Sunset Advisory Commission Staff Report
Health and Human Services Commission and System Issues
Comments on behalf of Nuestro Texas submitted by the National Latina Institute for Reproductive Health
October 17, 2014

Nuestro Texas is a human rights campaign calling for reproductive health access for all women, without distinction as to geographic location, ethnicity, race, economic class, or citizen status. The National Latina Institute for Reproductive Health (NLIRH) and the Center for Reproductive Rights launched the campaign in 2012 in response to the devastating 2011 cuts to family planning that resulted in the closure of 76 clinics statewide.

In November 2013, Nuestro Texas published a report—*Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Reproductive Health in the Rio Grande Valley*—documenting the impact of the 2011 budget cuts on Latinas living in the Lower Rio Grande Valley. In that region, 28 percent of state-funded family planning clinics closed entirely, and many more were forced to reduce services and raise fees. While we were heartened when the 83rd Texas Legislature sought to restore women's access to preventive care by returning to pre-2011 funding levels, to our knowledge only one of the nine family planning clinics forced to close down entirely was able to begin serving clients again. Tens of thousands of low-income women in the Valley remain without affordable care.

NLIRH, on behalf of Nuestro Texas, welcomes the chance to revisit opportunities to strengthen and rebuild the reproductive health safety net. Accordingly, we respectfully submit the following recommendations concerning the proposal to consolidate the three streams of state funding for women's reproductive healthcare in Texas, as presented under Issue 8 of the Sunset Advisory Commission Staff Report issued October 3, 2014. As a member of the Texas Women's Healthcare Coalition, NLIRH supports all of the additional recommendations brought to you by the Coalition ahead of the October 17, 2014 deadline.

Change in Statute (8.1): Require HHSC to establish a single women's health and family planning program for the health and human services system

1. *Client Eligibility*

Income: NLIRH recommends increasing the cutoff for client eligibility to 250 percent of the federal poverty level, as in the DSHS Family Planning program currently. Texas Latinos are nearly three times as likely to live in poverty as whites.[1] Seventeen counties in South Texas and on the border of Mexico with high Latino

populations also have disproportionately high rates of poverty among women, with 17 counties exceeding 46.8% of women less than 200% FPL. Raising the eligibility to 250 percent will help ensure there are fewer gaps in this needed coverage, and—as the Sunset Report acknowledges—at minimal cost to the state.

Fertility: NLIRH recommends extending eligibility to include women over 44 years-of-age who are not yet menopausal, as well as women who have been sterilized. Many Latinas who cannot access affordable and consistent contraception will pull together limited resources to pay for sterilization. However, as our documentation showed, many women who chose to be sterilized reported an unexpected dilemma: while they felt relief at no longer having to pay for contraception, now they do not qualify for reduced rates for breast exams and Pap tests.[2] Whether or not they retain reproductive capacity, all women continue to need preventive care such as breast and cervical cancer screenings, and sexually transmitted infection screening and treatment. Cervical cancer screenings are particularly important to the Latina community because we have the highest cervical cancer incidence and death rates of any racial or ethnic group in Texas.

Parental consent: NLIRH supports expanding the age of client eligibility to women 15 years-of-age. Additionally, NLIRH recommends waiving the parental notification requirement for teens accessing contraception. Latina women are less likely than white women to receive any formal instruction on methods of birth control before age 18,[3] and they are also less likely than white or black women the same age to receive any formal instruction before age 18 on how to say no to sex.[4] Additionally, as of 2010, publicly funded clinics in Texas were only meeting 22 percent of the need of teenage contraceptive clients.[5] Not surprisingly, sexual and reproductive health outcomes for Texas youth are some of the worst in the country. Texas has one of the highest teen pregnancy rates[6] and ranks highest in prevalence of repeat teen births.[7] Texas should support the family planning decisions of young parents by allowing them to access the contraception of their choice without additional barriers to care.

2. *Eligibility Determination and Enrollment Process*

Point-of-service eligibility: NLIRH recommends same-day eligibility determination and services to achieve the most effective family planning and sexually transmitted infection control outcomes. Clinics need the capacity to determine a patient's eligibility when a patient arrives in order to provide efficient and effective care. Many Texas women face significant challenges to making a second trip to the clinic after eligibility is determined, particularly in large swaths of the Lower Rio Grande Valley where transportation infrastructure is almost nonexistent. Additionally, NLIRH is concerned with any eligibility determination model where the provider carries all of the financial risk of treating a patient before eligibility has been confirmed.

3. *Covered services:*

FDA-approved contraceptives: NLIRH recommends that Health and Human Services Commission develop guidelines to require all providers in the proposed women's health and family planning program to offer a full range of FDA-approved contraceptives, including long-acting reversible contraceptives (LARCs) available onsite, in addition to comprehensive options counseling and referrals. NLIRH supports the ability for Latinas to have access to comprehensive contraception options and for all women to have the option to choose the form of birth control that is right for her.

Our documentation in the Valley and additional research by the Texas Policy Evaluation Project has shown a strong preference in the Latina community for LARC methods, such as IUDs. Though more expensive than other methods, these are not only more effective in preventing unintended pregnancy, but also more suitable to the needs of low-income women who face difficulties in accessing clinics. The 2011 cuts to family planning forced clinics to make difficult choices about allocating funds, and many were forced to stop stocking LARCs. Moreover, unlike Title X clinics, providers contracted through the current EPHC system are not required to stock all FDA-approved contraceptive methods. This necessitates that women take another trip to fill their prescriptions at a pharmacy, an extra step that burdens low-income women who already face significant transportation barriers.

