Family Planning Funding Through Four Federal-State Programs, FY 1997

By Rachel Benson Gold and Adam Sonfield

Context: *The maternal and child health (MCH) and the social services block grants have long played an important role in the provision of family planning services in the United States. The extent to which states have incorporated family planning services into the newer federally funded, but state-controlled, programs—Temporary Aid to Needy Families (TANF) and the State Children's Health Insurance Program (CHIP)—has yet to be identified.*

Methods: *The health and social services agencies in all U.S. states, the District of Columbia and five federal jurisdictions were queried regarding their family planning expenditures and activities through the MCH and social services block grants and the TANF program in FY 1997. In addition, the states' CHIP plans were analyzed following their approval by the federal government. Because of differences in methodology, these findings cannot be compared with those of previous attempts to determine public expenditures for contraceptive services and supplies.*

Results*: In FY 1997, 42 states, the District of Columbia and two federal jurisdictions spent $41 million on family planning through the MCH program. Fifteen states reported spending $27 million through the social services block grant. Most of these jurisdictions indicated that they provide direct patient care services, most frequently contraceptive services and supplies. Indirect services—most often population-based efforts such as outreach and public education—were reported to have been provided more often through the MCH program than through the social services program. MCH block grant funds were more likely to go to local health departments, while social services block grant funds were more likely to be channeled through Planned Parenthood affiliates. Four states reported family planning activities funded under TANF in FY 1997, the first year of the program's operation. Virtually all state plans for the implementation of the CHIP program appear to include coverage of family planning services and supplies for the adolescents covered under the program, even when not specifically required to do so by federal law.*

Conclusions: *Joining two existing—but frequently overlooked—block grants, two new, largely state-controlled programs are poised to become important sources of support for publicly funded family planning services. Now more than ever, supporters of family planning services need to look beyond the traditional sources of support—Title X and Medicaid—as well as beyond the federal level to the states, where important program decisions are increasingly being made.*

Family Planning Perspectives, 1999, 31(4):176–181

While a wide variety of federal programs support family planning services in the United States, two programs have consistently received the attention of both supporters and opponents of family planning. Medicaid (Title XIX of the Social Security Act), the largest source of family planning funding, is an open-ended entitlement program through which eligible individuals are legally entitled to covered services. All states participate in the Medicaid program, and all state Medicaid efforts include family planning services, as mandated by federal law.

Although it provides fewer dollars than Medicaid, the Title X program (authorized in the Public Health Service Act) is the only federal program dedicated to family planning; it is the program through which the federal government sets its family planning policy, and it historically has been a lightning rod for opponents. Title X funds are distributed directly by the federal government to a range of grantees, which include state agencies as well as nonprofit organizations such as Planned Parenthood affiliates and regional family planning councils. Title X funds are distributed in all states.

Two major federal block grants, the maternal and child health (MCH) and the social services block grants (Titles V and XX of the Social Security Act, respectively), stand in sharp contrast to either Medicaid or Title X. By federal law, both Medicaid and Title X must fund family planning. Under the block grants, inclusion of family planning is left entirely to the discretion of each state. Under these two programs, federal funds go directly to a single state agency, which in turn has broad discretion over their use. States determine the specific activities that will be funded and the populations that will be targeted. The federal government does not set strict income-eligibility criteria for either program.

Federal MCH block grant dollars go directly to state health departments, which are required to match every four federal dollars with three state dollars. These funds may be used for activities aimed at improving maternal and child health, including providing low-income mothers and children with "access to quality maternal and child health services."[1] States decide what specific activities (direct patient care, as well as indirect services) to fund and to which providers (such as health departments, nonprofit agencies and private physicians) money will be allocated. Historically, most states have used portions of their block grant allotments to fund family planning services and supplies.

Social services block grant allotments go to state social service agencies; no state match is required under this program. States have broad latitude to design their own programs, which must be aimed at preventing, eliminating or reducing dependence on government aid and promoting self-sufficiency. As its name implies, the program focuses on funding social services, rather than health care services. The federal statute lists several types of services that states *may* provide under the program, including child care, services for children in foster care and employment services; family planning is the only medical service specified in the statute. As with the MCH block grant, states determine the providers to whom program funds will be allocated. Traditionally, the social services block grant has been an important source of support for family planning services in selected states.

