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THE NEED FOR FREE OR SUBSIDIZED SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN THE U.S.: UPDATED ESTIMATES

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Abstract

Objectives. To update the estimated number of people in the U.S. who may need free or subsidized sexual and reproductive health (SRH) services and the potential cost of providing them.

Methods. We used data from three sources: (1) the IPUMS American Community Survey (2021), to estimate the population by income, sex, age group, and insurance status; (2) the National Survey on Family Growth (2017–2019), to estimate the portion of the population who may need free or subsidized SRH services; and (3) the Family Planning Annual Report: 2022 National Summary, to estimate the potential cost of meeting that need both nationally and for U.S. geographic regions.

Results. We estimate that 2.9 million people may need free or subsidized SRH services, at a cost of $1.38 billion nationally. The estimated regional need for services and associated cost vary significantly.

Conclusions. Although many federal and state programs and policies aim to increase access to SRH services, there remains significant need for publicly funded programs to provide free or subsidized SRH services.

INTRODUCTION

Sexual and reproductive health (SRH) is essential to individual and public health.[1,2,3] Access to SRH services is related to positive individual and social outcomes, including lower maternal mortality rates,[4] improved birth outcomes,[5,6] and higher rates of high school completion.[7]

Because SRH is so important, many federal and state programs and policies are designed to increase access to SRH services. These programs and policies include requiring private insurance to cover some of them, expanding the SRH services Medicaid covers, expanding Medicaid eligibility, and providing free or subsidized SRH services through programs like Title X, a federal grant program that provides SRH services throughout the United States to people with low incomes.[8]

Many of these programs and policies are interconnected—if one provides access to an SRH service, it lessens the need for services from another. For example, the Patient Protection and Affordable Care Act (ACA) required most insurance companies to fully cover more SRH services, including contraception, testing for sexually transmitted infections (STIs), and cervical cancer screening. This led to a decline in the use of federally funded STI services and an increase in the use of private and hospital-affiliated clinics.[9] Likewise, ACA implementation expanded access to contraception and cervical cancer screenings.[10] Under the assumption that the ACA policies would remain fully in effect, the estimated need for publicly funded contraception declined.[11]

Barriers to accessing SRH services persist, however. For example, although the ACA addressed racial disparities in insurance coverage, young Black and Latino men rely on federally funded STI clinics at the same rate as they did before ACA implementation.[9] Latinas, uninsured women, and immigrant women still access SRH services at lower rates than White, insured, and native-born women, and rely more on publicly funded service sites.[12]

In 2016, August et al. estimated that between 2.2 and 2.6 million women in the United States need publicly funded programs that provide free or subsidized access to SRH services.[11] Specifically, they estimated the number of women of reproductive age (ages 15 to 44) who had

low incomes, were at risk for unintended pregnancy, and either lacked insurance coverage or needed confidential services. At that time, August et al. estimated the cost of providing publicly funded direct services to these women at $628 million to $763 million, based on the national average revenue per user for publicly funded service delivery sites.

In this paper, we provide updated estimates of the number of people who may need free or subsidized SRH services and the potential cost meeting these needs. Since the August et al. estimates, national changes in SRH policies and programs have impacted the availability of SRH services, possibly increasing the need for publicly funded SRH services. For example, in 2019, the penalty for not having personal health insurance was eliminated; consequently, the uninsured population is higher today than previously estimated.[13] In addition, some people with insurance are unable to use it for their SRH needs. Under the ACA, young adults may remain on a parent's insurance until age 26; thus, some young adults may seek confidential services at publicly funded clinics.[14] Additionally, exemptions to the ACA mean some adults are underinsured and may need free or subsidized SRH services.[15] Clients with insurance (either public or private) are the majority of family planning clients at federally funded Title X clinics.[16] Our updated estimates account for the potential need for free or subsidized SRH services among people with insurance.

There is an increased focus on the role of publicly funded clinics in providing services for men (both cisgender and transgender) and nonbinary people, and more emphasis on broader sexual and reproductive health services such as STI prevention, testing, and treatment in addition to contraception.[17] These services have long been provided by publicly funded clinics but were not included in previous estimates of need. Our updated estimates of need for free or subsidized SRH services include people of all genders and those who use a broader range of publicly funded SRH services.

