HHS Public Access

Author manuscript

Perspect Sex Reprod Health. Author manuscript; available in PMC 2016 June 01.

Published in final edited form as:

Perspect Sex Reprod Health. 2015 June ; 47(2): 63–70. doi:10.1363/47e2815.

Women's Experiences Seeking Publicly Funded Family Planning Services in Texas

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Abstract

CONTEXT—Little is known about low-income women's and teenagers' experiences accessing publicly funded family planning services, particularly after policy changes are made that affect the cost of and access to such services.

METHODS—Eleven focus groups were conducted with 92 adult women and 15 teenagers in nine Texas metropolitan areas in July–October 2012, a year after legislation that reduced access to subsidized family planning was enacted. Participants were recruited through organizations that serve low-income populations. At least two researchers independently coded the transcripts of the discussions and identified main themes.

RESULTS—Although most women were not aware of the legislative changes, they reported that in the past year, they had had to pay more for previously free or low-cost services, use less effective contraceptive methods or forgo care. They also indicated that accessing affordable family planning services had long been difficult, that applying and qualifying for programs was a challenge and that obtaining family planning care was harder than obtaining pregnancy-related care. As a result of an inadequate reproductive health safety net, women experienced unplanned pregnancies and were unable to access screening services and follow-up care. Teenagers experienced an additional barrier, the need to obtain parental consent. Some women preferred to receive family planning services from specialized providers, while others preferred more comprehensive care.

CONCLUSION—Women in Texas have long faced challenges in obtaining subsidized family planning services. Legislation that reduced access to family planning services for low-income women and teenagers appears to have added to those challenges.

Publicly funded family planning programs in the United States provide poor and low-income women essential access to subsidized contraceptives and other preventive reproductive health services, such as screening for cervical cancer and STDs. Federal guidelines recommend that these programs provide a broad range of contraceptive methods and that women receive evidence-based information to help them choose the most

appropriate method for their reproductive goals.[1] In 2010, contraceptive services provided to women through publicly funded programs averted an estimated 2.2 million unintended pregnancies, resulting in $10.5 billion in Medicaid savings.[2] Studies demonstrate that women highly value and are satisfied with the services they receive from publicly funded providers.[3,4]

But publicly funded programs do not reach all poor and low-income women in need of subsidized family planning,[2] and access to these programs has become more restricted in many states. Indeed, some states have significantly reduced public funding for family planning, or have passed legislation to exclude Planned Parenthood and other specialized family planning providers from receiving public funds to provide contraceptive and other reproductive health services.[5] Many of these states also have not expanded Medicaid under the Affordable Care Act. Women who live in states that do not expand Medicaid, or who are excluded from the Affordable Care Act (such as many immigrants), will continue to rely on a patchwork of programs for their reproductive health care. Moreover, while evidence from Massachusetts has shown that disadvantaged women frequently have difficulty maintaining coverage and getting timely services even when services have been expanded,[6] little is known about women's experiences obtaining family planning services from publicly funded programs after significant policy changes have restricted access to those programs.

In this article, we report findings from focus groups that examined low-income women's and teenagers' experiences obtaining publicly funded services in Texas after significant changes were made to the funding and administration of the state family planning programs. This study is part of the Texas Policy Evaluation Project, a five-year evaluation documenting the impact of reproductive health legislation implemented by the 2011 and 2013 Texas legislatures on family planning services,[7,8] the provision of abortion,[9,10] and women's contraceptive use and preferences.[11]

BACKGROUND

In 2010, approximately 1.7 million of the 5.3 million reproductive-age women in Texas did not want to become pregnant and were eligible for publicly funded family planning services (i.e., they were adult women with incomes less than 250% of the federal poverty level or were sexually experienced teenagers of any income).[2,12] Of these 1.7 million women, only 26% received services from publicly funded clinics.[2] In 2010, such clinics were supported by funding from the Title X program and from Titles V and XX federal block grants; specialized family planning providers served 41% of the 218,000 women served by this funding.[8] Additionally, Texas operated a Medicaid family planning waiver program, the Women's Health Program (WHP), which provided fee-for-service reimbursements for contraceptive services, well-woman exams and STD testing for nonsterilized legal U.S. resident women aged 18–44 with incomes up to 185% of the federal poverty level. Nearly half of the 119,000 women served by the WHP in 2010 received services from Planned Parenthood clinics.[8] Other federal and local programs that funded or directly provided family planning services for some low-income women in Texas (and that continue to do so today) include full-benefit Medicaid, which in 2010 covered parents who had dependent children and who earned up to 12% of the federal poverty level; county indigent care

programs, which provided discounted services to low-income county residents; and a very limited number of local health clinics funded through private foundations. Medicaid also paid (and continues to pay) for family planning services for 60 days postpartum for eligible women (legal U.S. residents whose income does not exceed 185% of the federal poverty level).

