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THE ALAN GUTTMACHER INSTITUTE

NEW YORK & WASHINGTON

August 1999

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Dear Colleague:

I am pleased to enclose "Block Grants Are Key Sources of Support for Family Planning," an examination of the role played by two long-standing federal block-grant programs—the maternal and child health and social services block grants—in the provision of publicly subsidized family planning services in the United States.

Reprinted from the August issue of *The Guttmacher Report on Public Policy,* this analysis is the latest in a series of special reports on public policy issues of particular relevance to the family planning field that The Alan Guttmacher Institute is preparing under a grant from the Office of Population Affairs of the Department of Health and Human Services. This piece describes both block grants; details their funding history and, especially, recent severe cuts to the social services program; and examines the impact of these cuts on publicly funded services in those states that have long relied on this funding source to support their family planning efforts.

I hope you find this information useful in your work. If we can provide further information or assistance, please feel free to contact us here in the Institute's Washington Office.

Sincerely,

Cory L. Richards
Vice President for Public Policy

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Population Affairs
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cl.

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

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

Guarded Optimism

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

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

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

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

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 FPR000057. The conclusions and opinions expressed in this article are those of the authors and AGI, and do not necessarily represent the views of DHHS.

Special Analysis

Block Grants Are Key Sources of Support For Family Planning

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

By Rachel Benson Gold and Adam Sonfield

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

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

The MCH Block Grant

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

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

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

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

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

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

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

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

The Social Services Block Grant

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

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

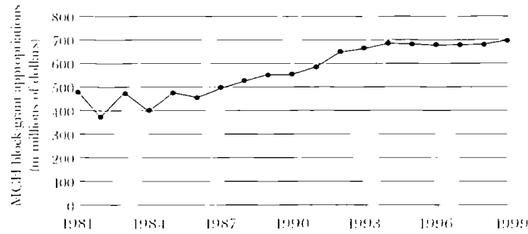
When Congress transformed the program into a block grant in 1981, it eliminated numerous federal requirements. States were now free to set their own eligibility requirements and determine which population groups to serve, and they were no longer required to match federal spending. The block grant, however,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

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

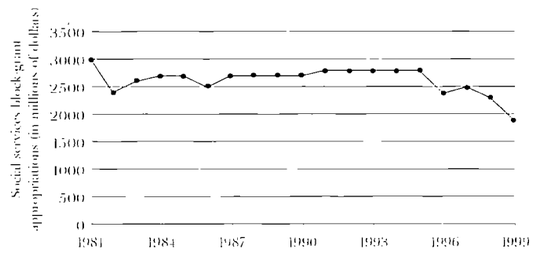
Although funding for the social services program followed the same pattern as funding for the MCH block grant during the 1980s—a dramatic cut followed by steady recovery—its fortunes seemed to plummet in the mid-1990s (see chart), concurrent with congressional repeal of the traditional welfare program, Aid to Families with Dependent Children, and its replacement with a new program, Temporary Assistance for Needy Families (TANF).

Divergent Trends

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



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



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

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

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

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

Impact on Family Planning

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

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

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

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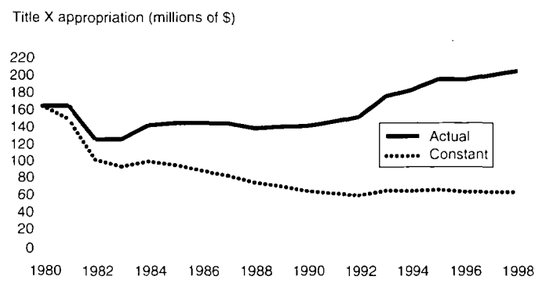
APRIL 1999 VOLUME 2, NUMBER 2 8 DOLLARS

chart b

Title X Funding

When inflation is taken into account, funding for Title X has decreased over the years.



Notes: Calculation of constant dollars based on Consumer Price Index for Medical Care. Years shown are fiscal years.

ing costs of contraceptives and reproductive technologies, the need to serve growing numbers of uninsured women, and the imperative to expand service delivery to males and hard-to-reach populations such as substance abusers and the homeless.

• Title X is unable to serve all those in need of contraceptive services. At least one million U.S. women with incomes below 250% of the federal poverty level are not using any form of contraception even though they are at risk of having an unintended pregnancy—that is, they are sexually active and capable of becoming pregnant but do not wish to do so.

• The program needs to expand service capacity to accommodate the increasing numbers of the uninsured. The number of Americans without any public or private health insurance coverage has increased by 10 million over the last decade to 43 million people.

• The squeeze on Title X dollars grows even tighter as clinics increasingly serve individuals—often free of charge—who have lost Medicaid coverage because of welfare reform.

• Funding for the program has not kept pace with inflation. In terms of constant dollars, the FY 1998 funding level of $203 million represented a 61% decrease since the FY 1980 funding level of $162 million (Chart B).

