

Trends in Receipt of Contraceptive Services: Young Women in the U.S., 2002–2015

Jennifer J. Frost, DrPH, Laura D. Lindberg, PhD



Introduction: In order to understand adolescent girls' and young women's use of contraceptive services, this paper examines trends in receipt of contraceptive services, focusing on provider type and payment source.

Methods: The analysis uses nationally representative data from females aged 15–25 years in the 2002, 2006–2010, and 2011–2015 National Surveys of Family Growth. In 2018, summary measures for receipt of any contraceptive service, the type of provider visited and payment used were created and compared across survey years and age groups (15–17 and 18–25 years).

Results: From 2002 to 2011–2015, the proportion of adolescent girls aged 15–17 years relying on publicly funded clinics for contraceptive care fell from 47% to 24% (95% CI=38.4%, 55.0% and 95% CI=19.0%, 29.9%), whereas the proportion relying on private providers increased from 49% to 69% (95% CI=40.7%, 57.1% and 95% CI=61.6%, 76.2%). A significant, but smaller, shift away from clinics occurred among women aged 18–25 years. Over the same period, use of health insurance to pay for contraceptive services among all females aged 15–25 years increased from 68% to 81% (95% CI=64.7%, 71.3% and 95% CI=78.5%, 83.8%), whereas the proportion who had private insurance during the year, but did not use it to pay for contraceptive care, declined from 21% to 9% (95% CI=18.3%, 23.5% and 95% CI=6.8%, 10.7%).

Conclusions: Private providers now provide the bulk of contraceptive services to adolescent girls and young women, with reduced reliance on publicly funded clinics. Supporting private practices in providing confidential and comprehensive family planning services must be a priority. Publicly funded clinics remain an important safety-net provider of contraceptive care for adolescent girls and young women.

Am J Prev Med 2019;56(3):343–351. © 2018 American Journal of Preventive Medicine. Published by Elsevier Inc. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

INTRODUCTION

To achieve their sexual and reproductive health (SRH) goals, adolescent girls and young women need access to contraceptive services, information, and care. Historically, most adolescent girls seeking contraceptive care went to publicly funded clinics (51%–62% in 1982–1995).¹ By 2002, however, that proportion had fallen to 48% and by 2006–2010, to 39%.² By contrast, among women aged 20–24 years, about 40% relied on public providers for their contraceptive care throughout this period.

Women report choosing publicly funded providers because of the belief that they provide quality,

nonjudgmental, confidential care for free or at low cost.³ Studies have also found that women obtaining care from publicly funded clinics typically receive a broader range of SRH services compared with those going to private providers, and are more likely to have conversations about condoms or birth control during certain kinds of visits.^{2,4}

The purpose of this paper is to examine changes in the receipt of contraceptive services among adolescent girls

From the Guttmacher Institute, Research Division, New York, New York
Address correspondence to: Jennifer Frost, DrPH, Guttmacher Institute, 125 Maiden Lane, New York NY 10038. E-mail: jfrost@guttmacher.org
0749-3797/\$36.00
<https://doi.org/10.1016/j.amepre.2018.10.018>

(ages 15–17 years) and young women (ages 18–25 years) in the U.S. between 2002 and 2015, focusing on those girls and women whose age put them at high risk both for unintended pregnancy and for barriers that may obstruct efforts to obtain confidential care.^{5,6} It is hypothesized that changes in where adolescent girls and young women go for contraceptive services may be related to changes in insurance coverage, as well as to other changes in the financing and delivery of SRH care services.

There are many potential drivers of change in patterns of adolescent girls' and young women's contraceptive care. Over the last decade, policies have been implemented to improve access to both health care generally and to contraceptive and other SRH services specifically. These include contraceptive coverage mandates,^{7,8} Medicaid family planning expansions,⁹ and parts of the Affordable Care Act¹⁰ that cover young adults on their parents' insurance policy to age 26 years (effective from September 2010); require preventive care (including SRH services) to be provided with no cost sharing (effective from January 2013)¹¹; and expand access to health-care coverage (effective from January 2014). These changes improve adolescent girls' and young women's ability to pay for care from private doctors, reducing the pool who must rely on publicly funded clinics for affordable care. By contrast, demographic and economic shifts over the past two decades have resulted in rising proportions of adolescent girls and young women living in poverty,¹² increasing the pool of girls and women who need free or low-cost care. At the same time, declining or stagnant public funding for family planning services through the Title X program¹³ has resulted in a steady drop in the number of Title X-funded clinics since 2008.¹⁴ Concerns about confidentiality of care for minors/dependents, even among young adults on their parents' insurance plans, may also act as a barrier to adolescent girls and young women obtaining contraceptive care.^{5,15}

There are also supply-side drivers if private providers increase their provision of contraceptive methods or counseling to adolescent girls and young women in response to improved reimbursement rates by private insurance companies. Increased emphasis on contraceptive counseling and services may also be fueled by new evidence-based SRH clinical practice guidelines advanced by governmental agencies and medical organizations including the Centers for Disease Control and Prevention, the Office of Population Affairs, American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists, and the Society for Adolescent Health and Medicine.^{16–21}

Although this analysis is unable to untangle the impact of all of these drivers on observed trends in

where adolescent girls and young women receive contraceptive care and how they pay for this care, it is important to monitor these patterns to better understand how shifts in policy and service delivery may impact adolescent girls' and young women's SRH.