Finally, we examined whether the need for free or subsidized SRH services is geographically concentrated. Health care policies, including Medicaid expansion, vary at the state level, so we examined whether potential need and the cost of providing free and subsidized SRH services vary in different U.S. regions.

METHODS

Estimating the population in need

To update the estimated number of people who may need free or subsidized SRH services through publicly funded programs, we followed August et al. by first estimating the number of low-income, uninsured women who may need SRH services.[11] We then expanded the estimates to include men and insured people. For all groups, we used the 2021 American Community Survey (ACS) accessed through IPUMS[18] to estimate population counts. For most respondents, IPUMS ACS reports state of residence, age, sex, insurance status, and household income. We estimated both national counts and counts for different geographic regions.

Low-income, uninsured women who may need SRH services

Using IPUMS ACS, we first estimated the total number of uninsured adult women (ages 18 to 44) with incomes below 250% of the federal poverty level (FPL). We defined "uninsured" as (1) self-reporting no insurance and (2) ineligible for their state's Medicaid family planning services. In some states Medicaid covers certain SRH services for adults who are not otherwise Medicaid eligible and have incomes under a state-specific threshold; these are known as state plan amendments or waivers.[19] We counted all people eligible for Medicaid family planning services in their states as having insurance coverage. We included adolescent women (ages 15 to 17) at all household income levels because household income may not reflect the resources available to adolescents.

The ACS has information on the age and insurance status of people who live in group quarters, including dormitories, but does not have an estimated household income because they do not live in a household. Consequently, we could not directly apply the 250% FPL criterion to people living in group quarters and could not determine their eligibility for Medicaid family planning services. Instead, we used the non-group–quarters population to calculate the proportion of uninsured people at or below 250% FPL and not eligible for Medicaid family planning by state, age, race, and sex. We applied these proportions to the group quarters population in the ACS to indirectly estimate the corresponding population count for each group.

We used the 2017–2019 National Survey of Family Growth (NSFG) to adjust all

population counts by the estimated proportion of adolescent and adult women who may need free or subsidized SRH services. Following the approach used by August et al. (2016), we include women who (1) have had sex, (2) may be able to become pregnant, and (3) are not currently seeking a pregnancy. We calculated this proportion separately for adolescent and adult women. For both age groups, we pooled estimates for women with and without insurance, as in August et al. (2016).

In addition to contraceptive services, publicly funded SRH services include STI prevention, testing, and treatment and annual cervical, ovarian, or testicular cancer screenings.[17] We estimated potential need for these SRH services based on self-reported use. We used the 2017–2019 NSFG to estimate the proportion of uninsured women who obtained (1) STI prevention, testing, or treatment or (2) a pap smear or pelvic exam from a family planning or community clinic and paid out of pocket for these services or received free care (not covered by Medicaid). Because this approach is based on use of STI services and annual exams, it may underestimate need for STI services and annual cervical or ovarian cancer screenings and should therefore be considered a lower-bound estimate.

Low-income, uninsured men who may need SRH services

To include men in the updated estimates of the number of people who may need free or subsidized SRH services, we used the IPUMS ACS 2021 to estimate the total number of uninsured men ages 18 to 44 with incomes at or below 250% FPL who are ineligible for their state's Medicaid family planning services. We used the same method we used for women to adjust for men who live in group quarters. As we did for women, we included adolescent men (ages 15 to 17) at all household income levels, because household income may not reflect the resources available to adolescents.

We then used the NSFG to estimate the proportion of men without insurance who may need free or subsidized SRH services. We defined this as men who (1) obtained information on preventing unintended pregnancy or on STI screening, testing, or treatment; or an annual exam from a family planning clinic and (2) paid out of pocket for these services or received free care (not covered by Medicaid). This approach is based on estimated usage of SRH services among uninsured men and therefore could underestimate the potential need for SRH services if some low-income men without insurance may need SRH services but are not receiving them because of other barriers to care.

Need for free or subsidized SRH services among low-income people with insurance

We again used the 2021 IPUMS ACS to estimate the total number of adults (ages 18 to 44) with incomes at or below 250% of the FPL who reported having health insurance or may have been eligible for family planning services through Medicaid. We used the same method to include people living in group quarters and included adolescents at all household income levels.

