Block Grants Are Key Sources of Support For Family Planning

Although much of the attention of the family planning world is focused on the leading funding sources—Title X, Medicaid and state revenues—two long-standing federal block-grant programs are important sources of financial support for the provision of publicly subsidized family planning services. While the widely popular maternal and child health block grant has been comparatively well funded in recent years, funding for the massive social services block grant has been slashed in the wake of welfare reform, a move that already is having distressing repercussions for providers and patients in need of subsidized family planning care.

By Rachel Benson Gold and Adam Sonfield

In the early days of the so-called Reagan Revolution, Congress moved to consolidate several long-standing categorical programs into a series of block grants in which allocations are made to state agencies, which then decide how the funds will be spent. The move was generally supported by states seeking freedom from what they considered to be onerous federal requirements, a sentiment echoed in the regulations issued by the Department of Health and Human Services (DHHS), which assert that states should not to be burdened with "definitions of permissible and prohibited activities, procedural rules, paperwork and record keeping requirements."

Two of the newly created block grants, the maternal and child health (MCH) and social services block grants—Titles V and XX, respectively, of the Social Security Act—were the successors of programs that historically had provided important financial support for family planning services and supplies for low-income women. Although both programs continue to fund family planning, the MCH program has achieved a level of political and financial stability that has eluded the social services program.

The MCH Block Grant

Dating from the 1930s, the MCH program supports a range of activities designed to reduce infant mortality and promote the health of mothers and children. State programs provide a variety of services, including prenatal care, immunization, well-child care, school health and education services and specialized services for children with developmental disabilities or chronic illness. States must contribute three dollars for every four dollars of federal funds they receive through the program.

Family planning traditionally has been seen as an important aspect of the program's overall mission; as far back as 1966, as many as 30 states were spending a total of $3 million in MCH funds for family planning. In fact, prior to the creation of the block grant, federal law required that at least 6% of total program spending nationwide be for family planning services. Although this requirement was removed as part of the transformation of the program in 1981, data collected by The Alan Guttmacher Institute (AGI) indicate that family planning spending through the program has roughly kept pace with the program's overall growth. In FY 1997, according to a recent AGI study, 42 states and the District of Columbia spent $41 million in MCH block-grant funds for family planning (see table)—a spending level that continues to be approximately 6% of the total federal grant, even in the absence of the specific federal requirement.

In 31 states and the District of Columbia, MCH block-grant funds support direct medical care related to contraceptive services. Increasingly, however, with Medicaid underwriting the bulk of the medical care provided to low-income pregnant women and children, state MCH programs have moved away from an emphasis on direct patient care and toward underwriting a range of supportive services that Medicaid is unlikely to cover. As a result, programs now emphasize infrastructure building (including such services as needs assessment, quality assurance and training) and population-based services (such as newborn and lead screening, immunization, outreach and education), as well as so-called enabling services (including transportation, translation and case management). Mirroring this larger trend, programs in 34 states and the District of Columbia fund some of these supportive services related to family planning.

The MCH block grant has evolved in other ways as well. In 1989, Congress moved to reinstate some of the federal "strings" that had been dropped at the block grant's creation. It required states to formally assess the needs of the three target populations—pregnant women; mothers and infants; and children with special health care needs—every five years and to prepare a plan describing which services are to be provided to each of these groups. Under these new requirements, about one-third of MCH funds are to be spent on preventive and primary

Reported Expenditures for Family Planning Services, FY 1997 (in 000s)

State	MCH Block Grant	Social Services Block Grant
U.S. Total	$40,911*	$26,968
Alabama	1,900	0
Alaska	344	0
Arizona	875	50
Arkansas	192	0
California	0	0
Colorado	50	0
Connecticut	21	1,072
Delaware	183	0
District of Columbia	250	0
Florida	0	0
Georgia	0	0
Hawaii	120	0
Idaho	795	0
Illinois	204	3,255
Indiana	1,289	1,201
Iowa	0	147
Kansas	U	0
Kentucky	2,714	0
Louisiana	1,200	0
Maine	0	273
Maryland	0	0
Massachusetts	154	0
Michigan	1,640	0
Minnesota	977	0
Mississippi	U†	556
Missouri	1,465	U
Montana	79	0
Nebraska	100	U
Nevada	109	0
New Hampshire	25	336
New Jersey	598	1,634
New Mexico	240	0
New York	1,900	0
North Carolina	4,134	43
North Dakota	105	0
Ohio	1,131	465
Oklahoma	500	0
Oregon	1,159	0
Pennsylvania	1,644	4,175
Rhode Island	169	0
South Carolina	63	0
South Dakota	535	0
Tennessee	2,772	0
Texas	5,515	13,642
Utah	270	5
Vermont	0	114
Virginia	1,159	0
Washington	115	0
West Virginia	1,455	0
Wisconsin	1,828	U
Wyoming	167	0

*Includes $17,000 from American Samoa and $750,000 from Puerto Rico. †Mississippi reports spending MCH block-grant funds on family planning, but the amount is unknown. *Notes:* U=amount unknown. Data may not add to totals because of rounding.

health care for children, and one-third on services for children with special health care needs. In other words, the MCH program has come to look *less* like a traditional block grant over time, and its increased level of accountability to federal policymakers—along with the fact that it provides a set of readily identifiable, politically popular services—may well have helped it build and retain the high level of support it enjoys today. In fact, while the MCH program suffered serious funding cuts in the early 1980s, as did many other federal domestic programs, its funding has grown at a steady pace over the last decade (see chart, page 8).