Together, these two block grants are key sources of funding for family planning agencies across the country. A 1995 sur-

Rachel Benson Gold is assistant director for policy analysis and Adam Sonfield is senior public policy assistant with The Alan Guttmacher Institute, Washington, DC. The research on which this article is based was supported in part by the U.S. Department of Health and Human Services (DHHS) under grant no. FPR000057. The conclusions and opinions expressed in this article do not necessarily represent the views of DHHS. The authors express their gratitude for the important contributions of several AGI colleagues, including Rebekah Saul and Anjali Dalal.

vey found that 35% of family planning agencies received funding through the MCH block grant and 15% received monies through the social services block grant; the percentages were higher (44% and 21%, respectively) for those agencies that were also funded through the Title X program.[2]

Congress added a new component in 1996 when it overhauled the nation's welfare program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 repealed Aid to Families with Dependent Children (AFDC), replacing it with Temporary Assistance for Needy Families (TANF). The two programs have major differences. TANF ended individual enrollees' legal entitlement to benefits, long a hallmark of AFDC. Instead, each state is allotted a set amount of funds, to use largely at its discretion.

In line with the overall program goal of reducing pregnancies to teenagers and unmarried women, the statute allows—but does not require—states to provide "prepregnancy family planning services," a term that Congress left undefined. (The statute also provided another indirect way for TANF funds to be used for family planning, by enabling states to transfer up to 10% of their TANF allotment to the social services block grant. These transferred funds could then be used to fund services under the social services program, including family planning.)

To encourage states to develop policies to further the goal of reducing nonmarital births, Congress added the so-called illegitimacy bonus as an incentive. Under this provision, the federal government will give up to $100 million to as many as five states that achieve the greatest decline in out-of-wedlock births while also lowering their abortion rates.[3]

In 1997, Congress added yet another new program to the mix, with the establishment of the State Children's Health Insurance Program, or CHIP (Title XXI of the Social Security Act). Enacted as part of the Balanced Budget Act of 1997, CHIP seeks to provide insurance coverage to uninsured children and adolescents younger than age 19 who are generally in families with incomes below 200% of poverty; states may go higher than this in some instances. States may provide this coverage either by expanding eligibility for their current Medicaid program or by establishing a separate, state-designed program, or both. States taking the combination approach typically will provide Medicaid coverage to enrollees with incomes up to a specified income level and offer state-designed (and often somewhat less comprehensive) coverage to higher income enrollees. (Early reports from several states indicate that many may initially expand their Medicaid programs and then switch to a state-designed effort in future years.)

If a state chooses to expand its Medicaid program, enrollees will be Medicaid recipients, entitled to the full range of Medicaid-covered services, including Medicaid-covered family planning services and supplies. (The federal Medicaid statute specifically mandates coverage of family planning services to "individuals of childbearing age," including "minors who can be considered to be sexually active."[4]) States choosing to establish separate CHIP programs would determine their own benefit packages. Whether family planning services, like most other services, are covered in these programs is left to the state's discretion; the statute, similar to the welfare reform measure, clearly gives states the option to cover "prepregnancy family planning services."

To participate, a state must obtain approval of its state CHIP plan from the Health Care Financing Administration (HCFA), the federal agency that oversees both CHIP and Medicaid. By the end of 1998, 48 states and the District of Columbia had submitted plans to HCFA, and 45 states and the District of Columbia had obtained federal approval. Two states, Washington and Wyoming, have chosen not to participate in the program.

This article has two main purposes. One is to examine the role played by the two long-standing block grants—the MCH and social services block grants—in the provision of family planning services in the United States. The second is to study the extent to which states have incorporated family planning services into the newer federally funded but largely state-controlled programs—TANF and CHIP.

While data on family planning expenditures under the older block grants are presented here, it is important to note that these data differ in two key respects from those collected in past attempts by The Alan Guttmacher Institute (AGI) to document expenditures on publicly funded family planning services.[5] First, they do not include information from other key funding streams, such as Title X, state sources or Medicaid. Medicaid expenditures were excluded, in large part because the transition to managed care has made it difficult to identify family planning expenditures under the program. The problem, which was already emerging when AGI conducted its last funding survey in 1994, has become more acute since then; almost all low-income women enrolled in Medicaid have been enrolled in managed care plans. As a result, these data should not be taken as a comprehensive statement of public funding for family planning.

