

Methodology for Measuring Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001

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This research was supported in part by the U.S. Department of Health and Human Services under grant FPR00072.

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The authors thank Jennifer J. Frost for assistance in research design and analysis, and Cory L. Richards, Cynthia Dailard, Jennifer Nadeau and Rebecca Wind for reviewing drafts of the report, and for their advice and guidance throughout the project.

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(www.guttmacher.org/pubs/fpfunding/tables.pdf)

This report describes the methodology used to estimate FY 2001 spending levels and trends since FY 1980 in public funding for contraceptive, sterilization and abortion services, as well as for family planning education and outreach activities. We look at expenditures nationally, for each state and jurisdiction, and for each funding source. Also, we compare FY 2001 data with those from a series of prior surveys between FY 1980 and FY 1994. As in the past, we look at data on abortion utilization; because of restrictive reporting requirements and other policies around abortion, it is the only one of the services for which reasonable estimates of utilization are widely available.

The data in this report represent the most complete summary of public funding available. Given the methodological concerns mentioned below, however, the data (along with data from prior surveys) should be considered an approximation, rather than a precise accounting. The methodology for this study, as well as for prior studies in this series, has been through double-blind peer review.

Background on Funding Sources

Public funds for subsidized contraceptive services come from a variety of federal and state sources. Until the mid-1990s, there were four primary federal sources of funding: Title X of the Public Health Service Act, Medicaid, the maternal and child health (MCH) block grant and the social services block grant (Titles XIX, V and XX of the Social Security Act).¹ Another federal source, the Temporary Assistance for Needy Families (TANF) block grant, was created in 1996; TANF is the main federal source of financial “welfare” aid. The relative importance of these sources, as well as of states’ own programs, differs largely according to how each state’s policymakers have decided to fund their family planning effort.

Title X is the sole federal program dedicated to family planning and is the program through which the federal government sets overall policy regarding family planning. Title X is administered by the U.S. Department of Health and Human Services (DHHS), which awards grants to public and nonprofit private agencies for the operation of clinics that provide care largely to the uninsured and underinsured. For FY 2001 (October 1, 2000 through September 30, 2001), the DHHS Office of Population Affairs awarded Title X service grants to 39 state agencies and 38 nonstate organizations (such as regional family planning councils, Planned Parenthood affiliates and community health agencies) that collectively provided services in all 50 states, the District of Columbia and Puerto Rico.²

The MCH and social services block grants are solely provided to and controlled by state governments, although the funds are often passed on to other public and private agencies. The MCH grant goes to the state’s health agency, and the social services grant goes to the state’s social services agency, although the same agency serves both functions in some states. Federal law specifically allows states to use either grant for family

planning services. States are required by federal law to match every four federal MCH dollars with three state dollars. A match is not required for the social services block grant.

The TANF block grant is also provided directly to state social services agencies, which administer the states' welfare programs. The 1996 law authorizing TANF included reducing nonmarital pregnancies as one of four overriding goals for the program and allowed spending for "prepregnancy family planning services" as the single exception to a rule against funding medical services.³ Federal law does not require states to match TANF dollars, but it does require them to maintain a specified level of state expenditures on TANF-related services.

Medicaid is a program jointly funded and shaped by the federal and state governments to provide medical care to various low-income populations. Unlike Title X and the federal block grants, Medicaid is an entitlement program, meaning that federal law guarantees reimbursement for services provided to everyone enrolled under federal- and state-set eligibility criteria. For most expenses, the federal government pays for 50–77% of states' Medicaid expenditures. By federal law, however, the federal government pays for 90% of each state's Medicaid expenditures for family planning services and supplies. Although federal law requires that Medicaid cover family planning services, states have leeway in deciding what exactly is included under that rubric.

The entitlement to family planning also applies to expansions to Medicaid (called "M-SCHIP") created by states under the State Children's Health Insurance Program, a companion program for Medicaid enacted by Congress in 1997 to provide care to low-income children. States were also given the option to create separate, state-designed programs (S-SCHIP); states have more latitude in designing S-SCHIP benefits, of which family planning services are optional.