METHODS

Study Sample

This study uses nationally representative data from female respondents in several rounds (2002,²² 2006–2010,²³ 2011–2015^{24,25}) of the National Survey of Family Growth (NSFG), a periodic national probability household survey of females and males aged 15–44 years in the U.S. In-person interviews were conducted in 2002 and then continuously from June 2006 to December 2010 and again from June 2011 to June 2015. The analysis was restricted to female respondents who were aged 15–25 years at the time of each survey (4,399 respondents, 2011–2015; 4,838 respondents, 2006–2010; 2,780 respondents, 2002). The female response rate varied between 72% and 80% for the full sample and was slightly higher among adolescent girls and young women. The NSFG public use data sets include recoded variables that have imputed values for missing data. See above references for more detail on the methodology for imputing missing values. Methods of data collection and dissemination of the public use data set were approved by NCHS's IRB for protection of human subjects.

Measures

All females were asked whether they received any of seven specific contraceptive services from a doctor or other medical care provider in the prior 12 months. This analysis created a summary recode that measures receipt of any contraceptive service in the past year, and also presents data on three of the individual contraceptive services. These include counseling or information about birth control, a checkup or medical test related to using a birth control method, a method of birth control or a prescription for a method, counseling or information about getting sterilized, a sterilizing operation, counseling or information about emergency contraception, and emergency contraception or a prescription for it.

For each service received, females were provided a list and asked to identify the type of provider visited. The list read: private doctor's office, HMO, community or public health clinic, family planning or Planned Parenthood clinic, school/school-based clinic, hospital outpatient clinic, employer or company clinic, hospital emergency room, hospital regular room, urgent care center, and some other place. For this analysis, provider type is grouped into three main categories: private doctor's office/HMO, publicly funded clinic, and other.

Clinics are further divided according to funding source (Title X-funded and non-Title X-funded clinics) and type (public health department, community/Federally Qualified Health Center, family planning/Planned Parenthood, and other clinics). These classifications were assigned using a detailed database of publicly funded clinics and were not based on information asked of the respondent. The clinic database is updated and maintained by the Guttmacher Institute and is loaded onto the NSFG interviewers' computers. Respondents were asked for the name and address of visited clinics so they could be matched to the clinic list and classified according to funding source and type.

Females' reports of their health insurance coverage over the past year were grouped into a summary measure with three mutually exclusive categories: private health insurance, including military coverage, at all during the year; Medicaid or other public health insurance at all during the year; and no health insurance coverage all year. Military health coverage is provided to military personnel and their families because of their service, not their income, and is therefore more similar to employer-based private health insurance than to public insurance. Women who reported having both private and public health insurance during the year were classified according to the type of insurance that they reported using for their contraceptive visit.

Females' reports of how they paid for each service were grouped into four mutually exclusive categories: private insurance, Medicaid or other public insurance, out-of-pocket payment/other, and no payment necessary or copayment only.

Responses on health insurance were combined with those on payment type to create a summary variable with five mutually exclusive categories: had and used private insurance to pay for care, had private insurance during the past year but did not use it to pay for care, had and used Medicaid to pay for care, had Medicaid in the past year but did not use it to pay for care, and uninsured all year. There are several reasons why females may not have used insurance or Medicaid to pay for their care, even though they reported coverage during the year: they were not insured at the time of their visit (among females [aged 15–25 years] receiving contraceptive services, 10%–19% of those privately insured and 23%–33% of those covered by Medicaid had ≥1 months without coverage); their insurance did not cover the service they received; or they opted not to use their coverage, either for confidentiality or for some other reason. It is not possible, using the NSFG, to untangle these reasons.

Statistical Analysis

All analyses used Stata, version 15.1, and were completed in 2018. Sampling weights provided in the NSFG data files account for the complex sampling design and allowed division of the data into nationally representative and non-overlapping periods. In making comparisons of proportions between survey cycles, significance tests were calculated using weighted logistic regression; the resulting 95% CIs are presented in the tables. ORs and *p*-values are not presented but are available upon request. Only tests statistically significant at *p*<0.05 are reported in the text, unless otherwise noted. Analyses are stratified by age in order to examine differences between adolescent girls and young women.

RESULTS

Of the ≈22 million U.S. females aged 15–25 years in each time period, approximately half reported receipt of contraceptive services during the prior year; 41%–43% received a birth control method or prescription, 28%–31% reported a checkup related to birth control, and 22%–26% received birth control counseling (Table 1). There was no significant change in overall receipt of contraceptive services between 2002 and 2015.