In 2011, the Texas legislature cut the 2012–2013 family planning budget from $111 million to $38 million. In addition, it created a priority system in which public organizations that provide family planning services (e.g., health departments) and federally qualified health centers receive the highest priority for funding, followed by organizations that provide comprehensive primary care (including family planning); specialized family planning providers, such as Planned Parenthood, receive the lowest priority for funding. As a result of the budget cuts and priority system, 77% of specialized providers lost funding in the period immediately following the changes (January 2012–March 2013), compared with 33% of primary care providers.[8]

The legislature also required enforcement of the "abortion affiliate ban" on participation in the WHP. This rule, which had been enacted in 2007 but was not being enforced, was meant to exclude providers who had any affiliation with an abortion provider from participating in the WHP, even if they did not perform abortions; the legislature's intention was to exclude Planned Parenthood clinics from receiving state family planning funds. The WHP was discontinued on December 31, 2012, when the federal government denied the state's request to renew the program on the grounds that it excluded qualified family planning providers. On January 1, 2013, Texas replaced the WHP, which had received 90% of its funding from the federal government, with the fully state-funded Texas Women's Health Program (TWHP). Like its predecessor, the TWHP provides contraceptive services, well-woman exams and STD testing for nonsterilized legal U.S. resident women aged 18–44 whose income does not exceed 185% of the federal poverty level. Unlike the WHP, the TWHP also covers STD treatment.

In 2013, the legislature allocated additional funds to family planning programs, but kept the priority funding system in place. In addition to reauthorizing the TWHP, the legislature established the Expanded Primary Health Care program, which provides family planning services (as well as primary care services for conditions, such as diabetes, that are diagnosed during the family planning visit) to Texas women aged 18 or older with incomes up to 200% of the federal poverty level.

METHODS

Study Design and Setting

We conducted focus groups with adult and teenage women between July and October 2012 in nine metropolitan areas of Texas. To capture attitudes toward and experiences with family planning services in the selected communities, we used focus groups as our data collection method, because this approach allows participants to interact and reveals commonalities and differences in experiences within and among communities. The groups were conducted approximately one year after the 2011 family planning budget cuts and the priority funding

system went into effect, but before the transition to the state-funded TWHP and the creation of the Expanded Primary Health Care program.

We developed a semistructured interview guide to assess participants' perceptions of reproductive health services in their communities, of any changes they may have experienced in the last year and of their views on how to improve family planning services in Texas. To determine whether women's experiences with family planning services changed following (and possibly as a result of) the 2011 legislation, we asked focus group participants to think specifically about the "last year" when answering the following questions: Has anyone heard that women need to pay for a family planning visit that they had not had to pay for before? How do women feel about being asked to pay for these services? Do staff explain why they are charging more than they used to? What happens if someone is not able to pay? Are any types of birth control methods harder to get now than they were a year ago?

To maximize the geographic diversity of the sample, we conducted at least one group in each of the health service regions designated by the Texas Department of State Health Services. We included three cities (Austin, Lubbock and San Angelo) whose populations have a racial and ethnic profile similar to that of Texas as a whole (44% white, 38% Hispanic, 12% black and 6% other); three cities (El Paso, McAllen and San Antonio) in which very high proportions of residents are Hispanic (81%, 85% and 63%, respectively); and three cities or metropolitan areas (Dallas/Fort Worth, Houston and Tyler) in which high proportions of residents are black (23%, 23% and 25%, respectively).[12] We conducted a total of 11 focus groups, nine with adults (six in English, three in Spanish) and two with teenagers (both in English).

Eligibility and Recruitment

Women were eligible for the study if they were aged 18–44 (adult groups) or 15–17 (teenage groups); had public or no health insurance; and were sexually active, not pregnant and not planning to get pregnant in the next year. Those whose primary language was Spanish were included in a Spanish-language group. Participants were recruited by community-based organizations, such as community centers and child development centers, that offered non–health-care-related services to low-income populations. We sought organizations that worked with Spanish-speaking, Hispanic or black communities, because women of color are disproportionately represented among those using publicly funded family planning services.[13,14] Participating organizations were supplied with a recruitment script and asked to recruit 12 women, if possible, for each group; they received a flat fee for recruiting participants and hosting (providing a room for) the discussions.

