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Public Funding for Contraceptive, Sterilization and Abortion Services, 1994

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In 1994, federal and state funding for contraceptive services and supplies reached $715 million. Funding totaled $148 million for contraceptive sterilization and $90 million for abortion services. According to a survey of state health, Medicaid and social service agencies, reported spending on contraceptive services and supplies increased by 11% between 1992 and 1994. In the same period, spending under Title X rose by 37%, making it the third largest public funding source for contraceptive services and supplies. The largest source of public funds for family planning services continues to be the joint federal-state Medicaid program. Medicaid family planning expenditures increased by only 4% between 1992 and 1994, a sizable decrease in growth from previous years. State funds continue to be the second largest source, providing almost one-quarter of reported public expenditures in 1994. The maternal and child health and social services block grants remain relatively minor sources of support nationally, although in a handful of states they provide the majority of public-sector funds. State governments were virtually the sole source of public support for the 203,200 abortions provided in 1994 to low-income women. Despite the loosening of federal abortion funding criteria in FY 1994 permitting payment in cases of rape and incest, federally funded abortions numbered only 282. (Family Planning Perspectives, 28:166–173, 1996)

The average American woman will spend almost half of her life making decisions about childbearing. At various times during her reproductive years, a woman who is sexually active and unprotected by contraceptive sterilization will face the risk of unintended pregnancy. Approximately 31 million women aged 13–44 currently face this risk; half of these women are in need of subsidized family planning services either because they have low incomes or they are young.[1] Government-sponsored assistance in providing reproductive health care services has proven to be a key resource in helping low-income women and teenagers attain their childbearing goals.

Public funds to provide subsidized family planning come from diverse federal and state programs. The federal government makes funds available for family planning services through four major sources: Title X of the Public Health Service Act, and Titles V, XIX and XX of the Social Security Act. The latter three sources are better known as the maternal and child health (MCH) block grant, Medicaid and the social services block grant, respectively. The importance of each of these individual funding sources for family planning services varies across states, since each state can structure its family planning effort individually.

Title X is the only federal program with the primary purpose of providing family planning services. While no longer the major source of public funds for these services, Title X is still vital.[2] Title X funds allow clinics to offer services to the uninsured at reduced fees and to women in managed care plans who seek services outside their provider network. Clinics established with these funds also provide essential services to women who rely on Medicaid or other funding sources.

The U.S. Department of Health and Human Services (DHHS) administers the Title X program and awards family planning–specific grants through its 10 regional offices to a variety of public and private agencies. In FY 1994 (October 1, 1993, through September 30, 1994), the DHHS Office of Population Affairs awarded 85 Title X service grants to agencies in each of the 50 states, the District of Columbia and eight U. S. jurisdictions. Forty-four of those grants went to state government health agencies and 41 went to nonstate agencies, including regional family planning councils, Planned Parenthood affiliates and public and community health services entities.

In contrast, the MCH and social services block grants go exclusively to state government agencies. These funds may be used by the state or passed on to other government and private-sector agencies. The states can use these block grants to make a wide variety of services available and can decide what portion of funds, if any, to designate for family planning services. Under the MCH block-grant program, the federal government requires states to match every four federal MCH dollars with three state dollars, and these funds are then allocated by the state health agency. Social services block-grant funds, for which there is no matching requirement, are allocated by the state social services agency.

The fourth major source of family planning funds is Medicaid, a program that uses both federal and state funds to provide medical care to low-income populations. Unlike other federal programs that fund family planning services, Medicaid is an entitlement program, in which funding is reimbursement for services provided to eligible clients and is not a set congressional appropriation. The federal government reimburses states for a portion of their Medicaid expenditures based on a reimbursement rate set by DHHS that is inversely related to each state's median income. The reimbursement rate varies between 50% and 80% of the cost of providing services. However, family planning services receive a preferential reimbursement rate of 90% in all states. Because DHHS has never issued a formal definition of family planning services, there is some variability among the states regarding what services are included under this rubric.[3]

During the 1980s, Congress enacted legislation to expand eligibility for Medicaid-funded maternity care services; these measures also expanded access to family planning services. The provisions allow low-income pregnant women to qualify for Medicaid even if their family income is significantly above the standard established for regular Medicaid eligibility. Under this expansion program, women remain eligible for 60 days postpartum, during which they may receive Medicaid-funded family planning services. Eligibility ends after the postpartum period unless the woman has an income low enough to meet the much more restrictive general Medicaid eligibility standard.

