Conservatives' Agenda Threatens Public Funding For Family Planning

On both fiscal and ideological grounds, conservatives are expected to renew and expand their attacks on a range of public health and social services programs, including Medicaid and Title X. These attacks threaten to undermine a network of funding that federal and state policymakers have crafted to subsidize family planning services for Americans who need assistance.

By Adam Sonfield and Rachel Benson Gold

The federal and state governments have a long history of helping to subsidize family planning services and supplies for disadvantaged Americans. In recent years, the largest source of this funding has been the joint federal-state Medicaid program, which provides health insurance coverage for millions of low-income parents and children, among others. Equally critical has been Title X of the Public Health Service Act, the federal government's only program dedicated to family planning. In addition, many states draw on other federal sources, such as the maternal and child health block grant and the Temporary Assistance for Needy Families (TANF) welfare program, as well as on their own revenues.

Together, these programs have helped millions of women and their partners to better plan the size and timing of their families and to maintain a healthy reproductive life. Almost 17 million women in the United States were in need of such publicly subsidized services in 2002, the most recent year for which data is available. This population grew by nearly 400,000 since 2000.

These programs and their funding have long been subjected to legislative and regulatory attacks. In some cases, the attacks have been directed specifically at reproductive rights, whereas in others, they have been motivated by broader cost-cutting goals. In the aftermath of Republican gains during the fall elections, these attacks are widely expected to intensify. The damage to publicly subsidized family planning and to the people who depend on it could be enormous.

The Changing Shape of Public Funding

The federal government and the states together spent $1.26 billion on reversible contraceptive services in FY 2001, according to a survey of public agencies by The Alan Guttmacher Institute (AGI).* Nationwide, public funding has increased by more than a third since the mid-1990s, when inflation is taken into account. Nevertheless, funding has not entirely recovered from Reagan-era attacks on social spending programs (see chart 1).

The national trends are in some ways misleading. Most of the recent funding increases have been concentrated in a few states that have boosted funding, whereas funding has declined in 29 states and the District of Columbia over the two decades. Largely because of state-level decisions, the amount that each state spends relative to the number of women in the state who are actually in need of publicly supported contraceptive services varies substantially, with South Carolina spending nine times as much as Kansas per woman in need (see table, page 6).

Medicaid and State-Initiated Expansions

Perhaps the most significant trend in public funding for contraceptive services has been the consistent growth in the importance of Medicaid, which has accounted for 80% of new public spending on contraceptive services since the mid-1990s. After adjusting for inflation, Medicaid funding for contraceptive services has tripled over the past two decades, whereas other sources have stagnated or decreased (see chart 1). By FY 2001, Medicaid accounted for 61% of public dollars spent for contraceptive services, $770 million.

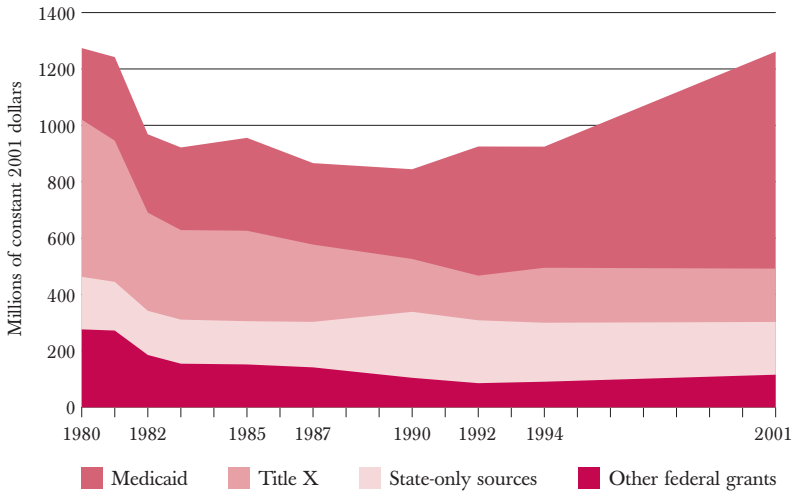
Some of this increase reflects broader trends of rising medical costs in Medicaid and the private sector. More significant, however, have been state-initiated Medicaid family planning eligibility expansions (often called "waiver" programs). Since 1996, 13 states have expanded their income-eligibility levels for family planning services well above their levels for Medicaid overall. (Several other states have created more limited programs that extend family planning eligibility for women who must otherwise leave Medicaid, typically after giving birth.)

Seven states initiated income-based expansions by 2001, early enough for their impact to be studied. These state programs have had a clear impact on public spending: Medicaid expenditures for contraceptive services increased six-fold between FY 1994 and FY 2001

*Contraceptive services include contraceptive drugs and devices, the time providers spend with patients during family planning visits and the supplies they utilize, such as tests and drugs for sexually transmitted infections, Pap smears and pregnancy tests. Details on this research and its methodology can be found on AGI's Web site at <www.guttmacher.org/pubs/fpfunding/index.html>.