An important development in Medicaid's role in providing contraceptive services has been state-initiated family planning eligibility expansions; these "waiver" programs require approval from DHHS.⁴ In 1996, Arkansas became the first state to initiate a waiver program, and by FY 2001, six additional states (Alabama, California, New Mexico, Oregon, South Carolina and Washington State) had expanded their income-eligibility levels for family planning services well above their levels for Medicaid overall. (Six additional states have created such income-based expansion programs in subsequent years. Several other states have created more limited programs that extend family planning eligibility for women who are otherwise leaving Medicaid, typically after giving birth.⁵)

Most state governments direct some of their own funds (in addition to funds required to match federal grants) to subsidize contraceptive services. Many states' Medicaid agencies use state-only funds to provide medical services (including contraceptive services) to people, such as certain categories of immigrants, who fail to meet federal criteria for Medicaid eligibility. Some local governments also provide public funds for contraceptive services.

The vast majority of publicly funded sterilizations are through Medicaid, although state-only funds and other federal programs have contributed. Sterilizations funded through DHHS are limited by regulations implemented in 1979. These rules include a complex procedure to ensure women's informed consent, a 30-day waiting period between consent and the procedure, and a prohibition on sterilization of anyone younger than 21 or who is mentally incompetent.⁶

The policies governing public funding for abortions, and thus the number of abortions funded, vary tremendously by state. Most states have restrictive policies, typically paying only their share of abortions provided to Medicaid recipients in accordance with federal law. That law requires federal Medicaid funds (at normal Medicaid matching rates, not the 90% family planning rate) to be used only for abortions that are necessary to save the life of the woman or those of pregnancies resulting from rape or incest. (A few states with restrictive policies also provide funding in additional rare circumstances, such as in cases of fetal abnormality.) By the end of FY 2001, 18 states officially had nonrestrictive policies, using their own funds to pay for most or all medically necessary abortions provided to Medicaid recipients. Four of these states had voluntarily adopted such a policy; the remainder were under court orders saying that less-extensive coverage was in violation of their state constitutions.⁷

Fielding, Response and Survey Instruments

In 2002, questionnaires were mailed to the health, social services and Medicaid agencies in all 50 states, the District of Columbia and Puerto Rico, as well as to 38 nonstate Title X grantees that were identified by the federal Office of Population Affairs as providing clinical services. Nonrespondents received a second mailing, and were contacted by telephone and electronic mail to obtain clarification and additional data. Fieldwork continued through September 2003.

Responses were obtained from all health agencies; social services agencies in 47 states, the District of Columbia and Puerto Rico; Medicaid agencies in 42 states and the District of Columbia; and 36 of the 38 nonstate Title X agencies.* We also obtained Medicaid/M-SCHIP and S-SCHIP expenditure data directly from the Centers for Medicare and Medicaid Services (CMS), which administers the programs on a national level. In a few cases, we mined other resources, such as published state reports, for data.

Four different, though similar, questionnaires were designed—one for each type of respondent: nonstate Title X grantees, and state health, social services and Medicaid agencies. The first three questionnaires requested data on total expenditures from various

* Nonrespondents included social services agencies in Michigan, Tennessee and Virginia; Medicaid agencies in Arizona, Colorado, Florida, Hawaii, Maine, Nebraska, New Hampshire, Puerto Rico and Tennessee; and grantees in Arizona and Colorado, neither of which were the primary Title X grantee in the state. Four U.S. jurisdictions—American Samoa, Guam, the Northern Mariana Islands and the Virgin Islands—were also queried but did not respond.

funding sources for family planning services and supplies in FY 2001, as well as the amount spent on a list of specific services and items. The list of funding sources differed depending on the particular agency. Sources included Title X, the MCH block grant, the social services block grant, TANF, other federal funding sources (not including Medicaid) and state-only funding sources (excluding state funds used to match federal grants, which we asked states to include with the appropriate grant). We also asked the health and social services agencies about the amount of state-only funds spent on abortions, and the number of abortions funded.

