The Impact of Dramatic Budget Cuts on Women's Experiences Seeking Affordable Family Planning Services in Texas

Kristine Hopkins, *University of Texas at Austin*
Kari White, *University of Alabama at Birmingham*
Fran Linkin, *Columbia University*
Celia Hubert, *University of Texas at Austin*
Daniel Grossman, *Ibis Reproductive Health*
Joseph E. Potter, *University of Texas at Austin*

Objective: The 2011 Texas Legislature cut its budget for family planning services by two-thirds, from approximately $55 million to just $19 million per year. This study explores low-income women's and teens' experiences obtaining affordable family planning services following the budget cuts.

Methods: We conducted 11 focus groups with women and teens throughout Texas: 9 adult groups (6 conducted in English and 3 in Spanish) and 2 teen groups (both in English). Participants were recruited through organizations that serve low-income populations. Overall, 92 adults and 15 teens participated in the groups. Recordings were transcribed and at least two researchers independently coded each transcript.

Results: Women reported that affordable family planning services have long been very difficult to access. Women recounted that programs are difficult to apply and qualify for, pregnancy-related care is easier to obtain than family planning services, and teens have unique barriers to obtaining care because many need to obtain parental consent. Significant negative consequences also accrue as a result of an insufficient reproductive health safety net, such as unplanned pregnancies and an inability to access preventive screening and follow-up care. Since the budget cuts, previously free services now require payment, leaving some to forego care. Finally, nearly all women expressed very strong support for government-funded family planning and provided concrete ideas for improving the system.

Conclusion: The funding cuts exacerbated the challenges low-income women in Texas already faced when trying to meet their reproductive health needs.

INTRODUCTION

Publicly funded family planning clinics in the US provide subsidized contraceptive and other reproductive health services to low-income women in need. In 2010, 6.7 million women received publicly funded services, of which 4.7 million were served in Title X clinics and 2.2 million from private doctors through Medicaid (Frost et al. 2013). Contraceptive services provided to women through these clinics in 2010 helped to avert 1.2 million unintended pregnancies and helped save $10.5 billion in public funds. Without access to publicly funded family planning clinics, the US unintended pregnancy rate would be 66% higher overall and 73% higher among teens. Since 2001, the percentage of women served by publicly funded providers (clinics and Medicaid providers) has gone down slightly (from 49% to 47%), while the percentage of women served in publicly funded clinics has gone down more–from 41% to 35% (Frost et al. 2013).

A major transformation of health care delivery is underway with the implementation of the Affordable Care Act (ACA) on the one hand, and undercutting of family planning funding on the other. Many states also do no plan to expand Medicaid under ACA, so women under 138% of the federal poverty level (FPL) in those states will not have access to health insurance nor will they have access to subsidies to help them pay for health insurance premiums.

Indeed, in 2010 states varied widely in the percentage of women in need receiving services at publicly funded clinics: from 63% in Alaska and 62% in California, to 21% in Louisiana, Tennessee, and Nevada, demonstrating that states are already underfunding their family planning services. Texas served only 26% of women in need at publicly funded clinics in 2010, down from 41% in 2001. In addition, only 22% of teens' needs were met at publicly funded clinics. Though publicly funded services in Texas only about a quarter of its population in need, Texas still saw a net savings of an estimated $503 million for the costs of Medicaid births that were averted (Frost et al. 2013).

Despite the cost savings that accrues to public funding for family planning, Texas legislators in 2011 dramatically reduced family planning funding by 66%, from approximately $55 million to just $19 million per year. In addition, the legislature created a tiering system that prioritized publicly run clinics (such as those run by health departments) and community health centers over specialized family planning clinics. In the year

following the implementation of the new budget rules, 33 clinics providing family planning closed in Texas, hitting the specialized family planning clinics the hardest (White et al. 2012). The legislature also attached restrictions to who could receive Medicaid funding through Texas's Medicaid waiver program, the Women's Health Program (WHP), by attempting to exclude any organization affiliated with an abortion provider. Due to legal challenges, this exclusion did not go into effect until January 2013 when Texas dropped out the Medicaid program and instituted its own entirely state-run program.

The loss of specialized family planning providers may have particularly pernicious effects, because women tend to prefer going to those specialized clinics for their reproductive health care needs. Among women who receive family planning services at specialized clinics, the reasons they most value those clinics over other providers are being treated respectfully, confidential services, availability of free or low-cost services, the staff know about women's health, and the staff take time to talk with them (Gold 2013).