Conclusion

Given the absence of universal contraceptive coverage in the United States, public policies designed to reduce unintended pregnancy rates—which are high compared with those of other developed countries—must concentrate on strengthening each piece of the existing patchwork system. This includes making sure that private insurance fully covers contraceptive supplies and services, that states can easily extend Medicaid family planning services to all poor women desiring contraceptives, and that Title X is adequately funded to meet program costs and to serve growing numbers of people.

Expanding access to contraceptives will not by itself solve the problem of unintended pregnancy; much more can and should be done to achieve this goal. At a minimum, other necessary measures include investing in contraceptive research to improve and increase the range of available methods, and promoting responsible sexuality education that supports and encourages young people who want to delay sexual initiation, even as it prepares them to protect themselves against unplanned pregnancy when they do become sexually active. But clearly, increasing access to contraception must be at the heart of any national strategy to reduce unintended pregnancy.

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Credits

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Issues in Brief
1999 Series, No. 2

THE ALAN GUTTMACHER INSTITUTE
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U.S. Policy Can Reduce Cost Barriers to Contraception

Unintended pregnancy is a major problem in the United States that cuts across racial, ethnic, socioeconomic and demographic lines. By helping women to time and space their births, contraceptive use helps avoid the adverse health, social and economic consequences associated with unintended pregnancies.

In stark contrast to the situation in other developed nations, where contraceptives are easily affordable under universal health insurance systems, contraceptive supplies and services are expensive in this country, and American women must rely on a variety of fragmented systems and programs to help them cover these costs. In the absence of a more comprehensive system, any effective public policy effort to reduce levels of unintended pregnancy—and the abortions or unwanted births that inevitably result—must focus on strengthening the ability of these various systems and programs to meet the contraceptive needs of women and couples across the nation.

Background

Every year, three million pregnancies in the United States, or half of all pregnancies among American women, are unintended. These pregnancies often cause significant hardship for women, their families and society at large. For many women, an unintended pregnancy is a difficult, even life-altering, experience—because it occurs when the woman is too young to be a parent or is unmarried, too soon after her previous birth or after she has achieved her desired family size.

Unintended pregnancies have ramifications for individual and public health. Women who experience such pregnancies are less likely to obtain timely prenatal care than those whose pregnancies are planned; as a result, their chances of adverse health outcomes increase. Health risks are also heightened when pregnancies follow shortly after another birth or occur among young adolescents or women past their childbearing prime.

Additionally, an unintended pregnancy may threaten a woman's ability to complete her education and participate in the workforce, jeopardizing her ability to support herself and her family. For this and other reasons, half of women experiencing an unintended pregnancy seek abortion—a reality that causes considerable anxiety and division among policymakers and within the general public.

However, using contraceptives is effective in reducing rates of unintended pregnancy. In any given year, 85 of 100 sexually active women not using a contraceptive become pregnant. By contrast, among women taking birth control pills (the most commonly used reversible method), only eight of 100 become pregnant. It is therefore not surprising that about half of all unintended pregnancies occur among the small proportion (7%) of women at risk of such pregnancies who do not use birth control.

One of the major barriers to universal contraceptive access in this country is that contraceptives can be expensive. For example, costs for *supplies alone* can run approximately $360 per year for oral contraceptives, $180 per year for the injectable, $450 for the implant and $240 for an IUD. In addition, the bulk of the cost for some of the most effective methods must be paid up front.

While most U.S. women rely on employer-based private insurance to pay for their health care, these plans historically have provided far less extensive coverage for contraceptives than for most other prescription drugs and devices. Public programs—Medicaid, the health insurance program for the poorest Americans; and Title X, the family planning safety-net program for low-income women without another source of payment—exist to help those who lack adequate private insurance. But many low-income Americans do not qualify for Medicaid, and Title X funding has not kept pace with program costs or inflation, hindering the program's ability to serve all those seeking care. Thus, many women, even those who are privately insured, face financial barriers to obtaining their chosen contraceptive methods.

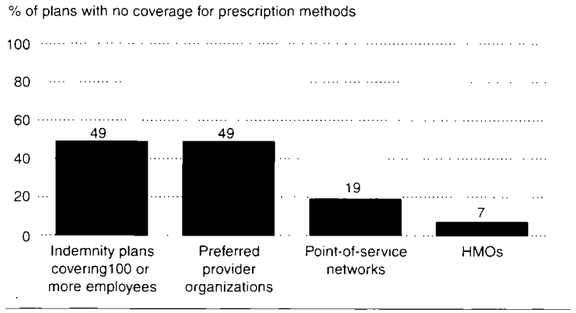
Private Insurance

Three-quarters of American women of childbearing age rely on private insurance to defray their medical expenses. Yet many private insurance plans provide inadequate coverage of contraceptive services and supplies. This gap increases many women's risk of experiencing an unintended pregnancy and helps explain why women of reproductive age spend 68% more on out-of-

chart a

Private Insurance

Many plans cover no contraception at all.



Note: Prescription methods are the oral contraceptive, IUD, implant, injectable and diaphragm.

pocket health care costs than do men.