Because we obtained data on federally reimbursed Medicaid expenditures from CMS, the questionnaire for Medicaid agencies asked about state-only expenditures by the agency on contraceptive, sterilization and abortion services. The questionnaire also included a series of questions about managed care coverage under Medicaid, to help in estimating contraceptive services expenditures under capitated plans.

Terminology and Data Analysis

Throughout this report, we use the term “contraceptive services” to refer to the broad package of direct patient care services provided through family planning programs. Contraceptive services include the time providers spend with patients during family planning visits, as well as such items as contraceptive supplies, tests and drugs for sexually transmitted infections (STIs), Pap smears and pregnancy tests. Whenever possible, we separated out services that are not part of the standard package provided to clients seeking contraception, such as sterilization services, outreach and education activities (both of which we report separately), and administrative expenses. CMS provided data according to this definition of contraceptive services for every state’s Medicaid program. Data obtained from state agencies and Title X grantees for the other funding sources, however, often include some sterilization, outreach, education and administrative expenses, as noted in the tables. In part for that reason, the expenditure data we report for sterilization services and outreach and education activities should not be viewed as complete.

States have the option of transferring a portion of their TANF funds to the social services block grant; when states indicated this was the case, we counted such funds under the TANF category, to reflect their initial source. Some states, however, may have reported such funds under the social services block grant.

A number of respondents indicated that some or all of their data were not for federal fiscal year 2001 (October 1, 2000 through September 30, 2001), as requested, but rather for either the calendar year or the state’s fiscal year, which for most states ran from July 1, 2000 through June 30, 2001.

For the sections in which we group states according to state policy (e.g., Medicaid family planning eligibility expansions and policies on public funding for abortion), we

use state policies as of October 1, 2001. Only income-based Medicaid family planning eligibility expansions are used in this analysis, because enrollment in and expenditures for the more limited postpartum programs were small.

Comparative data from prior years is culled from prior published articles.⁸ For the section in which we compare data over time for contraceptive services in constant dollars, we converted data to constant 2001 dollars using the Medical Care Consumer Price Index–All Urban Consumers, with \$1.00 in 1980 equal to \$0.27 in 2001.⁹ Data on the number of women in need of publicly supported contraceptive services include women who are aged 13–44, sexually active, fecund and neither intentionally pregnant nor trying to become pregnant; and are either younger than 20 or have a family income under 250% of the federal poverty level.¹⁰

Changes made to question wording and methodology in the FY 2001 survey may have resulted in some loss of comparability with prior surveys. First, researchers in prior surveys attempted to use a narrower definition of contraceptive services, excluding such services as STI tests and drugs, Pap smears and pregnancy tests. Only a small proportion of respondents, however, were able to separate out these services in prior surveys, and reported contraceptive expenditures under Medicaid always included them. We calculated contraceptive services for FY 2001 under both the narrow and broader definitions; using the broader definition added only 1% to overall expenditures. Second, FY 2001 data on most Medicaid expenditures was obtained directly from CMS, rather than from state agencies. The CMS data included claims made retrospectively by states and should be more accurate than data received in past surveys. It should be noted, however, that comparability among versions of this survey has always been a problem, because researchers have repeatedly refined their questionnaires and have made other methodological changes to improve precision.¹¹

Medicaid Managed Care

The previous survey in this series, from FY 1994, identified a serious and potentially growing methodological problem: the increasing importance of managed care in the Medicaid program. In FY 1994, 23% of Medicaid enrollees were in managed care plans; by FY 2001, that figure was 57%.¹² Although states have a financial incentive to keep track of expenditures for contraceptive services, given the special 90% matching rate, not all states are able to identify contraceptive services provided through capitated managed care plans (i.e., plans that pay a set amount per patient, rather than by specific service). This results in a potentially serious undercount of expenditures.