Eligible adults provided verbal consent to participate. Minors provided assent and obtained parental consent. Most participants received $50 for taking part in the study; those in the El Paso and McAllen groups received a higher amount ($75) to defray additional transportation costs, because the groups were held outside the city center. Child care was provided for those who requested it. The study received approval from the institutional review boards at the University of Texas at Austin and the University of Alabama at Birmingham.

The English-language focus groups were led by the first two study authors, who are white, native English speakers. The Spanish-language groups were led by the fourth author, a native Spanish speaker who is Hispanic. An assistant attended all groups and took notes to help identify speakers for transcriptions. Discussions were recorded and subsequently transcribed in the original language, with each speaker noted by initials.

At the end of each discussion, participants filled out an anonymous survey that collected information about their age, race and ethnicity, parity (adults) or parenthood status (teenagers), education level, marital status, country of birth and current method of contraception. On average, the discussions lasted 60 minutes (range, 41–80) and included 10 participants (range, 3–12).

Analysis

From successive readings of the focus group transcripts, we used content analysis to produce a progressively more refined coding scheme. Using a preliminary coding scheme, the first three authors independently coded two English-language transcripts and then met to come to agreement on how to code each segment of text, add to or modify the coding scheme, and create a descriptive summary of the code. Thereafter, they worked in pairs to independently code the remaining English-language transcripts and reach a consensus on the coding. The first two authors, who are fluent in Spanish, worked in consultation with the native Spanish-speaking author to code the three Spanish-language transcripts. Below, we summarize the main themes that emerged from the discussions and present representative quotations; all Spanish quotations have been translated into English.

RESULTS

Overview

Overall, 92 adults and 15 teenagers participated in the focus groups. Sixty-three percent were Hispanic, 29% were black and 7% were white; one participant (1%) identified as multiracial (black, Native American and white). The focus groups were largely homogenous with respect to race and ethnicity. On average, participants in the adult groups were 31 years old, had 12 years of education (10 for Hispanics, 14 for blacks and 14 for whites) and had 2.3 children (range, 0–8). Two-thirds of the Hispanic adults were born in Mexico; the rest, and all of the black and white adults, were born in the United States. On average, teenage participants were 16 years old and had 10 years of education; Hispanics and whites had similar levels of education (no black teenagers participated). All of the teenagers were born in the United States; two-thirds were mothers.

A recurrent theme that emerged from our analysis was that participants experienced difficulties accessing affordable family planning care after the 2011 legislative changes. We also identified three themes that reflected the challenges that women and teenagers had experienced in obtaining care throughout their reproductive lives. Specifically, respondents indicated that government-supported family planning services had been difficult to obtain even before 2011; that the reproductive health safety net has substantial gaps; and that the need for parental consent was a barrier to teenagers' obtaining care. A final theme indicates

that while some women wished to receive family planning services as part of comprehensive primary care, others preferred specialized providers.

Service Access After Legislative Changes

The vast majority of women were unaware of the 2011 legislation, and none appeared to realize that the funding that supported subsidized clinic services had been reduced. However, they had noticed that they were being asked to pay for an increased proportion of the cost of their care, and they commented on the challenges of obtaining services through programs that provided coverage, like the WHP. Many women noted that in the past year (i.e., after the legislative changes had gone into effect), clinics had required payment for services that previously had been free. For instance, a black woman in Dallas recounted: "Now they're charging for everything.… Birth control pills used to be free. They gave you refills without a problem. You got a two- or three-months' supply." Likewise, a Hispanic woman in Tyler noted that family planning services "used to be free if you qualify for the program, but it's not free anymore." A black woman in Houston reported that a facility that "used to be a free clinic" had begun charging $50 for a well-woman exam.