• Half of traditional indemnity (fee-for-service) plans do not cover any reversible contraception (Chart A), and only 15% cover all five prescription methods—the pill, IUD, diaphragm, implant and injectable. While 97% cover prescription drugs, only 33% cover the pill.

• Of the major types of health insurance plans, traditional health maintenance organizations (HMOs)—in which participants may obtain a wide range of care, but through a limited network of providers—offer the most comprehensive contraceptive coverage. Nevertheless, 7% cover no prescription contraceptives, and only 39% cover all five.

• Preferred provider organizations and point-of-service networks—systems in which enrollees have considerable flexibility in their choice of providers but pay more out of pocket if they do not use a designated or network provider—fall somewhere between indemnity plans and HMOs in their levels of coverage.

• In sharp contrast to reversible contraceptives, sterilization is covered in almost nine in 10 plans of all types, and abortion in two-thirds.

Full contraceptive coverage in private insurance plans would be inexpensive and is popular among consumers.

• Providing full contraceptive coverage in employment-based plans would cost, at the most, only $21.40 per employee per year. For employers whose current plans offer no contraceptive coverage, the average cost of adding it, assuming that employers contribute 80% of the cost, would be $17.12 per year (or $1.43 per month) per employee, a premium increase of less than 1%. Employees' 20% share of the cost would be $4.28 per year. Added costs would be less for plans that already cover at least some methods.

• A nationwide poll indicated that 78% of privately insured adults support contraceptive coverage, even if it would increase their costs by five dollars a month—some 14 times the actual amount an employee would pay.

Policy initiatives at the state and federal levels promise to improve contraceptive coverage through private health insurance by requiring plans to cover contraceptives to the same extent that they cover other prescription drugs.

• In 1998, Congress moved to require full contraceptive coverage in plans participating in the Federal Employees Health Benefits Program, the world's largest employer-sponsored health plan, which includes 1.2 million women of reproductive age.

• That same year, Maryland became the first state to enact a law requiring full contraceptive coverage in private insurance. By July 1999, eight states had followed suit (Connecticut, Georgia, Hawaii, Maine, Nevada, New Hampshire, North Carolina and Vermont).

• The federal Equity in Prescription Insurance and Contraceptive Coverage Act of 1999 would require contraceptive coverage for all privately insured women enrolled in plans with a prescription drug benefit.

Need for Public Programs

Expanding access to family planning (contraceptives and closely related services) has been a major aim of the U.S. government since the mid-1960s. Federal support for family planning services derives principally from two sources: Medicaid, the joint federal-state health insurance program for poor Americans (created through Title XIX of the Social Security Act); and Title X of the Public Health Service Act, the only federal program devoted solely to the provision of family planning services. These programs have a long history of success in providing contraceptive services and reducing unintended pregnancy among low-income women, teenagers and other women in need of subsidized services; they also have made their mark by improving the health and financial well-being of women and their children.

• Each year, publicly funded contraceptive services help women avoid 1.3 million unintended pregnancies, which would result in 534,000 births, 632,000 abortions and 165,000 miscarriages. Services provided by clinics receiving funds under Title X are responsible for averting one million of these pregnancies.

• In the absence of publicly funded contraceptive services, the number of abortions performed in the United States would grow by 40%.

• If publicly funded contraceptive services were unavailable, an additional 386,000 teenagers would become pregnant each year. Of these, 155,000 would give birth, increasing the number of teenage births by one-quarter. Another 183,000 would have abortions, increasing the number of abortions among teenagers by nearly three-fifths. The remainder, roughly 48,000 teenagers, would have miscarriages.

• Without publicly funded contraceptive services, an additional 356,000 unmarried women would give birth each year, increasing total out-of-wedlock births by one-quarter.

• A 1992 North Carolina study found that women who used publicly funded family planning services in the two years before conception were more likely than those who did not use such services to begin prenatal care early and to receive adequate levels of care throughout pregnancy.

• By helping women to plan and space births, publicly funded contraceptive services prevented 20,000 occurrences of low birth weight, 6,500 infant deaths and 5,500 neonatal deaths between 1982 and 1988.

In addition to providing these social and medical benefits, publicly funded family planning is cost-effective.

• Every public dollar invested in family planning saves three dollars in Medicaid costs for pregnancy-related health care and medical care for newborns.

• Without publicly funded family planning, Medicaid expenditures for maternal and newborn care would increase by $1.2 billion each year.

Medicaid

Under Medicaid, the federal government and the states share the cost of providing medical care to eligible low-income individuals. The program is the largest source of public funds for contraceptive services in this country. In FY 1994, Medicaid expenditures for contraceptive care totaled $332 million.

Given the importance of equalizing access to family planning services for low-income women, the Medicaid program provides special consideration for these services.

• The federal government reimburses states for 90% of their costs for family planning services; for all other medical services, the rate is 50–80%.

• The Medicaid statute prohibits the imposition of copayments or deductibles for family planning services.

• Because of the sensitive nature of family planning services, Medicaid recipients participating in managed care are allowed to obtain such services from the provider of their choice, even if that provider is not affiliated with their plan.