Among adolescent girls aged 15–17 years, 26%–32% reported receipt of contraceptive services in the prior year

Table 1. Receipt of SRH Services in the Past Year Among Females Aged 15–25 Years, National Survey of Family Growth, 2002–2015

Type of service	Aged 15–25 years			Aged 15–17 years			Aged 18–25 years		
	2002	2006–2010	2011–2015	2002	2006–2010	2011–2015	2002	2006–2010	2011–2015
Women, weighted N (in thousands)	21,677	22,915	22,051	5,819	5,837	5,523	15,859	17,078	16,528
Unweighted N	2,780	4,838	4,399	674	1,304	1,204	2,106	3,534	3,195
Receiving any contraceptive service, %	51.9 (49.3, 54.6)	48.1 (45.3, 50.9)	50.0 (47.7, 52.2)	31.8 (27.5, 36.1)	25.5* (22.1, 28.9)	30.7 (26.6, 34.9)	59.3 (56.6, 62.0)	55.8 (52.8, 58.9)	56.4 (53.9, 58.8)
Birth control method or prescription	43.1 (40.5, 45.8)	41.2 (38.8, 43.5)	42.4 (38.8, 43.5)	22.2 (18.2, 26.3)	19.9 (16.8, 23.0)	24.5 (20.7, 28.3)	50.8 (47.9, 53.7)	48.4 (45.7, 51.1)	48.4 (45.9, 50.9)
Birth control checkup	29.1 (26.6, 31.5)	27.8 (25.7, 29.9)	30.7 (28.5, 33.0)	15.8 (12.5, 19.0)	12.4 (10.0, 14.8)	16.4** (13.4, 19.4)	33.9 (31.0, 36.9)	33.0 (30.6, 35.5)	35.5 (33.0, 38.0)
Birth control counseling	26.3 (23.9, 28.6)	22.1* (20.0, 24.1)	23.4 (21.3, 25.4)	19.0 (15.6, 22.4)	12.9* (10.5, 15.3)	16.5 (12.9, 20.2)	28.9 (26.2, 31.7)	25.2* (22.8, 27.5)	25.6 (23.3, 28.0)

Note: Values are weighted proportions (95% CIs). Boldface indicates statistical significance (*Significantly different from 2002 at *p*≤0.05; **Significantly different from 2006–2010 at *p*≤0.05).

compared with 56%–59% of young women aged 18–25 years. Among both age groups, there was a small, but significant, drop in the proportion reporting contraceptive counseling between 2002 and 2006–2010 (19% to 13%, and 29% to 25%, respectively). Among adolescents, there was also a dip in receipt of any contraceptive service between 2002 and 2006–2010 (from 32% to 26%), whereas the proportion remained stable among young women aged 18–25 years, as did the proportions receiving any contraceptive service between 2002 and 2011–2015 for both age groups.

Between 61% and 69% of females aged 15–25 years received contraceptive services from private providers in each survey year and 27%–35% received care from publicly funded clinics (Table 2). These patterns varied by age and time period. In 2002, adolescent girls aged 15–17 years were equally likely to obtain contraceptive care from publicly funded clinics (47%) as they were to go to private providers (49%), whereas among young women aged 18–25 years, 65% went to private providers and 33% to clinics. Over time, variation between the age groups diminished as the share of adolescent girls relying on publicly funded clinics for contraceptive care fell (from 47% to 24%), and the proportion relying on private providers increased (49% to 69%). The adolescent shift away from clinics occurred both among those receiving care from Title X-funded clinics (25% to 13%) and among those going to other publicly funded clinics (21% to 12%). From 2002 to 2011–2015, the proportion of adolescent girls who reported receiving contraceptive services from family planning/Planned Parenthood clinics declined from 14% to 3%. Young adults aged 18–25 years experienced smaller, but still statistically significant, shifts toward private providers and away from clinics for contraceptive services; this decline was only among non-Title X clinics and among family planning/Planned Parenthood clinics.

The shift in where adolescent girls and young women go for contraceptive services was accompanied by a shift in how they paid for this care (Table 3). The proportion of adolescent girls and young women who used some form of health coverage (either public or private health insurance) to pay for contraceptive services rose from 68% in 2002 to 75% in 2006–2010 to 81% in 2011–2015. Similar patterns occurred among both adolescents aged 15–17 years and young women aged 18–25 years. There were increases in both the proportions of young females (aged 15–25 years) using private (49% to 55%) insurance, as well as those using public (19% to 26%) insurance to pay for their contraceptive care. Use of private insurance increased significantly for young women aged 18–25 years (51% to 57%) whereas adolescents experienced a nonsignificant upward trend (40% to 47%); use of public

insurance increased for both age groups (25% to 36% for adolescent girls and 18% to 24% for young women).

What was most striking was a drop in the proportion of adolescent girls and young women who reported having, but not using, private insurance to pay for contraceptive services in 2011–2015 compared with 2002 (21% to 9%); among adolescent girls, this proportion declined from 24% to 8% and from 20% to 9% among young women.

As expected, the levels and type of coverage (public versus private), as well as the proportions who had but did not use private insurance to pay for care, differ according to whether or not the women visited a private provider or public clinic for contraceptive care (Table 4). However, the general pattern of decreasing proportions of adolescent girls and young women who had, but did not use, private health insurance to pay for care persists regardless of provider type. A majority of adolescent girls and young women receiving care from private providers used private health insurance to pay for that care, and >90% used either private or public coverage. Among adolescent girls and young women who received care from clinics, use of any type of insurance rose (from 43% to 57%), but remained much lower than for women receiving care from private providers. Despite a decrease in the proportions who have, but do not use, private coverage (from 36% to 19%), nearly half of all adolescent girls and young women who visited a clinic and reported having private insurance during the year did not use private insurance to pay for care. Moreover, among adolescent girls and young women who received care from clinics, the proportion uninsured all year rose from 12% in 2002 to 18% in 2011–2015.