Other sources of financial support for family planning services are not linked to the

federal government. For example, the overwhelming majority of states add funds of their own (in addition to monies that may be required to match federal funds) to make family planning services more widely available. State funds come from a variety of sources, including special appropriations made by legislatures, general assistance programs, general revenues allocated to state health or social services agencies, and expansions of state Medicaid programs to provide medical services, including family planning, to people who do not meet the eligibility criteria necessary for federal Medicaid reimbursement. In addition, some local governments contribute their own funds to family planning services, and providers also receive support from insurance payments and clinic fees.

In addition to providing reversible contraceptive methods, all four major sources of federal dollars for family planning services allow for the provision of sterilization services for low-income individuals. The majority of federal expenditures for sterilization are through Medicaid, although some are also made through Title X and the MCH and social services block grants. In 1979, DHHS implemented regulations to govern the availability of federally funded sterilization services. These federal regulations require a complex informed consent procedure and a 30-day waiting period between the time a woman gives consent and the performance of the sterilization, and they prohibit sterilization of anyone under age 21 or of anyone who is mentally incompetent.[4]

As a result of the federal restrictions on abortion funding that have been in place since 1979, almost the entire responsibility for providing public funds for abortion rests with individual states. Title X has never paid for abortion procedures. Subsidized support for abortion services for low-income women comes primarily from state funds. Medicaid pays for a very small portion of these services; a state may receive reimbursement from the federal government for an abortion obtained by a Medicaid recipient in limited circumstances: when the woman's life would be endangered if she continued the pregnancy and when the pregnancy is the result of rape or incest. However, each state establishes its own abortion funding policy concerning its own revenues. By the end of FY 1994, 15 states * and the District of Columbia allowed state-funded abortions for low-income women under all or most circumstances.

In this article, we present the results of our FY 1994 survey on public funding for contraceptive, sterilization and abortion services. These data are then analyzed with the results of previous survey data collected between 1980 and 1992. The purpose of this research is to examine current spending for family planning services in all 50 states, the District of Columbia and other federal jurisdictions from various funding sources and to identify trends in public funding for family planning services.

METHODOLOGY

For more than two decades, The Alan Guttmacher Institute (AGI) has periodically surveyed nonstate Title X grantees and state health, Medicaid and social services agencies to assess state and federal expenditures on contraceptive services and supplies, sterilization, abortion and other family planning services. The most recent published data were for FY 1992.[5]

In January 1995, the 41 Title X grantees that are not state agencies were sent

questionnaires about their use of FY 1994 Title X monies; 40 responded.† In February 1995, state health, Medicaid and social services agencies for all 50 states and the District of Columbia were sent questionnaires on expenditures for FY 1994. Responses were received from state health agencies in 50 states, Medicaid agencies in 46 states plus the District of Columbia, and social services agencies in 48 states plus the District of Columbia.‡

Health, Medicaid and social services agencies in the Commonwealth of Puerto Rico and various U. S. jurisdictions— American Samoa, Guam, the Northern Mariana Islands and the Virgin Islands— were included in the survey for the first time. Response rates were much lower for the jurisdictions.§

The nonstate Title X grantees and state health and social services agencies were asked to provide expenditures, according to funding source, on each of the following services: reversible contraceptive services and supplies, sterilization services, infertility services, STD services, pregnancy testing and HIV testing. Data on expenditures for outreach and education, administrative costs and "other" expenses (e.g. equipment and special initiatives) were also collected. State agencies were also asked for data on expenditures for abortion and the number of abortions funded.

State Medicaid agencies were asked to provide information on Medicaid expenditures for reversible contraception, sterilization and abortion services. For the first time, agencies were asked about family planning services for postpartum women funded under the Medicaid expansions for pregnant women. In 35 states and the Virgin Islands, data were provided on the total number of women receiving Medicaid-funded family planning services (including sterilization), the number of women receiving such services under the Medicaid expansions, and total Medicaid expenditures for family planning services and family planning expenditures for the Medicaid expansion group.

