Post-Attack Economic Woes Create Challenges for Family Planning Advocates

By Adam Sonfield

In December 2000, before George W. Bush had even taken office, his administration-to-be sounded the alarm that the economic boom had ended and the United States might be entering a recession. By summer 2001, most economists and policymakers, analyzing an array of disappointing economic indicators, were agreeing at least in part with that assessment. Among their myriad consequences, the events of September 11 served to severely exacerbate these trends. The resulting fiscal landscape will pose new hardships for people in all sectors of American life; among them are millions of young and low-income individuals in need of family planning services, as well as those who provide such services and those who advocate on behalf of both.

Problems, Before and After

The prognosis for a balanced federal budget in the fiscal year that began October 1 was at best slim by the beginning of September. After pushing through a massive package of tax cuts and a budget plan short on details, the Bush administration and its congressional allies were struggling to meet all of their funding priorities, including increased spending for education and the military. In August, the nonpartisan Congressional Budget Office predicted that Congress, despite promises from both parties, would have to dip into the Social Security trust fund surplus.

State budgets were more clearly in trouble. As far back as June, the National Association of State Budget Officers (NASBO) and the National Governors Association reported that many states were making midyear budget cuts and that policymakers were planning for scaled-back spending.

In late November, the National Bureau of Economic Research officially declared that the U.S. economy was in recession. The downturn stretches back to March, but it was clearly deepened by the terrorist attacks on New York and Washington, DC, and by the anthrax attacks that followed soon thereafter.

Hand-in-hand with recession comes an increase in unemployment. The national rate stood at 5.7% in November, up from 4.2% in January—and is expected to keep rising. As most Americans rely on employer-sponsored health insurance, the number without insurance also inevitably increases in times of recession. Since the recession began in March, over 900,000 laid-off workers—not counting their dependents—have become uninsured, according to a December analysis by Families USA, adding to the 39 million Americans who were uninsured in 2000.

Initial Responses…

In times of recession, people look to government for help, but recessions also result in declining tax revenues. Newspapers have been filled with articles about budget cuts and spending freezes in states across the country, and NASBO is reporting that states are already experiencing budget shortfalls. This is a legal as well as a practical problem: Most states have some restrictions on deficit spending, with 40 requiring that governors sign balanced budgets or having requirements with similar impact (see map). Given their budget woes, as well as their new security priorities, states will clearly be struggling to find funds to help the newly unemployed and uninsured.

At the federal level, the debate over how to maintain a balanced budget all but disappeared within days of September 11, with the White House itself finally forecasting in November that deficits would run through FY 2005. Intense debate remains, however, over how best to stimulate the economy and mitigate the effects of the recession; Congress is working toward a mix of additional tax cuts and new spending, with Republicans and Democrats emphasizing their traditional priorities.

One key proposed avenue of spending is for the provision of health insurance, private or public, for affected workers. The Democratic leadership has given its attention to possible short-term subsidies or tax credits to help displaced workers afford the high premiums (known as COBRA payments) necessary to continue in the insurance plans sponsored by their former employers. To help displaced workers unable to take advantage of this option, it has also pushed to expand, temporarily, eligibility for Medicaid to newly unemployed workers who do not currently qualify because they do not have children or because their income is still above states' eligibility ceilings (which average well below the federal poverty line).

The Bush administration and congressional Republicans have favored proposals that would instead provide new block grant funding to states that could be used to help workers purchase any type of private health insurance, including policies that are less expensive (and likely more limited) than those that might be continued through COBRA. These proposals would allocate significantly less money to the effort and are seen

by their proponents as less likely to expand the size of the federal government while allowing states maximum flexibility.

…Lasting Challenges

While these approaches, if adopted, would benefit many in immediate need, all have limited utility, particularly in terms of meeting the need among young and low-income women for family planning services. The degree to which any private insurance–based antirecession initiative will cover contraceptive services and supplies is questionable, given the long-standing inequities in contraceptive coverage in insurance plans. Moreover, even the most expansive of the federal proposals are framed in the context of an economic stimulus package and maintain that mindset: They are short-term, limited fixes, designed only to deal with an immediate problem. The much greater challenge will be to rebuild the nation's embattled safety-net system and, in the process, to ensure that due attention is given to the role of family planning needs and services.

