Title
Title X Regulatory Changes and Their Impact on Adolescent Health

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Abstract

Title X of the Public Health Act has provided access to confidential reproductive care for low income adolescents and adults since 1970. Originally passed with bipartisan support, Title X funds have helped bring adolescent pregnancy rates to historic lows. Recent changes that expand funding for programs offering a restricted range of contraceptive methods may reverse this trend. New limits to provider counseling options for pregnant adolescents have led to protests from a wide range of professional organizations and to a mass exodus of clinics from the Title X program. This policy brief will address the history and impact of Title X funding on adolescent access to reproductive health care, explain the implications of these recent regulatory changes in Title X implementation, and encourage advocacy to protect health care provider practice and adolescent access to confidential care.

On March 4, 2019, the Trump Administration published "Compliance With Statutory Program Integrity Requirements," the Final Rule, or regulations setting priorities and enforcement, for Title X of the Public Health Act (42 U.S.C. §§300 to 300a-6).[1] This legislation has funded contraceptive care and other programs for low income adolescents since 1970 (*Compliance with statutory program integrity requirements*, 2019; Napili & Elliott, 2019). In addition to major changes in funding requirements and priorities for Title X recipients, the 2019 Final Rule dramatically limits the allowable scope of counseling for pregnant adolescents (see Table 1), and has already resulted in the exit of high volume nonprofit and state-funded clinics from the program (Frederiksen, Salganicoff, Gomez, & Sobel, 2019). This policy brief will address the history and impact of Title X funding on adolescent access to reproductive health care, explain the implications of these recent regulatory changes in Title X implementation, and encourage advocacy to protect health care provider practice and adolescent access to confidential care.

Background

Birth rates for adolescents 15 to 19 years old reached a peak of 96.3/1000 in 1957, and have been declining ever since (Ventura, Hamilton, & Matthews, 2014). The birth rate in 2013 was 26.6/1000 teens (Ventura et al., 2014), less than ½ of the rate in 1991 (61.8/1000 births), and less than 1/3 of the

[1] The Title X legislation and amendments were passed by Congress. The regulations governing the interpretation and enforcement of the legislation are developed by the Department of Health and Human Services. Each new interpretation is called a Final Rule. To avoid confusion, this article will include the date for each Final Rule discussed.

rate in 1957 (96.3/1000). Rates vary by race, ethnicity and by geographic location, with the 10 lowest birthrates in northeastern states, and the 10 highest birth rates in southern and southwestern states (Ventura et al., 2014). Teen birth rates have continued to decline over the past 5 years, with a rate of 17.4/1000 in 2018 (Martin, Hamilton, & Osterman, 2019).

It is thought that multiple factors account for this drop, including declining rates of sexual activity, increase in use of contraception at first intercourse, and increased uptake of moderately effective (short term hormonal) and highly effective (long-acting) contraception (Ventura et al., 2014). Lindberg, Santelli and Desai (Lindberg, Santelli, & Desai, 2016) explored the drop in teen birth rates between 2007 and 2012, using data from the National Survey of Family Growth (NSFG), a time period in which rates of sexual activity increased slightly, and determined that the continued drop in pregnancy risk during this period could be entirely accounted for by an increase in effective contraceptive methods (Lindberg et al., 2016).

Confidentiality and Reproductive Health services

In the National Survey for Family Growth 2013-2105, only 38.1% of adolescents aged 15 to 17 spent time alone with a health care provider in the previous year, without a parent, guardian or other relative in the room (Copen, Dittus, & Leichliter, 2016). In another analysis of the same sample, 40.5% of females ages 15-17 who spent time alone with a provider received sexual or reproductive health services, compared with 25.2% who had not. In this sample, 22.6% of sexually experienced adolescents ages 15-17, 8.2% of

18 to22 year-olds and 5.4% of 23 to 25-year-olds stated that they would not use sexual and reproductive health care services because they feared that parents would find out (Leichliter, Copen, & Dittus, 2017). Earlier studies have found that lack of services would not affect adolescent decisions to engage in sexual activity (Reddy, Fleming, & Swain, 2002). A review of confidentiality practices among 423 Federally Qualified Health Centers (FQHC) found that 84% had policies supporting confidential care, but that only 43% blocked parental access to records and only 50% maintained separate and confidential contact information for adolescents (Beeson et al., 2016). Those FQHCs who received Title X funding were more likely to have addressed these issues. The legal, ethical and developmental underpinnings of confidentiality policies are beyond the scope of this article (See AUTHOR, 2010; AUTHOR, 2018).