To obtain a general impression of how the enrollment of Medicaid recipients in managed care plans may have affected Medicaid family planning expenditures in 1994, we asked state Medicaid agencies whether their family planning expenditure data included expenditures for Medicaid enrollees in capitated plans— those in which the state pays the managed care plan a one-year fixed fee to cover a designated set of health care benefits.

Three significant methodological issues have affected our ability to collect and analyze survey data. The first issue concerns changes over time in survey methodology aimed at increasing the accuracy of the data so that it more closely reflects actual spending levels. Prior to 1990, nonstate Title X grantees were not surveyed, and their expenditures for contraceptive services and supplies were represented by the total amount of the grantees' services award provided by DHHS. If expenditures are reported this way—as a lump-sum figure—then the contraceptive services and supplies expenditure data are overstated, a persistent problem in the data for both state and federal funds. To better isolate expenditures for contraceptive services and supplies from expenditures for other related reproductive health services, AGI subsequently surveyed these grantees themselves. The result has been a gradual lessening of the overstatement of expenditures on contraceptive services and supplies. Although this change has improved the quality of this data, it has not completely solved the problem; since grants provide for a range of family planning services rather than for specific

service components, grantees may not be able to separate out expenditures for specific components.

Changes in both the survey universe and the wording of the questions have, however, generated issues of noncomparability with data from previous AGI surveys. The result is that the data from recent years, gathered with refined instruments, more accurately account for contraceptive expenditures than do the data from earlier years. Thus, decreases in expenditures for contraceptive services and supplies, particularly for Title X, for the past two decades will be overstated, as data on more recent expenditures are now less inflated. Discussions of methodology from previous surveys show the extent of the dilemma over comparability.[6]

A second methodological problem arises because federal, state and local funds cannot always be completely segregated. The MCH block grant, for instance, requires states to match part of the federal expenditures, while Medicaid is funded jointly by the states and the federal government. Furthermore, many states match outlays from the federal social services block grant, even when they are not required to do so.

As in past AGI surveys, the federal expenditures presented here may include state monies used for matching federal funds; this is always the case with Medicaid expenditures. State expenditures not made specifically to match federal funds— e.g., family planning funds appropriated by the legislature or allocated by general health agencies—have been counted separately, when possible. While these procedures overestimate federal contributions and underestimate state expenditures, they provide an accurate measure of a state's level of commitment to family planning by indicating the amount a state contributes out of its own discretionary funds for the provision of family planning services.

The third methodological issue concerns Medicaid reimbursement for managed care. As of 1994, almost one-quarter of all Medicaid recipients were enrolled in some type of managed care plan—a doubling of the number of enrollees since 1992.[7] Expenses for family planning services incurred by Medicaid recipients not in managed care plans are readily traced by the state agencies that report these figures to obtain the 90% family planning reimbursement rate. However, similar expenses incurred by recipients in managed care plans cannot be isolated.

The adverse effect that managed care has had on our ability to fully monitor contraceptive services within managed care plans became apparent during this survey cycle; 14 states** reported that family planning expenditures for enrollees in capitated plans could not be included in the expenditures reported. This incomplete reporting caused Medicaid expenditures for family planning to be underestimated in 1994 and presents a dilemma for future data collection and analysis. Unless changes are made in Medicaid reporting systems, these difficulties will increase as managed care becomes more prevalent.[8]

Overall, changes in AGI data collection have resulted in each survey cycle providing a more reliable representation of public expenditures for contraceptive services and supplies than the previous cycle. The data in this article represent the most complete summary of public funding available. However, the advent of managed care and long-standing imperfections in state and grantee recordkeeping continue to hinder our

efforts to identify funds spent on contraception and other specific reproductive health services. Thus, the data presented here should be considered an approximation of general trends rather than a precise accounting.

CONTRACEPTIVE SERVICES

In 1994, federal, state and jurisdictional governments reported spending $715 million on reversible contraceptive services and supplies (Table 1). Seventy-seven percent of total reported public expenditures were federal funds ($554 million), while states and jurisdictions accounted for 23% of these outlays ($162 million). The single largest source of public funds was Medicaid—$332 million, representing 46% of total expenditures for contraceptive services and supplies. States and jurisdictions were the second largest source, followed closely by Title X, which provided $151 million (21% of total public funds). The social services block grant, MCH block grant and other federal funds (primarily the preventive health services block grant) contributed $70 million (10% of total expenditures).