Several women described feeling "shock" (black woman, Tyler), or being "pissed off" (black woman, Houston) or "distressed" (Spanish-speaking Hispanic woman, El Paso), as a result of these new or increased fees. Some stated that because of the new charges, they had had to choose between paying for contraceptives and meeting more immediate needs. For example, when asked about being able to pay $50–70 for a visit, one Hispanic woman in Houston answered, "That's hard when you're a single parent and have kids. That's expensive." Another added, "With the $50, we pay [for] gas, we buy the Pampers." The following exchange, which occurred among black women in Dallas, exemplifies the experiences of women in several groups:

> **Moderator:** So if you don't have Medicaid, you don't have insurance, and you go to one of these places to get birth control, how much do they charge you for a month of pills?
>
> **Participant 1:** You don't even go.
>
> **Participant 2:** That's the ugly truth, you don't even go. If you do go, more than likely there is not a payment plan method that you can pay. They want all their money at the end of that visit or—
>
> **Participant 3:** —or they can't see you.

Some women recounted that they would not be able to continue using the highly effective methods that they wanted to use because they no longer qualified for subsidized services or because other methods were more affordable as a result of the new fees. For instance, a Hispanic woman in Houston noted that "I have the [implant], and so I can go back in two years, and they can remove it, but that's it.… They're not going to give me another three years." A Hispanic woman in Tyler said she was told that she did not qualify for the implant (her preferred method) and that it would cost her "over a thousand dollars." Instead, she said she would continue to use vaginal contraceptive film, which costs a little more than $1 per film, "because I can afford that right now."

Difficulties Obtaining Subsidized Services

Women in all groups described long-term struggles (unrelated to the 2011 legislative changes) in obtaining affordable reproductive health services. Moreover, women in only four of the nine adult groups mentioned knowing about the WHP before being prompted (minors were not eligible for the program); even after prompting, women in several groups said that they had never heard of it. Additionally, women in all groups noted that qualifying for family planning programs could be very difficult. Many were frustrated by the income-eligibility criteria. For instance, a white woman in Lubbock said, “You can work and literally bring home $50 a week, and they’re going to say you make too much money.” Likewise, a black woman in Tyler said she had qualified for the WHP, but had later been notified by the Medicaid office that she was “like five or six dollars over the limit.” Others who knew about the program mentioned being unable to enroll and use services, as a black woman in Houston with a two-year-old child explained: “I’ve been applying since my baby was born, and nobody can tell me why they keep denying me. They just keep saying I’m not qualified.” Some Mexican-born participants noted that the WHP was not available to them because they did not fulfill the citizenship or legal residency requirements. For instance, a Hispanic participant in Fort Worth said that “without a social security number, you can’t do anything. You can’t qualify for anything.”

Some women pointed out that it was difficult to apply or meet eligibility criteria for county-funded discount programs and full-benefit Medicaid. For instance, the Gold Card program of the Harris County Hospital District, which serves Houston, provided services to low-income residents who qualified, but some women pointed out that the application process was very time-consuming and, in the words of one black woman, “demoralizing.” She continued, “You shouldn’t have to be waiting all day long from 6 A.M. until 5 … to get a little card for some help.” These safety-net programs also typically cover only county residents, even if a neighboring county does not have a program for its residents; as a black woman in Tyler said, “you can’t be from any other communities or anything.” Finally, even for those who eventually qualified for full-benefit Medicaid (such as most teenage participants, who were eligible because they were mothers), the application for benefits could be a challenge to complete; a white teenager in San Angelo described her difficult experience filling out “lots of paperwork. I didn’t know what half the stuff was, and I had to do it by myself.”

Many women pointed out that it was easier to obtain publicly funded pregnancy-related services than contraceptive and reproductive health services, and voiced dismay that they were not better supported in their efforts to prevent pregnancy and provide for their children. For instance, a Hispanic woman in Lubbock expressed frustration that “all of our programs are set [so that] if I just go and get pregnant, then all of my kids would qualify for the Medicaid. I’d get more food stamps. You are really rewarded for being pregnant and not having jobs.” A black woman in Houston detailed the large number of easily accessible services available during pregnancy and noted that few were available after the pregnancy ended: “When you’re pregnant, the Department of Health and Human Services gives you Medicaid.… You can go to the doctor. You don’t have to pay anything. If you’re pregnant, you can go to WIC [the Special Supplemental Nutrition Program for Women, Infants and

Children].… You get food stamps.... When you're not pregnant, you can still get help with food stamps, but you don't get medical assistance."