We then estimated the potential need for free or subsidized SRH services among people with insurance. For adult women, adult men, and adolescent men, we used the 2017–2019 NSFG to calculate the proportion of insured people who reported having paid out of pocket or received free contraceptive care from a family planning clinic or community clinic. We calculated this proportion separately by age group and sex and applied these proportions to the ACS population estimates.

For adolescent women, we followed the approach used by August et al., estimating 37% of adolescent women in families with insurance may not use their insurance for SRH services and are considered uninsured.[20] We found that 27% of all adolescent women have had sex, may become pregnant, and do not wish to become pregnant. Among insured adolescent women, the estimate of need based on using SRH services without using insurance was much smaller than .37*.27 = .10. To retain consistency with August et al. (2016), we used the pooled estimate of need and applied it to 37% of insured women to obtain the estimate of need among insured adolescent women.

Estimating the cost of SRH services

The process described above yielded estimates of the number of people with potential need for free or subsidized SRH services. To move from estimates of people to estimates of cost, we used Family Planning Annual Report (FPAR): 2022 National Summary data for regional estimates of per-user revenue for nonprofit service delivery sites that provide SRH services.[21] These data report revenue for publicly funded clinics offering free and subsidized SRH services to clients. Because they are nonprofit, their per-client revenue is an appropriate estimate of the per-client cost of providing SRH services. In 2022, regional per-user average revenue ranged from $326 in the Northeast to $858 in the Southwest, with a national average of $490.[21] These figures reflect revenue from Title X, client fees, third party payers (including Medicaid), and other sources (state and local government, TANF, block grant), and therefore vary by region depending on state policy context.[21] To calculate the total cost of potential need for free or subsidized SRH services, we multiplied the estimated number of people in each region who may need free or subsidized SRH services by the regional per-user revenue.

RESULTS

Table 1 shows the total estimated low-income population by sex, age group, and insurance status. Adult women with low incomes are more likely to be eligible for Medicaid family planning coverage or to have insurance than low-income, adult men, so there is some variation by sex. We estimated that 3,766,575 adult men with low incomes were uninsured and ineligible for Medicaid family planning, compared with 1,948,764 adult women with low incomes. Conversely, we estimated that 16,840,409 low-income, adult men have insurance or are eligible for Medicaid family planning, compared with 21,997,055 low-income, adult women. Approximately 327,521 adolescent women and 370,149 adolescent men are uninsured and ineligible for Medicaid family planning.

Table 1. Estimated total low-income population by sex, age group, and insurance status

	Age group	Uninsured and ineligible for Medicaid family planning	Insured or eligible for Medicaid family planning
Women	15–17	327,521	5,955,932
	18–44	1,948,764	21,997,055
Men	15–17	370,149	6,296,003
	18–44	3,766,572	16,840,409

Table 2 shows the estimated percentage of people in each population group who may need free or subsidized SRH services that are not covered by public or private insurance: 14.9% of uninsured adolescent women and 65.8% of uninsured, low-income adult women have had sex, are potentially able to become pregnant, and do not wish to become pregnant, or reported receiving free or subsidized STI services or annual exams at a family planning clinic. We estimated that 10% of adolescent women with insurance and 1.8% of low-income adult women with insurance may need subsidized SRH services. Likewise, 8.3% of uninsured adolescent men and 3.3% of uninsured adult men reported receiving subsidized or free SRH at family planning service sites. Among those with insurance or eligible for Medicaid family planning, an estimated 1.8% of adolescent and 2.1% of adult men reported receiving subsidized or free SRH services at family planning service sites.

Table 2. Percentage of low-income adults and adolescents who may need free or subsidized SRH services, by sex and insurance status

	Age group	Uninsured and ineligible for Medicaid family planning	Insured or eligible for Medicaid family planning
Women	15–17	14.9%	10.0%
	18–44	65.8%[1]	1.8%[2]
Men	15–17	8.3%	1.8%
	18–44	3.3%	2.1%

1. Estimated as the percentage of women without insurance who have had sex, may become pregnant, and do not wish to become pregnant, or who report having received free or subsidized STI services or annual exams at a family planning clinic.
2. Estimated as the percentage of women with insurance who report having received contraception services, STI services, or an annual exam at a family planning clinic and paid out of pocket or received free services.

