CHARLOTTE LOZIER INSTITUTE

*The education and research arm of the Susan B. Anthony List*

November 9, 2015

Mr. Chad M. Chirico
Unit Chief
Low-Income Health Programs and Prescription Drugs Cost Estimates Unit
Congressional Budget Office
Washington, DC

Dear Chad and Colleagues:

The Charlotte Lozier Institute is pleased to have the opportunity to submit comments and observations to the Congressional Budget Office (CBO) regarding its September 22, 2015 analysis of the budgetary effect of permanent elimination of Medicaid funding of affiliates of the Planned Parenthood Federation of America. We appreciate the time CBO staff members took to speak with us and elaborate elements of the letter, particularly with respect to certain assumptions regarding client numbers and client behavior patterns that affected CBO's calculations. In the comments that follow, we refer both to the letter of September 22 to the Majority Leader of the House of Representatives and to information and clarifications provided to us during our meeting with your staff on October 14. Please accept our apology and our willingness to adjust our comments if our notes do not comport with the particulars of CBO's analysis in any way.

First, we strongly concur with CBO's repeated acknowledgement that the effects of changes in federal direct spending characterized in the letter of September 22 are "highly uncertain." Because the potential changes involve the behavior of thousands of women and men, the conduct of literally thousands of clinics and personnel, and an arbitrary and lengthy timeline, CBO faced an extremely difficult, if not altogether impossible, task. Nonetheless, while this comment elects in light of these factors not to offer an alternative figure to CBO's calculation of a 10-year increase in direct outlays of $130 million, we believe there is substantial evidence of factors at play in this particular instance that reduce and may in fact eliminate any increase in outlays. In addition, while we are constrained to provide comments about impacts over a 10-year period, we note our special concern that any conclusions about direct outlays in connection with the birth of a large number of human beings are profoundly distorted by confinement to a limited budget window. For this reason, the analysis window itself is a limited and inappropriate basis on which Congress should make an informed policy judgment.

Specifically, we wish to express the following concerns:

1. **The CBO analysis over-estimates the number of family planning clients affected by a potential disruption of service.** CBO states at (3) that the patient population at the Planned Parenthood Federation of America is 2.6 million. The letter does not distinguish women from men but since its calculations refer only to additional births as a source of direct outlays, it can be presumed

that the impact of permanent Medicaid limit on only female clients is being considered. Since Planned Parenthood's client population is overwhelmingly female, this has little impact on the conclusions drawn. However, during our meeting, CBO indicated that, in order to achieve an apples-to-apples comparison, its analysis was restricted to Medicaid-using family planning clients and their projected access to/utilization of contraceptives before and after the end of Medicaid eligibility for Planned Parenthood.

This has a substantial effect on the calculations. An examination of published client figures shows that Planned Parenthood's female contraceptive client total is 20% smaller than the figure CBO cites and that this number declined by nearly 200,000 women from 2009-2013. (See Table 1) Moreover, media reports suggest that due to external factors such as the expansion of health insurance coverage under the Affordable Care Act, Planned Parenthood is now experiencing an overall decline in its client population that could be as high as 6% per year.[1] CLI has no access to 2014-15 client data for the Planned Parenthood Federation but the likelihood is that the family planning client population affected by a change in Medicaid reimbursement eligibility for Planned Parenthood is closer to 2.1 than 2.6 million women.

Table 1: Planned Parenthood Total Reversible Contraceptive Clients, by Year

| 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| 2,327,662 | 2,219,726 | 2,006,691 | 2,129,855 | 2,131,865 |

All data drawn from Planned Parenthood Federation of America Annual Reports for the Fiscal Year indicated

2. **CBO's singular focus on the "apples-to-apples" comparison of before-and-after effects for Medicaid family planning clients misses substantial effects on the relevant population that will tend to reduce direct outlays from a measurable, "whole-woman" perspective.** Estimating these effects requires distinguishing four main types of client – three existing groups of Planned Parenthood clients and the group of clients entering the health care system for the first time who are seeking family planning options or primary care, or both.

   CBO identifies three groups for purposes of analysis – precisely, women who will:

- "Continue to obtain services from Planned Parenthood without Medicaid reimbursement" (i.e., through whole or partial self-pay, new state or local sources of funding, or Planned Parenthood absorption of the cost);
- "Obtain services from other health clinics and medical practitioners that receive Medicaid reimbursement;
- "No longer obtain such services."