Second, past efforts attempted to isolate expenditures solely for contraceptive services and supplies; the data presented here are for the overall category of family planning services, of which contraceptive services are but one component. This was done because states seem to be finding it increasingly difficult to separate out other family planning services from just contraceptive services. As a result, the data presented are not comparable with past data, and should not be used as the basis for discussion of trends in public funding of family planning.

Methodology

In April 1998, we sent the health and social services agencies for all 50 states, the District of Columbia and five U.S. jurisdictions—American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands—questionnaires regarding expenditures on family planning for FY 1997 (October 1, 1996, through September 30, 1997). Responses were obtained from health agencies in 49 states, the District of Columbia, Puerto Rico, American Samoa and the Virgin Islands, and from social services agencies in 47 states, the District of Columbia and Guam.*

Each health agency was asked to provide information relating to three programs—the MCH block grant, the social services block grant and TANF; social service agencies were queried regarding the latter two only. For each program, we asked agencies to provide information on the amount of money (if any) that they spent on family planning services, the types of family planning activities funded and the types of providers through which such expenditures were made. (We also asked agencies about steps they had taken to win the illegitimacy bonus; these results are reported elsewhere.[6])

Agencies were asked to indicate whether expenditures were made on a range of direct patient care activities, including contraceptive services and supplies; sterilization services; infertility services; services for sexually transmitted diseases; pregnancy

*Nonrespondents were health agencies in Kansas, Guam and the Northern Mariana Islands, and social services agencies in Missouri, Nebraska, Wisconsin, Puerto Rico, American Samoa, the Northern Mariana Islands and the Virgin Islands.

Table 1. Reported public expenditures for family planning services (in 000s of dollars) through the MCH and social services block grants, by state, FY 1997

State	MCH block grant	Social services block grant
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
D.C.	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	nr	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	nr
Montana	79	0
Nebraska	100	nr
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	nr
Wyoming	167	0
American Samoa	17	nr
Guam	nr	0
No. Mariana Isl.	nr	nr
Puerto Rico	750	nr
Virgin Islands	0	nr

Notes: Data may not add to totals because of rounding. u=expenditures were made, but amount is unknown. nr=no response was made by the agency that administers this grant.

testing; HIV services; and other services.* In addition, we requested agencies to indicate whether expenditures were made on three types of indirect care: enabling services (i.e., transportation and case management); population-based services (i.e., outreach and public education); and infrastructure building (i.e., needs assessment, quality assurance and training).† Agencies were only to indicate *whether* expenditures were made in a specific service category, not the amount that was spent. Services relating to abortion were not included.

In addition, we asked agencies to indicate which types of providers received funding through their programs: health departments, hospitals, community health centers, Planned Parenthood affiliates, private physicians, independent agencies and others. For purposes of analysis, we have merged the last two categories.

As was the case in past attempts to examine federal and state expenditures on family planning services, state agencies were limited in their ability to segregate federal and state funds. The MCH block grant requires states to use state funds to match federal outlays, and many states match expenditures from the social services block grant, although they are not required to do so. As a result, the expenditures reported by some states under the block grants often include both the federal allotment and the state match.

Several other methodological issues arose in the course of this study. First, several states administer their programs at the county level, a system that can hinder a state agency's ability to track information regarding specific expenditures—including the broad category of family planning services. Second, several states appeared unable to provide data concerning providers acting as subcontractors. It must be assumed that this study does not completely reflect the use of subcontractors.

To determine the role played by CHIP, we asked states separately to provide a copy of their CHIP plan upon its approval by HCFA. We analyzed the approved plans to determine income and age eligibility levels, program type (Medicaid expansion, state-designed or combination) and coverage of family planning services and supplies. Territories were not considered in the analysis of state CHIP programs because territorial governments are generally allocating CHIP funds to support existing programs rather than expansions in either eligibility or coverage.

Findings

Maternal and Child Health Block Grant

Forty-two states, the District of Columbia, Puerto Rico and American Samoa reported a total of $41 million in family planning expenditures from the MCH block grant in FY 1997 (Table 1). Of these 45 jurisdictions, 38 reported spending at least $100,000 and 16 exceeded $1 million; Mississippi indicated that although expenditures were made, it was unable to provide a specific dollar amount.