Gaps in the Safety Net

Women commented that publicly funded programs did not necessarily offer meaningful coverage or allow for continuity of care. For instance, the hospital district that covers residents of Travis County (Austin area) offers a discount card to individuals who meet the income requirements, but our focus group participants reported that the federally qualified health centers that served the area had limited appointments available for women using the card. Similarly, some women in Lubbock described a hospital-based program that pays for doctors' visits for persons who qualify, but does not pay for prescriptions; as one black woman noted, the program "only covers you for whenever the doctor sees you and whatever he does," but "I would still have to pay for [any] medicine." Likewise, a black woman in Dallas noted that while qualifying women could receive free well-woman exams through the WHP, the program did not cover prescriptions for treating STDs: "You might go in there and get your services for free, but if … they tell you that you have chlamydia, then what about the medicine? That can be $50–60."

Many women described negative consequences of the lack of continuity of care. Several mentioned that gaps in coverage following the expiration of pregnancy-related Medicaid resulted in a rapid repeat pregnancy. For example, a Hispanic woman in Lubbock recounted: "I have six kids. After the one I had last year, I had actually missed my six-week checkup, and when I called to reschedule, my Medicaid had lapsed and my doctor wouldn't see me. When I was able to figure out everything to finally do it again, I was already pregnant again. That caused an avalanche of so many troubles." Others, such as a Hispanic woman in Houston, noted that some women become pregnant while trying to find affordable services: "When I was pregnant and I was on Medicaid, they gave me [oral contraceptives] after I had my baby, but they only gave … like six months [of pills], and Medicaid ends three months after you have your kid. So, I didn't have money to go back, and that's when I got pregnant with my second child." A black woman in Houston emphatically agreed: "The point is, if [women] can't get to the [postpartum] visit, then they're going to get pregnant. There ain't no doubt about it. Everybody agree? You're going to get pregnant within a year or six months."

The lack of continuity of care also impacted a few young women who had aged out of programs for young adults. A black woman in Houston said: "When I turned 18, [clinic staff] said … that I couldn't get the services anymore. After my birth control wore off, then I got pregnant." After this young woman learned from another participant in the group that she should have been able to continue to get services at that clinic until age 23, she exclaimed, "That's crazy.… I probably wouldn't have [gotten pregnant with] my son if I would have known that."

In addition, many women noted the challenges they faced accessing preventive screening services, because program rules either excluded certain women or required them to seek care from a different provider and pay for services out of pocket. For example, some reported that they were unable to get Pap smears or other reproductive health services after becoming

sterilized, since the WHP was only for women at risk for pregnancy. One such participant was a Spanish-speaking Hispanic woman in Austin, who discovered that sterilized women like her did not qualify for services: “Now there’s no Pap test, no mammogram, nothing.” A few women pointed out that follow-up care for abnormal Pap smears also was often difficult to obtain. For instance, a Hispanic woman in Fort Worth said she was unable to have regular colposcopies to monitor cervical dysplasia, because the cost of follow-up care was prohibitive: “They wanted $100 and something [at the time of service], and then the bill [the clinic sent after the colposcopy] was [for] more than $500.” Because of the high costs, she had not had the recommended six-month follow-up visit.

Moreover, as one black woman from Houston aptly noted, “It’s not just the bottom half, it’s the top half too”: That is, mammograms and follow-up breast cancer screening were also priced out of many women’s reach. Another black woman in Houston said that she made too much money to “qualify for the free [mammograms]. There are organizations that will do a free one, but you have to be unemployed.” Similarly, a Spanish-speaking Hispanic woman in El Paso said that she had “a little problem” with one of her breasts: “I called different clinics, and $175 was the least I’d be charged. But that was only for the consultation, and wouldn’t cover any follow-up care.”

Obtaining Parental Consent

In Texas, females younger than 18 must obtain parental consent for family planning services unless they are at least 16 years old, living apart from their parents and managing their own financial affairs;[15] they are the custodial parent of a child for whom they can give medical consent;[15] or they know of and have access to a Title X–funded clinic (which, by federal law, must provide confidential services). Indeed, participants in both teenage groups saw the need to obtain parental consent as an additional challenge to accessing family planning services. As evidenced by this exchange in the San Angelo group, teenagers considered the need for parental consent a barrier to obtaining family planning services because it required them to reveal to their parents that they were, or were contemplating becoming, sexually active:

> **Moderator:** What is it about [the need for] parental consent that makes it hard [to get contraceptives]?
>
> **Participant 1:** Having to tell your parents that you have sex.
>
> **Participant 2:** And some parents don’t like birth control.
>
> **Participant 3:** If parents are really religious, then they’re like, “You shouldn’t do that, blah, blah, blah.” My grandma is super religious, and she’s like, “That’s a sin to take it,” and stuff like that.
>
> **Participant 4:** It’s a sin to take birth control?
>
> **Participant 5:** [Yeah], ’cause it’s ruining chastity and it’s God’s plan or whatever.