For the current survey, we took several steps to assess and correct, when necessary, this potential undercount. First, we commissioned an in-depth study of Medicaid expenditures to assist in our development of a correction factor for expenditures under capitated plans. For this investigation, we were able to obtain data from four states (California, Georgia, Indiana, and Montana) with significant managed

care penetration and detailed utilization data for both managed care and fee-for-service enrollees. The study revealed no significant difference in the number of separate contraceptive services received per year by women enrolled in capitated managed care plans and in fee-for-service plans, indicating that expenditure data could be adjusted using the proportion of women or clients in the state enrolled in capitated managed care as an inflator.¹³

Because some women in capitated managed care, however, receive family planning services outside of their plan using a federally required “freedom of choice” option, a further adjustment was needed. (Expenditures for freedom-of-choice services are reported as fee-for-service and do not need to be estimated.) Conversations with state Medicaid officials confirmed that no data was available on the frequency with which freedom of choice was utilized. To be conservative in our adjustments, we estimated that half of women enrolled in capitated plans received freedom of choice services, and we created a final adjustment factor of half the capitated enrollment.

Second, to decide how and when to apply the correction factor, we asked state Medicaid agencies about the proportion of Medicaid enrollees (overall and of women 15–44) enrolled in fully or partially capitated managed care plans. We also asked these Medicaid agencies whether and how they claimed reimbursement at the 90% matching rate for family planning.

Third, depending on the responses to these survey questions, we determined how much the CMS Medicaid expenditure data needed to be adjusted for each state. For those states that reported no capitated managed care enrollment or that reported claiming all of their capitated expenses at the 90% rate, we have simply used the CMS expenditure data, adjusting for the states’ match. Similarly, no further adjustments were made for states that did not respond to the relevant survey questions and for which we had no basis for making adjustments.

For a number of jurisdictions, however, we adjusted the CMS data upward. Eleven states and the District of Columbia reported that none of the contraceptive services provided to enrollees of capitated managed care were claimed at the 90% rate. For nine of these states and the District of Columbia, we adjusted expenditures using an inflator equal to one-half the proportion of women 15–44 in managed care reported on our survey.[†] For the remaining two states (New Mexico and Wisconsin), which did not respond to our survey question on managed care enrollment, we used an inflator equal to one-half the overall proportion of managed care enrollees reported by CMS.¹⁴ A similar procedure was followed for two additional states (Hawaii and New Hampshire) that did not respond to the question about claiming at the 90% rate and for whom we suspected that the reported expenditures were too low, based on analysis of past expenditure data. These adjustments for the 13 states and the District of Columbia resulted in a nationwide

[†] District of Columbia, Illinois, Kansas, Kentucky, Minnesota, New York, North Dakota, Vermont, Virginia and Washington State; for Washington State, this adjustment was applied to all CMS-reported expenditures except those through the state’s Medicaid family planning waiver.

increase in estimated Medicaid expenditures on contraceptive services of less than 2% for FY 2001.

Capitated managed care also impacted our estimation of abortion expenditure data for those states that fund medically necessary abortions. (Federally reimbursed abortions have strict reporting requirements, regardless of capitation, and expenditure data on such abortions should therefore be reported.) Data obtained from California and New York purportedly included the complete number of abortions paid for through fee-for-service and managed care arrangements, but only included expenditure data for fee-for-service abortions. We adjusted for the expenditure undercount by adding an amount equal to the number of managed care abortions multiplied by the average cost per fee-for-service abortion in the state.

It is also possible that capitated managed care affected our estimates of sterilization expenditures under Medicaid; however, we had no basis upon which to make adjustments. On a related note, we report only those sterilization expenses under Medicaid claimed at the family planning matching rate of 90%, so as to exclude noncontraceptive procedures such as hysterectomies; for states that are inconsistent in claiming the 90% rate for contraceptive sterilizations, our estimates (in this and prior surveys) would be low.

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