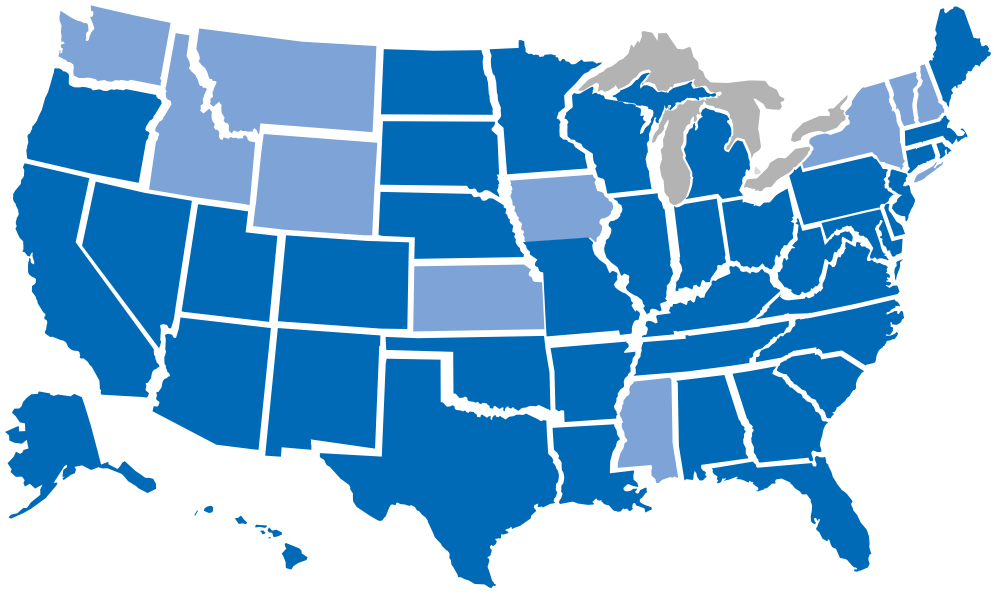
Family planning is not simply about avoiding or delaying pregnancy; it is critical to meeting the broader health and economic needs of women and their families (see related story, page 1). Closely spaced births and very early or late childbearing are risky both for women's health and for the health of the children they bear. Equally important, unintended, and especially early, childbearing has economic and social costs as well, by reducing women's chances of completing an education and participating and excelling in the workforce. In short, family planning services are critical to the well-being of women and their families and are a critical strand in the nation's safety net.

That net is seriously frayed and needs to be rewoven over time, with family planning woven in tightly. Exhibit One is the nation's welfare system, which Congress and the Clinton administration radically overhauled in 1996. Moving indigent, unmarried women with children into the workforce became an overriding goal. A major investment in so-called abstinence-only education, which actually withholds or slants information about contraception, was instituted as a primary means of "helping" unmarried Americans to avoid childbearing, as were several other, similarly motivated provisions. At the same time, the new law dropped a pre-1996 requirement that states provide information about family planning to welfare recipients and make voluntary services available to them so they might avoid pregnancies they themselves do not want (although the law permits states to provide these services with welfare funds).

To be sure, welfare reform has been successful in reducing welfare rolls, aided in large part by a booming economy. But the program, slated for reauthorization in 2002, is only now facing its real test: How well will it serve the country when it is most needed? The jobs that welfare recipients are able to get are likely the most vulnerable in an economic downturn. Many now-former workers will find themselves in need of financial assistance but unable to receive it (or receive it for long), because welfare reform instituted a five-year lifetime limit on an individual's eligibility to receive benefits—a limit that is just now taking effect for many recipients. States will feel the effects of the new welfare system in a decidedly different way: The surplus funds generated by declining welfare rolls in good economic times—which states were permitted to shift to other, related priorities—will disappear just when the need for those funds is most critical.

