HIV and the Role of Federal Funds for Sexual and Reproductive Healthcare Serving Women in California

CALIFORNIA HIV / AIDS POLICY RESEARCH CENTERS

October 2018 Brief | Northern California HIV/AIDS Policy Research Center

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Sexual and reproductive healthcare and rights (SRHR) are integral to gender equity, HIV prevention, and the provision of high-quality services for people of all genders living with HIV (PLWH).[1] Sexual and reproductive healthcare (SRH) services include: screening and treatment for reproductive cancers and infections, including HIV and other sexually transmitted infections (STIs); family planning and contraception; and comprehensive sex education.[2] In the United States, safety net SHR services are primarily paid for by the federal government.[3] In light of recent shifts in the domestic policy environment surrounding federal SRH programs, the Northern California HIV/AIDS Policy Research Center reviewed the role of these programs for cisgender women at risk of and living with HIV in California.[4]

CALIFORNIA WOMEN, HIV, AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

HIV. Although women make up a smaller portion of California's HIV epidemic, the risk they face is real: the impacts of structural gender inequality can exacerbate women's vulnerability to HIV, which is higher than men's.[1,5] In California in 2016, 587 cisgender women were newly diagnosed with HIV, and the over 15,000 cisgender women living with HIV (WLHIV) in the state were less likely than HIV-positive, cisgender men to be virally suppressed.[6,7]

Evidence is growing that the integration of SRH and HIV services improves healthcare quality and outcomes.[8] HIV prevention is considered a central component of quality SRH services, and research has found that SRH settings offer an opportunity for growth in HIV testing, prevention, and linkage to care efforts.[9,10,11,12]

STIs. 2017 data showed significant overall increases in STI rates in California, with particular disparities among low-income women and Black women.[13] Having an STI can make both HIV infection and HIV transmission more likely.[14] WLHIV may experience more severe STI symptoms and more frequent infections, and are more likely to be infected with strains of human papillomavirus (HPV) that have been linked to cancer.[15]

Family Planning. Unintended childbearing can negatively impact women's health, mental health, and economic opportunity, and is more common among low-income women, who also are disproportionately affected by HIV.[5,7,16,17] Around one-quarter of WLHIV may experience an unintended pregnancy.[18] Contraception access is therefore an important tool for improving HIV outcomes, women's health, and gender equity. California law currently requires insurers to provide all contraceptive methods without cost sharing (i.e., without patients needing to make a co-pay).[19] Nationwide, increased access to contraception has been linked to a decline in the rate of unintended pregnancy.[20] However, rates are still disproportionately high among lower-income women, a third of whom access contraception from federally funded SRH programs.[3,20] Also, for WLHIV in the United States, discussion of family planning desires is still a relatively unmet need.[1,21,22]

Intimate Partner Violence. Efforts are increasing to effectively integrate screening for intimate partner violence (IPV) within SRH service settings, in part because survivors of IPV have an increased likelihood of unintended pregnancy.[23] IPV screening bears particular relevance for HIV prevention and care because women who experience IPV may engage in more HIV and STI risk behavior, and WLHIV are significantly more likely to experience IPV and subsequently have poorer HIV-related health outcomes.[24,25]

FEDERAL FUNDS FOR SEXUAL AND REPRODUCTIVE HEALTHCARE

The federal government is the largest funder of SRH services in the United States, which are primarily delivered in the healthcare safety net through Medicaid, the Title X Family Planning Program, and Section 330 of the Public Health Services Act.[3] The role of federal SRH funds in reducing undesirable health outcomes and associated costs is sizable: in 2010 alone, these funds averted nearly $13.6 billion in healthcare costs, 410 HIV infections, 2,110 deaths due to cervical cancer, and 2,229,900 unintended pregnancies.[26]

Medicaid. The Medicaid program is integral to providing SRH and HIV-related services, and serves populations vulnerable to HIV, including low-income women, young women, and women of color.[7,27] More federal SRH financing is delivered through Medicaid than any other program, and the federal government is also the primary payer for SRH services in Medicaid, paying for 90 percent of the service cost instead of half; the federal government most commonly shares Medicaid service cost burdens evenly with states.[3] Research has shown Medicaid SRH to be relatively comprehensive, as compared to private care. For example, Medicaid enrollees are more likely to have discussed HIV and IPV with their provider, as well as their sexual history than private care enrollees.[28]

SRH services in Medi-Cal (California's Medicaid program) include IPV screening, HIV and STI screening and treatment, and contraception options, as well as abortion access (paid for with state funds).[29,30] Under the Affordable Care Act (ACA), states were permitted to establish, with federal approval, permanent programs that expanded limited family planning services to low-income individuals who were not eligible for Medicaid, using Medicaid funds under a State Plan Amendment.[28] Through this authorization, California has created the largest such program in the nation, the Family Planning, Access, Care, and Treatment (Family PACT) program, through which many of Medi-Cal's SRH and family planning services are also offered to low-income Californians who do not have other insurance coverage for these services.[28,31]