On the other hand, we know very little about low-income women's experiences navigating among the providers available to them and about how they experience getting family planning services. The purpose of this paper is to highlight the experiences of low-income women and teens in Texas trying to obtain affordable family planning services in general and any changes that they experienced following the budget cuts to family planning services.

METHODS

This study was conducted as part of the Texas Policy Evaluation Project, a three-year evaluation of the impact of reproductive health legislation implemented by the Texas Legislature in 2011. We conducted focus groups with adult women and teen girls who were in need of publicly funded family planning in Texas approximately one year after the budget cuts went into effect (July to October 2012). We conducted 11 focus groups with women and teens throughout Texas: nine adult groups (six conducted in English and three in Spanish) and two teen groups (both in English). Focus groups averaged 60 minutes long (range, 41 to 80 minutes) and averaged 9.7 participants (range, 3 to 12). In order to maximize geographic diversity of our findings, we conducted at least one group in each of Texas's Health Service Regions (see Figure 1).

Eligibility and Recruitment

In order to be eligible for the study, women needed to be 18 to 44 years (age 15-17 for the two teen groups), have public health insurance or no health insurance, be sexually active, not be pregnant or planning to get pregnant within the next year, and, for the three Spanish-speaking groups, be comfortable speaking Spanish. Community-based organizations (CBO) that serve low-income populations recruited participants for the groups. Because we wanted to recruit women and teens who were in need of family planning services but who might not have access to services, we approached CBOs that offered services other than health services, such as community centers and child development centers. To increase racial and ethnic diversity, we targeted some organizations that specifically worked with Spanish-speaking, Hispanic, or African-American communities. After a CBO agreed to participate, we supplied its staff with a script to recruit their clients for the group, with a target of 12 women for each focus group. CBOs received a flat fee for recruiting participants.

Adult women were given consent forms at the time of recruitment or when they arrived for the group; women provided their verbal consent to participate at the beginning of the group. Several days before the focus group, minor teens were given consent forms to take home for their parent or guardian to sign agreeing to their teen's participation; on the day of the focus group minor teens returned the signed parental consent form and provided their own assent to participate. All participants received $50 for participating in the study and child care was provided for those who requested it. This study received approval from the Institutional Review Boards at University of Texas at Austin and the University of Alabama at Birmingham.

The English-language focus groups were led by two native English-speaking study authors, both of whom are non-Hispanic white; the native Spanish-speaking author, who is Hispanic white, led the Spanish-language groups. All groups had an assistant/note taker, were digitally recorded and professionally transcribed into their original language with each speaker noted by initials. We used a semi-structured focus group guide that covered the following topics: knowledge of and ability to access free or low-cost family planning services in their community; cost of family planning and reproductive health services in their community; any changes in the availability of services or contraceptive from area providers in the last year;

and views about government funding for family planning services. Women and teens also filled out an anonymous survey at the conclusion of the group that included socio-demographic questions such as age, race/ethnicity, parity, education level, marital status, country of birth and current method of contraception.

Analysis

To analyze the data, we used content analysis to progressively produce a more refined coding scheme based on successive readings of the focus group transcripts. Using a preliminary coding scheme, three of the authors coded two English-language transcripts independently and then met to come to agreement on how to code each segment of text, to add to or modify the coding scheme, and to include notes on what each code meant. Thereafter, the remaining focus groups were independently coded by two of the authors who then met to come to agreement on the codes. We used NVivo 8 to manage the coded transcript data and Stata, version 12 to analyze data from the anonymous survey. The authors translated all Spanish-language quotations in this paper into English.

RESULTS

Sample Description

Overall, 92 adults and 15 teens participated in the groups, of whom 67 (63%) were Hispanic, 31 (29%) African-American, 7 (8%) non-Hispanic white; one participant identified as mixed race (African-American, Native American and white). The focus groups were largely homogenous with respect to race and ethnicity. Participants in the adult groups averaged 30.9 years, had an average of 11.7 years of education (10.2 for Hispanics, 13.6 for African-Americans and 14.0 for whites), and averaged 2.3 children each (range 0 to 8). All African-American and white adult women were US-born; two-thirds of the adult Hispanic women were born in Mexico. Teens were on average 16.3 years old, and averaged 9.9 years of education with little variation in education between Hispanics and whites (there were no African-American minor teens interviewed). Two-thirds of the teens were already mothers (we did not ask how many children teens had). All teens were US-born.