In describing her sister’s difficulty obtaining parental consent, a Hispanic teenager in San Angelo said that her sister was “scared to tell [our] mom that she’s having sex.” For some young women, this avoidance stemmed from fear of reprisals from parents who were “super,

super strict" (Hispanic teenager, San Angelo) and who they feared would strongly disapprove of their being sexually active. A white teenager in San Angelo also mentioned that teenagers were scared of disappointing their parents, because "I guess we all know that we shouldn't be having sex."

Though in the minority, some teenagers noted that at least one of their parents was supportive of their using contraceptives. For instance, a Hispanic teenager in San Antonio said that while her father opposed her getting injectable contraceptives because he believed that it was "a free pass to go have sex," her mother "didn't see it that way, because my sister, she's like 19. She has three [kids] already. So my mom was really happy that I brought [up the topic of contraception]. She was all for it." Likewise, a San Angelo teenage mother said that her friends "either have Medicaid or they get [birth control] at clinics. Their parents are like, 'You're not having a baby.'"

Ideas for Improving Services

In every group, women provided several ideas about how to improve the delivery of family planning and reproductive health services for low-income women in Texas. Provision of comprehensive services for the whole family appealed to several participants, including a white Lubbock woman who wanted to "do everything all in one place" and a black woman in Houston who thought that "they need to create something where the family can go as a whole." On the other hand, some women liked the idea of a specialized clinic that focused on women's reproductive health; for example, a black woman in Houston said, "I think overall it would be nice if … there were specific clinics—even if it was a city or county clinic—that catered to just women,… especially if we're not pregnant." This idea was echoed by a Spanish-speaking Hispanic woman in El Paso, who suggested the establishment of clinics that "specialized only in birth control methods, and also Pap smears and mammograms … just that, not for everything." Finally, to improve access to health services, many women said they would like to see the eligibility requirements for coverage expanded to make it easier for working women to qualify for support, and to have more clinics in more places. Teenagers in both groups said they would like to see the parental consent requirement lifted.

DISCUSSION

We anticipated that the family planning budget cuts and redistribution of remaining funds would disrupt the provision of reproductive health services for low-income women in Texas. In these 11 focus groups, held about a year after the changes went into effect, women reported that they were being charged higher fees than in the past, had less access to the highly effective contraceptive methods that they wanted to be using and were sometimes forgoing care altogether. These experiences correspond to our findings from interviews we conducted with executive directors and program administrators at family planning organizations across the state after the legislative changes.[8] Women also told us that they faced challenges in obtaining services throughout their reproductive lives. The recurring theme of long-standing gaps in the reproductive health safety net available to low-income women and teenagers is perhaps not surprising, given that only about a quarter of women

who wanted to avoid a pregnancy and were eligible for subsidized family planning services had received care at publicly funded clinics in the year before the legislative changes were enacted.[2] Nonetheless, the experiences of our study participants highlight the need for a robust network of subsidized family planning providers and suggest several policy actions that could improve reproductive health services in Texas.[5,16]

Women in all groups commented that it was easier to get pregnancy-related care than to get services to prevent pregnancy, and several had experienced gaps in coverage when pregnancy-related care ended. These gaps were likely due to several factors, which points to the need for multiple approaches to improve continuity of care. In the short term, such continuity could be accomplished by automatically enrolling women in the TWHP after their pregnancy-related Medicaid expires; this would ensure that they have access to contraceptives beyond 60 days postpartum,[17] and would help them prevent the unintended pregnancies and short birth intervals that are associated with adverse maternal and neonatal outcomes.[18] For this automatic rollover to be successful, women would need to be informed that they would continue to have coverage and, since their obstetrician might not take part in the program, be given a list of participating providers. To further enhance continuity of care, the Texas Health and Human Services Commission could encourage providers who accept pregnancy-related Medicaid to participate in the TWHP.