Of the states and jurisdictions responding to the survey, all but Hawaii and two jurisdictions were able to separate sterilization expenses from reversible contraceptive costs, and one state (Alaska) did not know the total expenditure for contraceptive services and supplies. Fourteen states could not provide figures for contraceptive services expenditures for women in capitated managed care plans.

In 1994, 39 states and the Virgin Islands reported that 2.2 million women received family planning services (contraceptive services and supplies and sterilizations) under the Medicaid program. This number amounts to one-quarter of the 8.5 million women of reproductive age covered by Medicaid.[9]

Data from the 35 state Medicaid agencies that provided the total number of enrollees under the Medicaid expansions for pregnant women indicate that 13% of all women receiving family planning services under Medicaid obtained care as a result of the Medicaid expansions (data not shown). These women accounted for 17% of all Medicaid expenditures for family planning services. Six states (Arkansas, Georgia, Idaho, North Carolina, South Carolina and Utah) reported that 30% or more of their state's total Medicaid family planning population consisted of women in the expansion group. Three states (Nebraska, New Hampshire and North Dakota) reported no family planning expenditures for women eligible as a result of the expansions.

All states, the District of Columbia and all federal jurisdictions except the Virgin Islands reported Title X expenditures for contraceptive services and supplies. However, 24 states, the District of Columbia and two jurisdictions were unable to separate out sterilization services, thus overstating their reversible contraceptive services and supplies expenditures. In addition, a majority of those reporting could not isolate expenditures for contraceptive services and supplies from those for other family planning services (such as infertility services, pregnancy testing, and STD and HIV services) or from outreach and education programs or administrative expenses.

Title X funds represented 21% of total expenditures for contraceptive services and supplies in 1994. State and jurisdiction health agencies comprised more than half of the 85 Title X grantees and accounted for 63% of Title X expenditures for contraceptive services and supplies.

Thirty-six states, Guam and Puerto Rico reported spending $34 million in MCH block-grant funds to provide contraceptive services and supplies in 1994. Thirteen of these states and Puerto Rico were unable to separate sterilization services from reversible contraceptive services, while 28 states and two jurisdictions could not isolate contraceptive services and supplies from other medical care related to the provision of family planning or from educational and administrative expenses.

Social services block-grant funds were utilized by 16 states and Puerto Rico for contraceptive services and supplies, amounting to expenditures of $34 million in 1994. Four states were not able to separate sterilization services from contraceptive services and supplies, and 13 states could not separate out other family planning care and educational or administrative expenses.

Thirty-nine states, two jurisdictions and the District of Columbia spent $162 million of their own funds to support the provision of contraceptive services and supplies to low-income women and men; two of these states and the District of Columbia were not able to supply specific data on expenditures. Eighteen states, Guam and Puerto Rico could not isolate sterilization services from contraceptive services and supplies; 29 states could not separate other medical care and educational or administrative expenses from expenditures on contraceptive services and supplies. Overall, state funds represented 23% of all expenditures for contraceptive services and supplies in 1994.

Trends in Expenditures

•1992–1994 (*actual dollars*). Total reported public expenditures for contraceptive services and supplies increased by 11% between 1992 and 1994, from $645 million to $715 million. While the two largest funding sources in 1994, Medicaid and state dollars, grew modestly between 1992 and 1994 (both up by 4%), Title X spending grew substantially over this period, increasing by 37%. (As noted in the methodology section, changes over time in completeness and specificity of reporting suggest that increases in expenditures may be understated.)

Overall, Title X expenditures increased from $110 million in 1992 to $151 million in 1994. Increases were widespread, with only Louisiana, Nebraska, Oklahoma and Washington reporting lower spending for contraceptive services and supplies. In 1994, Title X funds represented 21% of all reported public expenditures for contraceptive services and supplies, compared with 17% of the total in 1992.