As shown in Figure 1 (top panel), the estimated number of people who may need free or subsidized SRH services is geographically concentrated: 27% of people with potential need live in the southeastern region of the United States. The total estimated regional cost of providing free and subsidized SRH services is driven by both the number of people with potential need and the region's estimated per-user cost, which ranged from $326 in the Northeast to $858 in Arizona, California, Hawaii, and Nevada. As Figure 1 shows, Arizona, California, Hawaii, and

Nevada account for 25% of all estimated costs for free and subsidized SRH services and just 14% of those with need, because of the high estimated per-user cost in that region.

Figure 1. Estimated number of people (top panel) who may need free or subsidized SRH services, and the estimated cost to provide these services in millions of dollars (bottom panel), by region

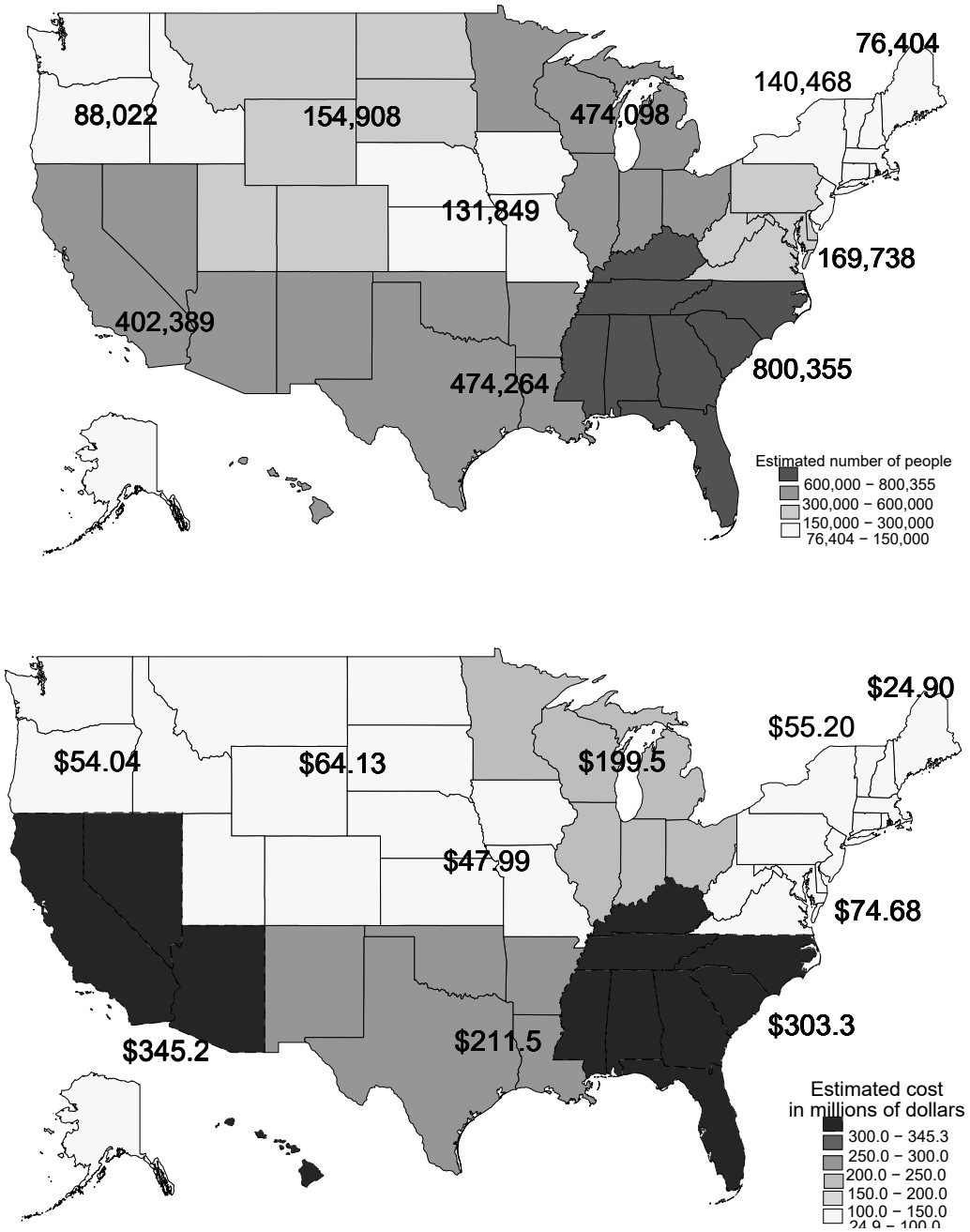

Table 3 shows the estimated total cost for the entire United States, summing across each region shown in Figure 1. We estimated that it would cost $904 million per year to provide free or subsidized SRH services to 1.9 million women without insurance and to adolescent women who may need confidential care. Including men without insurance increased the estimates by 156,610 people and added a cost of $71 million per year. We estimated that 831,134 people with insurance may need free or subsidized SRH services, for an estimated cost of $405 million per year. We estimated that 2.9 million people may need free or subsidized contraception, STI services, and annual exams, for an estimated total cost of $1.38 billion per year.

Table 3. Estimated number of low-income people who may need free or subsidized SRH services, and the cost to provide these services

	People	Cost
Women (ages 15 to 44) without insurance and ineligible for Medicaid family planning + adolescent women who may need confidential services	1,924,753	$904,223,617
Men without insurance and ineligible for Medicaid family planning	156,610	$71,368,975
People with insurance or eligible for Medicaid family planning	831,134	$405,076,465
Total	**2,912,497**	**$1,380,669,057**

DISCUSSION

Many federal and state programs and policies aim to increase access to SRH services, yet there remains significant need for publicly funded programs providing free or subsidized SRH services. We estimated that 2.9 million people in the United States may need free or subsidized SRH services, at an estimated of cost $1.38 billion. Nearly half the total national cost (47%) is accounted for by two U.S. regions: (1) Arizona, California, Hawaii, and Nevada ($345 million) and (2) the southeastern United States ($303 million).

The ongoing need for publicly funded programs that provide free or subsidized SRH services likely reflects a complex interplay of factors. Most obviously, some changes to ACA implementation muted the law's impact on insurance coverage and access to SRH services. For example, there are more people without insurance than predicted, and people with insurance