In each instance, CBO is referring to women obtaining family planning services. In CLI's view, the analysis should not and cannot assume away changes in expanded preventive health services for the middle group of women, which CBO indicated to us it sees as including 1) women entering the U.S. health care system for the first time over the estimation period, who will be accessing more comprehensive care than the reproduction-related services emphasized by Planned Parenthood

[1] Julian Mincer, "Planned Parenthood faces unexpected challenge from Obamacare," Reuters (September 8, 2015). http://www.reuters.com/article/2015/09/08/us-usa-plannedparenthood-insight-idUSKCN0R80B420150908

Federation of America clinics, as well as 2) women currently served at Planned Parenthood clinics who rely upon those clinics for all of the health services they receive.

We discuss the second group first. A substantial number of women who currently lack access to, or do not choose to access, the kind of comprehensive preventive services and primary care generally available at FQHCs and not at Planned Parenthood appear to be overlooked in the CBO analysis. One spring 2011 Guttmacher Institute paper, discussing the 8,000 publicly funded family planning centers[2] in the United States, says that six in 10 women who visit a family planning center describe it as their usual source of medical care. The paper cites a 2000 survey conducted at Planned Parenthood of Los Angeles (of limited value given the survey's age, the fact that it is a single center, and the fact it predates enactment of the Affordable Care Act), which found that 29 percent of the center's adult clients used Planned Parenthood as their only source of health care. It would be valuable to know whether CBO has access to more recent data on the percentage of Planned Parenthood's female family planning clients who currently have no other provider of health care.

CLI estimates that the annual per patient cost at Planned Parenthood clinics is in the neighborhood of $339. Published estimates of the annual per-patient cost at community health centers are approximately $600 per year for a much wider array of services.[3] Thus a woman without a primary care provider who transfers from Planned Parenthood to a community health center would have an average new cost of $261 per year, a substantial percentage of which would represent an increase in federal outlays.

But community health centers have consistently estimated that the decline in other costs to the health care system, resulting from fewer emergency room visits, fewer and shorter hospital stays, and averted illnesses, averages at least $1,000 per client per year. A 2013 analysis in the *Northwestern Journal of Law and Social Policy* explains, "Uninsured individuals living within close proximity to an FQHC are less likely than other uninsured individuals to possess an unmet medical need, less likely to visit the emergency room or have a hospital stay, and more likely to have had a general medical visit [citation omitted]. Overall, the FQHC model has enhanced community health outcomes, created system-wide savings through reduced hospital and emergency room visits, and stimulated economies in numerous low-income communities." [citation omitted][4] These impacts are so significant, the author states, that they have reduced and even "eliminated" disparities in health status among different social and income groups.

The National Association of Community Health Centers (NACHC) has likewise relied upon estimated system-wide savings of this size, citing $24 billion in health care savings accruing to a CHC patient population of 23 million people. A March 2011 paper from the George Washington University Department of Health Policy reiterates this broad estimate of savings. More specifically, discussing the

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[2] In our discussion on October 14, CBO indicated that its analysis rested upon a total of 4,000 family planning clinic alternatives to Planned Parenthood, not the higher number cited in this Guttmacher Institute paper. Our scanning of cited documents suggests that there are 4,100 family planning clinics that receive funds under Title X of the Public Health Service Act. We are uncertain if this is the source of the number of clinics CBO relied upon and unsure why the smaller number of clinics would be the more appropriate comparator.

[3] "Community Health Centers: The Local Prescriptions for Better Quality and Lower Costs," NACHC (March 2011). https://www.nachc.com/client/A%20Local%20Prescription%20Final%20brief%203%2022%2011.pdf at p. 3.