States set income eligibility requirements for the program within broad federal parameters, but many low-income women in need of contraceptive services fail to qualify. Recognizing the value of family planning services, states have petitioned the federal government for special permission to expand services to women with incomes above their general eligibility ceilings.

• State-set ceilings for women with children range from 15% of the federal poverty level in Alabama to 86% in California and average 46% nationally.

• Special federal eligibility guidelines apply to pregnant women: States must cover pregnant women with incomes up to 133% of the federal poverty level, and may go as high as 185%. These women qualify for care, including family planning services, for 60 days following delivery, at which time their Medicaid eligibility expires.

• By the end of 1998, the federal government had approved special waivers allowing 12 states to expand eligibility for family planning by either continuing eligibility beyond the 60-day postpartum period or covering women with higher incomes than would otherwise be allowed.

• Benefits of expanded eligibility are already evident in Rhode Island, one of the first states to obtain a waiver and, therefore, to generate data. The number of women having Medicaid-funded deliveries who became pregnant within nine months of a previous birth fell by almost 50% within the first three years of the program. Furthermore, while the state estimates that it spent $5.7 million on family planning between 1994 and 1997, it reports having saved $14.3 million in costs related to deliveries and newborn care.

• Many states, however, have found the waiver process—with federal approval taking up to three years—to be time-consuming and cumbersome. In response to their concerns and other states' interest in expanding Medicaid eligibility for family planning, federal legislation introduced in 1999 (the Family Planning State Flexibility Act) would allow them to do so on their own, without first obtaining a federal waiver.

Title X

Title X is a critical source of assistance for low-income women and teenagers, who often are uninsured or have insurance under a plan that does not include adequate coverage of contraceptives. The program was created in 1970 with broad bipartisan support in response to research showing that rates of unwanted childbearing among low-income women were at least twice those for more affluent women.

Over the past three decades, the Title X clinic system has played a major role in helping women prevent unintended pregnancies, abortions and unplanned births. While Medicaid is the largest public funder of family planning services, Title X remains the heart of the national family planning system, largely determining both its structure—through the nationwide network of clinics—and the types and quality of services that are provided to subsidized and fee-paying clients alike.

• Each year, 4.5 million young and low-income women obtain care through the 4,400 Title X–supported family planning clinics nationwide; for many, these clinics are the first point of entry into the health care system.

• In addition to financing the provision of contraceptive services, Title X funds support a wide range of reproductive health care, including pelvic and breast examinations, blood pressure checks, Pap smears, and testing and treatment for sexually transmitted diseases.

• To ensure that women receive services on a purely voluntary basis, the Title X statute and regulations require that clinics offer clients a range of contraceptive choices on a confidential basis. They also contain safeguards to ensure that women are not pressured to accept a particular contraceptive method—or any method at all.

• By statute, the amount a clinic can charge a woman depends on her ability to pay. If her income is below the federal poverty level, the clinic must provide the services free of charge. If her income is between 100% and 250% of poverty, she must be charged on a sliding-fee scale; she pays full fees if her income is above 250% of poverty.

Today, Title X–supported clinics face the challenge of maintaining high-quality care while they confront increas-

Sylvia – knew of their previous level –
would like more –
Sylvia & Dan – explained – should be happy –
generous.

94 enc	99 request	99 enacted	2000 reg	PB
203	218	215	253	230 (77.7% in 97 enacted)

HERSA did not appeal.

Ang. current prog –
target adolescents – 6th become sexually active.
male reqs.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	handwritten, info re meeting attendees (partial) (1 page)	nd	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
OA/Box Number: 15421

FOLDER TITLE:
Title X

2012-1035-S
kc1089

RESTRICTION CODES

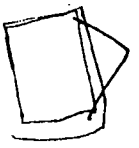
Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



Denese Shirvington

P6/(b)(6)

Sofia Lawson

P6/(b)(6)

Barbara Cohen

P6/(b)(6)

Ellen Caplan

P6/(b)(6)

Thomas Crimp

P6/(b)(6)

P6/(b)(6)

