationalism out of this topic so that it can no longer be used by militants who have no real knowledge of the voluntary nature of the [Title X national family planning] program but, rather are using it as a political stepping stone. If family planning is anything, it is a public health matter. [i]

As the new administration crafts its fiscal year (FY) 2018 budget request, NFPRHA respectfully requests that it similarly recognizes the essential role of publicly funded family planning and sexual health care services.

NFPRHA's approximately 800 organizational members operate or fund a network of more than 3,500 safety-net health centers and service sites in all 50 states and the District of Columbia. NFPRHA's members provide affordable, high-quality, voluntary, comprehensive, and culturally sensitive family planning and sexual health care services to millions of Americans who might otherwise lack access to health care. Accordingly, NFPRHA believes public financing for family planning and sexual health services – through Title X, Medicaid, the section 330 federally qualified health center program, federal block grants including the Maternal and Child Health Block Grant and the Social Services Block Grant, as well as state funding programs – is essential to the survival of the family planning safety net upon which millions of people rely. Furthermore, NFPRHA supports efforts to ensure that family planning and sexual health continue to be delivered through a family planning safety net that is designed by communities for communities. For decades, family planning administrators, both governmental and non-governmental, have established service delivery networks that include a range of providers: state, county, and local health departments, as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers, and other nonprofit organizations.

The nation's family planning safety net leverages multiple public funding sources to deliver care to predominantly low-income, uninsured, and underinsured individuals and to those seeking confidential care. The providers' programs are largely anchored by Title X, the nation's only

dedicated source of family planning funds, and Medicaid. These programs represent, on average, 19% and 40% of a health center's revenue, respectively.[ii] According to the US Department of Health and Human Services' Family Planning Annual Report, another 2% of these health centers' revenue comes from a combination of block grants and other federal sources that work in conjunction with Title X and Medicaid.[iii] The remaining comes from private insurance reimbursement, state and local government support, patient fees, and other funding, such as grants from private foundations.[iv] In 2014, 20.2 million women were in need of publicly funded family planning services, and that number continues to increase annually. However, with current funding levels, the publicly funded family planning network only had sufficient resources from these various public and private sources to meet the needs of 7.8 million people.[v] **To sustain the family planning safety net's ability to keep its doors open to communities in need, NFPRHA specifically requests continued investments for the following essential federal programs**:

Title X

The Title X family planning program, whose authorizing language was chiefly sponsored by then-Representative George H.W. Bush (R-TX), passed the House with only 32 dissenters and cleared the Senate unanimously, and was signed into law by President Richard Nixon in 1970. The program remains a cornerstone of the publicly funded family planning safety net. Six in ten women seen in a Title X setting have reported that a Title X-supported health care center was their usual source of medical care[vi] and four in ten women said it was their only source of care.[vii] In 2014, Title X-funded health centers helped prevent approximately 904,000 unintended pregnancies, thereby preventing 326,000 abortions and 439,000 unplanned births.[viii] In addition to direct clinical care, Title X also supports critical infrastructure needs, including new medical equipment and staff training, that are not reimbursable under Medicaid and private insurance.

Title X sets the standard for high-quality family planning and sexual health service provision by focusing on outcomes and increasing service efficiency. In April 2014, "Providing Quality Family Planning Services - Recommendations of CDC and the U.S. Office of Population Affairs" was released. The recommendations are a rigorous set of clinical guidelines developed for family planning providers, including Title X-funded providers.[ix] Such efforts reinforce the network's providers as centers of excellence for high-quality health care and make Title X-supported health centers the provider of choice for people with and without insurance.