Title X. The federal Title X program funds SRH services for uninsured and low-income individuals, including HIV and STI screening and education, reproductive cancer screening, contraceptives, and pregnancy counseling.[32] Research has found that Title X funding tends to be additive, expanding the scope of contraceptive options offered by clinics, improving adherence to SRH best practices, and incorporating SRHR education.[3,33] Nationwide, in 2016, Title X primarily served poor, young women and paid for nearly 1.2 million HIV tests, identifying 2,824 individuals as HIV-positive.[34] California's Title X program served over a million individuals in 2016—a majority of whom were under the age of 30, in poverty, and uninsured—in clinics across the state, and saved $64.2 million in averted healthcare costs associated with unplanned pregnancy and STIs.[32]

Section 330. Federally qualified health centers (FQHCs) receive federal funding under Section 330 of the Public Health Services Act, which requires them to refer for or provide obstetric and gynecological care, screening for reproductive cancers, HIV, Hepatitis C, and other STIs, and contraceptive methods and counseling.[35] Increasingly, health centers have been providing these services directly at their clinical sites, but recent research has indicated that many do not have significant remaining capacity for growth in this area.[33]

SHIFTS IN THE POLICY LANDSCAPE

The elections in 2016 introduced a governing majority that holds a different ideology regarding SRH and has made a number of new proposals that may negatively impact federally funded, safety-net SRH services.

Sexual and Reproductive Health Education. As of June 30, 2018, all grants under the federal Teen Pregnancy Prevention Program (TPPP) were ended ahead of schedule.[36,37] Grantees included seven programs in California, which collectively reached tens of thousands of young Californians each year with SRHR interventions including: sex education that specifically included discussion of HIV prevention and beliefs; referral to culturally competent services for youth; education designed specifically for Black youth, Latinx youth, homeless youth, and young queer women; and evidence-based curricula emphasizing condom and contraceptive use skills, healthy relationships, and sexual communication and agency, including sex refusal.

Press coverage has also documented a trend toward filling Executive branch SRH positions with individuals who promote a primary strategy of sexual abstinence, despite evidence that comprehensive SRHR education that explicitly addresses HIV prevention methods is more effective at reducing sexual risk behaviors.[37,38,39]

Contraceptive Methods and Access. As noted, improved contraception access was linked to a decline in the unintended pregnancy rate.[17] In spite of this improvement, the Trump Administration has shifted toward promotion of "natural contraceptive" methods (e.g., the rhythm method) by adding a requirement that new Title X grant recipients offer these methods, without a requirement that they also offer more effective contraceptive methods.[40] Although natural contraceptive methods should be an available option, they are not as effective at preventing unintended pregnancy, and they do not protect against HIV or STI infection.[41]

Funding SRH Providers That Support Abortion Access. Unintended childbearing can negatively affect women's health and economic opportunity and occurs more frequently within groups that are also disproportionately impacted by HIV.[5,16,17] Nonetheless, many elected officials disfavor abortion access and have made a number of recent proposals aimed at either making the provision of SRH by abortion providers extremely difficult or blocking federal funding to these providers outright.

Increasing the Difficulty of Funding Requirements. A February 2018 Title X grant funding announcement indicated that priority would be given to primary care providers, making it more difficult for SRH clinics—which are more likely to provide abortion access—to successfully apply for funding.[42] New proposed regulations issued for Title X in June 2018 also require: abortion services to be physically, monetarily, and administratively separated from other services; providers to only offer abortion referrals at patient request; referral of all pregnant patients to prenatal care; grantees to be located close to a primary care provider; submission to more stringent oversight and reporting; and, that grantees provide, with no additional funding, services to women whose employers refuse on religious grounds to offer cover contraception.[42] These requirements would likely function in practice as a federal funding ban for many SRH providers.

Federal Funding Bans. Members of Congress have made several attempts to include with other legislation an amendment blocking all federal funds from organizations that provide abortion, even though such agencies are already barred through the Hyde Amendment from using federal funds to pay for abortion.[43,44,45] At the state level, lawmakers are already free to block federal funding for abortion providers because the Trump Administration reversed an Obama Administration regulation that would have, as of January 2017, prohibited states from keeping Title X funds from going to providers that perform abortions using other funds.[3] California has not adopted a state-level ban on federal funding to SRH providers that offer abortion.

Spotlight on Planned Parenthood. Planned Parenthood has received political attention for its role as an abortion provider. However, its other SRH services are significant: in 2016, the organization conducted 706,903 HIV tests and diagnosed 222,365 STIs, nationwide.[46] Planned Parenthood served over 40 percent of lower-income women accessing contraceptive services supported by public funds in California in 2015.[3] Recently, the organization began to expand its HIV services, including provision of pre-exposure prophylaxis (PrEP).[46] **Table 1** illustrates Planned Parenthood's role as an HIV testing provider in California in 2016.