Medicaid Multiplies

Despite the erosion of Title X and other federal grants, public funding for contraceptive services, adjusted for inflation, has nearly recovered from cuts during the early 1980s, almost entirely because of Medicaid.



Notes: Constant-dollar data is adjusted for inflation, using the Medical Care Price Index, with $1.00 in 2001 equal to $1.29 in 1994 and $3.64 in 1980. *Source:* Sonfield A and Gold RB, *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001,* New York: The Alan Guttmacher Institute, 2005, <www.guttmacher.org/pubs/fpfunding/index.html>.

in the states with income-based expansions, accounting for two-thirds of all new Medicaid spending on these services. The expansions had a similarly strong impact on spending relative to the number of women in need of publicly supported services (see chart 2, page 7).

The state family planning expansion programs have had a real-world impact on the ability of women to access the care they need to prevent unintended pregnancies. A 2003 federally commissioned evaluation of Medicaid family planning expansions found evidence that the programs improved access to care and geographic availability of services, while producing cost savings for the government ("Doing More for Less: Study Says State Medicaid Family Planning Expansions Are Cost-Effective," *TGR,* March 2004, page 1). According to a recent AGI study, publicly funded clinics in states with income-based expansions in 2001 served half of the women in need of subsidized contraceptive services in those states; similar clinics in states without expansions served four in 10 of those women. Between 1994 and 2001—the period when the seven expansions began—the clinics had increased this proportion, as well as the number of clients served, by about one-quarter; the states without expansion programs did not gain any ground.

Title X, Block Grants and State Programs

Although Medicaid nationally may be the primary source of public funding for contraceptive services, the Title X program—which accounts for 15% of U.S. funding, $189 million—remains critical to the family planning effort. First, it subsidizes services for women and men who do not meet Medicaid's narrow eligibility requirements. Second, Title X funds can be used for broad clinic operations; in contrast, Medicaid funds are tied to specific patients. Finally, Title X sets standards for the public provision of family planning services in the United States, ensuring that provision is voluntary, confidential and affordable. But despite its importance, inflation-adjusted funding through Title X has declined by two-thirds since FY 1980.

Funding through the other federal block grants has also seriously declined over the past two decades, and combined they account for 9% of national funding, $115 million. The advent of TANF in 1996, with its goal of reducing nonmarital pregnancies, has reversed this trend somewhat, helping to offset the vanishing of the social services block grant as a major source of public funding for contraceptive services. Despite their diminished importance nationally, each of the federal block grants is a notable funding sources in several states.

Funding through states' own revenues has experienced a different trend: Adjusting for inflation, the national total jumped sharply in the late 1980s but declined somewhat afterwards. These changes in spending, however, varied greatly according to states' disparate decisions. In recent years, several states have more than doubled their expenditures, while others have slashed their funding almost entirely. States' revenues accounted for 15% of the national total spent on contraceptive services in FY 2001, $187 million.

Programs as Targets

Notwithstanding its value to American women and men, public funding for family planning has suffered repeated attacks by conservatives, particularly under the Reagan administration and after the Republican takeover of Congress in 1994. And in the wake of the 2004 elections, it is once again seriously threatened. Some of the motivation for today's attacks stems from anti–family planning animus. Another primary motivation is to cut costs—either to balance the federal or state budgets, or to fund expensive priorities such as tax cuts or the partial privatization of Social Security. Some conservatives also see budget cutting as an ideological goal in itself, viewing public programs as anathema to the ideals of an "ownership society" and as a disincentive for Americans to purchase private insurance (see related story, page 8).

Target number one on conservatives' cost-cutting hit list appears to be Medicaid. The program costs nearly $300 billion annually and accounts for a substantial portion of federal and state budgets. Moreover, spending through Medicaid—and U.S. health care spending in