The Social Services Block Grant

The history of the social services block grant—and its political fortunes—could not be more different.

Dating back to the 1970s, the social services program required states to address several major goals: promotion of self-support and self-sufficiency; prevention of or remedying abuse of children or adults; prevention of inappropriate institutionalization; and referral and admission services when necessary for institutional care. State programs were required to fund at least one program addressing each of these goals, and the law required that at least half the funding be spent on individuals eligible for welfare or Medicaid. Family planning was virtually alone as a medical service that could be funded in this program, which otherwise focused exclusively on social services such as day care, protective services for children and home-based services. Moreover, while the federal government reimbursed states for 75% of most of their expenses, family planning was eligible for reimbursement at 90%.

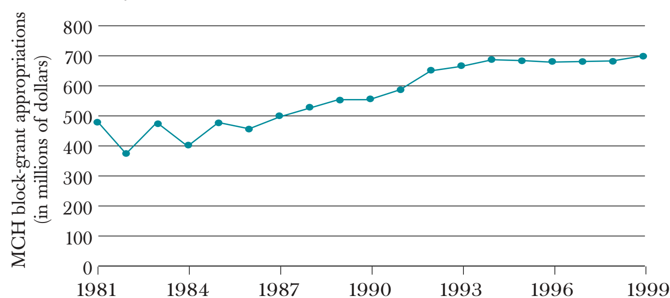
When Congress transformed the program into a block grant in 1981, it eliminated numerous federal requirements. States were now free to set their own eligibility requirements and determine which population groups to serve, and they were no longer required to match federal spending. The block grant, however, continued to list family planning among the services states *could* provide.

In FY 1997, 15 states reported spending $27 million in block-grant funds for family planning services. Fully 12 of the 15 states reported funding the delivery of actual contraceptive services and supplies for patients; however, in sharp contrast to the experience with the MCH block grant, only eight states reported funding nonmedical supportive efforts, such as infrastructure building or population-based or enabling services. This finding is also particularly striking given that the overall block grant focuses almost exclusively on social services and generally supports little in the way of direct patient care.

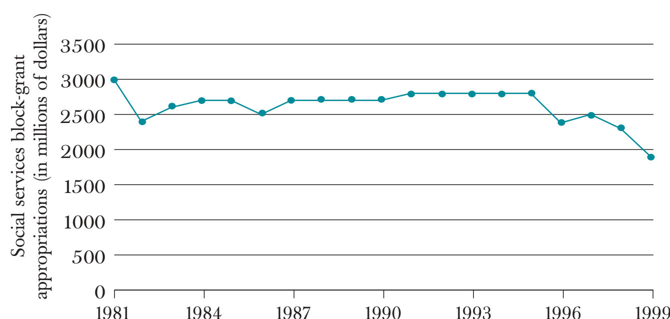
Although funding for the social services program followed the same pattern as funding for the MCH block grant dur-

Divergent Trends

Appropriations for the MCH block grant have risen steadily since the mid-1980s…



…while funds for the social services block grant have been deeply cut this decade.



ing the 1980s—a dramatic cut followed by steady recovery—its fortunes seemed to plummet in the mid-1990s (see chart), concurrent with congressional repeal of the traditional welfare program, Aid to Families with Dependent Children, and its replacement with a new program, Temporary Assistance for Needy Families (TANF).

As part of that move, Congress cut funding for the social services block grant by 15%, from $2.8 billion to $2.4 billion per year. This reduction, designed to help offset the short-term costs of reform, was intended to be temporary; the block grant was to be restored to $2.8 billion in FY 2003, by which time anticipated long-term savings from the new TANF program were expected to have materialized. In the meantime, states were allowed to transfer, with some restrictions, up to 10% of their TANF allocations to shore up the social services block grant.

This promise of a *temporary* and *limited* cut was quickly broken, however, and the block grant was cut further, to $1.9 billion for FY 1999. A 1998 federal law will force further cuts starting in FY 2001 and slash by more than half the amount of money that may be transferred to the social services block grant from TANF. The block grant now faces the 21st century with an authorized funding level of $1.7 billion—the lowest level since the early 1970s, not even accounting for inflation—and with its support from the bulging TANF coffers crippled.