Table 2. Number of states reporting family planning services, by type of service and provider, according to funding source, FY 1997

Type of service/ provider	MCH block grant	Social services block grant
SERVICES		
Total	**43***	**14†**
Total, direct patient care	**36***	**13**
Contraceptive services and supplies	32*	12
Sterilization services	14	4
Infertility services	12	4
Sexually transmitted disease services	19	5
Pregnancy testing	27*	5
HIV services	13*	1
Other	5	4
Total, indirect activities	**34***	**8**
Enabling services	12*	3
Population-based services	28*	8
Infrastructure building	24*	3
PROVIDERS		
Total	**43***	**15**
Health departments	35	7
Community health centers	19*	8
Private physicians	8	3
Hospitals	17*	7
Planned Parenthood affiliates	24	11
Independent agencies/other	22	9

*Includes the District of Columbia. †Utah was unable to provide information regarding services. *Notes:* Includes only states and, where indicated, the District of Columbia. For the MCH block grant, Puerto Rico listed contraceptive services and supplies, population-based services and infrastructure building under services, and listed health departments and community health centers under providers. American Samoa listed infrastructure building under services and health departments under providers.

Most states used MCH block grant monies for a broad spectrum of family planning activities (Table 2). A total of 35 states and the District of Columbia provided some form of direct patient care. Thirty-one states and the District of Columbia offered contraceptive services and supplies as part of their efforts. (Puerto Rico also provided some form of direct patient care and offered contraceptive services and supplies.) Twenty-five states provided at least three types of direct services, and nine provided at least five types (not shown).

*STD services, pregnancy testing and HIV services were defined as testing, counseling and treatment beyond that provided in the course of a contraceptive visit.

†These categories were designed around federal guidelines developed for the MCH block grant, which were published in: Core public health services delivered by MCH agencies, Washington, DC: Maternal and Child Health Bureau, U.S. Department of Health and Human Services, March 3, 1997.

Thirty-three states and the District of Columbia offered indirect care using MCH block grant funds (Table 2). (Puerto Rico and American Samoa also offered indirect services.) Population-based services were the most common of the indirect care activities funded, provided by 27 states and the District of Columbia. Seven states exclusively funded indirect care activities (not shown).

Several states used MCH block grant expenditures for narrowly defined purposes. South Carolina and Washington provided only sterilization services. Mississippi used MCH funds purely for follow-up on abnormal Pap smear reports, the purchase of pregnancy tests and salaries for regional family planning coordinators. Similarly, Rhode Island initiated a pilot program to provide pregnancy testing free of charge, and Washington directed funds to boost a vasectomy project.

For family planning services funded through the MCH block grant, local health departments were the most commonly included category of providers, cited by 35 states (Table 2). (Puerto Rico and American Samoa also utilized health departments.) Nearly half of the states cited Planned Parenthood affiliates as providing family planning services under the MCH block grant. Few relied solely on a single type of provider: Thirty-five states listed at least two types of providers, and 15 states listed at least four types (not shown).

Social Services Block Grant

Fifteen states reported spending $27 million in social services block grant funds for family planning activities in FY 1997 (Table 1). Twelve of these states cited expenditures of more than $100,000, and six surpassed $1 million.

Thirteen states indicated that they provided direct patient care services through the social services block grant (Table 2). Contraceptive services and supplies were almost universally included: Twelve of 14 states listed such activities.* Nine of these 12 states reported using the block grant for other forms of direct patient care services—six provided at least two additional types of direct care, and three provided at least four more types (not shown).

Eight states provided some type of indirect care activities through the social services block grant, including in each case population-based services. Only one state funded indirect care services exclusively.

Eleven of the 15 states that reported family planning expenditures through the social services block grant listed Planned Parenthood affiliates, making them the most commonly listed type of provider. Ten states listed at least two types of providers, and six listed at least four types (not shown).

Temporary Assistance for Needy Families

Four states reported having used TANF funds for family planning in FY 1997. Only three of these could provide expenditures, for a total of $210,000; none of the three exceeded $100,000.†

Two of the TANF programs were narrowly focused: In Oklahoma, the money was used to train TANF clients as outreach workers for established teenage pregnancy prevention programs, while Oregon funded 5% of an abstinence-based life-skills education program for teenage parents. Alaska's program was broader, covering contraception, pregnancy testing and population-based services. Georgia's TANF-funded program—part of a multimillion dollar grant toward the initial year of the state's Teen Plus program of youth centers—covered activities in every category except for sterilization services and "other." None of the four states provided sterilization services through TANF.