We identified four primary themes about the way women think about and interact with family planning and reproductive health services: government-supported family planning services were difficult to obtain even before the budget cuts, an insufficient reproductive health safety net exists leading to many negative consequences, access to affordable family planning care after the budget cuts has become even more difficult, and there is strong support for publicly-funded family planning services among low-income women in Texas.

- ***State-supported Family Planning Services Difficult to Obtain (unrelated to the budget cuts).***

This theme encompasses four main subthemes: free family planning services are virtually impossible to obtain; applying for, qualifying for, and maintaining coverage for government health care programs is very challenging; subsidized pregnancy-related care is much easier to obtain that subsidized family planning services; and teens have unique challenges to obtaining care.

Free family planning services were unheard-of to many of the women in the focus groups. An exchange between the moderator and one of the participants in Lubbock is exemplary of some of the sentiments around the lack of free clinics:

> Moderator: Are there any free [family planning] services?
> Participant: Absolutely free services?
> Moderator: Yeah.
> Participant: Absolutely not.

Later in the group, this same participant noted that since the health department clinic had closed, "there is literally not anywhere free anything medicalwise." A Houston participant who had previously lived in California noted: "California has 'real' free clinics. Here [in Houston], they are not free. I've never experienced free, me personally, because I would go use Planned Parenthood. You may pay very little, but it was not free. I don't have an experience of free." Several Spanish-speaking participants in the El Paso and Rio Grande Valley groups noted that they buy more affordable contraceptive methods from flea markets in town or travel across the border to Mexico: "I buy my oral contraceptive pills in Mexico because I don't have insurance here."

One exception to women's inability to access free services is for those women who qualify for the Medicaid waiver program (WHP). One woman from Houston described that the WHP "is what they offer

for low-income people like myself. It is basically a program where they offer you to get your well women's every year for free, so free Pap smear, STD tests, and whatever, free birth control, and stuff like that." However, women in only four of the 9 adult groups mentioned knowing about WHP before being prompted. Even after being prompted, women in several groups said that they had never heard of the program. A woman in Dallas also noted that while exams are free, WHP doesn't cover medications for STIs: "You might go in there and get your services for free, but if you go in there and they tell you that you have Chlamydia then what about the medicine? That can be $50-$60." However, qualifying for WHP is also often difficult, as this Houston woman can attest: "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. They say I'm qualified and then they say I'm denied and nobody will tell me why I was denied." Finally, some of the Spanish-speaking participants noted that free services through WHP are not available to them because they do not fulfill the citizenship or legal residency requirements: "without a Social Security number you can't do anything. You can't qualify for anything."

Another common discussion across the groups was that qualifying for programs to help pay for family planning and other health care services can be very difficult. Women were especially frustrated with the income-eligibility criterion for these programs. For instance, a woman in Lubbock said that "You can work and literally bring home $50 a week and they're going to say you make too much money. Right. You could have $200 a month that you make and they're going to say you make too much money to survive." Or, like this woman in Tyler who had qualified but then went over the income threshold and said that she was notified by the Medicaid office that she "ended up being like 5 or $6 over the limit of the budget or whatever it was. I was like, 'Really? $5?' … That don't make sense." And even those who eventually qualify for full-benefit Medicaid (as did most of the participants in the teen focus groups), the application for benefits can be challenging to complete, as exemplified by this teen in San Angelo who described her experience filling out the "lots of paperwork," "I didn't know what half the stuff was and I had to do it by myself. I didn't know what it meant. I didn't know what to answer. … [And]…they don't sit down and help you fill it out. You just have to do it by yourself basically." However, these teens also said that once they had Medicaid that getting

family planning services was "pretty easy. As long as they accept the type of Medicaid that I have, I can usually get assistance. I don't really have any problems with that."

Some communities in Texas offer care to their low-income residents through county-funded or hospital discount programs. And while these programs provide an additional way to qualify for discounted services, they are also often difficult to qualify for or do not offer meaningful coverage. For instance, Houston's hospital district provides a "Gold Card" to its low-income residents that qualify but some participants in that city pointed out the application process is very time-consuming, and as one woman said "a little demoralizing. You shouldn't have to be waiting all day long from 6:00 AM until 5:00. I've never been told 'no' when I did it because I knew that I would qualify. It's like, 'Really? It takes all that? In the age of technology it takes a whole day for me to get a little card for some help?'" Women in Lubbock described a hospital-based program that pays for doctors' visits for those who qualify, but does not cover prescriptions: "but as far as [the doctor] giving you a prescription, you're on your own with that." Similarly, a community program in Austin offers a discount card to those who meet the income requirements but they have limited appointments available for women using that card. Moreover, these safety net programs typically only cover residents of the county, so women in outlying regions are shut out, as this woman in Tyler said, "You can't be from any other communities or anything."