History of Title X

Title X of the Public Health Service Act (42 U.S.C. §§300 to 300a-6), was enacted in 1970 under the Nixon Administration, with bipartisan support, to provide family planning services to low income individuals (English, 2014; Napili, 2017). From the time of its inception, Title X encouraged family participation in adolescent reproductive health care. However, the law extended confidentiality protections to adolescents who did not wish to involve their families, specifically prohibiting providers from contacting parents before or after care was provided without the adolescent's explicit consent, whether or not the states in which they lived protected their

confidentiality in other settings (Napili, 2017). These protections have been stable since the program's inception, both through renewals of the legislation and case law (English, 2014). Revisions to the law have made encouragement for family involvement and counseling about sexual coercion more explicit, and have also reinforced that the confidentiality provisions do not negate State laws for reporting child abuse (English, 2014; Napili, 2017).

The use of Title X funds to pay for abortion "as a method of family planning," has been specifically prohibited from the beginning of the program until the present (Napili, 2017, p. 21). Title X grantees have historically been allowed to use non-public funds for abortion, as long as these funding streams were separate and distinct, with monitoring by the Office of Population Affairs (OPA). From 2000 until 2019 regulations interpreting the law have specified that Title X-funded programs had to provide "neutral, factual and nondirective counseling" (Napili, 2017, p. 22) on pregnancy, delivery, infant care, foster care and adoption, and abortion, unless the pregnant individual refused counseling on any of the options. The law also specified that patients who requested referrals for abortions be given that information (Napili, 2017).

Title X usage

Title X was designed to aid low income clients and Title X-funded programs have served as many as 5 million clients per year (Napili, 2017). In 2015, 66% percent of those served had incomes under the federal poverty guideline (FPL), while 86% had incomes less than 200% FPL (Napili, 2017). In

2018, 53% of those who used Title X-funded services self-identified as white, 22% as black or African-American, 4% as Asian, and 2% as Native American/ Alaska native, Hawaiian or other Pacific Islander. Race was unknown or not reported for 16%. Overall, 33% identified as Hispanic or Latinx (Fowler, Gable, Wang, Lasater, & Wilson, 2019). In addition to contraceptive care, Title X funded clinics offer screening and treatment for sexually transmitted infections (STI), including HIV testing, and cervical and breast cancer screening, and some provide full scope primary care.

Title X and adolescents

In 2018, 17% of Title X-funded program users (681,786) were under 20 years of age (Fowler et al., 2019). Almost the same percentages of female (17%) and male (16%) users were in their teens. Although all 50 states and the District of Columbia allow minors to consent for STI testing and treatment, 18 states allow providers to notify parents about these visits (Guttmacher Institute, 2019). Nineteen states have some restrictions on minor consent for contraception, and 4 have no specific guidance on confidential care (Guttmacher Institute, 2019). For adolescents living in these states, clinics funded by Title X have been the only reliable source of confidential care (English, 2014). In 2018, the most popular methods for adolescents under 15 years of age seeking treatment from programs funded by Title X were pills (17%), injectables (16%) and hormonal implants (7%). For females aged 15 to 19, the most popular methods were pills (29%), injectables (18%) and male condoms (12%); 5% used IUDs and 10% used

implants (Fowler et al., 2019). Fewer than 5% of adolescents indicated that their nonuse of contraception was due to a desire to be pregnant.

Fertility awareness methods (FAM) rely on tracking one or more indicators of fertile days in a menstrual cycle, including estimated fertile days by calendar, daily basal body temperatures, cervical mucous changes or urine hormonal assays, and either avoiding intercourse or using condoms and/or emergency contraception (EC) during estimated fertile days (Polis & Jones, 2018). A secondary analysis of contraceptive use data from the National Survey of Family Growth indicated that 3% of all women using contraception used a FAM with or without additional methods; the majority were either married (68%) or cohabiting (13%), and 84% were aged 25-44 (Polis & Jones, 2018). In 2018, approximately 0.25% of the 602,400 female adolescents in Title X funded programs used either FAM or reliance on lactational amenorrhea (LAM) after childbirth (Fowler et al., 2019).

Changes in Title X – the 2019 Final Rule

The major changes in the 2019 Final Rule are listed in Table 1. The 2019 Final Rule mandates yearly training about sexual abuse and trafficking, specifies that providers document sexual abuse screening for adolescents who are pregnant or have an STI, document the age of the adolescent and sexual partner in states where this reporting is required, and document attempts to involve family at each visit (Napili & Elliott, 2019). Another major change is that Title X programs no longer have to offer a full range of medically approved contraceptive options, nor do they have to educate

clients about additional options. For example, a program that promotes primarily abstinence and FAM could receive Title X funding (Hasstedt, 2018).