DISCUSSION

Over the past decade, the proportion of all adolescent girls and young women who report obtaining contraceptive services from a healthcare provider each year has remained mostly level. However, there has been a clear shift in where they receive contraceptive care and how they pay for that care. Increasing proportions of adolescent girls and young women are obtaining care from private providers, fewer are going to publicly funded clinics, and more are using health insurance to pay for their care. In particular, there has been a decline in adolescent girls and young women receiving contraceptive care from family planning/Planned Parenthood clinics. Whereas in the past adolescent girls were distinct, in that most sought care from clinics, their behavior has become more similar to adult women; the majority of females now receive contraceptive care from private providers.

Table 2. Type of Provider Visited for Contraceptive Services Among Females Aged 15–25 Years, National Survey of Family Growth, 2002–2015

Survey year and age	Receiving contraceptive services, N (in thousands)	Type of publicly funded clinic visited									
		Type of provider visited				By funding status		By type			
		Total	Private doctor/HMO	Publicly funded clinic	Other	Title X	Non–Title X	Public health department	Community clinic/FQHC	Family planning/PP	Hospital/school
Ages 15–25 years											
2002	11,258	100	62.6 (59.0, 66.1)	35.0 (31.2, 38.7)	2.5 (1.5, 3.4)	18.7 (16.0, 21.5)	16.2 (13.7, 18.7)	8.9 (7.1, 10.7)	8.0 (6.5, 9.6)	13.2 (10.6, 15.7)	4.9 (3.6, 6.2)
2006–2010	11,024	100	61.0 (57.3, 64.7)	35.0 (31.3, 38.7)	4.0* (2.8, 5.2)	17.7 (14.7, 20.8)	17.3 (14.2, 20.4)	6.8 (4.7, 8.9)	9.3 (6.8, 11.9)	12.6 (10.1, 15.2)	6.3 (4.7, 7.8)
2011–2015	11,015	100	68.8*, ** (65.7, 71.8)	27.1*, ** (24.1, 30.0)	4.2 (2.6, 5.8)	16.1 (13.7, 18.5)	10.9*, ** (8.8, 13.0)	6.8 (5.1, 8.6)	9.1 (7.2, 10.9)	6.9*, ** (5.3, 8.5)	4.3 (2.8, 5.8)
Ages 15–17 years											
2002	1,853	100	48.9 (40.7, 57.1)	46.7 (38.4, 55.0)	4.4 (1.0, 7.8)	25.3 (17.7, 32.9)	21.4 (15.0, 27.7)	11.3 (6.3, 16.2)	13.2 (7.6, 18.8)	14.3 (7.0, 21.6)	7.9 (3.5, 12.2)
2006–2010	1,487	100	52.5 (45.4, 59.5)	40.3 (34.2, 46.4)	7.2 (2.7, 11.7)	17.4 (12.2, 22.6)	22.9 (17.0, 28.7)	8.5 (4.5, 12.5)	11.8 (7.0, 16.6)	10.1 (6.3, 13.8)	9.9 (6.0, 13.9)
2011–2015	1,698	100	68.9*, ** (61.6, 76.2)	24.5*, ** (19.0, 29.9)	6.7 (1.2, 12.1)	12.8* (8.8, 16.9)	11.6*, ** (7.8, 15.5)	7.5 (4.3, 10.6)	8.2 (5.0, 11.4)	3.4*, ** (1.4, 5.4)	5.5 (2.5, 8.4)
Ages 18–25 years											
2002	9,405	100	65.3 (61.2, 69.3)	32.7 (28.5, 36.8)	2.1 (1.3, 2.9)	17.5 (14.5, 20.4)	15.2 (12.4, 18.0)	8.4 (6.2, 10.6)	7.0 (5.3, 8.7)	12.9 (10.3, 15.5)	4.3 (2.9, 5.7)
2006–2010	9,537	100	62.3 (58.6, 66.1)	34.2 (30.4, 37.9)	3.5 (2.3, 4.7)	17.8 (14.5, 21.0)	16.4 (13.2, 19.7)	6.5 (4.4, 8.7)	8.9 (6.4, 11.5)	13.0 (10.3, 15.7)	5.7 (3.9, 7.4)
2011–2015	9,318	100	68.7** (65.6, 71.9)	27.5** (24.3, 30.7)	3.7 (2.1, 5.4)	16.7 (14.1, 19.3)	10.8*, ** (8.6, 13.0)	6.7 (5.0, 8.5)	9.2 (7.2, 11.2)	7.5*, ** (5.7, 9.4)	4.1 (2.4, 5.7)

Note: Values are weighted proportions (95% CIs). Boldface indicates statistical significance (*Significantly different from 2002 at $p \leq 0.05$; **Significantly different from 2006–2010 at $p \leq 0.05$).

^aOther providers include hospital inpatient care, emergency room, urgent care center, and some other place. FQHC, federally qualified health center; PP, Planned Parenthood.