Advocates for the social services block grant and others involved in the appropriations process cite a variety of related causes for the program's apparent vulnerability. Michael Bird of the National Conference of State Legislatures (NCSL), an organization that strongly supports the block grant, contends that information coming from what little monitoring the federal government has conducted of state expenditures has been released only belatedly and reluctantly; it should come as no surprise, Bird says, that members of Congress have little knowledge of, or attachment to, a program about which very little is known.

Others suggest that the program's very breadth may be an impediment to its garnering significant support from most interest groups. Laurie Rubiner, who specializes in a range of public health and social services issues for Sen. John Chafee (R-RI), a senior member of the Senate Finance Committee and a key player in the welfare reform debate, notes that most service-related advocacy organizations have other legislative priorities—programs (like the Title X family planning program, for example) that more directly address their concerns and that fund services in every state in the nation. Furthermore, Rubiner says, many lawmakers and advocates interested in social services have turned their attention toward TANF in recent years and may view the block grant as extraneous in the wake of welfare reform, despite the fact that the block grant helps fund a far wider population.

Impact on Family Planning

In that core group of states that have long chosen to devote some of their social services funding to family planning, these services have been hit hard by overall cuts to the program. Several years into continuing and severe cuts, states' tactics of shifting funds from other sources have begun to fail, leaving clinics to cut back on the number of clients they can serve—or to close altogether.

This may be best illustrated by the situation in Pennsylvania, where, according to John Boyle of the state health department, the state's regional family planning councils have had to absorb a 9% cut in social services block-grant funding. This, according to Boyle, has led 14 clinics to reduce office hours, and 10 to close their doors entirely. In addition, Boyle notes, clinics have had to reduce the availability and selection of oral contraceptives and other medications; one particularly distressing outcome is that some clinics are moving to give clients prescriptions, which they then need to fill at a pharmacy, rather than directly dispensing medications on-site.

The impact has also been severe in Texas, a state that spent over $13 million in social services block-grant funds for family planning in FY 1997—half the total expenditure nationwide (see table, page 7). Although

the state initially found ways to compensate with other revenues, the family planning program was cut $3.1 million in FY 1999. As a result, according to Peggy Romberg of the Texas Family Planning Association, 22,000 low-income Texas women will be turned away from clinics this year. While much of the lost block-grant revenue has been replaced for FY 2000 with money from TANF, Romberg notes that what "could have been an opportunity to enhance family planning services and increase the number of women served" has turned into no more than filling the void created by cuts in block-grant funding.

North Carolina was also hit hard when the state's long-standing seven-digit allocation for family planning through the social services block grant was all but terminated in FY 1997. Although the funds were replaced with monies from TANF, the impact of that switch has been considerable. According to Margaret Woodcock of the state's health department, while the program was not restricted in how it could use the social services block-grant funds as part of its family planning effort, "state TANF funds, to date, carry more restrictive eligibility requirements, and the program must document that each individual recipient is specifically eligible for TANF." As a result, Woodcock says that as of June 1999, the dollars were no longer available to support either the clinic infrastructure or the overall population in need of subsidized family planning services across the state; rather, the dollars were limited to the much smaller population of welfare recipients.

Guarded Optimism

It is somewhat ironic that the greatest strength of the social services block grant—its extreme flexibility—appears to have become the key to its weakness. Some of the same members of Congress who, in 1981, trumpeted the benefits to the states of cutting federal strings, have now felt free to slash the program essentially because those strings are not there—even while pushing forward with other initiatives, like TANF, based on the very same principle.

Nonetheless, advocates for the social services block grant are guardedly optimistic about the program's fiscal future. The administration's FY 2000 budget asked that the social services block grant be funded up to the authorization ceiling set in federal law, and key congressional committee members are supporting this request. Groups such as NCSL and the American Public Human Services Association are pushing hard for Congress to reverse the damaging provisions of the 1998 law before they go into effect. Meanwhile, support for the MCH program seems to be running as high as ever, both in the Clinton administration and on Capitol Hill.

Advocates and policymakers interested in maximizing fiscal support for family planning–related activities may be well advised to join in efforts to bolster both programs. It is clear that the MCH and social services block grants are vital components of a national family planning program. It is equally clear that the fate of family planning funding through these block grants is critically dependent on the fortunes of the overall grants and that every dollar lost threatens services for women in need. Advocates of family planning—as well as of other health care– and social services–related goals—must look beyond such programs as Title X that are more prominently linked to their interests.

At the same time, family planning supporters must recognize that the nature and purpose of block grants obligates them, and policymakers, to pay closer attention to activities in the individual states. Critical decisions both about funding levels and about the shape and scope of family planning programs are being made in legislatures, governors' offices and state agencies—and these decisions invariably will change the weave of the nation's family planning support network.

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