The change that most directly affects pediatric health care providers (HCPs) caring for adolescents, is the change in counseling requirements if an adolescent has a positive pregnancy test. For most of Title X's history, HCPs were not restricted in counseling pregnant clients about their options. From 1988 to 1993, there was a "gag rule" instituted, that forbade Title X providers from mentioning abortion. Beginning in 2000, updated regulations mandated that clinics offer "nondirective counseling on, and referral for abortion, at the request of a Title X client" (*Compliance with statutory program integrity requirements*, 2019, p. 7721). The regulations did not specify who could conduct the counseling, allowing clinics to use nurses, health educators, or behavioral health staff to offer this counseling. Clinic providers and staff who had religious or other objections could opt out of counseling if clients were referred to someone else in the facility. As of 2019, all requirements for nondirective counseling have been eliminated, although clinics can choose to offer it with certain restrictions: only clinicians with a graduate degree (such as physicians and NPs) can offer this counseling, and they may not explicitly state which local facilities actually offer abortion (See Table 1) (*Compliance with statutory program integrity requirements*, 2019; Napili & Elliott, 2019). For example, if a pediatric HCP in a Title X-funded clinic gave an adolescent requesting an abortion a list of 6 names of

providers, only 2 of those 6 names could be abortion providers, and the HCP would be prohibited from indicating who they were.

This change in regulations was justified by stating that referral to another facility for abortion by a Title X provider was essentially no different than providing the abortion with Title X funds (*Compliance with statutory program integrity requirements*, 2019). Previous amendments to Title X have recognized a balance between protecting the conscientious objections of those opposed to abortion or contraception and honoring the rights of Title X recipients to access their choice of legal health services (Napili, 2017). The 2019 Final Rule, along with a conscience provision that is currently on hold, protects opponents of these services, but does not protect HCPs whose own conscience and ethics impel them to give trustworthy answers to client questions about contraceptive and pregnancy options (Gacioch et al., 2019; Keith, 2019; "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, Title 45, Part 88," 2019).

Although it is too soon to tell what the impact of the current Title X changes will be, Planned Parenthood®, which is the only Title X provider in Utah, and the major Title X provider in Alaska, Connecticut, and Minnesota, exited the program in August, 2019 (Frederiksen et al., 2019). In all, 23% of current Title X recipients have announced their intentions to leave the program, and in 13 states, over half of the clinics state that they are in the process of declining future title X funds. Although states and localities are promising to make up the funding shortfall, it is unclear how much and for

how long they will be able to contribute, which may result in fewer and more expensive family planning services (Frederiksen et al., 2019). The average wholesale price for a contraceptive implant is $1121, IUDs range from $950 to $1444, and depot medroxyprogesterone injections range from $54 to $250 each (Lexicomp, 2019). Without Title X support, it is unclear what percentage of the medication and the visit charge adolescents with no other contraceptive coverage might be expected to pay, or if they will be able to access these services without parental consent.

Several lawsuits have been filed in response to the publication of the final rule (Frederiksen et al., 2019). However, when lawsuits over the 1988 “gag rule,” reached the Supreme Court in 1991, the rule was affirmed (*Compliance with statutory program integrity requirements*, 2019), and current policy analysts are not optimistic that the new regulations will be invalidated by the courts (Frederiksen et al., 2019). One major difference between the 1988 “gag rule” and the current regulations, is that in 1988, IUDs were not recommended for nulliparous adolescents and contraceptive implants had not yet been introduced. Researchers credit the increased use of IUDs and implants in adolescents with the current historically low teen birth rates (Fowler et al., 2019; Lindberg et al., 2016; A. Napili, 2017), yet these are the methods that require increased training, supervision, and extra appointment time and are least likely to be provided in pediatric and adolescent primary care settings that do not specialize in reproductive health (Pritt, Norris, & Berlan, 2017).

Conclusion

When the proposed rule was initially published on June 1, 2018, many nursing and medical organizations responded with comments in opposition to the restrictions on providers' abilities to counsel according to professional guidelines (See Box 1). On July 3, 2019, NAPNAP joined these organizations in requesting that Congress refrain from funding the 2019 Final Rule's changes to Title X, out of concern that up to 40% of Title X patients would lose access to "critical preventive and primary care" (American Academy of Family Physicians, 2019, P. 2). Pediatric HCPs should educate themselves about the history and current changes in Title X regulations, and advocate for access to a full range of reproductive health services to improve adolescent health outcomes.

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