In spite of the increasing need for publicly funded family planning services and the demonstrated public health and fiscal benefits of the program, Title X investments have been substantially cut in recent fiscal years. In FY 2010 the program received $317 million, but in FY 2017 it received only $286.5 million. The reduced program investment is counter to research published in the *American Journal of Public Health* stating Title X would need at least $737 million to support all women in need of publicly funded family planning services.[x] It also unfortunately aligns with dramatic decreases in number of Title X-supported service sites -

from 4,389 in 2010[xi] to 3,951 in 2015[xii] – and in the number of patients served – from 5.22 million in 2010[xiii] to 4.02 million in 2015.[xiv] NFPRHA is deeply concerned about this diminished access to high-quality family planning and sexual health services and urges increased funding to reverse this devastating trend. **For these reasons, NFPRHA asks OMB to request a modest investment in the Title X program by including $327 million for the program in FY 2018.**

Medicaid

Medicaid is the predominant funding source for publicly funded family planning care. It is proven to save taxpayer dollars by expanding access to contraception and increasing women's use of more effective contraceptive methods – essential factors in reducing high rates of unintended pregnancy among low-income women.[xv] NFPRHA supports the provision of family planning and sexual health and supplies through Medicaid as an essential component of preventive care. NFPRHA strongly opposes any changes to the structure or financing of Medicaid, including a conversion to a per-capita cap system or a block grant, which would shift costs to states and result in reductions in eligibility, benefits, protections for enrollees, and provider reimbursement. NFPRHA further opposes any rollback of the Affordable Care Act's (ACA) Medicaid expansion, which would risk health insurance coverage for the estimated 11 million adults made newly eligible for Medicaid in 2015.[xvi]

Title V Maternal and Child Health (MCH) Block Grant

In addition to the many other important programs it supports, the Maternal and Child Health (MCH) Block Grant provides additional funds that states can use to help women plan their families. As a result, Title V funding is an important part of the publicly funded family planning network. Unfortunately, MCH Block Grant funding has been reduced in recent years, even as the number of women and children in need of these support services increases. Increasing Title V funds is vital in sustaining the coordinated care system between family planning and maternal and child health services. **NFPRHA supports $650 million for Title V MCH block grant in FY 2018.**

Other Federal Block Grants

Federal block grants, such as the Temporary Assistance for Needy Families (TANF) block grant, the Social Services Block Grant, the Community Development Block Grant, and the Community Services Block Grant provide private and public organizations with funding to engage in a number of social support, economic development, and community health projects. TANF, for example, is typically associated with cash assistance to needy families. However, one of the TANF program's goals is to "prevent and reduce the incidence of out-of-wedlock pregnancies."[xvii] States have latitude to operationalize that goal and some have done so by using TANF dollars to support public and private health centers that provide contraceptive services to low-income and uninsured women and men. Portions of the other aforementioned block grants are also used to foster the economic self-sufficiency of women and families by ensuring they have access to the health services that help them prevent unintended pregnancies.[xviii] **NFPRHA requests the following support for essential federal block grants:**

- **$16.7 billion for the Temporary Assistance to Needy Families Block Grant**
- **$1.7 billion for the Social Services Block Grant**
- **$2.8 billion for the Community Development Block Grant**
- **$674 million for the Community Services Block Grant**

Centers for Disease Control and Prevention (CDC) – National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)

Funding from NCHHSTP is utilized by STD, HIV, and viral hepatitis prevention, treatment, and control programs in local health departments and nonprofit health care organizations. In some of these health settings, funding from NCHHSTP is combined with Title X and other federal funds to create comprehensive sexual health programs by paying for the cost of family planning nurse practitioners, testing supplies, and medications. **NFPRHA supports $1.12 billion in FY 2018 for CDC's NCHHSTP program.**

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutritional support to low-income pregnant women and parents with children under five years of age through food packages, health education, and referrals to health and social services. The program, administered through grants distributed by state WIC agencies, complements the Title X program and the efforts of the publicly funded safety net to ensure access to health services for low-income women and families. WIC has improved birth outcomes, reduced health care costs, improved nutrition-related health outcomes, increased access to medical care, and improved preconception nutritional status.[xix] **NFPRHA supports $6.37 billion for the WIC program in FY 2018.**

Sexual Health Education – Teen Pregnancy Prevention Program (TPPP)

