Title X, the Domestic Gag Rule and the HIV Response

This issue brief provides the history of the program, what it offers and projections about HIV service disruptions.

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On August 19, 2019, Planned Parenthood announced it was pulling out of Title X as a result of a new Trump administration rule prohibiting clinics from referring women for abortions. In anticipation of this outcome, amfAR, The Foundation for AIDS Research, published the following issue brief in February 2019 to understand the potential consequences.

Title X: The National Family Planning Program

The Title X National Family Planning Program is the only federal grant program dedicated to providing individuals with comprehensive family planning and related health services. Created in 1970, Title X offers care to low-income or uninsured individuals through the provision of grants to public health departments, community health organizations, and other nonprofit agencies. By providing women, their partners, and their families with a range of birth control methods, cancer screening, and other reproductive health services, Title X funding reduces unintended pregnancies, allows the early diagnosis of potentially deadly cancers including breast and cervical cancers, and promotes healthy child development.

On June 1, 2018, the Trump Administration proposed a rule change to Title X stating that health care providers in the program may not “perform, promote, refer for, or support, abortion.” On February 22, 2019, The Department of Health and Human Services posted a draft of the final rule, which would take effect 60 days to a year after its publication in the Federal Register—which is pending. Using Title X funds for abortion has been prohibited since the inception of the program. As such, the Administration’s rule (the so-called ‘domestic gag rule’) does not regulate the provision of abortion services, but rather limits the ability of health care providers to deliver information on the full scope of legally available medical services and dictates the types of care that organizations may provide using their own financial resources.

Increasing access to sexual and reproductive health (SRH) information is known to result in increased use of contraceptives, which leads to fewer unintended pregnancies. This is especially important in the United States, which continues to have higher numbers of unintended pregnancies than most other high-income countries, and where nearly half of all pregnancies are

unintended. Since unintended pregnancies are associated with greater health risks for the mother and child, reducing unintended pregnancies is a national priority.

Policies that restrict or enable the provision of information about contraceptives, or impede access to them, can impact pregnancy rates. In one case, Delaware piloted a two-year program that provided quality improvement and technical assistance to Title X programs in order to ensure access to reliable contraceptive methods for all women. An evaluation of the program found that unplanned pregnancies among Title X clients fell by 15%. In another case, when Texas excluded Planned Parenthood from its Medicaid program in 2013, the number of insurance claims for women receiving long-acting, reversible contraceptives declined by 35.5% and the proportion of childbirths reimbursed by Medicaid increased by 27.1%.

Title X and HIV

Title X grantees are also an important national provider of HIV-related care, with all grantees required to provide, at a minimum, HIV prevention, counseling, testing, and referral for treatment when appropriate. Changes to Title X can therefore impact communities' abilities to prevent and treat HIV. In 2013, state budget cuts to family planning programs led to the closure of a Planned Parenthood health center in Austin, Indiana, which served as the only site providing free HIV testing in Scott County. One year later, the same county experienced a devastating HIV outbreak among people injecting opioid drugs, totaling more than 200 new HIV infections, with over 90% co-infected with hepatitis C—this, in a county that normally sees less than five new HIV cases a year. Better access to affordable and nearby HIV testing services could have prevented delays in identifying the outbreak and enabled a faster public health response.

The HIV epidemic in the United States is marked by extreme inequality. While overall prevalence is low (approximately 0.3%), significant variations exist in both incidence and outcomes. Gay and bisexual men account for 67% of all new HIV diagnoses, with half of all black and Latino men who have sex with men projected to have a diagnosis of HIV in their lifetimes. Women of color are disproportionately impacted, with 61% and 16% of new diagnoses among women occurring among African American and Hispanic women, respectively. Significant regional disparities exist, with 44% of all people living with HIV living in the Southern states. Consequently, the success of the U.S. HIV response relies on the ability to reach these groups.

At the end of 2015, there were an estimated 1.1 million people in the U.S. living with HIV, 15% of whom were unaware of their status. Delivering HIV testing services to the populations at highest risk requires that people have access to health care options that are affordable, accessible, and appropriate to their needs. Publicly funded family planning providers, including those supported by Title X, are often a primary source of affordable health care. Indeed, more than 60% of women obtaining care at a publicly funded family planning center reported it as their usual source of health care. A 2012 analysis found that 14% of all women and 20% of women below the federal poverty level who received an HIV test did so at a Title X-supported clinic.