211 OEOB

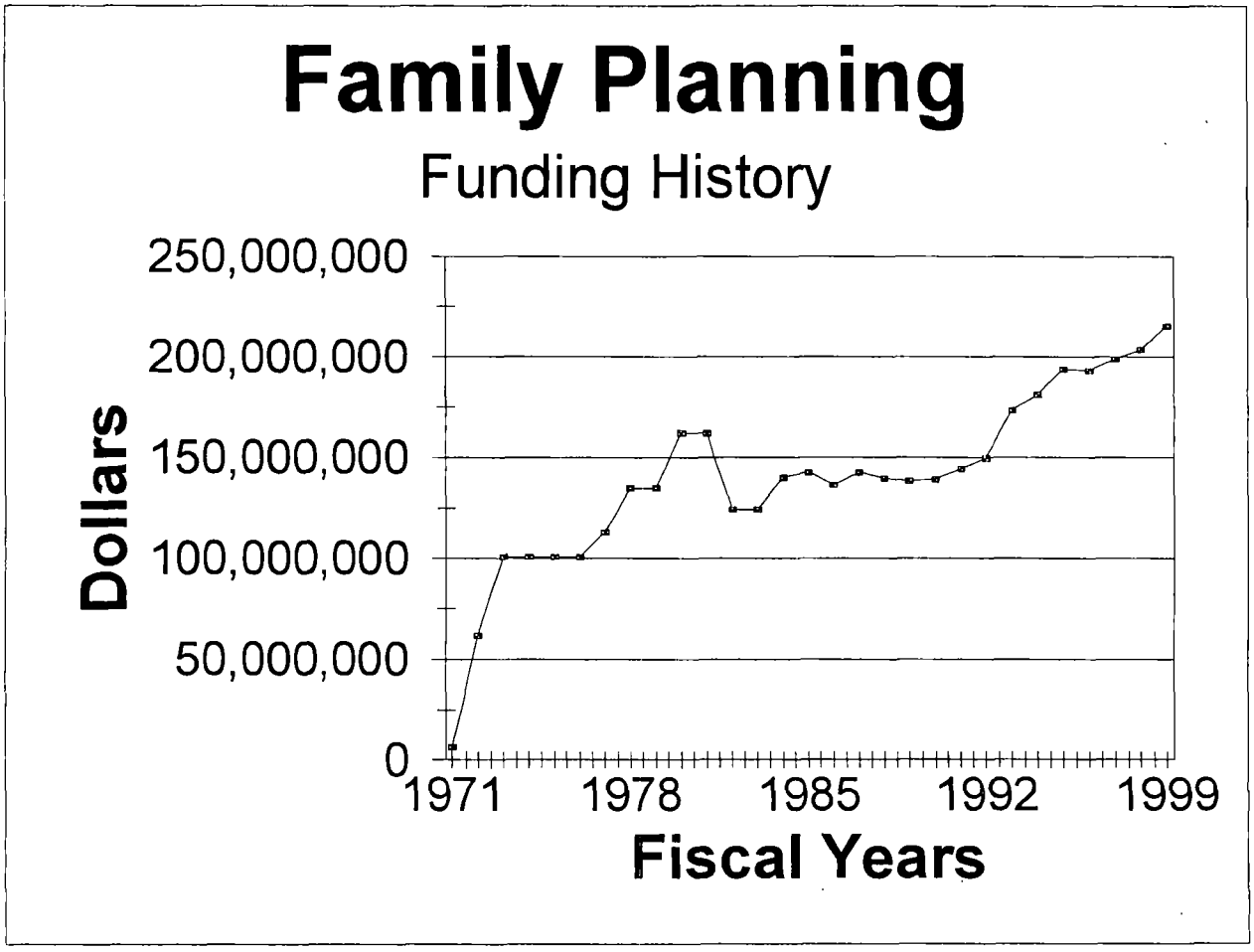
Jacqueline Cary

301-594-7612

FROM HHS

FAMILY PLANNING PROGRAM--Title X
HISTORY TABLE

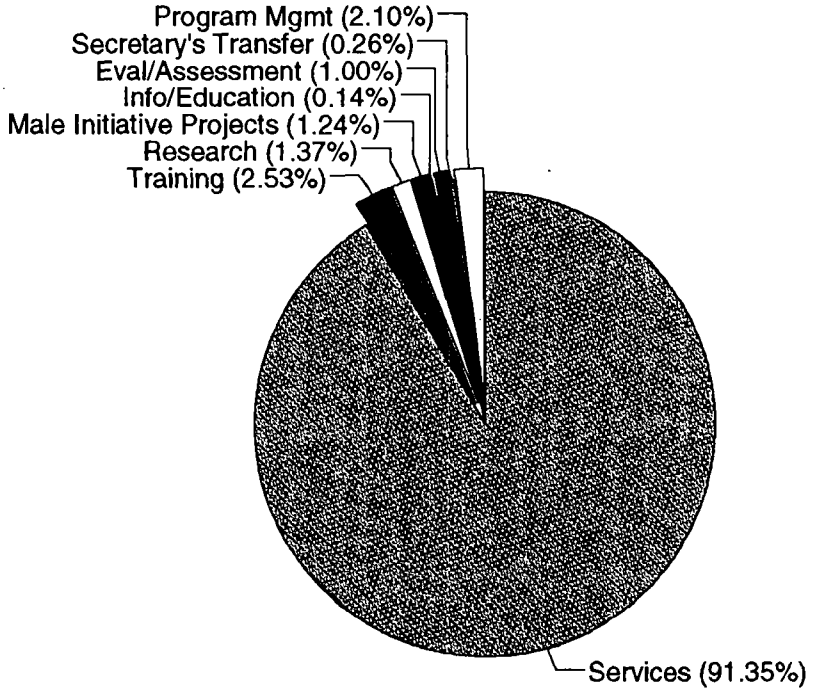
Fiscal Year	Appropriation
1971	$6,000,000
1972	61,815,000
1973	100,615,000
1974	100,615,000
1975	100,615,000
1976	100,615,000
1977	113,000,000
1978	135,000,000
1979	135,000,000
1980	162,000,000
1981	161,671,000
1982	124,176,000
1983	124,088,000
1984	140,000,000
1985	142,500,000
1986	136,372,000
1987	142,500,000
1988	139,663,000
1989	138,320,000
1990	139,135,000
1991	144,311,000
1992	149,585,000
1993	173,418,000
1994	180,918,000
1995	193,349,000
1996	192,592,000
1997	198,452,000
1998	203,452,000
1999	215,000,000
2000 Estimate	239,952,000