[4] James Hennessy, *FQHCs and Health Reform: Up to the Task?,* 9 Nw. J.L. & Soc. Pol'y. 122 (2013), at 124.

potential impact of new community health center spending under the American Recovery and Reinvestment Act (ARRA), the authors write, "Based on historical growth, funding patterns and coverage expansions, we estimated that ARRA would double health center capacity to serve 33.8 million to 44.1 million patients by 2015 and save approximately $1,551 per person in health care costs."[5] Additional revenue would accrue to federal and state governments as well if estimates of an 8-5 ratio of new economic activity stimulated by dollars invested in health centers holds true.[6] In addition, some authors have estimated high costs in uncompensated care, whose burden is shared by hospitals, state governments, and a wide variety of federal programs which pick up a major portion of this cost. Any patients relying on Planned Parenthood for family planning but now passing on uncompensated care costs in this manner will affect direct outlays under these programs via transfer to a community health center.[7]

CLI has been unable to identify any previous CBO estimate that has recognized such savings through the operation and expansion of community health centers, but we regard the NACHC and other authoritative estimates as reasonable and certainly as no less speculative than conclusions drawn from the mere possibility of increased pregnancies and births due to incremental differences in the effectiveness of family planning methods chosen over a five-year period. If only half of the estimated per-patient savings in health system outlays are achieved by expanded enrollment in community health centers, the annual savings in federal direct spending (assuming federal outlays comprise 50 percent of the nation's health care spending, a conservative estimate here given the focus of family planning programs generally on the lowest-income population) for clients completing a transfer from Planned Parenthood to a CHC would be more than $250. This number would be higher if the client is entering the health care system for the first time and has previously relied on emergency rooms or other, higher-cost options.

### 3. CBO's Estimation of Reduced Access to LARCs May Overestimate the Impact of This Change and Discounts Overall Trends in Service Provision

CBO broadly describes the number of women affected by the acquisition of more comprehensive preventive services supplied by federally qualified health centers and their rate of transfer to FQHCs or arrival at FQHCs because of the decline in access to Planned Parenthood facilities. CLI agrees with that broad description except as to the smaller family planning client base already discussed. Therefore, we accept that a mid-range of 15 percent of the current Planned Parenthood female family planning client

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[5] P. Shin and S. Rosenbaum, "The Health Care Access and Cost Consequences of Reducing Health Center Funding," citing Ku L., Richard P., Dor A et al., June 30, 2010, "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform."

[6] Ibid., p.6.

[7] Coughlin, T.A., Holahan, J., Caswell, K., McGrath, M. "Uncompensated Care for the Uninsured in 2013: A Detailed Examination," May 30, 2014. The authors write, "Providers do not bear the full cost of their uncompensated care. Rather, funding is available through a wide variety of sources to help providers defray the costs associated with uncompensated care. This funding may be linked to an individual patient's care or may be paid as a lump sum or grant to a provider. We estimate that in 2013, $53.3 billion was paid to help providers offset uncompensated care costs. Most of these funds ($32.8 billion) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, the Indian Health Service, Community Health Centers block grant, and Ryan White CARE Act (Figure omitted). States and localities provided $19.8 billion, and the private sector provided $0.7 billion."

base faces a potential disruption in care, but suggest that this mid-range is closer to 315,000 women.[8] The current acceptance rate of LARCs at Planned Parenthood clinics is indeed increasing, as shown in Table 2.

Table 2: Planned Parenthood LARC patients (total and percentage of family planning clients).

| Method | | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|
| Orals | | | 39.5% | 37.7% | 37.9% | 37.0% |
| Unknown | | | 8.4% | 20.8% | 20.9% | 21.2% |
| Barrier | | | 17.8% | 18.1% | 17.6% | 14.2% |
| No Method | | | 11.9% | | - | - |
| Progestin-Only Injectable | | | 9.4% | 10.1% | 10.1% | 11.6% |
| IUD | | | 4.1% | 4.3% | 4.4% | 6.4% |
| Ring | | | 5.7% | 5.8% | 5.8% | 5.1% |
| Implant | | | 0.7% | 1.1% | 1.1% | 2.4% |
| Patch | | | 2.3% | 2.1% | 2.1% | 2.1% |
| Other | | | 0.2% | | | |
| **Total Reversible Contraceptive Patients** | | 2,327,662 | 2,219,726 | 2,006,691 | 2,129,855 | 2,131,865 |

All data drawn from PPFA Annual Reports for the Fiscal Year Indicated. Gray highlight indicate LARC.