Mobile clinics: NLIRH recommends promoting and investing in mobile health clinics to serve rural and low-income communities. In addressing challenges to accessing providers, the Sunset Advisory Commission's staff report notes: "Considering the large majority, approximately 90 percent, of clients earn below 100 percent of the federal poverty level and have limited transportation options, their ability to get to a second provider at a different site is further limited."

The Texas Legislature should explore creative solutions to address transportation barriers for women in rural and underserved areas, including the use of cost-effective mobile health clinics. Such clinics are in high demand in areas like the Lower Rio Grande Valley, where knowledge of the healthcare system is low and transportation barriers deter women from traveling outside their communities to seek services. At mobile reproductive health clinics, women who are low-income can receive free or low-cost contraceptive counseling and supplies, Pap tests, and breast exams without negotiating the costs and burdens of transportation to a clinic far from their communities. Another advantage is that mobile clinics can also tailor their services to particularly hard-to-reach communities by providing linguistically and culturally appropriate care.

4. *Transition*

Stakeholder involvement: NLIRH recommends for the process of consolidation to include substantial, meaningful, and ongoing stakeholder involvement from providers and constituents most affected by recent disruptions to the reproductive health safety net. Accordingly, stakeholders should include Latinas, rural women, young people, LGBT populations, and other disproportionately impacted populations in all stages of planning, implementation, and evaluation of proposed changes to state women's health services.

Management Action (8.2): Direct HHSC to study the feasibility of automatically transitioning new mothers in Medicaid to the new women's health program

Automatic enrollment: NLIRH recommends automatically transitioning new mothers in the Medicaid program, who are not eligible for Medicaid coverage, to the new woman's health program after giving birth. Latinas are the highest population of women of childbearing age (15-44) in Texas (approximately 2.5 million out of 5.7 million).[8] Although the fertility rate among Latinas has declined the fastest of all major racial and ethnic groups from 2003-2012, Latinas continue to have the highest fertility rate of 78.6 live births per 1,000 women of childbearing age.[9] Additionally, Latinas are the most likely group of Texas women to lack a personal

doctor,[10] and the least likely to have seen a doctor in the past year due to cost.[11] Therefore, every opportunity a woman has to meet with a healthcare provider should be maximized to ensure a continuity of care – an automatic transition of new mothers in Medicaid to the new women's health program will help achieve this objective, and should be done without further delay.

Thank you for the opportunity to offer recommendations. NLIRH looks forward to the opportunity to discuss these and other concerns with you further. If you have any questions, please do not hesitate to contact me at ana@latinainstitute.org or 512.963.6001.

Sincerely,

Ana DeFrates
Director, Texas Policy & Advocacy
National Latina Institute for Reproductive Health

[1] KFF, Poverty Rate by Race/Ethnicity (2011-2012), http://kff.org/other/state-indicator/poverty-rate-by-raceethnicity/ (last accessed May 15, 2014) (showing that the rate of poverty among Hispanic Texans is 33 percent compared to 12 percent of non-Hispanic white Texans).

[2] CENTER FOR REPRODUCTIVE RIGHTS & NATIONAL LATINA INSTITUTE FOR REPRODUCTIVE HEALTH, Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Reproductive Health Care in the Rio Grande Valley, pg. 31 (2013), http://www.nuestrotexas.org.

[3] CDC, *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2002*, 37 (2004), http://www.cdc.gov/nchs/data/series/sr_23/sr23_024.pdf [hereafter CDC, *Teenagers in the United States*] (showing 35.4 percent of Latina women did not receive this instruction, as compared to 27.8 percent of white women).

[4] CDC, *Teenagers in the United States*, 36 (showing 18.6 percent of Latina women did not receive this instruction, as compared to 13.2 percent of white women and 15.6 percent of black women).

[5] Jennifer Frost ET AL., Contraceptive Needs and Services, 2012 Update, GUTTMACHER INST. 15 (2014), http://www.guttmacher.org/pubs/win/contraceptive-needs-2012.pdf

[6] Kathryn Kost & Stanley Henshaw, *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity*, GUTTMACHER INST. 17 (2014), http://www.guttmacher.org/pubs/USTPtrends10.pdf [hereafter Kost et al., *U.S. Teenage Pregnancies, Births and Abortions*]. In 2010, the teen pregnancy rate in Texas was 73 per 1,000 women aged 15-19 compared to the national rate of 57 per 1,000 women in the same age group.

[7] Kinsey Hasstedt, The State of Sexual and Reproductive Health and Rights in the State of Texas: A Cautionary Tale, GUTTMACHER INST. 14 (2014), http://www.guttmacher.org/pubs/gpr/17/2/gpr170214.pdf

[8] Kyle Janek et al., Presentation to Senate Committee on Health and Human Services: Texas Women's Health and Family Planning Programs by the Texas Health and Human Servs. Comm'n & Texas Dept. of State Health Servs. (Feb. 20, 2014)

[9] *Id*.

[10] The Henry J. Kaiser Family Foundation (KFF), State Health Facts, No Personal Doctor/Health Care Provider for Women, by State and Race/Ethnicity, 2006-2008 (2006-2008), http://kff.org/disparities-policy/state-indicator/no-personal-doctor/ (last accessed Aug. 25, 2014).

[11] KFF, State Health Facts, No Doctor Visit in Past Year for Women Due to Cost, by State and Race/Ethnicity, 2006-2008 (2006-2008), http://kff.org/disparities-policy/state-indicator/no-doctor-visit-in-past-year-due-to-cost/ (last accessed Aug. 25, 2014).