Even though reported Medicaid expenditures increased by 4% between 1992 and 1994, Medicaid's overall contribution to total reported public expenditures for contraceptive services and supplies decreased from 50% in 1992 to 46% in 1994. In comparison to explosive growth in previous years, reported Medicaid expenditures for contraceptive services and supplies leveled off from 1992 to 1994, growing by only $13 million. Nonetheless, Medicaid remained the single largest source of support for publicly funded contraceptive services.

Expenditures of state funds for contraceptive services and supplies grew by 4% between 1992 and 1994, an increase of $6 million. However, state funds represented about the same proportion of all such expenditures—24% in 1992 and 23% in 1994. During this time period, a nearly equal number of states (41 in 1992 and 39 in 1994)

reported using state funds for contraceptive services and supplies.

Funding patterns for the two block grants displayed similar trends between 1992 and 1994: Spending for contraceptive services and supplies from the MCH block grant increased by $5 million (a 17% increase), while spending from the social services block grant increased by $4 million (13%).

•1980–1994 (*constant dollars*). Adjusting the data for the period 1980 to 1994 to account for inflation*† indicates that expenditures for contraceptive services and supplies decreased dramatically in the early 1980s, leveled off at the end of the decade and increased slightly during the early 1990s (Figure 1). Reported expenditures for contraceptive services and supplies decreased by 27%, in constant dollars, from 1980 to 1994.

Medicaid and state funding are the only funding sources for contraceptive services and supplies to have grown since 1980. By 1994, Medicaid expenditures had increased 70% above their 1980 levels, and state funds had risen by 12%. Title X fell dramatically over this period, having decreased by 65% from its 1980 level. Similarly, both the MCH and social services block grants fell significantly over this period.

Title X accounted for 44% of all spending on contraceptive services and supplies in 1980, but only 21% of such expenditures in 1994; Medicaid accounted for only 20% of expenditures in 1980, but 46% in 1994 (Figure 2). State expenditures, which represented only 15% of all public funding in 1980, grew to account for 23% of these expenditures in 1994.

STERILIZATION SERVICES

Reported public expenditures on sterilization services totaled $148 million in 1994 (Table 2). All states and the District of Columbia reported some funding for these services, but nine states were unable to provide the specific amounts and half of the states were unable to provide complete data on sterilization services. The seven states (Georgia, Illinois, New Jersey, New York, North Carolina, Pennsylvania and Texas) that reported spending more than $8 million each on sterilizations accounted for 52% of public spending on these services nationwide.

Medicaid paid for an overwhelming portion (94%, or $140 million) of publicly funded sterilization services, although expenditures for women enrolled in capitated managed care plans are understated here, as elsewhere. Title X funds constituted less than 1% of all reported sterilization-related expenditures. Other federal funds—MCH and social services block grants—amounted to 2% of total reported sterilization expenditures. State funds accounted for the remaining 3% of reported public expenditures for contraceptive sterilization services nationwide.

Between 1992 and 1994, total reported public expenditures for sterilization rose by 7%, substantially less than the 46% increase recorded between 1990 and 1992. Whereas Medicaid funding for sterilization in 1994 increased by 11% over funding in 1992, Title X expenditures dropped by 32%, and state spending fell by 40%. The decrease in state expenditures for sterilization services can be accounted for by greatly reduced expenditures recorded in California, Illinois and Texas. However, the loss of Title X and state funds for sterilization was almost entirely offset by the $14 million

increase in Medicaid's sterilization expenditures during this period.

ABORTION SERVICES

In 1994, federal and state governments reported overall spending of $90 million to pay for 203,200 abortions nationwide; less than 1% of this funding was contributed by the federal government (Table 3, page 172).

Nineteen states reported spending $464,000 in federal Medicaid funds for 282 abortions in 1994; 27 states reported no such expenditures, and four states and the District of Columbia did not respond. Twenty-one states reported spending over $89 million of their own funds for 202,918 abortions in 1994, although three of these states could not report the specific amount; 24 states reported no abortion expenditures, and five states and the District of Columbia did not respond.