CLI calculates that 8.8% (assuming rounding) of current Planned Parenthood clients accept LARCs (acknowledging a higher percentage for 2014 and 2015 is possible) and that an estimated 27,720 women using these methods would experience a service disruption beginning in the year funding is cut off. These clients would appear to have the least impact on Medicaid costs over the first years of transfer to other women's health care centers due to the nature of the family planning option they have chosen, which will remain more effective than other available options and require less follow-up care. It appears likely therefore that CBO's additional Medicaid costs are attributable to the remainder of the disrupted female clients not making a decision to adopt a LARC method due to lack of access in the period following the funding cut-off. Our analysis would be aided by knowing any projections CBO may have used regarding the conversion rate to other methods of the remaining client population subject to disruption.

We note, however, that it would be an error to presume that LARC access and acceptance rates at FQHCs will remain immutable over the period analyzed. As the data above demonstrate, the rate at which women accept the contraceptive implant can double in a single year, and the rate at which IUD use increases can be as high as 50% per year. If CBO has relied upon the persistence of a significant margin in LARC acceptance between Planned Parenthood and community health alternatives, and/or a flat rate of acceptance at the latter over the decade analyzed, it would be helpful to clarify that

[8] We note that CBO's calculations, to simplify comparison, rely on an assumption that the female patient population losing access to preventive services is receiving Medicaid-funded services both before and after the change in access. This is statistically reasonable but in the real world it is likely that a possibly significant percentage of the women losing services would be patients at a facility that closes or limits service hours as a result of the permanent Medicaid funding restriction. Such a patient pool would include women who are not reliant on Medicaid as well as some who do rely on the program; one Planned Parenthood source – at http://www.plannedparenthoodaction.org/issues/medicaid-and-women/planned-parenthood-and-medicaid/ - notes that fewer than half of Planned Parenthood patients rely on Medicaid. If so, the number of affected patients whose changes in service would affect direct spending is even lower than the 315,000 we propose here.

assumption and any basis on which it rests. A study of LARCs published in 2010 found no difference in acceptance rates of LARCs based on the type of clinic at which the study participants were contacted. "We anticipated a lower LARC utilization rate among women enrolled at the community clinics, as provider myths and misperceptions may persist; however we did not observe a significant difference in the selection of LARC versus other methods at the family planning and community clinics compared to the university clinic."[9]

**4. In a real world example of smaller-scale funding reduction, Planned Parenthood income recovery has outpaced the CBO estimate of a 50% replacement of lost revenue from Medicaid and this recovery has persisted over time. In fact, lost Planned Parenthood state revenue was fully replaced, even if an increase in federal funding over the period is excluded from the calculations.**

CLI acknowledges that its criticism of this element of CBO's estimating is uncertain at best. As CBO indicates, there is no "clear basis" on which to draw conclusions about the extent to which Planned Parenthood and its affiliates would be able to replace lost revenue due to the permanent ending of Medicaid funding. The selection of a mid-range, 50% replacement level is elementally fair, though we are less persuaded that this replacement level will be the high-water mark for a very strong nonprofit with a history of excess revenue of more than $750 million over a nine-year period at a national aggregate level.[10] In fact, at an average of $339 per patient per year in cost, a recent single year of excess revenue ($127.1 million) for the nation's 38th largest nonprofit would allow continued services for an estimated 375,000 women, the entirety of the potentially displaced client load, whether CBO's calculation or CLI's lower figure is used.

Funding reductions on a smaller scale have already occurred in some locales. In March 2010, for example, New Jersey Gov. Chris Christie inaugurated a series of budget vetoes that blocked, in years one and two, $7.5 million in funding from going to family planning centers in the state, including Planned Parenthood. Those vetoes have continued to the present day.[11] The table below presents the revenue track of Planned Parenthood centers in the state from 2010 through 2013, showing a sharp reduction in income in 2012 for one affiliate but substantial year-over-year increases for Planned Parenthood of New Jersey considered as a whole. In fact, in 14 of the 16 years tracked, the six New Jersey Planned Parenthood affiliates enjoyed revenue increases, and the annual rate of total revenue increase during the period 2010-2013 was +9.3%. The lines marked in gray track what happened to overall affiliate

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[9] Secura, G., Allsworth, J. et al. "The Contraceptive CHOICE Project: Reducing Barriers to Long-Acting Reversible Contraception," Am J Obstet Gynecol. 2010 Aug; 203(2): 115.e1–115.e7 (accessed October 26, 2015). The authors also looked at the impact of their study sample and design with respect to socio-economic, ethnic or other factors: "Other strengths include a large sample size and a diverse group of women in terms of race/ethnicity, marital status, and socioeconomic status which strengthens the generalizability of our findings to populations at greatest need for contraception. Our data are collected using well-designed, tested, and standardized instruments administered by trained interviewers."