Family Planning
Funding History
250,000,000
200,000,000
150,000,000
100,000,000
50,000,000
0
Dollars
1971
1978
1985
1992
1999
Fiscal Years

Title X- Family Planning
FY 1995--FY 1998 Funding Distribution

Categories	1995	1996	1997	1998
Services	180,156,000	178,272,000	182,264,000	186,348,750
Training	4,920,680	5,752,952	5,666,000	5,164,088
Research	2,788,067	2,684,075	2,670,654	2,677,338
Male Initiative Projects	*0*	*0*	*1,935,346*	*2,539,662*
Information and Education	357,000	180,000	303,000	289,270
Evaluation and Assessments	903,000	1,560,000	1,408,000	2,172,884
Secretary's Transfer	*0*	*0*	*0*	*(526,185)*
Program Management	4,224,253	4,142,973	4,205,000	4,260,008
Total Title X	**193,349,000**	**192,592,000**	**198,452,000**	**202,925,815**
Secretary's Transfer Add Back				*526,185*
Total Title X Appro	**193,349,000**	**192,592,000**	**198,452,000**	**203,452,000**

Family Planning Funds Distribution
FY 1998



TITLE X—POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES

SEC. 1001. [300] (a) The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects which shall offer a broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents). To the extent practicable, entities which receive grants or contracts under this subsection shall encourage family participation in projects assisted under this subsection.

(b) In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance. Local and regional entities shall be assured the right to apply for direct grants and contracts under this section, and the Secretary shall by regulation fully provide for and protect such right.

(c) The Secretary, at the request of a recipient of a grant under subsection (a), may reduce the amount of such grant by the fair market value of any supplies or equipment furnished the grant recipient by the Secretary. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment on which the reduction of such grant is based. Such amount shall be deemed as part of the grant and shall be deemed to have been paid to the grant recipient.

(d) For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; $111,500,000 for the fiscal year ending June 30, 1973; $111,500,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $115,000,000 for fiscal year 1976; $115,000,000 for the fiscal year ending September 30, 1977; $136,400,000 for the fiscal year ending September 30, 1978; $200,000,000 for the fiscal year ending September 30, 1979; $230,000,000 for the fiscal year ending September 30, 1980; $264,500,000 for the fiscal year ending September 30, 1981; $126,510,000 for the fiscal year ending September 30, 1982; $139,200,000 for the fiscal year ending September 30, 1983; $150,030,000 for the fiscal year ending September 30, 1984; and $158,400,000 for the fiscal year ending September 30, 1985.

FORMULA GRANTS TO STATES FOR FAMILY PLANNING SERVICES

SEC. 1002. [300a] (a) The Secretary is authorized to make grants, from allotments made under subsection (b), to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services. No grant may be made to a State health authority under this section unless such authority has submitted, and had approved by the Secretary, a State plan for a coordinated and comprehensive program of family planning services.

(b) The sums appropriated to carry out the provisions of this section shall be allotted to the States by the Secretary on the basis of the population and the financial need of the respective States.

(c) For the purposes of this section, the term "State" includes the Commonwealth of Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, the Virgin Islands, the District of Columbia, and the Trust Territory of the Pacific Islands.

(d) For the purpose of making grants under this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1971; $15,000,000 for the fiscal year ending June 30, 1972; and $20,000,000 for the fiscal year ending June 30, 1973.

TRAINING GRANTS AND CONTRACTS

SEC. 1003. [300a-1] (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to provide the training for personnel to carry out family planning service programs described in section 1001 or 1002.

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1971; $3,000,000 for the fiscal year ending June 30, 1972; $4,000,000 for the fiscal year ending June 30, 1973; and $3,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $4,000,000 for fiscal year 1976; $5,000,000 for the fiscal year ending September 30, 1977; $3,000,000 for the fiscal year ending September 30, 1978; $3,100,000 for the fiscal year ending September 30, 1979; $3,600,000 for the fiscal year ending September 30, 1980; $4,100,000 for the fiscal year ending September 30, 1981; $2,920,000 for the fiscal year ending September 30, 1982; $3,200,000 for the fiscal year ending September 30, 1983; $3,500,000 for the fiscal year ending September 30, 1984; and $3,500,000 for the fiscal year ending September 30, 1985.