Many women also pointed out that it is easier to obtain government-supported pregnancy-related services than it was to find support for contraceptive and reproductive health services. Women voiced dismay that they were not better supported in their efforts to prevent pregnancy and support the children they have. For instance, a Lubbock woman exemplified this frustration, "All of our programs are set [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." Another woman in Houston detailed the large number of easily-accessible services available during pregnancy and how there are few available after the pregnancy has 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. You can get help with milk and food for your family. You get food stamps and things like that if you're pregnant and

you're low income. You get a lot of help, both medically and with your family. When you're not pregnant you can still get help with food stamps, but you don't get medical assistance." This same woman also noted that she had continuity of care with the same provider during her pregnancy, but since delivery, she and other women like her "have to try to piece everything together from different places."

Finally, minor teens in Texas face unique challenges to obtaining family planning services because they must obtain parental consent for those services (unless they have knowledge of, and access to, a Title X clinic which enables them to obtain confidential services). Some young women in the teen groups noted that at least one of their parents is supportive of their getting contraceptives. For instance, a young San Antonio woman recounted that while her father was against her getting the injection because he believed it was "just like a free pass to go have sex," she said, "my mom 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 it up. She was all for it." Likewise, a San Angelo teen mom said that "my friends either have Medicaid or they get [birth control] at clinics. Their parents are like, 'You're not having a baby.'" However, teens more frequently discussed the ways that parental consent interferes with obtaining family planning services because it requires them to reveal to their parents that they are, or are contemplating becoming, sexually active, as evidenced by this exchange in the San Angelo group:

Moderator:	What is it about parental consent makes it hard [to get contraception]?
Participant 1:	Having to tell your parents that you have sex.
Participant 2:	And some parents don't like birth control.
Participant 3:	If their 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 San Angelo teen, who is a mother herself, said: "[My sister's] like, 'You know mom is not going to take me and all this kind of stuff,' because she's scared to tell my mom that she's having sex." For some girls, this avoidance stems from fear of reprisals from their parents who are "super, super, super strict" and who will kick them out of the house if they were to become pregnant. One also mentioned that teens fear disappointing their parents because of the belief that "I guess we all know that we shouldn't be having sex."

- ***Insufficient Reproductive Health Safety Net.*** Women recounted a variety of negative consequences due to limited coverage and the patchwork of services available to them. Many women commented on the lack of continuity of care in finding the most affordable options. For instance, several women mentioned gaps in coverage following the expiration of pregnancy-related Medicaid that resulted in a rapid repeat pregnancy, as a Lubbock woman recounted: "I have six kids. After the one I had last year, I had actually missed my six week check-up and when I called to reschedule, my Medicaid had fallen 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. It was all because I didn't do it fast enough." Similarly, others noted that women become pregnant while trying to find affordable services, like a Houston women who told her story, "When I was pregnant and I was on Medicaid, they gave me Yaz after I had my baby, but they only gave you 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." Another Houston woman emphatically agreed: "The point is, if they can't get to the 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."

This lack of continuity of care also impacts young women who age out of teen programs: "When I turned 18 they said [at the clinic]…that I couldn't get the services anymore. After my birth control wore off then I got pregnant." In addition, after one young woman learned from another participant in the group that she should have been able to continue to get services at that site until age 23, she exclaimed with irritation, "That's crazy. … I probably wouldn't have my son if I would have known that because I've been on birth control since my first baby. That was five years. Then they said 'you can't get anymore' and then I got pregnant. I would probably not have my son."

In addition to contraception, women frequently commented on the challenges they faced accessing preventive screening services because program rules either exclude certain types of women or requires them to seek care from a different provider who may not have enough appointments. For example, some noted with frustration that they were unable to get Pap smears after becoming sterilized, since the WHP is only for women at risk of pregnancy. A Lubbock woman recounted how she learned about this exclusion only after

she had been sterilized: "And you can't get that Women's Health Insurance if you're sterile because I, myself, had my tubes tied after my son and my aunt has told me to go ahead and fill out the paperwork for that [program]." When this woman was told that being sterile would "disqualify" her, she "got upset because I told [the clinic staffperson]. '[Getting my tubes tied] was something I thought was in my best interest for right now because I'm a single parent. … I don't want to bring too many children that I cannot afford to take care of because it's hard with just one.'" Likewise, a woman in Austin also discovered that sterilized women like her do not qualify for reproductive health services: "Now there's no Pap test, no mammogram, nothing."