Other public assistance programs, most notably state Medicaid programs, are also finding themselves severely challenged. Medicaid is the primary avenue for delivering health care to poor Americans and accounts for fully half of all public

State Policies Restricting Deficit Spending



Approved Budget Must Be Balanced*

Yes

No

*Or another requirement has the same effect (e.g., a prohibition on public debt). *Source:* National Association of State Budget Officers, *Budget Processes in the States*, Washington, DC, October 1999.

dollars spent on family planning. Welfare reform, by eliminating the program's traditional link with Medicaid, contributed, however inadvertently, to a drop in Medicaid enrollment; the proportion of women of reproductive age covered by Medicaid dropped 21% between 1994 and 1998, and the proportion without any insurance rose 13% over the same period ("Implications for Family Planning of Post–Welfare Reform Insurance Trends," *TGR*, December 1999, page 6). Now, the converging pressures of tightening state budgets and increasing Medicaid enrollment, from the ranks of the newly unemployed, make the program a particular burden for states (see box). Direct state appropriations for family planning services, the second largest source of public family planning dollars, may be even more vulnerable.

Meanwhile, clinic-based providers of family planning services must find a way to meet the increasing demands for their services in the new economic climate. Nine in 10 clinic clients are poor or low-income (under 250% of the federal poverty level). Because relatively few are covered by Medicaid or private insurance, most of the clinics serving them are highly dependent on support from the federal Title X program. These clinics are key safety-net providers—not only of contraceptive services, but also of preventive services such as Pap tests, breast examinations and testing for HIV and other sexually transmitted diseases ("Title X: Three Decades of Accomplishment," *TGR*, February 2001, page 5). And their budgets have already been stretched thin because of the rising cost of new contraceptive methods and diagnostic technologies and the need to expand the range of services they provide even as they reach out to harder-to-serve individuals ("Challenges Facing Family Planning Clinics and Title X," *TGR*, April 2001, page 8).

In short, family planning advocates are facing a daunting series of interrelated challenges to ensure that the needs of the poor and disadvantaged are met. In the near term, they must fight for a stimulus plan that provides direct assistance to those who need it most. They must be strategic and tenacious in evaluating and pressing for needed revisions during the congressional welfare reauthorization process in 2002. They must help policymakers find ways to support Medicaid, Title X and the other programs that allow family planning providers to continue and expand their important services. And they will need to do all of this at a time when the federal government and the states will also be called upon to meet a host of other compelling needs.

Crisis Highlights Medicaid's Value and Flaws

Inextricably linked to the state of the economy, Medicaid is one of the major factors driving states' budget woes. Representing one-fifth of all state expenditures, the program is now the second largest component of state spending, after education.

For the very poorest of the poor, Medicaid-subsidized medical care is an "entitlement." Rather than subjecting the program to annual appropriations decisions, the federal Medicaid statute guarantees that everyone who meets the program's state-set eligibility requirements (its so-called mandatory enrollees) will be provided at least a specified set of services; the cost of those services is shared by the federal government and the states. This fact gives the program great potential for addressing the needs of the poorest Americans, whose numbers ebb and flow with economic conditions. This can be extremely costly, however. The Urban Institute estimates that if unemployment reaches 6.5% (from a baseline of 4.5%), states' Medicaid costs will have increased by $2.3 billion.

Since September 11, policymakers have grown increasingly concerned about these costs. The National Conference of State Legislatures reports that as of late October, Medicaid was already over budget in 14 states and was a concern in six others. Because many states are unable to accrue debt even in a recession, they are faced with an old but pressing dilemma: how to fulfill their legal obligation to cover those newly eligible for Medicaid, without recourse to new funding. (The National Governors Association and others have asked Congress to increase the proportion of Medicaid costs paid for by the federal government, so far without success.)

Unlike in past recessions, however, when states were forced to shift other resources to bolster Medicaid, states have a new, and worrisome, option. In August, the Bush administration announced a new initiative that expands states' control over their programs. For their nearly 12 million "optional" enrollees—basically the same groups of people (including indigent parents, pregnant women, and children through age 18) as their mandatory enrollees but with slightly higher incomes—states are now permitted to provide a truncated benefits package. Specifically, they may increase patient cost-sharing or even cut back on the services they cover ("Administration's New Medicaid Rules Could Limit Family Planning," TGR, *August 2001, page 12). Theoretically, states were given this option to enable them to expand eligibility for at least some Medicaid-subsidized care to additional uninsured individuals beyond their mandatory and optional enrollees, without increasing costs for the federal government. Significantly, however, states are not* required *to do so under the president's initiative. Advocates are worried that policymakers may be tempted to use the option, instead, to offset their increasing costs generally—reducing the quality and breadth of services to millions of needy individuals in the process.*