Three of the states that used TANF funds for family planning services included health departments in their lists of providers; Oklahoma relied exclusively on health departments. Georgia's funds went to its Teen Plus centers only. The other two states listed independent agencies or other providers, while one state (Alaska) included Planned Parenthood affiliates.

Children's Health Insurance Program

Of the 46 approved CHIP plans (45 states and the District of Columbia), 41 states and the District of Columbia will provide coverage up to age 19, making the program a potentially significant source of care for many sexually active adolescents. Only five states have set lower age limits: Arkansas (16 years), Minnesota (two years), Oklahoma (15 years), Rhode Island (17 years) and West Virginia (five years).

Sixteen of the 46 approved plans set income-eligibility ceilings at or below 150% of the federally designated poverty level (Table 3, page 180).‡ Of the remainder, 24 states and the District of Columbia have established limits between 151% and 200% of poverty. Five allow enrollees with incomes above 200% of poverty to qualify.

The federal CHIP statute allows states to determine the overall structure of their programs. Twenty-one states and the District of Columbia have chosen to expand their existing state Medicaid programs, and 14 states have developed their own state-designed program. Ten states have taken a combination approach, most often expanding Medicaid for lower income children and adolescents and using a state-designed program for the higher income, but still eligible, enrollees.

In Medicaid-expansion programs, as well as in the Medicaid component of a combination program, enrollees are entitled to the full range of Medicaid-covered benefits, including family planning services and supplies. The situation is not so clear-cut in the state-designed programs and the state-designed components of combination plans.

Of the 24 states that have some state-designed component of their program, 15 specifically indicated that family planning services will be covered for enrolled adolescents. Eight simply indicated that the general category "prenatal care and prepregnancy family planning services" will be covered, but did not provide any additional information on the coverage of either of these two services. Only one state, Pennsylvania, indicated in its plan that it does not cover the general category.

Similarly, 13 states specified that prescription contraceptive drugs will be covered. Eleven other states indicated that prescription drugs in general will be covered, with no specific mention of contraceptives. (Georgia excluded coverage of all contraceptive devices, and Utah specifically excluded the hormonal implant.) No approved plan excluded coverage of prescription drugs in general.

Discussion

The two long-standing federal block grants provide much-needed support across the country for government-supported family planning services. Yet these block grants are by no means used in the same manner. Almost every state in the nation uses the MCH block grant for family planning, while the social services block grant was used for this purpose by only 15 states in FY 1997. However, expenditures through the social services program often were much larger than MCH expenditures in states where they were both used.

These two block grants tend to fund somewhat different types of family planning activities. Direct patient care services, particularly contraceptive services and supplies, were provided through most reported pro-

*Utah used a small amount of social services block grant funding for family planning, but was unable to provide information regarding services.

†Alaska ($90,000), Oklahoma ($100,000) and Oregon ($20,000).

‡The poverty line was $13,330 for a family of three in 1997.

Table 3. Approved state plans for implementation of the Children's Health Insurance Program (CHIP), as of December 31, 1998