Table 3. Health Insurance Status and Payment Source for Contraceptive Services, National Survey of Family Growth, 2002–2015

Survey year and age	Receiving contraceptive services, N (in thousands)	Total % using public or private insurance to pay for care	Insurance status and payment source for contraceptive services ^a					
			Total	Private insurance past year		Medicaid past year		Uninsured all year ^c
				Used to pay for care	Did not use for care ^b	Used to pay for care	Did not use for care ^b	
Ages 15–25 years								
2002	11,258	68.0 (64.7, 71.3)	100.0	49.1 (45.3, 52.8)	20.9 (18.3, 23.5)	19.0 (16.1, 21.9)	4.4 (3.0, 5.7)	6.7 (5.0, 8.4)
2006–2010	11,024	74.7* (71.8, 77.7)	100.0	51.0 (46.8, 55.2)	13.5* (11.5, 15.6)	23.8* (20.5, 27.0)	4.1 (3.0, 5.2)	7.6 (5.6, 9.6)
2011–2015	11,015	81.2*, ** (78.5, 83.8)	100.0	55.5* (51.6, 59.4)	8.8*, ** (6.8, 10.7)	25.7* (22.6, 28.8)	3.4 (2.6, 4.3)	6.6 (5.1, 8.1)
Ages 15–17 years								
2002	1,853	65.0 (56.4, 73.5)	100.0	40.3 (32.6, 48.0)	23.6 (17.4, 29.7)	24.7 (17.6, 31.7)	7.6 (4.1, 11.1)	3.8 (0.6, 7.1)
2006–2010	1,487	71.4 (65.3, 77.4)	100.0	42.0 (35.8, 48.1)	16.0* (11.4, 20.6)	29.4 (23.4, 35.4)	10.9 (6.2, 15.6)	1.7 (0.4, 3.1)
2011–2015	1,698	83.1*, ** (78.4, 87.8)	100.0	47.3 (39.6, 55.0)	7.9*, ** (4.7, 11.1)	35.7* (28.3, 43.2)	6.0 (3.1, 8.9)	3.0 (1.2, 4.9)
Ages 18–25 years								
2002	9,405	68.6 (65.2, 72.1)	100.0	50.8 (46.5, 55.1)	20.4 (17.6, 23.2)	17.9 (15.0, 20.8)	3.8 (2.4, 5.1)	7.2 (5.3, 9.2)
2006–2010	9,537	75.3* (72.2, 78.3)	100.0	52.4 (48.0, 56.8)	13.2* (10.9, 15.4)	22.9* (19.3, 26.5)	3.0 (2.0, 4.0)	8.5 (6.2, 10.8)
2011–2015	9,318	80.9*, ** (77.8, 83.9)	100.0	57.0* (52.5, 61.4)	8.9*, ** (6.6, 11.2)	23.9* (20.6, 27.2)	3.0 (2.0, 4.0)	7.3 (5.6, 9.0)

Note: Values are weighted proportions (95% CIs). Boldface indicates statistical significance (*Significantly different from 2002 at $p \leq 0.05$; **Significantly different from 2006–2010 at $p \leq 0.05$).

^aHealth insurance status during the past 12 months and whether women used their insurance to pay for their contraceptive service visit.

^bWomen may not have used their health insurance to pay for their visit for several reasons: They were not insured at the time of the visit, their insurance did not cover the service they received, or they opted not to use their insurance for confidentiality or other reasons. These women paid for the visit themselves (self-pay) or received free or reduced-fee care.

^cUninsured women paid for the visit themselves (self-pay) or received free or reduced-fee care.

The observed shifts in young women's reports about where they obtain care are consistent with data reported by clinics themselves. Among clinics receiving federal Title X funding for family planning services, the number and proportion of clients who were under age 20 years has dropped since 2002, falling from 1.4 million (29%) in 2002 to 707,000 (17%) in 2015.^{14,26}

Between 2002 and 2011–2015, the proportion of young women covered by and using Medicaid to pay for contraceptive services increased, as did the proportion who used their private insurance to pay for such care. These changes likely allowed more adolescent girls and young women to access care from private providers, contributing to the decline in clinic use documented in this analysis. Increased Medicaid use parallels its increased availability, driven both by rising poverty levels and by multiple public policies expanding Medicaid eligibility. Improved use of private insurance likely reflects improved contraceptive coverage by insurance companies, greater knowledge among young women about their insurance

coverage options, and greater willingness among young women to use their coverage. Some of the latter changes may be related to cohort effects; the current cohort of adolescent girls and young women may have reduced stigma around their sexuality and SRH behaviors. It will be important to continue to track their service needs and utilization to better understand drivers of these trends.

Additionally, improved coverage and reimbursement for contraceptive counseling and related services, as well as guidelines that recommend adolescent contraceptive needs be addressed in primary care settings,^{10,27} may have influenced private physicians' interest or willingness to provide these services.