continue to use free or subsidized SRH services. Additionally, the estimated per used cost of providing SRH services has increased from a national average of $289 in 2016 to $490 today.[11,21] Less obvious is the role of Medicaid expansion, which gave states federal funds to expand Medicaid eligibility to almost all adults below 138% of the FPL. In the data used for this analysis, only one state in the southeastern region of the United States (Kentucky) had implemented Medicaid expansion. (North Carolina's expansion went into effect December 1, 2023.) This region accounts for 27% of the 2.9 million people we estimated as needing free or subsidized SRH. The lack of Medicaid expansion likely increased the potential need for free or subsidized SRH services that Medicaid covers in other regions where eligibility increased.

The updated estimates also reflect changes in population composition and SRH risk factors. For example, sexual initiation among teenagers[22] and sexual activity among teenagers[23] and young adults[24] have declined in the past decade, potentially changing the need for SRH services. Other things being equal, these trends may have worked to reduce the number of adolescents and young adults needing free or subsidized SRH services. Conversely, increasing STI rates may have worked to increase the number of people in need of STI treatment.[25] As publicly funded SRH service sites continue serving increasingly diverse populations and providing a range of services, estimates of costs need to be adjusted for the populations served and services provided.

LIMITATIONS

Four limitations to our analysis should be noted. First, estimates of the total cost of providing subsidized or free SRH services are sensitive to several factors, including the source of the estimated per-user cost of SRH services and the definition of the population in need of SRH services. Our estimate of $1.38 billion should be interpreted within the specific definitions used for this study. Second, to estimate per-user cost of SRH services, we used FPAR 2022 data on regional revenue per user among nonprofit clinics providing SRH services. This is an imperfect proxy of per-user cost. Third, we defined people as potentially needing SRH services based on publicly available characteristics, such as sex, income, and insurance status, or their use of related services. Other approaches to defining people in need—for example, based on their expressed desire to receive SRH—might yield different results. Fourth, the ACS does not ask

gender identity, and the Census Bureau inputs sex of those who do not choose an option. If the ACS miscategorized more people as “male” than “female”, we may have underestimated the potential need for free or subsidized SRH services. Our analytic approach applies stricter requirements for counting men as needing SRH services, resulting in a lower estimate for men.

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