State	Income ceiling	Program type	Benefits	
			Prenatal care and pre-pregnancy family planning	Prescription drugs
Alabama	100%	Medicaid	Medicaid	Medicaid
	200%	State-designed	General	General
Alaska	200%	Medicaid	Medicaid	Medicaid
Arizona	150%	State-designed	FP specified	FP specified
Arkansas	100%	Medicaid	Medicaid	Medicaid
California	100%	Medicaid	Medicaid	Medicaid
	200%	State-designed	FP specified	FP specified
Colorado	185%	State-designed	General	FP specified
Connecticut	185%	Medicaid	Medicaid	Medicaid
	300%	State-designed	FP specified	FP specified
Delaware	200%	State-designed	FP specified	General
D.C.	200%	Medicaid	Medicaid	Medicaid
Florida	100%	Medicaid	Medicaid	Medicaid
	200%	State-designed	General	General
Georgia	200%	State-designed	FP specified*	General*
Idaho	150%	Medicaid	Medicaid	Medicaid
Illinois	133%	Medicaid	Medicaid	Medicaid
Indiana	150%	Medicaid	Medicaid	Medicaid
Iowa	133%	Medicaid	Medicaid	Medicaid
Kansas	200%	State-designed	FP specified	General
Kentucky	100%	Medicaid	Medicaid	Medicaid
	200%	State-designed	FP specified	FP specified
Louisiana	133%	Medicaid	Medicaid	Medicaid
Maine	150%	Medicaid	Medicaid	Medicaid
	185%	State-designed	General	General
Maryland	200%	Medicaid	Medicaid	Medicaid
Massachusetts	150%	Medicaid	Medicaid	Medicaid
	200%	State-designed	FP specified	FP specified
Michigan	150%	Medicaid	Medicaid	Medicaid
	200%	State-designed	FP specified	FP specified
Minnesota	280%	Medicaid	Medicaid	Medicaid
Mississippi	100%	Medicaid	Medicaid	Medicaid
Missouri	200%	Medicaid	Medicaid	Medicaid
Montana	150%	State-designed	FP specified	FP specified
Nebraska	185%	Medicaid	Medicaid	Medicaid
Nevada	200%	State-designed	General	General
New Hampshire	300%	Medicaid	Medicaid	Medicaid
	300%	State-designed	General	FP specified
New Jersey	133%	Medicaid	Medicaid	Medicaid
	200%	State-designed	FP specified	FP specified
New York	185%	State-designed	General	FP specified
North Carolina	200%	State-designed	FP specified	FP specified
North Dakota	100%	Medicaid	Medicaid	Medicaid
Ohio	150%	Medicaid	Medicaid	Medicaid
Oklahoma	185%	Medicaid	Medicaid	Medicaid
Oregon	170%	State-designed	FP specified	General
Pennsylvania	200%	State-designed	Category not covered	General
Rhode Island	250%	Medicaid	Medicaid	Medicaid
South Carolina	150%	Medicaid	Medicaid	Medicaid
South Dakota	133%	Medicaid	Medicaid	Medicaid
Texas	100%	Medicaid	Medicaid	Medicaid
Utah	200%	State-designed	FP specified†	FP specified†
Vermont	300%	State-designed	General	General
Virginia	150%	State-designed	FP specified	General
West Virginia	150%	Medicaid	Medicaid	Medicaid
Wisconsin	185%	Medicaid	Medicaid	Medicaid

*Contraceptive devices are not covered in the benchmark plan. †The contraceptive implant is excluded. *Notes:* Hawaii, New Mexico and Tennessee have submitted plans and approval is pending. Washington State and Wyoming have not submitted a plan.

grams. However, while many MCH expenditures also included population-based services or other indirect care activities, only half of states reporting allocations through the social services block grant provided such indirect services—despite the fact that the program is, in general, geared toward support services to promote self-sufficiency.

Similarly, agencies reported providing services under the two grants through different types of providers. The MCH block grant funds were distributed primarily to the network of local health departments. Social services block grant funds, by contrast, were most often distributed through Planned Parenthood affiliates. These findings complement those of a 1995 survey of family planning providers that found, for example, that half of local health departments received MCH block grant funds and that one-third of Planned Parenthood affiliates received funding through the social services block grant, compared with only 14% of health departments.[7]

The MCH and social services block grants differ in more significant respects from other sources of federally funded family planning services. First, these programs are not limited by the strict eligibility criteria of Medicaid, allowing for more flexibility to serve a broader population. Second, decisions about the shape and scope of the program are made at the state, not the federal, level.

Moreover, unlike Title X, which focuses on family planning services, both of the two long-standing block grants, as well as TANF and CHIP, are much broader programs that provide a wide array of services, many unrelated to family planning. The $41 million spent for family planning through the MCH block grant in FY 1997 comprises only 6% of the total federal appropriation for the program that year. The proportion of total appropriations for the social services block grant spent on family planning (1%) is even less.

Clearly, family planning is not the central priority of either of these massive programs. As a result, family planning in these programs may follow the political winds affecting the core purposes of the overall block grant, such as the health of mothers and children or the promotion of self-sufficiency; depending on the unique political situation in each state, this dependence may bode well or ill for family planning.