[10] "Planned Parenthood Shows $3/4 Billion of Excess of Revenue Over Past Decade," Charlotte Lozier Institute (September 15, 2015). https://www.lozierinstitute.org/planned-parenthood-shows-%C2%BE-billion-of-excess-of-revenue-over-past-decade

[11] Katie Sanders, "Chris Christie vetoed Planned Parenthood funding 5 times, Hilary Rosen claims," Politifact (November 10, 2013). http://www.politifact.com/punditfact/statements/2013/nov/10/hilary-rosen/chris-christie-vetoed-planned-parenthood-funding-5/

income from non-federal sources during the period 2011-2013, and even here Planned Parenthood of New Jersey's revenue held steady and ultimately increased at an average annual rate of approximately 3.6%. In brief, Planned Parenthood's New Jersey affiliates have suffered no net income loss during the period of restrictions on state grant funding.

While no single group of affiliates would necessarily represent what would happen nationally in the event of a privatization or partial privatization of Planned Parenthood, this growth rate suggests the nonprofit has considerable resilience. All data shown here are derived from the affiliate 990s for these years found at guidestar.org.

| PP New Jersey Affiliate | 2010 | 2011 | 2012 | 2013 | Total |
|---|---|---|---|---|---|
| Central & Greater Northern | $8,108,711 | $10,073,109 | $13,168,977 | $13,886,729 | |
| Federal Grant Amount | | $2,597,686 | $4,118,494 | $3,725,247 | |
| Non Federal Income | | $8,476,423 | $9,050,483 | $10,161,482 | |
| Metropolitan | $6,366,937 | $6,323,036 | $6,282,836 | $6,312,788 | |
| Federal Grant Amount | | $2,028,413 | $2,115,677 | $1,889,214 | |
| Non Federal Income | | $4,294,623 | $4,167,159 | $4,423,574 | |
| Southern New Jersey | $3,495,622 | $3,956,552 | $2,949,755 | $3,255,386 | |
| Federal Grant Amount | | $1,913,968 | $1,802,406 | $1,680,938 | |
| Non Federal Income | | $2,042,584 | $1,147,349 | $1,574,448 | |
| PP Affiliates of New Jersey | | $152,930 | $357,955 | $431,194 | |
| PP Action Fund | | $33,469 | $19,736 | $385,640 | |
| PP Association of Mercer County | $3,477,633 | $3,246,218 | $3,768,594 | $3,130,167 | |
| Federal Grant Amount | | $648,534 | $624,534 | $632,600 | |
| Non Federal Income | | $2,598,684 | $3,144,060 | $2,498,567 | |
| Total Income (all sources) | $21,448,903 | $23,785,314 | $26,547,853 | $27,401,904 | |
| Total Income (nonfederal) | | $17,412,314 | $17,509,051 | $18,658,071 | |

**5. Medicaid cost estimates for new births produce self-evident distortions in long-term budget calculations due to the constrained budget window and the failure to assume a base value to individual human life.**