RESEARCH

SEC. 1004. [300a-2] The Secretary may—

(1) conduct, and

(2) make grants to public or nonprofit private entities and enter into contracts with public or private entities and individuals for projects for,

research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.

INFORMATIONAL AND EDUCATIONAL MATERIALS

SEC. 1005. [300a-3] (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials).

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $750,000 for the fiscal year ending June 30, 1971; $1,000,000 for the fiscal year ending June 30, 1972; $1,250,000 for the fiscal year ending June 30, 1973; $909,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; $2,000,000 for fiscal year 1976; $2,500,000 for the fiscal year ending September 30, 1977; $600,000 for the fiscal year ending September 30, 1978; $700,000 for the fiscal year ending September 30, 1979; $805,000 for the fiscal year ending September 30, 1980; $926,000 for the fiscal year ending September 30, 1981; $570,000 for the fiscal year ending September 30, 1982; $600,000 for the fiscal year ending September 30, 1983; $670,000 for the fiscal year ending September 30, 1984; and $700,000 for the fiscal year ending September 30, 1985.

REGULATIONS AND PAYMENTS

SEC. 1006. [300a-4] (a) Grants and contracts made under this title shall be made in accordance with such regulations as the Secretary may promulgate. The amount of any grant under any section of this title shall be determined by the Secretary; except that no grant under any such section for any program or project for a fiscal year beginning after June 30, 1975, may be made for less than 90 per centum of its costs (as determined under regulations of the Secretary) unless the grant is to be made for a program or project for which a grant was made (under the same section) for the fiscal year ending June 30, 1975, for less than 90 per centum of its costs (as so determined), in which case a grant under such section for that program or project for a fiscal year beginning after that date may be made for a percentage which shall not be less than the percentage of its costs for which the fiscal year 1975 grant was made.

(b) Grants under this title shall be payable in such installments and subject to such conditions as the Secretary may determine to be appropriate to assure that such grants will be effectively utilized for the purposes for which made.

(c) A grant may be made or contract entered into under section 1001 or 1002 for a family planning service project or program only upon assurances satisfactory to the Secretary that—

(1) priority will be given in such project or program to the furnishing of such services to persons from low-income families; and

(2) no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge.

For purposes of this subsection, the term "low-income family" shall be defined by the Secretary in accordance with such criteria as he may prescribe so as to insure that economic status shall not be a deterrent to participation in the programs assisted under this title.

(d)(1) A grant may be made or a contract entered into under tion 1001 or 1005 only upon assurances satisfactory to the Secretary that informational or educational materials developed or made available under the grant or contract will be suitable for the purposes of this title and for the population or community to which they are to be made available, taking into account the educational and cultural background of the individuals to whom such materials are addressed and the standards of such population or community with respect to such materials.

(2) In the case of any grant or contract under section 1001, such assurances shall provide for the review and approval of the suitability of such materials, prior to their distribution, by an advisory committee established by the grantee or contractor in accordance with the Secretary's regulations. Such a committee shall include individuals broadly representative of the population or community to which the materials are to be made available.

VOLUNTARY PARTICIPATION

SEC. 1007. [300a-5] The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such v- ice or information.

PROHIBITION OF ABORTION

SEC. 1008. [300a-6] None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

PLANS AND REPORTS

SEC. 1009. (a) Not later than seven months after the close of h fiscal year, the Secretary shall make a report to the Congress ting forth a plan to be carried out over the next five fiscal years for—

(1) extension of family planning services to all persons r- ing such services,

(2) family planning and population research programs,

(3) training of necessary manpower for the programs authorized by this title and other Federal laws for which the Secretary has responsibility and which pertain to family planning, and

Section 1009 repealed by P.L. 105-362, Federal Reports Elimination Act of 1998

(4) carrying out the other purposes set forth in this title and the Family Planning Services and Population Research Act of 1970.

(b) Such a plan shall, at a minimum, indicate on a phased basis—

(1) the number of individuals to be served by family planning programs under this title and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information and educational materials to be developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;

(2) an estimate of the costs and personnel requirements needed to meet the purposes of this title and other Federal laws for which the Secretary has responsibility and which pertain to family planning programs; and

(3) the steps to be taken to maintain a systematic reporting system capable to yielding comprehensive data on which service figures and program evaluations for the Department of Health, Education, and Welfare shall be based.

(c) Each report submitted under subsection (a) shall—

(1) compare results achieved during the preceding fiscal year with the objectives established for such year under the plan contained in the previous such report;

(2) indicate steps being taken to achieve the objectives during the fiscal years covered by the plan contained in such report and any revisions to plans in previous reports necessary to meet these objectives; and

(3) make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan contained in such report.

Public Law 91-572
91st Congress, S. 2108
December 24, 1970

An Act

84 STAT. 1504

To promote public health and welfare by expanding, improving, and better coordinating the family planning services and population research activities of the Federal Government, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Family Planning Services and Population Research Act of 1970.

SHORT TITLE

SECTION 1. This Act may be cited as the "Family Planning Services and Population Research Act of 1970".

