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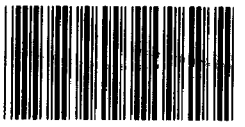

STATEMENT OF
GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

FAMILY PLANNING ACTIVITIES UNDER
TITLE X OF THE PUBLIC HEALTH SERVICE ACT

Mr. Chairman and Members of the Committee, we are pleased to be here today to summarize the results of our recently completed review of federally funded family planning programs. We addressed a range of issues that were of particular interest to the Subcommittee on Aging, Family and Human Services, and the Subcommittee on Health and the Environment, House Committee on Energy and Commerce. Today, in the interest of time, we would like to limit our discussion to ways we believe HHS can reduce family planning program costs, make services more attractive to clients, and facilitate fee collections from those who have ability to pay.

In fiscal year 1980, the Department of Health and Human Services (HHS) spent about $375 million for family planning services and contraceptive supplies through several different programs. Under the largest program, authorized by title X of the Public Health Service Act, which was enacted in 1970, over $1 billion has been provided for project grants for family planning services. In fiscal year 1980, about $156 million of these funds went to about 5,125 clinics serving about 3.8 million persons.

How well these clinics are managed significantly affects the efficiency, effectiveness, and costs of federally funded family planning programs. From our work at 26 clinics located in seven States we concluded that family planning clinics can provide quality care more efficiently and that clinics could raise more revenue from clients if consistent fee policies were followed.

CLINICS CAN PROVIDE QUALITY CARE MORE EFFICIENTLY

Family planning clinics we visited were generally providing the medical services required by HHS. However, in our opinion, HHS' title X program guidelines recommended:

--Too many revisits for women using oral contraceptives;

--Education that does not appear to be needed by all clients; and

--Some routine medical tests that do not appear to be necessary for all clients.

In addition, many of the clinics were performing tests and examinations not required by HHS or professional medical standards. These included:

--Routine tests for syphilis and gonorrhea in spite of test results indicating the population served is not always at high-risk for these diseases, and

--Semi-annual routine physical examinations, including pelvic examinations, which are not recommended by HHS, or professional standards.

We believe these practices unnecessarily add to program cost. They may also contribute to long waits for appointments and long office visits at some clinics, which, in turn, may deter participation by some or discourage some clients from continuing in the program.

We could not determine the costs associated with these practices but a rough estimate for unnecessary clinic revisits recommended by HHS could range from $6 million to $13 million annually. We believe the costs of other questionable practices are substantial.

HHS has been revising its family planning program guidelines. During our review, we met with HHS representatives on several occasions to discuss our findings and suggest changes in the guidelines which would help alleviate the problems we were identifying. HHS representatives were generally very receptive and made several modifications to their draft revised guidelines. They disagreed, however, with our suggestion to delete a proposed requirement for routine gonorrhea screening. Title X program guidelines currently in effect do not require such screening.

CONSISTENT FEE POLICIES ARE NEEDED

Although some clinics have successfully used sliding fee scales to charge clients who had ability to pay, other family planning projects have made little or no effort to generate fee income. Although HHS requires projects to have sliding fee scales based on ability to pay, the fee policies at clinics we visited varied considerably. Some charged no one, while others charged even low-income clients who should, according to title X, have received free service. One grantee was vigorously collecting fees from low-income clients, except Medicaid clients, and was making fee payment a condition of service.

These inconsistencies stemmed in part from:

--Obsolete HHS regulations defining low-income families;

--Lack of workable guidance in applying the family income test to teenagers seeking services without parental knowledge;

--HHS regional officials not uniformly enforcing fee scale requirements;

--Some States adopting title XX policies which conflicted with title X regulations; and

--Perceptions by clients and clinic personnel that services were free.

With the confusion over the fee policy, some clinics have lost revenues they might have collected, and clients have not been treated equitably according to their incomes.

Conflicts in fee policies between the title X and title XX Social Services programs posed an especially difficult problem. These conflicts have made it difficult or impossible for some clinics to collect fees as required by title X regulations and have resulted in inequitable treatment of clients.

Title X regulations generally require grantees to collect fees, using a sliding scale, from clients with incomes exceeding the Federal poverty level. On the other hand, title XX permits States to determine eligibility for free family planning services. This has led to conflict with title X regulations in two ways.

First, some States have elected to provide free family planning services under their title XX programs regardless of client income. Second, other States have adopted income standards for eligibility that differ from those specified in HHS' title X program regulations. For example:

--An Indiana clinic had successfully been collecting fees from those with ability to pay, but collections declined after title XX funds became available in large amounts. The State provides free family planning services under title XX regardless of income.

--California based title XX eligibility on 80 percent of the State median income, a level which equated roughly to 225 percent of the Federal poverty level. A Los Angeles County health department official said few of the clients served by the department would be charged using the title XX standard and this makes fee collection impractical.

To resolve this conflict, we believe that the Congress should consider consolidating Federal funding for family planning programs. Such a consolidation would include family planning funds under the title X and title XX programs and the Maternal and Child Health program. In the interim, HHS needs to consider how best to resolve the differences between the title X and title XX programs regarding eligibility for free or subsidized service.

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Mr. Chairman, this concludes our statement. We would be pleased to answer any questions you or other Members of the Committee may have.