PUBLIC EXPENDITURES FOR CONTRACEPTIVE SERVICES

State	FY 2001 total (in 000s of dollars)	% change in constant dollars		FY 2001 total per woman in need
		since FY 1994	since FY 1980	
U.S. Total	$1,261,351	36.5	-1.0	$74.98
Alabama	26,597	38.0	37.1	96.73
Alaska	4,228	384.5	263.9	139.08
Arizona	16,697	239.1	30.3	49.54
Arkansas	16,321	168.7	29.3	97.93
California	322,367	184.8	40.6	146.11
Colorado	8,771	42.3	-29.5	37.05
Connecticut	16,967	40.7	21.1	102.24
Delaware	4,119	44.9	5.4	99.73
Dist. of Columbia	1,279	-33.4	-75.8	35.69
Florida	46,113	-19.8	-10.8	52.03
Georgia	41,533	92.8	-16.8	84.61
Hawaii	1,339	-53.2	-87.5	21.59
Idaho	3,102	59.4	-7.6	37.32
Illinois	26,544	6.9	-38.5	37.65
Indiana	23,735	190.2	-11.9	65.81
Iowa	6,934	0.8	-39.8	40.77
Kansas	3,123	-32.4	-59.3	19.49
Kentucky	13,030	-17.5	-33.2	54.00
Louisiana	20,689	395.6	-20.6	68.00
Maine	6,971	-6.5	-8.9	87.95
Maryland	21,082	5.1	18.4	85.85
Massachusetts	29,579	58.6	20.5	89.06
Michigan	27,692	-8.4	-31.6	47.57
Minnesota	11,429	-21.6	-35.4	43.64
Mississippi	10,375	-14.0	-48.1	53.50
Missouri	30,876	37.8	45.1	88.46
Montana	2,829	-7.6	-50.7	51.19
Nebraska	3,073	3.5	-36.8	29.24
Nevada	4,818	-18.1	50.5	39.43
New Hampshire	2,826	-50.6	-25.6	43.23
New Jersey	26,726	42.5	-39.9	67.74
New Mexico	6,670	-2.0	-26.4	53.03
New York	96,072	-25.8	-11.2	78.88
North Carolina	27,234	0.0	11.4	58.24
North Dakota	1,580	-19.0	-41.4	38.58
Ohio	23,062	-19.3	-48.8	34.59
Oklahoma	24,083	142.8	58.8	111.69
Oregon	22,985	117.2	194.3	112.22
Pennsylvania	50,734	57.5	-10.8	70.74
Puerto Rico	3,398	-32.1	u	u
Rhode Island	2,676	180.8	20.8	39.41
South Carolina	43,717	134.3	88.9	175.32
South Dakota	1,724	70.7	-8.4	35.89
Tennessee	31,767	156.2	-4.6	95.34
Texas	65,656	-20.8	-29.1	48.73
Utah	3,923	-5.6	36.5	25.50
Vermont	4,093	2.3	6.7	109.29
Virginia	30,474	-9.1	9.4	82.00
Washington	17,229	16.8	6.8	52.20
West Virginia	6,611	-4.0	12.7	62.23
Wisconsin	14,518	3.0	-27.1	48.31
Wyoming	1,380	-28.5	-31.9	47.98

general—has grown far more rapidly than inflation or government spending overall. And Medicaid, with its historical links to welfare, enjoys less political support than the other government programs that match its scope and rate of growth, such as Social Security, and defense and security spending. (The social services block grant—another program related to welfare, although far smaller than Medicaid—has also frequently tempted congressional budget hawks.)

Medicaid's growth—in fact, its very nature as a counter-cyclical program, designed to expand as economic problems force Americans into the ranks of the unemployed and uninsured—has strained the federal budget and the budgets of many states ("States Eye Medicaid Cuts as Cure for Fiscal Woes," *TGR,* August 2003, page 6). The Bush administration and members of Congress have used this problem to justify tens of billions of dollars in proposed funding cuts, along with a series of proposals and less forthright actions that would cap spending on Medicaid, often in exchange for increased flexibility for states to shape the benefits of different groups of enrollees ("Different Paths, Same Goal: End Medicaid as We Know It," *TGR,* August 2004, page 4).

These various cost-cutting proposals would likely impact several features of Medicaid that bolster its role as a source of funding for family planning. Most directly endangered is Medicaid's guarantee of enrollment and coverage to all who meet its eligibility standards. This entitlement to individual Americans has helped the program serve as a health insurer of last resort for seven million women of reproductive age and nearly four in 10 of those who have incomes below poverty. And these figures do not even include the women and men enrolled in the state-initiated family planning expansions.

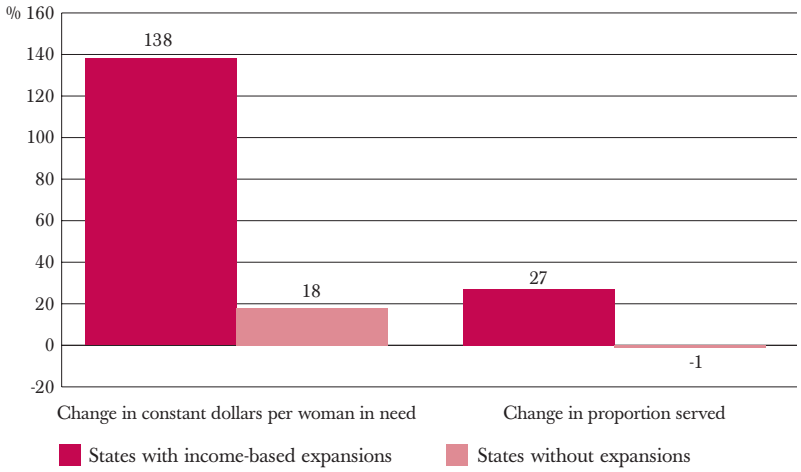
In addition, current Medicaid law requires states to include family planning services in the package of benefits it provides to almost all enrollees. This requirement has resulted in a substantial floor of family planning funding in every state, even those with policymakers who are hostile to reproductive rights. Some proposals would eliminate this requirement for at least some enrollees and thus erode this funding floor.