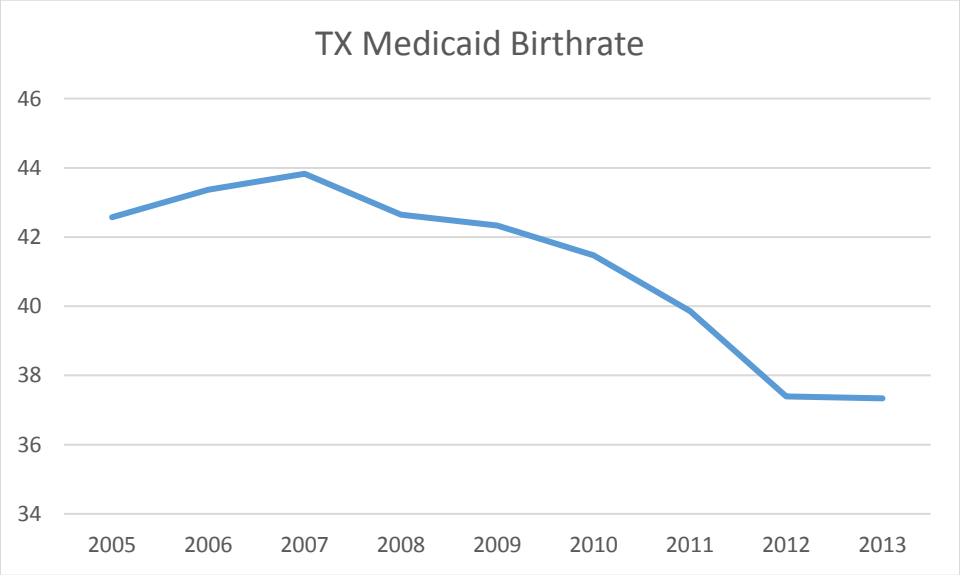
Ultimately, the bulk of the increase in direct spending cited by CBO results from an increase, CBO says, in births that would result as women, presumably, "lose access" to family planning that averts births. CBO, without more, says that it estimates these increased births at several thousand per year, leading to direct spending attendant upon the births and additional outlays as the children themselves qualify for Medicaid benefits. Here, of course, CBO's analysis – and its overall significance – are heavily limited, as the letter could well have noted, by the 10-year window over which these "highly uncertain" calculations are made. The 10-year impact of any human being on direct spending (no matter by whom – federal, state or local government or parents and relatives) is surely a cost, but human beings are not depreciating equipment or simply a component of consumption; for other purposes, federal budgeting accounts for human beings as an asset and the value of that asset is typically realized no earlier than 15-years post-birth or perhaps 20 or more. If the time-horizon used by CBO is fixed by historical budget practice, nothing prevents CBO from noting the limited usefulness of this analysis for policy purposes when a longer time-horizon is surely relevant to the calculation of the one statistic the analysis yields – long-term direct spending.

Attributing new costs to "unwanted births" is an ultimately misleading indicator by which to set federal fiscal policy. All births impose new short-term costs on society, as investments in the young are rarely offset until they reach adulthood, earn income, produce goods, make inventions, pay taxes, and/or voluntarily serve their country. If CBO's constrained approach were finally meaningful, it would be fiscally prudent to prevent all births and thereby save immense sums. This is clearly false and an instance where CBO's "uncertainty" about its projections is in fact welcome. The U.S. Environmental Protection Agency, for example, uses a figure of $7.4 million[12] (2006 dollars) for the "value of a statistical life." The inability of CBO to employ a longer time horizon in projecting future benefits from human births is a structural problem that is worth noting in an assessment of this kind if an accurate portrait of future costs and benefits is to be achieved.

**6. Lastly, evidence exists that the many complex drivers of the Medicaid-subsidized birth rate, including such factors as changes in the size of the affected population, changes in sexual behavior, and economic factors, render predictions of simple, straight line changes due to a single factor like "type of contraceptive used" unreliable.**

Texas is another state where changes in state-originated funding of family planning centers led to a reduction in support for Planned Parenthood. CLI has reviewed initial Medicaid funding data for births in the first full year (2013) after the funding reduction and we note that the rate of Medicaid-funded births in Texas did not increase (see Figure 1). This represents a single year, of course, but Texas is a large state, subject to significant changes in the female population due to immigration and population in-flow. Further data may elucidate whether the Medicaid-financed birth rate did not continue its long-term decrease due to the changes in family planning funding, but here it suffices to show that the impact is unpredictable at best and that a reduction in the Medicaid-funded birth rate is possible under a variety of circumstances and for a multiplicity of reasons.

Figure 1: Texas Medicaid Birthrate (2005-2013)




[12] "Frequently Asked Questions on Mortality Risk Valuation," EPA. http://yosemite.epa.gov/ee/epa/eed.nsf/pages/MortalityRiskValuation.html#whatisvsl

Thank you again for allowing the Charlotte Lozier Institute to submit these comments on the CBO letter of September 22. We look forward to future interactions and discussions on these issues.

Sincerely,

Charles A Donovan, Sr.
President