Medically accurate sexual health education and counseling are key components of publicly funded family planning services. The Teen Pregnancy Prevention Program (TPPP) provides funding to public and private organizations to engage in evidence-based initiatives that reduce teen pregnancy. These funds are often used by NFPRHA members to support their community education and outreach initiatives. **NFPRHA supports $130 million for TPPP, as well as the removal of all funding for abstinence-unless-marriage programs, in FY 2018.**

Exclude the Hyde Amendment and Other Harmful Policy Riders

The president should remove Hyde language from his FY 2018 budget request. That harmful language prevents women who utilize Medicaid, work as federal employees, or otherwise depend on the federal government for health care coverage or services from using those insurance sources to access abortion. Abortion is a medical service that must be legal, safe and accessible to all women who seek it; women's access to abortion should not be dependent on how they access their health care or coverage.

Lastly, the president's budget should be free of any policy riders that seek to eliminate certain family planning and sexual health providers from accessing public funds based on moral objections, including objections to a provider's scope of service beyond family planning. Such riders are to the detriment of patients and public health.

Conclusion

The president's FY 2018 budget request should strengthen the safety net to make certain that millions of current and future patients can obtain high-quality, affordable health care. NFPRHA encourages the president and OMB to support the successes created by the ACA that have helped increase access to affordable, comprehensive health coverage and high-quality health care services, including family planning and sexual health, in addition to supporting the aforementioned direct sources of funds for family planning and related services. Millions of Americans rely on publicly funded health care programs, including publicly funding family planning, to make the best decisions for themselves and their families and to lead their best possible lives.

Thank you for considering these requests.

Sincerely,

Clare Coleman
President & CEO

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[i] Clare Coleman and Kirtly Jones, "Title X: a proud past, an uncertain future," *Contraception* 84 (2011): 209-211. http://www.arhp.org/UploadDocs/journaleditorialsept2011.pdf

[ii] Christina Fowler et al, "Family Planning Annual Report: 2015 National Summary," RTI International (August 2016). https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2015.pdf.

[iii] Ibid.

[iv] Ibid.

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

[vi] Adam Sonfield, Kinsey Hasstedt, and Rachel Gold, "Moving Forward: Family Planning in the Era of Health Reform," Guttmacher Institute (March 2014). https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

[vii] Ibid.

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

[ix] Loretta Gavin, et al, "Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, 2014," *Morbidity and Mortality Weekly Report* 63 (April 2014): 1**-29.** https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm**.**

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

[xi] Christina Fowler et al, "Family Planning Annual Report: 2010 National Summary," RTI International (September 2011). https://www.hhs.gov/opa/sites/default/files/fpar-2010-national-summary.pdf.

[xii] Fowler et al, "Family Planning Annual Report: 2015 National Summary."

[xiii] Fowler et al, "Family Planning Annual Report: 2010 National Summary."
[xiv] Fowler et al, "Family Planning Annual Report: 2015 National Summary."
[xv] Jennifer Frost et al, "Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program," *The Milbank Quarterly* (December 2014): 696-749. DOI: 10.1111/1468-0009.12080.
[xvi] Robin Rudowitz, Samantha Artiga, and Katherine Young, "What Coverage and Financing is at Risk Under a Repeal of the ACA Medicaid Expansion?" The Kaiser Commission on Medicaid and the Uninsured (December 6, 2016), http://kff.org/medicaid/issue-brief/what-coverage-and-financing-at-risk-under-repeal-of-aca-medicaid-expansion/.
[xvii] Temporary Assistance for Needy Families Program: Ninth Report to Congress. U.S. Department of Health and Human Services. (2012). https://www.acf.hhs.gov/sites/default/files/ofa/9th_report_to_congress_3_26_12.pdf.
[xviii] Ibid.
[xix] Marianne Bitler and Janet Currie, "Does WIC Work? The Effects of WIC on Pregnancy and Birth Outcomes," *Journal of Policy Analysis and Management* (Winter 2005): 73-91. DOI 10.1002/pam.20070.