Many Title X-supported facilities are also known to be trusted providers of HIV services. For

example, Planned Parenthood health centers deliver a comprehensive program of HIV prevention including PrEP—the once daily medication used to reduce the risk of acquiring HIV—and give referrals to treatment for those newly diagnosed with HIV. Known to clients as a “non-judgmental” and inclusive provider, Planned Parenthood affiliates are also important and trusted providers of health care services for populations at highest risk of acquiring HIV, including sexually active adolescents and young adults, Black and Latina women, and transgender people, who are three times more likely to be diagnosed with HIV than the national average.

For transgender individuals, 31% of whom report no regular ac-cess to health care, Planned Parenthood is an important source of care. It offers gender-affirming hormone therapy in 82 of its health centers and a range of preventive care to people of all gender identities, including an expanded focus on providing HIV testing and other services to transgender patients. Further-more, by providing services for Medicaid enrollees and those without health insurance, Planned Parenthood is also an afford-able option for gay and bisexual adults, who are more likely to be underinsured or uninsured.

Impacts of a domestic gag on Title X grantees

The Administration’s rule could impact access to services in several ways. First, by limiting providers’ ability to communicate with clients, people receiving care in Title X-supported facilities may not receive complete and medically accurate counseling and referrals that meet their needs. As we have learned from the Mexico City Policy—the ‘global gag rule’—this policy is likely to result in unforeseen impacts beyond the effects of its strict requirements, due to misinformation, lack of clarity about the provisions of the rule, and over-implementation to err on the side of compliance, in what is known as the ‘chilling effect.’

Facilities that do not comply with the provisions of the policy would be unable to receive Title X grants. Planned Parenthood, for example, has made clear that due to its organizational commitment to ensure patients have full information about their medical options, the “gag rule” would force its health centers to withdraw from Title X. Planned Parenthood is the largest private provider of reproductive health services in the U.S., serving 41 percent of patients who rely on Title X for contraception nationwide (1.6 million). As a result, the enactment of the rule would result in the termination of federal contracts with one of the most extensive and effective sexual and reproductive health providers in the nation.

As outlined in a 2015 Congressional Budget Office (CBO) analysis, ending federal contracts with Planned Parenthood health centers could lead to several adverse outcomes.

As a consequence of losing Title X, it is likely that many of these health centers would be required to reduce their client load, resulting in clients either being displaced to other clinics or falling out of care. Disrupting stable connections to health care is not just a logistical challenge, but also threatens clients’ continued use of services, especially for women living below the poverty level who are already less likely to report a usual source of care. Having a usual source of health care increases utilization of preventive health services and results in better health outcomes. The loss

of this source of funding may also result in a reduction of services, including the provision of contraceptives, cancer screenings, and preconception care.

In the most extreme case, some Planned Parenthood health centers may close entirely, with all of their patient population displaced to surrounding facilities—if they exist. This is not unlikely: an assessment of historical examples of states ending their contracts with Planned Parenthood reveals that at least some health centers are likely to close. The closure of health centers would impact not just those receiving family planning services, but also the entire client population receiving care at these sites, including Medicaid recipients and those without insurance.

Finally, because Planned Parenthood affiliates vary in their level of participation in Title X, the near-term financial impact of losing Title X in some communities may be more limited. In all likelihood, however, facilities would not be able to sustain these budget cuts over multiple years. Additionally, the CBO estimates that in some cases the loss of Medicaid funding could not be offset by other funding sources. However, while Title X funds constitute a smaller proportion of Planned Parenthood's revenue than Medicaid, a cut of this magnitude is unlikely to be replaced by other sources over the long term.

The state of Texas provides a glimpse into the possible consequences of significant funding cuts for Planned Parenthood. In 2011, Texas enacted two pieces of legislation that dramatically reduced public funding for family planning. Title X funding was reduced by approximately 67%. The remaining funds were allocated according to a tiered system, with Planned Parenthood health centers lowest in funding priority. Of the 200,000 Texans receiving care through publicly funded programs, 40% had been patients at a Planned Parenthood health center.