A third feature of Medicaid law that could be in danger is a special 90% rate of federal reimbursement for family

Notes: u=unavailable. Women in need refers to women in need of publicly supported family planning services in 2002. This is defined as 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. Constant-dollar data is adjusted for inflation, using the Medical Care Price Index, with $1.00 in 2001 equal to $1.29 in 1994 and $3.64 in 1980. *Source: Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001.*

Expansion Experience

Between FY 1994 and FY 2001, states initiating income-based expansions far out-performed states without expansions in increasing their funding of contraceptive services and the proportion of women in need of subsidized services who are served at publicly funded clinics.



Note: The states with income-based expansions were Alabama, Arkansas, California, New Mexico, Oregon, South Carolina and Washington State. States without expansions include all other states and the District of Columbia, aside from seven states with limited family planning expansions for women leaving Medicaid after pregnancy or for other reasons. Also, see note, table on page 6. *Source:* unpublished tabluations from *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001* and Frost JJ, Frohwirth L and Purcell A, The availability and use of publicly funded family planning clinics: U.S. trends, 1994–2001, *Perspectives on Sexual and Reproductive Health,* 2004, 36(5):206–215.

planning services. Every dollar spent by a state on family planning draws in nine federal dollars, a far better rate of return than even the poorest states receive for other medical services covered by Medicaid. This 90% rate encourages states to provide a full range of contraceptive options and assist Medicaid enrollees in preventing unintended pregnancy—and the extensive costs of a Medicaid-financed birth and the subsequent care for the infant. Moreover, the 90% match has served as an incentive for states to initiate family planning expansions, because it means that states reap substantial savings through little of their own investment. The power of this cost savings is evident in the fact that states that are conservative but relatively poor—such as Alabama, Arkansas, Mississippi and South Carolina—have implemented these expansions.

In contrast to Medicaid, the Title X program has long been targeted for ideological reasons, rather than to save government money. The nationwide rules set by Title X enforce some principles that many conservatives detest, such as the idea that teenagers should be offered confidential care and that women facing unintended pregnancy are entitled to unbiased, nondirective counseling on all their legal options, including abortion. Conservatives have repeatedly attempted to undermine these principles: Their latest success was a provision included in a FY 2005 appropriations law that, among other things, effectively could negate Title X's requirement that clinics provide abortion referrals upon request as part of nondirective counseling ("New Refusal Clauses Shatter Balance Between Provider 'Conscience,' Patient Needs," *TGR,* August 2004, page 1).

Funding cuts to Title X are also especially damaging, because Title X provides flexible funding for clinics, which is used to support clinic infrastructure and personnel salaries, as well as to subsidize care to clients who are uninsured or underinsured. In most states, for instance, Medicaid is not available to childless adults, and Title X helps to fill that gap. In addition, the program's funds are federally allocated, protecting them from the vagaries and swings of state politics and priorities. Thus, the program serves as another mechanism by which federal policy ensures that all Americans who need it have access to subsidized family planning. Every cut in Title X funding undermines the program's ability to fill these roles.

A number of states' own family planning programs have faced similar, ideologically motivated attacks ("Efforts Renew to Deny Family Planning Funds to Agencies That Offer Abortions," *TGR,* February 2002, page 4). Missouri legislators, for instance, spent years attempting to prevent organizations that provide or refer for abortion services from receiving state family planning funds, only to see their efforts repeatedly struck down by the courts. In 2003, the legislators gave up their efforts and simply eliminated the entire family planning program. Attacks of this nature are not uncommon: Five states are currently enforcing abortion-related restrictions on their family planning funds, and two others prohibit their funds from being used to provide minors with confidential contraceptive services. In other states, however, family planning programs are facing cuts motivated primarily by budgetary concerns, heightened by the fact that state governments have far less ability than the federal government to run deficits when their revenues are low.

Medicaid and Title X, along with other state and federal programs, are strung together to form a family planning safety net—stronger in some states than others, but ultimately national in scope. Within the next few years, numerous attempts by the administration, Congress and their allies in the states to rework and cut funding from each of these programs are likely—for reasons both specific to and unrelated to opposition to family planning. The safety net has weathered such attacks in the past, albeit each time somewhat worse for the wear. It now faces perhaps its most dangerous series of threats ever, and unless family planning advocates succeed in countering these efforts, what might remain in the aftermath could be little more than shreds.