Between 1992 and 1994, total reported public expenditures for abortion rose from $80 million to $90 million, an increase of 12%, while the total number of publicly funded abortions increased by less than 1% over this time period. The number of federally funded abortions rose by 6%, from 267 to 282, between 1992 and 1994. However, federal expenditures for abortions rose from $331,000 in 1992 to $464,000 in 1994, an increase of 40%. These discrepancies between the numbers of abortions and the levels of spending are due to inconsistencies in reporting; some states provided specific abortion figures but not associated expenditures, while other states provided expenditures but not the actual number of procedures performed. State abortion expenditures increased by 12% ($10 million) from 1992 to 1994. As was the case in 1992, nearly all of the 1994 state-funded abortions (202,715) were performed in the few states that fund all or most medically necessary abortions for poor women.

DISCUSSION

The modest increase in reported public spending on contraceptive services and supplies in FY 1994 over the amount reported in FY 1992 masks important changes in Title X and Medicaid, two of the key funding sources for contraceptive services and supplies. The 37% jump in Title X expenditures is clearly related to increases in funding for this national family planning program. Strong bipartisan support in Congress, along with support from President Clinton, greatly improved the political climate for Title X during this period. In FY 1994, Congress appropriated $181 million for the program, compared to $150 million in 1992, an increase of 21%.

Two methodological factors also con-and experienced an explosion in medical tributed to the apparent increase in re-costs in the post-Reagan years. However, ported Title X expenditures; for the first this pattern changed somewhat in 1994 time the AGI survey included expendi-with the upswing in Title X funds and the tures reported by U. S. jurisdictions ($1.9 million), and in 1994 fewer states were able to separate expenditures on contraceptive services and supplies from spending on other related medical services. Because reported Title X contraceptive services and supplies expenditures in 1994 were overstated, the increase over 1992 is also overstated. While improved survey methodology has lessened the inflation of current data for Title X expenditures, imperfect state reporting continues to result in overestimates of these figures.

Although Title X expenditures grew significantly in 1994, this growth was not sufficient to reinstate Title X as the preeminent funding source for contraceptive services and supplies—a position it has not held since the mid-1980s, when Medicaid assumed the lead role. The reversal of Title X and Medicaid has its roots in the surge in overall Medicaid spending evident throughout the 1980s and early 1990s and in the persistent decline in Title X appropriations during this period.

As was the case with many other federally funded health and social programs, Title X suffered major budget cuts during the Reagan administration, but unlike some others, Title X has been unable to recoup these losses over the last decade. Medicaid, meanwhile, reimbursed an ever-escalating number of enrollees and experienced an explosion in medical costs in the post-Reagan years. However, this pattern changed somewhat in 1994 with the upswing in Title X funds and the slowing of growth under Medicaid.

Medicaid continues to be the largest source of funding for contraceptive services and supplies. However, the reported $332 million spent in 1994 represents only a 4% increase above 1992 levels. Three forces account for this leveling off: the maturing of the program to expand Medicaid reimbursement for pregnant women that began in the 1980s, the slowing of overall program growth and the dramatic increase in the use of managed care systems.

The Medicaid expansions brought coverage to hundreds of thousands of pregnant women each year in the late 1980s and the early 1990s.[10] These women were eligible for postpartum family planning services as well as other care related to their pregnancies; in 1994, the so-called expansion women accounted for 13% of the recipients of Medicaid-funded family planning services. By 1992, however, the period of rapid expansion had ended, and the influx of new enrollees abated.

The second force contributing to the leveling off of reported Medicaid expenditures is a slowdown in overall Medicaid spending. Between 1992 and 1994, Medicaid expenditures grew by 19%, compared with the enormous 68% increase recorded from 1990 to 1992.[11]

Third, changes in reported Medicaid expenditures for contraceptive services and supplies are undoubtedly linked to the surge in managed care enrollment. Enrollment in such plans doubled between 1992 and 1994; 23% of all Medicaid recipients were in managed care in 1994.[12] While the extent to which managed care is reducing health care costs for Medicaid enrollees remains uncertain, growing enrollment in capitated plans is making it increasingly difficult to isolate expenditures for a specific service, such as family planning. With the number of Medicaid enrollees entering managed care plans likely to continue to grow, the ability to identify and monitor Medicaid contraceptive services and supplies expenditures is only expected to become less feasible in future years.