Cancer screening for low-income women in Texas is administered by different programs with different funding streams and may be unavailable or unknown to many women. Indeed, some women recounted difficulties accessing follow-up care for abnormal Pap smears and mammograms. For instance, a Fort Worth woman discussed how she was unable to comply with recommended regular colposcopies to monitor cervical dysplasia because the costs of follow-up care were prohibitive: "They want $100 and something, and then the bill was more than $500. It was a lot." Because of the high costs, it had been more than the recommended six months since she had a follow-up visit. Mammograms and follow-up breast cancer screening is also priced out many women's reach. A Houston woman said that she made too much money to "qualify for the free [mammograms]. There organizations that will do a free one, but you have to be unemployed. It's not just the bottom half, it's the top half too" for which women have difficulties finding affordable care. Similarly, an El Paso woman described 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. [At the clinic], they said, 'Look, you're really young and don't qualify for a mammogram. You only need to come see the doctor and get checked out and if you have any problem, [only then] will you be sent for more follow-up.' But they told me it would about $600, so I said I would wait."

- ***Family Planning Access after the Budget Cuts***. We identified two subthemes that describe how women have experienced obtaining family planning services since the budget cuts: previously free services now require payment and for women who cannot pay these new fees, they simply no longer get reproductive

health care since the budget cuts. For instance, a woman from the Rio Grande Valley said that, "I used to go to the Planned Parenthood, but now supposedly there's no funding. I think they charged me the regular fee…$60" and another in Houston said that that they are now charging $50 at clinic that used to be free. Because of these new charges, some women stated that they have to make tough choices between paying for contraception and meeting more immediate needs like this exchange between Houston women:

Moderator: Okay. So $50, $70 is kind of…
Participant 1: That's hard when you're a single parent and have kids. That's expensive. …
Participant 2: With the $50 we pay gas, we buy the Pampers.

When we asked women how their reactions about now being asked to pay for previously free services or are asked to pay more than before the cuts, women said they felt "pissed off," "mad," "shock," and anxiety.

Because of the new fees, many women said that they themselves or people they know forego services altogether because of the inability to pay. For example, a Fort Worth woman described how her daughter wasn't going to go to her local family planning clinic anymore because making $10 an hour meant that she had only enough money to cover her bills and could not afford what the clinic was now charging. A Houston woman echoed this theme of making difficult choice about their health care: "Yeah, sometimes for us who are single women, if you don't have any help for our service… we have to stop because the babies are first. Their Pampers and everything else is going to be first before us. It's really hard." Similarly, the following exchange in the Dallas group, in which many women contributed to the discussion about foregoing services that are out of reach financially, was common across 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. [*Crosstalk*]
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.

- ***Support for Publicly-funded Family Planning***. Finally, we found strong support for government assistance for family planning in all of the focus groups and ideas for how to improve the system for low-income women. Many believe that it would make more sense for the government to help women prevent unintended pregnancies because, as a Fort Worth woman explained then "[women] don't have children that

they can't afford to support and then the government ends up supporting those children anyway." Another group of women noted that making family planning services affordable will also lead to "hav[ing] more chances for the individual to progress with them going to school and getting a job." Some women also stated that since they pay taxes they should be able to get help from the government to pay for family planning. To improve access to these services, many women said they would like to see an expansion of groups that are covered, like to make it easier for working women to qualify for support, and have more clinics in more places. Teens in both groups said they would like to see the parental consent requirement lifted.

DISCUSSION

We found clear evidence that women in Texas have long had a difficult time accessing affordable family planning services in Texas. Even prior to the budget cuts women experienced numerous challenges obtaining care, and frequently fell through one of many holes in the reproductive health care safety net. The dramatic budget cuts have made getting care even more difficult for low-income women. Organizations' responses to the cuts, such as charging new or higher fees for services, has led some women to forego care altogether. Our findings were remarkably consistent in the focus group held across the state, suggesting that we have captured many of the experiences of low-income women who seek to obtain affordable family planning and other reproductive health services in Texas.