Table 1. Selected Characteristics of Planned Parenthood Patients and Services in California in 2016

California Counties with Clinics	Non-White Patients	Patients Under 138% Federal Poverty Level	Female Patients Under Age 35	Patients Covered by Medi-Cal	Patient Encounters Covered by FamilyPACT	Total # of HIV Tests	Encounters with HIV Test Performed
35	36%	79%	75%	37%	48%	234,521	18%

Source: California Office of Statewide Health Planning and Development, 2016 Primary Care Clinic data. (n = 106 reporting clinics)

A ban on federal funding for Planned Parenthood in Texas increased the low-income birth rate, and SRH services suffered due to inexperience and limited staffing when primary care became the default provider.[3,47]

Related Funding Support. Efforts such as recent attempts to repeal the ACA could have significant effects on SRH services through changes to Medicaid. While ACA repeal proposals have thus far failed, Congressional leadership has indicated interest in revisiting this effort.[48] Also, the 340B Drug Discount Program, a source of revenue for SRH clinics, has recently been targeted for reductions.[28,49]

IMPLICATIONS FOR HIV AND WOMEN'S HEALTH IN CALIFORNIA

Policy changes aimed at SRH services may have notable consequences for HIV-related services utilized by California women. These present both challenges and opportunities across several domains.

Getting to Zero in California. SRH service reductions may impact California's ability to meet some of the objectives of its *Integrated HIV Surveillance, Prevention and Care Plan* by the plan's target date of December 2021, which include: increasing the percentage of Californians who know their HIV status; reducing new diagnoses; increasing the rate of STI testing among sexually active PLWH; and, improving integration between HIV, STI, and other health services, which can be particularly important for women.[1,50,51,52] Plan implementers may have to contend with how to still reach these targets amid a reduced SRH service environment. A recently passed California law extending comprehensive sex education—including HIV prevention education—requirements to charter school youth provides an example of how the state can work to reach HIV-related public health goals despite decreased federal support.[53]

Support for Planned Parenthood and Community Health Centers. Government estimates have found that blocking federal funding from Planned Parenthood would cut off some communities' access to SRH services.[54] The 2018 Title X grant funding announcement appears to intend to shift SRH to health centers.[42] However, health centers may not currently be able to adequately meet increased demand.[3,33,47] In 2017, Maryland enacted a law to fund Planned Parenthood using state dollars in the event that these clinics are barred from receiving federal funding; no such law currently exists in California.[3] Should SRH clinics be forced to close or reduce services in California, health officials would need to work closely with health centers to identify and address needs created by this shift. Health centers would perhaps need additional funds to increase capacity but California is not among states that provide direct funding to support health centers.[55,56] In addition, policymakers in California would need to identify and address emergent gaps in abortion access.

Maintaining Quality of Care. Scientific recommendations for quality SRH services include routine, opt-out HIV testing, linkage to HIV care, frequent STI screening for women living with HIV, and evidence-based HIV risk

education.[57] Recent policy trends would make it more difficult to meet these quality standards. In the absence of federal participation, states may need to increase SRH service oversight and support to promote quality care and desirable health outcomes. A recent California proposal, passed by the State Legislature but vetoed by Governor Brown, aimed to increase quality and performance measures to reduce health disparities among Medi-Cal Managed Care enrollees.[58] This measure may have provided an opportunity to incorporate more standardized SRH service quality measures into Medi-Cal Managed Care.

Supporting Medi-Cal. As the largest federal program supporting SRH services, it is critical that support for a robust Medicaid program be maintained. California has already begun to incorporate evidence-based SRH services in Medi-Cal, allowing since 2016 for trained pharmacists to dispense contraception to customers without a prescription from a doctor.[59] However, pharmacies have been slow to adopt this service and will not be reimbursed for it until mid-2021.[59] Should access to contraception decrease as a result of federal policy, California lawmakers may wish to consider accelerating the timeline toward pharmacist reimbursement, and working with pharmacies to improve implementation of pharmacy-based contraceptive dispensing.

California recently adopted legislation intended to maintain stable enrollment in Medi-Cal by allowing California to seek waivers from new federal regulations that would alter services or eligibility, which may allow the State the opportunity to better preserve access to evidence-based SRH services.[60] Efforts are also underway to explore a universal public insurance option in California; were this option to take shape, it would be critical to incorporate all SRH services and quality measures currently recommended for Medi-Cal.[61]

CONCLUSIONS

The evidence is clear that SRHR, HIV, gender equality, and women's health are interrelated issues that require robust, evidence-based, and coordinated healthcare and policy responses. Further research and dialogue are needed to identify optimal strategies for maintaining high-quality, integrated SRH services for women impacted by HIV in California, should the federal government continue to reduce or redirect its involvement.

ACKNOWLEDGEMENT

This product was developed using funds from the California HIV/AIDS Research Program, Office of the President, University of California, Grant Number RP15-SF-096.

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