The MCH block grant, for example, has fared quite well in recent years, as the program has commanded widespread political support. The overall program budget soared over a 10-year period, from $478 million in FY 1985 to $687 million in FY 1994, and reached $700 million in FY 1999. Expenditures through the MCH block grant on family planning, which has traditionally been viewed as an important aspect of the program's mission of promoting the health of mothers, have roughly kept pace with the program's overall growth.

Funding for the social services block grant, on the other hand, has plummeted in recent years, dropping from $2.8 billion in FY 1994 to $2.5 billion in FY 1997 and to $1.9 billion in FY 1999, at the behest of both the Clinton administration and Congress.* Family planning funding through this

*The social services block grant was bolstered by $304 million transferred from TANF in FY 97 by nine states, primarily in New York and Michigan, neither of which spent social services block grant funds on family planning. Connecticut, Iowa, Maine and Vermont, however, both transferred funds from TANF to the social services block grant and spent social services block grant funds on family planning. The impact of TANF on family planning in FY 1997 may, therefore, be larger than what is immediately obvious. (Source: Administration for Children and Families, State spending under the new welfare reform law, Feb. 6, 1998, http://www.acf.dhhs.gov/programs/opa/facts/finanfs.htm.)

grant has felt severe aftershocks of these cuts. Several states reported significant cuts in their programs between FY 1994 and FY 1997, including the virtual elimination of multimillion-dollar family planning programs in North Carolina and Tennessee.

Family planning appears to be faring well under the nascent TANF program. While only four states reported expenditures in the program's initial year, information reported elsewhere indicates that family planning efforts have expanded significantly since then. A number of states have reported family planning expenditures under the program in the years subsequent to FY 1997, including seven-digit allocations in New York and both Carolinas.*

TANF has enjoyed widespread political support. At the state level, with federal allocations remaining constant even as welfare rolls fall (because of both welfare reform and a robust economy), surplus funds abound. However, since either the surpluses or the appropriations could evaporate as the result of a recession or a loss of political support, that situation could change dramatically.

Yet, TANF has one additional distinction that sets it apart from either the MCH or social services block grants. Several of the program's core goals, such as reducing pregnancies to teenagers and unmarried women, are clearly related to support for family planning services. In addition, Congress added the inducement of the illegitimacy bonus, providing yet another potentially powerful incentive for states. The relationship to the core mission of the program could translate into an increased likelihood of continued family planning funding.

How states will utilize their funding under the CHIP program is also unresolved. The analysis of the approved state plans indicates that CHIP has enormous potential for providing family planning services to many of the estimated 1.3 million uninsured females aged 13–18 in the United States,[8] and state programs appear to be structured, at least initially, to realize much of that potential. In general, CHIP is being groomed as a parallel program to Medicaid, run by the same agencies even if not as an actual expansion. Many states, however, have indicated that a Medicaid expansion may only be an interim measure, and that they plan to move to a state-designed program at a later date. While most of the initial state-designed programs include family planning services, the situation bears close watching at the state level as these important decisions are made.

Those interested in maximizing funding for family planning activities need to look beyond Title X and Medicaid, to the developing TANF and CHIP programs, as well as to the two long-standing block grants. However, these programs have a reach and focus that is much broader than family planning, and advocates need to look not only at the federal level, where overall program budgets are determined, but also at the state level, where vital decisions about programs' shape and scope are increasingly being made.

*New York, $7 million; North Carolina, $1.6 million; and South Carolina, $3.5 million. (Source: reference 3).

References

1. U.S. Social Security Act 501(a).

2. Frost JJ and Bolzan M, The provision of public-sector services by family planning agencies in 1995, *Family Planning Perspectives,* 1997, 29(1):6–14.

3. Donovan P, The 'illegitimacy bonus' and state efforts to reduce out-of-wedlock biths, *Family Planning Perspectives,* 1999, 31(2):94–98.

4. U.S. Social Security Act 1905(a)(4)(c).

5. Sollom T, Gold RB and Saul R, Public funding for contraceptive, sterilization and abortion services, 1994, *Family Planning Perspectives,* 1996, 28(4):166–173.

6. Donovan P, 1999, op. cit. (see reference 3).

7. Frost JJ and Bolzan M, 1997, op. cit. (see reference 2).

8. Alan Guttmacher Institute, 1999, unpublished tabulations based on data from the 1995 National Survey of Family Growth and 1995 population estimates updated from the 1990 census.