Given that a substantial proportion of Texas politicians have stated their opposition to Medicaid expansion,[19] a more feasible long-term strategy to expand family planning access and reduce the fragmentation of care in Texas would be to enact the recommendations of the Sunset Advisory Commission,[20] a group that makes recommendations to the Texas legislature about the effectiveness of the state's agencies and programs. In its October 2014 review, the commission reported that the current system of multiple state-funded women's health programs has resulted in a patchwork of services with excessive administrative costs. The commission proposed that the women's health and family planning programs be consolidated into a single program that would start in 2017. The proposed program would cover Texas resident women aged 15–44 who are not sterilized, are seeking family planning services and have incomes less than 185% of the federal poverty level. In addition to covering well-woman exams and all family planning methods (except emergency contraceptives), it would cover mammograms and follow-up care for cervical dysplasia. Like the current Expanded Primary Health Care program, the proposed consolidated program would provide additional primary care services for conditions diagnosed during family planning visits. If these recommendations were codified and funded appropriately, many of the problems identified by women in the focus groups would be alleviated. Eligible undocumented women would have full access to program benefits, and all eligible women would benefit from the greater number of covered services and better continuity of care. On the other hand, these recommendations would not remove the parental consent requirement, and sterilized women would continue to lack coverage for preventive and follow-up care. At the programmatic level, it is unclear how specialized family planning providers would fare under such a program.

Whatever efforts are undertaken, policymakers should ensure that women have access to a range of qualified providers. Similar to previous work,[5] we found that many focus group

participants preferred to receive care at specialized family planning clinics. Despite the federal government's recognition of Planned Parenthood as a qualified provider, the trend in Texas clearly has been to prioritize primary care providers. Our previous research,[8] as well as work by others,[21–23] has indicated that highly effective methods, such as the IUD and implant, are not as widely available at federally qualified health centers and other primary care providers as they are at specialized family planning clinics. The Texas legislature could reconcile the competing goals of expanding women's access to primary care and providing access to specialized family planning providers by making providers' receipt of state funding conditional on the on-site provision of a range of reversible contraceptive methods, including long-acting ones.

Finally, in our focus groups with teenagers, we found that the state requirement for parental consent for contraceptive services was an obstacle to care. One reason is that teenagers were uncomfortable with their parents' knowing they were sexually active, a finding supported by studies documenting that a majority of teenagers believe their parents disapprove of their having sex.[24] Texas is virtually alone in the United States in requiring parental consent for family planning services outside of Medicaid and Title X–funded clinics. Removing this requirement may help further reduce the high rates of teenage pregnancy in the state, as parental consent or notification laws are associated with increased birthrates[25] and reduced use of family planning services[26] and contraceptives[27,28] among teenagers. Without such a change, teenagers' access to confidential services is likely to remain limited, as the number of Title X–funded clinics in the state declined following the legislative changes.[8]

Strengths and Limitations

Our study has several strengths and limitations. Our sample was geographically diverse, but consisted of urban residents; women in rural areas may have even more limited access to family planning services. Hispanic and black women were well represented, but we did not have many white participants, who make up approximately 19% of women obtaining services from Title X–funded clinics in the state.[29] Moreover, the range of responses from participants could have been restricted because of social desirability bias. Nevertheless, our findings were remarkably consistent in focus groups held across the state, suggesting that we have captured the experiences of many urban, low-income women and teenagers (particularly those of color) who seek affordable family planning and other reproductive health services in Texas.

Another important limitation of this study is that we conducted focus groups only after the 2011 legislation was implemented; thus, we do not have a comparison group documenting women's experiences before the changes took effect. Although we asked women to discuss their experiences obtaining affordable family planning care "in the last year" (i.e., after the changes), they sometimes described earlier experiences. Additionally, our study captured women's perspectives on accessing care in a policy environment that has since changed. Two major changes that took place after we conducted the research were the exclusion of Planned Parenthood from the TWHP and the creation of the Expanded Primary Health Care program. It is unclear how these policies have affected women's access to services; we intend to examine these issues in future studies.

Conclusion

Women and teenagers in Texas have long experienced challenges in obtaining subsidized family planning services. These challenges appear to have been exacerbated by the 2011 budgetary and administrative changes. Undocumented women, teenagers who needed to obtain parental consent and sterilized women were all particularly vulnerable in the aftermath of these changes. Any policy changes whose goal is to reduce the fragmentation of services and improve continuity of care should take into consideration these women's and teenagers' experiences with barriers to care and preferences about care providers.

Acknowledgments

This project was supported by a grant from an anonymous foundation and by National Institute of Child Health and Human Development grant 5R24HD042849.

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