Although expansion of insurance coverage may allow more adolescent girls and young women to obtain contraceptive care from private providers, it is important to consider the implications on these girls and women as well as those who continue to rely on publicly funded clinics. Shifting contraceptive care for adolescents and young adults to private providers creates potential opportunities to integrate

Table 4. Health Insurance Status and Payment Source for Contraceptive Services by Provider Type, National Survey of Family Growth, 2002–2015

Provider type and survey year, ages 15–25 years	Receiving contraceptive services, N (in thousands)	Total % using public or private insurance to pay for care Total	Insurance status and payment source for contraceptive services ^a					
			Private insurance past year		Medicaid past year		Uninsured all year ^c	
			Used to pay for care	Did not use for care ^b	Used to pay for care	Did not use for care ^b		
Private doctor								
2002	7,044	82.6 (79.8, 85.4)	100	68.8 (65.4, 72.2)	12.3 (9.7, 14.8)	13.8 (11.0, 16.6)	1.6 (0.9, 2.3)	3.6 (2.3, 4.8)
2006–2010	6,724	91.2* (89.1, 93.2)	100	70.1 (65.5, 74.7)	5.4* (3.9, 6.9)	21.1* (17.1, 25.0)	1.3 (0.5, 2.0)	2.1 (0.9, 3.3)
2011–2015	7,574	91.8* (89.6, 94.0)	100	69.7 (65.6, 73.8)	4.3* (2.6, 6.0)	22.1* (18.6, 25.6)	1.8 (1.1, 2.6)	2.1 (1.2, 2.9)
Publicly funded clinic								
2002	3,937	42.9 (37.9, 47.8)	100	15.3 (11.6, 19.0)	36.1 (31.5, 40.7)	27.6 (22.9, 32.3)	9.1 (6.0, 12.3)	11.9 (8.4, 15.5)
2006–2010	3,859	47.6 (42.0, 53.1)	100	19.3 (15.0, 23.7)	27.4* (22.3, 32.4)	28.3 (23.2, 33.3)	8.1 (5.6, 10.5)	17.0 (12.5, 21.5)
2011–2015	2,979	56.9*, ** (49.9, 63.9)	100	21.8 (14.7, 29.0)	18.7*, ** (13.7, 23.7)	35.1 (29.0, 41.1)	6.7 (4.3, 9.1)	17.7* (13.2, 22.3)

Note: Values are weighted proportions (95% CIs). Boldface indicates statistical significance (*Significantly different from 2002 at $p \leq 0.05$; **Significantly different from 2006–2010 at $p \leq 0.05$).

^aHealth insurance status during the past 12 months and whether women used their insurance to pay for their contraceptive service visit.

^bWomen may not have used their health insurance to pay for their visit for several reasons: They were not insured at the time of the visit, their insurance did not cover the service they received, or they opted not to use their insurance for confidentiality or other reasons. These women paid for the visit themselves (self-pay) or received free or reduced-fee care.

^cUninsured women paid for the visit themselves (self-pay) or received free or reduced-fee care.

SRH into overall health care, but also creates challenges for preserving the same levels of confidentiality and service quality that are traditionally available from clinics.

Many of the differences in the quality of contraceptive care provided by clinics versus private providers are rooted in the fact that clinics have legislative and administrative protocols that mandate confidential receipt of services²⁸; and they follow national guidelines that specify expectations for the delivery of quality family planning services.^{19,29} Compared with Title X clinics, smaller private practices often lack the administrative and procedural oversight to design, implement, and monitor specific protocols for this care.³⁰

Moreover, improved access to SRH services for adolescents and young adults, especially at private providers, may be complicated by confidentiality concerns³¹ if they are dependent on their parents' health insurance plan. A recent study found that concerns about receipt of confidential SRH care were greater for adolescents and young adults covered by private insurance compared with those on Medicaid,⁵ indicating a challenge for private providers in being able to address the confidentiality concerns of their clients. This study found that nearly half of young women going to clinics who reported having private insurance did not use this private health insurance to pay for care. A recent study of clients visiting

Title X-funded clinics found that among women under age 20 years who had private health insurance, a majority of those who did not use their insurance reported confidentiality concerns as the reason.³² Thus, supporting private healthcare providers in delivering confidential and comprehensive quality family planning services to young women must be a priority.

Even with increased use of health insurance to pay for contraceptive services, the publicly funded clinic network remains important, as more than one in four adolescent girls and young women who received contraceptive care went to such a clinic. These clinics, especially those funded by Title X, remain the ultimate safety net and continue to serve the most vulnerable women, including poor and low-income women of all ages.³³ Moreover, the proportion uninsured among adolescents and young adults receiving care from clinics rose from 12% in 2002 to 18% in 2011–2015. Possible reductions to the protections afforded by the Affordable Care Act moving forward may increase the pool of women in need of this safety net, so efforts to support and monitor clinic access to contraceptive and other SRH care services will remain essential. This is especially important because safety-net family planning clinics, including Planned Parenthood sites, offer much more than contraception, including cancer screenings, sexually transmitted infection care, and other

preventive care services that many adolescent girls and young women may not have access to otherwise.