While the majority of the focus group participants faced significant barriers to care, women in communities with county-based programs that provide more comprehensive services to their low-income populations may be better off, though these services appear to be difficult to obtain and only last for a limited duration. Women on full-benefit Medicaid seem to be the best off and were less affected by the cuts, since their changes to their coverage were not part of the 2011 legislation. However, the income requirements for full-benefit Medicaid in Texas is so low – 12% of the federal poverty level (FPL) for jobless recipients and 25% of FPL for working recipients for a parent with a dependent child – that most women do not meet these requirements.

Other legislative changes have taken effect in Texas since this study was conducted that might affect how low-income women are currently experiencing obtaining family planning. In 2011, the Texas Legislature

passed rules to exclude family planning providers affiliated with an abortion provider from the Medicaid waiver program. This exclusion applied to all of the Planned Parenthood clinics throughout the state, which had served 40% of the WHP clientele. Legal challenges led to Texas dropping out of the federal program and creating its own Texas Women's Health Program (TWHP) beginning in January 2013, after these focus groups had been conducted. It is unclear how women who had received WHP services at Planned Parenthoods have fared after the switch to TWHP. However, the TWHP has maintained the same exclusion for sterilized women.

In the 2013 Texas legislative session, more funding was put back into the system to replace much of the funding that was cut in the 2011 session and to replace Title X funding that was lost when the federal grant was awarded to a private nonprofit. However, much of the new state funding will go to providers that do not specialize in family planning, which can make access to long-acting and reversible contraception and other expensive methods more difficult for many women. Finally, the new state family planning money that replaced the Title X money does not offer a confidentiality guarantee, which could lead to significant gaps in minor teens' ability to access services without parental consent.

Medicaid expansion under the Affordable Care Act (ACA) has the potential to mitigate some of the negative consequences low-income women experience as a result of the patchwork of care. However, Texas does not currently plan to participate in the Medicaid expansion. For poor women who are eligible for the health care exchanges under ACA, it is still unclear if monthly insurance premiums will be in their reach. On other hand, if women do enroll in the health insurance exchanges, they will not be subject to the high deductibles that many of the lower-priced plans require for their annual well woman exams and contraceptive supplies, which will be covered with no additional cost sharing.

It is also unclear how women in states that do expand Medicaid will fare if their incomes bounce around the 138% FPL income threshold – will they immediately lose coverage or will there be a grace period, and how many will them will then obtain private insurance on the health care exchanges? Finally, Medicaid and the ACA exclude undocumented women, so they will continue to be at the mercy of a patchwork of services that they may or may not be eligible for. Older teens and young adults who stay on their parents'

insurance until age 26 also may face challenges with ACA in obtaining family planning services because they may not want the explanation of benefits, revealing that they received contraception or STI testing, going home to their parents.

Our study has several strengths and limitations. We have wide geographic diversity but we did not interview women in any rural sites where we would expect that access to family planning services is even more limited than it is for women in the urban sites of our study. We also have language diversity, but we did not conduct English- and Spanish-language groups in the same sites to determine if those groups might be different. However, because of the similarities in findings across the English- and Spanish-language groups of low-income women in different cities, we do not believe that we would have learned much more if we had conducted both language groups in the same city. We also have good coverage of Hispanic and African American women in our sample but we only interviewed a small number of white women and no African American minor teens (a few young African American older teens and young women were included in the adult women groups). Because of the similarity of findings across the sites, we believe that our findings do a very good job in capturing the experiences of urban, low-income Texas women and teens in the year following the significant budget cut to family planning in that state.

Conclusion

The funding cuts to family planning have exacerbated the challenges low-income women and teens in Texas already faced trying to access contraceptive and preventive reproductive health screenings. Indeed, we found that now more than ever disadvantaged women must choose between getting contraception and meeting other immediate economic needs. Low income women and teens would benefit from an expansion of free and affordable services so that they can consistently access services. This would enable them to take personal responsibility for their health and prevent unintended pregnancies.

Figure 1. Focus Group Sites by Texas Health Service Region

References

Frost, Jennifer J., Mia R. Zolna, and Lori Frohwirth. 2013. *Contraceptive Needs and Services, 2010*. New York: Guttmacher Institute, <http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf>.

Gold, Rachel Benson. 2013. "Besieged family planning network plays pivotal role." *Guttmacher Policy Review* 16(1): 13-18.

White, Kari, Daniel Grossman, Kristine Hopkins, Joseph E. Potter. 2012. "Cutting family planning in Texas." *New England Journal of Medicine* 327(13): 1179-1181.