FY 1994 was also a year of significant change in federal policy on abortion funding. For the first time since 1981, the highly restrictive federal Medicaid policy governing subsidized abortion services for low-income women expanded slightly. This new, marginally expanded policy allowed federal funds to be available for abortions when a pregnancy resulted from rape or incest. Consequently, both the number of federally

funded abortions and the total amount of federal expenditures increased in 1994. Prior to this policy change, federal abortion funds were available only when the woman's life would be endangered if her pregnancy were carried to term.

This expanded policy proved to be controversial. State compliance was erratic throughout FY 1994; several states defied implementation altogether and insisted on the previous "life-only" policy. Nine states*‡ were eventually ordered by federal courts to comply with the law or risk the loss of Medicaid funds. One state decided not to seek any federal Medicaid reimbursement, choosing instead to rewrite state regulations to expand its abortion policy so that most abortions for poor women would be paid for with state funds.

Since 1981, the federal government's role in subsidizing abortion services for low-income women has diminished greatly. As a consequence, the states have shouldered a larger share of the financial liability for abortion services to this group of women. Between 1977 and 1992, the states reported abortion expenditures ranging from $50 million to $80 million per year; in 1994, states spent over $89 million of their own revenues to pay for 202,918 abortions for indigent women. The total number of state-funded abortions in 1994, however, was underreported by several thousand, since two states reported sizable payments but were not able to provide the number of abortions covered.

Besides the change in the federal Medicaid abortion funding policy, significant policy changes occurred in several states in fiscal 1994. In Idaho and Minnesota, state-level courts invalidated long-standing funding bans on constitutional grounds and ordered the states to begin covering all medically necessary abortions. A similar court ruling was handed down in West Virginia after the legislature's 1992 action that repealed the state's policy to cover most abortions and enacted a law severely restricting funds. In the District of Columbia, where Congress controls the city's annual appropriations, the policy was returned to the pre–FY 1988 standard, which permitted the city to use locally raised revenues to pay for most abortions for low-income women. From FY 1988 to the end of FY 1993, the District of Columbia was subject to a federal amendment prohibiting the use of its own funds for abortion services.

Federal and state programs that subsidize family planning services, particularly Medicaid and Title X, play a critical role in helping millions of low-income women and teenagers avoid unintended pregnancies. Title X has been the preeminent national family planning program, setting the standard of care, confidentiality and service provision for reproductive health care. Nonetheless, these programs are currently under scrutiny, and their future is uncertain. Whether Medicaid should remain an entitlement program or be recast as a block grant to the states, how much flexibility the states should have in determining the scope of their programs and who should pay the costs are all under consideration. Congressional attacks on Title X, especially in regard to minors' access to contraceptive services, are likely to continue.

Efforts to restructure these programs could potentially leave large numbers of low-income women at risk of unintended pregnancy without coverage for family planning services. Fundamentally changing the structure of these programs would disrupt data collection and reporting systems as well, making it difficult to evaluate the success of these programs in providing essential services to women in need of subsidized care.

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*Alaska, California, Connecticut, Hawaii, Idaho, Maryland, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Oregon, Vermont, Washington and West Virginia.

†The nonrespondent was Healthworks of Massachusetts, which ceased to exist in October 1994; there were a total of five nonstate Title X grantees in Massachusetts during FY 1994.

‡Nonrespondents included: the District of Columbia health agency; Medicaid agencies in Arizona, Louisiana, Rhode Island and South Dakota; and social services agencies in Rhode Island and Virginia.

§Nonrespondents included the health agency in the Virgin Islands; the Medicaid agencies in American Samoa and the Northern Mariana Islands; and all jurisdictional social services agencies.

**California, Colorado, Delaware, Hawaii, Illinois, Iowa, Michigan, Minnesota, New Jersey, Oregon, Pennsylvania, Tennessee, Washington and Wisconsin.

*†Data for 1994 were converted to constant 1980 dollars using the Medical Care Price Index, with $1 in 1980 equal to $0.36 in 1994. (See: U. S. Bureau of the Census, *Statistical Abstract of the United States*, 1994, U. S. Government Printing Office, Washington, D. C., 1994.)

*‡Arkansas, Colorado, Illinois, Louisiana, Michigan, Montana, Nebraska, Oklahoma and Pennsylvania.

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