Limitations

There are a number of limitations to this analysis. The data do not identify the types of private clinicians seen by adolescent girls and young women—pediatricians, obstetrician-gynecologists, or other specialists—and whether SRH services are being provided as part of comprehensive primary care or as a specialized service.³⁴ Young women may have incorrectly identified the type of provider visited. Among women who reported having but not using health insurance to pay for services received, the data do not allow specification of reasons, such as women not being covered at the time of their visit, the insurance plan not covering the service received, or women choosing not to use their insurance for confidentiality or other reason. More direct research on the quality of contraceptive care offered by different providers is warranted given these shifts in utilization, including access to a range of contraceptive methods, appropriate non-directive counseling, and confidential care.

CONCLUSIONS

Finally, future research should consider how source of care may impact SRH behaviors and outcomes; the observed changes in service use patterns documented in this study have occurred during a period of dramatic declines in the adolescent pregnancy rate, but increases in sexually transmitted infection rates.^{35,36} Ensuring young people's continued access to contraceptive care, regardless of healthcare provider or source of payment, is a critical component of preventive health care.

ACKNOWLEDGMENTS

The research presented in this paper is that of the authors and does not reflect the official policy or views of any funders. This work was supported by grants from the JPB Foundation and the David and Lucile Packard Foundation. Additional support was provided by the Guttmacher Center for Population Research Innovation and Dissemination (NIH grant 5 R24 HD074034). Dr. Frost led the conception and design of the study, data analysis and interpretation, and writing of the article. Dr. Lindberg contributed to interpretation of the findings and writing of the article. Research assistance was provided by Elizabeth Witwer, Doris Chiu, and Zoe Pleasure, all from the Guttmacher Institute. Preliminary findings were previously presented at the 2018 Society of Adolescent Health and Medicine Annual Meeting.

No financial disclosures were reported by the authors of this paper.

REFERENCES

1. Frost JJ. Public or private providers? U.S. women's use of reproductive health services. *Fam Plann Perspect*. 2001;33(1):4–12. <https://doi.org/10.2307/2673736>.
2. Frost JJ. *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995–2010*. New York, NY: Guttmacher Institute. www.guttmacher.org/sites/default/files/report_pdf/sources-of-care-2013.pdf. Published 2013. Accessed October 8, 2018.
3. Frost JJ, Gold RB, Bucek A. Specialized family planning clinics in the United States: why women choose them and their role in meeting women's health care needs. *Womens Health Issues*. 2012;22(6):e519–e525. <https://doi.org/10.1016/j.whi.2012.09.002>.
4. Liddon N, Steiner RJ, Martinez GM. Provider communication with adolescent and young females during sexual and reproductive health visits: findings from the 2011–2015 National Survey of Family Growth. *Contraception*. 2018;97(1):22–28. <https://doi.org/10.1016/j.contraception.2017.08.012>.
5. Fuentes L, Ingerick M, Jones R, Lindberg L. Adolescents' and young adults' reports of barriers to confidential health care and receipt of contraceptive services. *J Adolesc Health*. 2018;62(1):36–43. <https://doi.org/10.1016/j.jadohealth.2017.10.011>.
6. Zolna MR, Finer LB. Shifts in intended and unintended pregnancies in the United States, 2001–2008. *Am J Public Health*. 2014;104(suppl 1):S43–S48. <https://doi.org/10.2105/AJPH.2013.301416>.
7. Sonfield A, Gold RB, Frost JJ, Darroch JE. U.S. insurance coverage of contraceptives and the impact of contraceptive coverage mandates, 2002. *Perspect Sex Reprod Health*. 2004;36(2):72–79. <https://doi.org/10.1363/3607204>.
8. Atkins DN, Bradford WD. Changes in state prescription contraceptive mandates for insurers: the effect on women's contraceptive use. *Perspect Sex Reprod Health*. 2014;46(1):23–29. <https://doi.org/10.1363/46e0314>.
9. Sonfield A, Gold RB. *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future*. New York, NY: Guttmacher Institute. www.guttmacher.org/sites/default/files/report_pdf/medicaid-expansions.pdf. Published 2011. Accessed October 8, 2018.
10. 29 CFR 2590.715-2713 - Coverage of Preventive Health Services. www.law.cornell.edu/cfr/text/29/2590.715-2713. Published 2018. Accessed June 5, 2018.
11. Sonfield A, Tapales A, Jones RK, Finer LB. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update. *Contraception*. 2015;91(1):44–48. <https://doi.org/10.1016/j.contraception.2014.09.006>.
12. U.S. Census Bureau. Census explorer: young adults: then and now edition. U.S. Census Bureau. www.census.gov/censusexplorer/census-explorer-youngadults.html. Published 2014. Accessed June 5, 2018.
13. HHS. Funding history. HHS, Office of Population Affairs. www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/funding-history/index.html. Published August 3 2016. Accessed August 15, 2018.
14. Fowler C, Gable J, Wang J, Lasater B. *Family Planning Annual Report: 2016 National Summary*. Research Triangle Park, NC: RTI International. www.hhs.gov/opa/sites/default/files/title-x-fpar-2016-national.pdf. Published 2017. Accessed March 19, 2018.
15. English A, Gold RB, Nash E, Levine J. *Confidentiality for Individuals Insured as Dependents: A Review of State Laws and Policies*. New York, NY: Guttmacher Institute, 2012: 37.
16. Zapata LB, Tregear SJ, Curtis KM, et al. Impact of contraceptive counseling in clinical settings: a systematic review. *Am J Prev Med*. 2015;49(2S1):S31–S45. <https://doi.org/10.1016/j.amepre.2015.03.023>.
17. Burke PJ, Coles MS, Di Meglio G, et al. Sexual and reproductive health care: a position paper of the Society for Adolescent Health and Medicine. *J Adolesc Health*. 2014;54(4):491–496. <https://doi.org/10.1016/j.jadohealth.2014.01.010>.