The new legislation greatly reduced access to family planning clinics, with one-quarter of clinics closing in 2012. Clinics that remained open were often forced to reduce hours of operation and the size of their staff. Funds previously distributed to high-volume providers, like Planned Parenthood, were instead re-allocated to smaller organizations that were incapable of absorbing a large client population. For example, in 2017, the anti-abortion Heidi Group was contracted to serve 70,000 patients, yet delivered services to less than 5% of that number. The Heidi Group was not an isolated case; in 2018, half of the Figure 2. Percentage of HIV testing facilities that are Planned Parenthood health centers Healthy Texas Women (the state's Title X-funded program) contractors had funds revoked after underperforming.

If implemented, the domestic gag rule could not only undermine women's access to reproductive health services, but also impede access to HIV testing for low-income populations, threatening the national response to the HIV epidemic as a result. Although the global effects of the Mexico City Policy continue to be examined, the potential impacts of a domestic gag rule are poorly understood. Using clinic and client data for Planned Parenthood health centers receiving Title X grants, we analyzed how the rule could impact one major Title X grantee. Other Title X recipients could similarly reject the terms and the funding; however, this analysis conservatively estimates the impact on Planned Parenthood health centers alone.

Estimated impacts of domestic gag rule on the HIV response: a primary analysis

According to our analysis, $245.8 million in Title X grants was awarded to states in 2017 for the provision of family planning services, of which 25.3% ($63.4 million) was allocated to Planned Parenthood health centers. There are currently 617 Planned Parenthood health centers in operation in the U.S., 420 of which received Title X funding grants (68.1%). Disrupting stable connections to health care threatens clients' continued use of services.

The termination of these grants is likely to create large gaps in access to HIV testing. In 2016, Title X-supported clinics administered 1.2 million HIV tests and diagnosed 2,824 people with HIV, accounting for 7.1% of the 39,782 diagnoses that year. Planned Parenthood health centers administered more than 700,000 tests, and based on estimates from the Guttmacher Institute, they diagnosed between 729 and 1,158 people with HIV in 2016.

In many states, Planned Parenthood health centers are an important part of the HIV testing infrastructure. Of the 7,666 clinics and hospitals currently providing HIV testing in the U.S., 8% are Planned Parenthood affiliate sites. This proportion is highly variable by state. In Vermont, for example, more than 23% of all HIV testing sites are Planned Parenthood health centers. In Connecticut, where Planned Parenthood facilities constitute 16% of HIV testing sites, the closure of these sites would reduce the density of HIV testing facilities by 22%. In these contexts, it is unlikely that such a large patient volume could be shifted from Planned Parenthood affiliates to other nearby facilities without service disruptions. The impact would be greater still if other Title X recipients such as state and county health departments similarly lost grant funding.

Furthermore, our analysis showed that in seven states, more than 40% of all Title X grant recipients are Planned Parenthood affiliates. This suggests that in some communities these facilities may be the only Title X recipients, or nearby clinics may be unable to absorb the sites' entire clientele. In other states, there may not be any other providers at all due to severe shortages of health care providers. In Alaska, Washington, Montana, and rural states where Planned Parenthood is a major Title X recipient, less than 40% of primary health care need is being met. People living with HIV who experience stigma and discrimination at other clinics are likely to fall out of care entirely. In rural states or in regions with large gaps in access to care, defunding a major provider of sexual health services is likely to leave a growing number of small communities—such as Scott County—without any site for uninsured individuals to receive HIV testing and prevention services.

Conclusion

This analysis reveals the critical role of Title X clinics and Planned Parenthood health centers specifically in the national HIV response. If implemented, the Title X rule change is likely to reduce access to HIV testing services in many states. This comes in the wake of President Trump's State of the Union Address pledging to end HIV in the U.S. by 2030—an ambitious goal that cannot be met if other Administration-led polices undermine the delivery of HIV services for the country's most vulnerable. As shown in the Scott County outbreak, insufficient access to HIV services can be

devastating. With the continuing public health crisis of opioid use in the U.S., gaps in access to HIV testing and preventive services will leave more communities vulnerable to HIV outbreaks, undermining the national response to the HIV epidemic.

This issue brief was originally published on amfAR.org. To read the original brief, which includes notes on methodology and references, click here.