18. Ott MA, Sucato GS, Adolescence CO. Contraception for adolescents. *Pediatrics*. 2014;134(4):e1257–e1281. <https://doi.org/10.1542/peds.2014-2300>.
19. Gavin L, Moskosky S, Carter M, et al. Providing quality family planning services: recommendations of CDC and the U.S. Office of Population Affairs. *MMWR Morb Mortal Wkly Rep*. 2014;63(RR-04):1–60.
20. Workowski L, Bolan KA, Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2015. *MMWR Recomm Rep*. 2015;64(RR-03):1–137.
21. Hallum-Montes R, Middleton D, Schlanger K, Romero L. Barriers and facilitators to health center implementation of evidence-based clinical practices in adolescent reproductive health services. *J Adolesc Health*. 2016;58(3):276–283. <https://doi.org/10.1016/j.jadohealth.2015.11.002>.
22. Groves RM, Benson G, Mosher WD, et al. Plan and operation of Cycle 6 of the National Survey of Family Growth. *Vital Health Stat 1*. 2005;42:1–86.
23. Lepkowski JM, Mosher WD, Davis KE, Groves RM, Van Hoewyk J. The 2006–2010 National Survey of Family Growth: sample design and analysis of a continuous survey. *Vital Health Stat 2*. 2010;(150):1–36.
24. Daugherty J, Martinez G. Birth expectations of U.S. women aged 15–44. *NCHS Data Brief*. 2016;260:1–7. www.cdc.gov/nchs/data/data-briefs/db260.pdf. Accessed June 5, 2018.
25. Daniels K, Daugherty J, Jones J, Mosher W. Current contraceptive use and variation by selected characteristics among women aged 15–44: United States, 2011–2013. *Natl Health Stat Report*. 2015;86:1–14. www.cdc.gov/nchs/data/nhsr/nhsr086.pdf. Accessed October 8, 2018.
26. Fowler C, Gable J, Wang J, Lasater B. *Family Planning Annual Report: 2006 National Summary*. Research Triangle Park, NC: RTI International. www.hhs.gov/opa/sites/default/files/fpar-2006-national-summary.pdf. Published 2008. Accessed March 19, 2018.
27. Committee on Adolescence. Contraception for adolescents. *Pediatrics*. 2014;134(4):e1244–e1256. <https://doi.org/10.1542/peds.2014-2299>.
28. 42 CFR 59.11—Confidentiality. www.law.cornell.edu/cfr/text/42/59.11. Accessed June 5, 2018.
29. Gavin L, Pazol K. Update: providing quality family planning services—recommendations from CDC and the U.S. Office of Population Affairs, 2015. *MMWR Morb Mortal Wkly Rep*. 2016;65(9):231–234. <https://doi.org/10.15585/mmwr.mm6509a3>.
30. Carter MW, Gavin L, Zapata LB, Bornstein M, Mautone-Smith N, Moskosky SB. Four aspects of the scope and quality of family planning services in U.S. publicly funded health centers: results from a survey of health center administrators. *Contraception*. 2016;94(4):340–347. <https://doi.org/10.1016/j.contraception.2016.04.009>.
31. Brittain AW, Williams JR, Zapata LB, Moskosky SB, Weik TS. Confidentiality in family planning services for young people. *Am J Prev Med*. 2015;49(2S1):S85–S92. <https://doi.org/10.1016/j.amepre.2015.04.001>.
32. Kavanaugh M, Zolna M. Use of health insurance among clients seeking contraceptive services at Title X facilities. *Perspect Sex Reprod Health*. 2018;50(3):101–109. <https://doi.org/10.1363/psrh.12061>.
33. Sonfield A, Hasstedt K, Gold RB. *Moving Forward: Family Planning in the Era of Health Reform*. New York, NY: Guttmacher Institute. www.guttmacher.org/sites/default/files/report_pdf/family-planning-and-health-reform.pdf. Published 2014. Accessed October 8, 2018.
34. Dixon S, Hogan K, Kaplan C, Montanaro E. Contraceptive education among adolescent providers: current practices and next directions. *J Adolesc Health*. 2018;62(2):S74. <https://doi.org/10.1016/j.jadohealth.2017.11.149>.
35. Kost K, Maddow-Zimet I, Arpaia A. *Pregnancies, Births and Abortions Among Adolescents and Young Women in the United States, 2013: National and State Trends by Age, Race and Ethnicity*. New York, NY: Guttmacher Institute. www.guttmacher.org/sites/default/files/report_pdf/us-adolescent-pregnancy-trends-2013.pdf. Published 2017. Accessed October 8, 2018.
36. Centers for Disease Control and Prevention (CDC). Sexually Transmitted Disease Surveillance 2016. Atlanta, GA: HHS. www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf. Published 2017. Accessed October 8, 2018.