DECLARATION OF PURPOSE

SEC. 2. It is the purpose of this Act—

(1) to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services;

(2) to coordinate domestic population and family planning research with the present and future needs of family planning programs;

(3) to improve administrative and operational supervision of domestic family planning services and of population research programs related to such services;

(4) to enable public and nonprofit private entities to plan and develop comprehensive programs of family planning services;

(5) to develop and make readily available information (including educational materials) on family planning and population growth to all persons desiring such information;

(6) to evaluate and improve the effectiveness of family planning service programs and of population research;

(7) to assist in providing trained manpower needed to effectively carry out programs of population research and family planning services; and

(8) to establish an Office of Population Affairs in the Department of Health, Education, and Welfare as a primary focus within the Federal Government on matters pertaining to population research and family planning, through which the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the "Secretary") shall carry out the purposes of this Act.

OFFICE OF POPULATION AFFAIRS

Establishment. Deputy Assistant Secretary for Population Affairs, appointment.

SEC. 3. (a) There is established within the Department of Health, Education, and Welfare an Office of Population Affairs to be directed by a Deputy Assistant Secretary for Population Affairs under the direct supervision of the Assistant Secretary for Health and Scientific Affairs. The Deputy Assistant Secretary for Population Affairs shall be appointed by the Secretary.

Staff and consultants.

(b) The Secretary is authorized to provide the Office of Population Affairs with such full-time professional and clerical staff and with the services of such consultants as may be necessary for it to carry out its duties and functions.

FUNCTIONS OF THE DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS

SEC. 4. The Secretary shall utilize the Deputy Assistant Secretary for Population Affairs—

(1) to administer all Federal laws for which the Secretary has administrative responsibility and which provide for or authorize the making of grants or contracts related to population research and family planning programs;

(2) to administer and be responsible for all population and family planning research carried on directly by the Department of Health, Education, and Welfare or supported by the Department through grants to, or contracts with, entities and individuals;

(3) to act as a clearinghouse for information pertaining to domestic and international population research and family planning programs for use by all interested persons and public and private entities;

(4) to provide a liaison with the activities carried on by other agencies and instrumentalities of the Federal Government relating to population research and family planning;

(5) to provide or support training for necessary manpower for domestic programs of population research and family planning programs of service and research; and

(6) to coordinate and be responsible for the evaluation of the other Department of Health, Education, and Welfare programs related to population research and family planning and to make periodic recommendations to the Secretary.

PLANS AND REPORTS

Report to Congress.

SEC. 5. (a) Not later than six months after the date of enactment of this Act the Secretary shall make a report to the Congress setting forth a plan, to be carried out over a period of five years, for extension of family planning services to all persons desiring such services, for family planning and population research programs, for training of necessary manpower for the programs authorized by title X of the Public Health Service Act and other Federal laws for which the Secretary has responsibility, and for carrying out the other purposes set forth in this Act and in such title X.

Post, p. 1506.

(b) Such a plan shall, at a minimum, indicate on a phased basis—

(1) the number of individuals to be served by family planning programs under title X of the Public Health Service Act and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information and educational materials to be developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;

(2) an estimate of the costs and personnel requirements needed to meet these objectives; and

(3) the steps to be taken to establish a systematic reporting system capable of yielding comprehensive data on which service figures and program evaluations for the Department of Health, Education, and Welfare shall be based.

Reports to Congress.

(c) On or before January 1, 1972, and on or before each January 1 thereafter for a period of five years, the Secretary shall submit to the Congress a report which shall—

(1) compare results achieved during the preceding fiscal year with the objectives established for such year under the plan;

(2) indicate steps being taken to achieve the objective during the remaining fiscal years of the plan and any revisions necessary to meet these objectives; and

(3) make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan.

AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

SEC. 6. (a) Section 1 of the Public Health Service Act is amended by striking out "Titles I to IX" and inserting in lieu thereof "Titles I to X". 79 Stat. 930. 42 USC 201 note.

(b) The Act of July 1, 1944 (58 Stat. 682), as amended, is further amended by renumbering title X (as in effect prior to the enactment of this Act) as title XI, and by renumbering sections 1001 through 1014 (as in effect prior to the enactment of this Act), and references thereto, as sections 1101 through 1114, respectively.

(c) The Public Health Service Act (42 U.S.C., ch. 6A) is further amended by adding after title IX the following new title:

"TITLE X—POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

"PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES

"SEC. 1001. (a) The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects.

"(b) In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance.

"(c) For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; and $90,000,000 for the fiscal year ending June 30, 1973. Appropriation.

"FORMULA GRANTS TO STATES FOR FAMILY PLANNING SERVICES

"SEC. 1002. (a) The Secretary is authorized to make grants, from allotments made under subsection (b), to State health authorities to assist in planning, establishing, maintaining, coordinating, and evaluating family planning services. No grant may be made to a State health authority under this section unless such authority has submitted, and had approved by the Secretary, a State plan for a coordinated and comprehensive program of family planning services.

"(b) The sums appropriated to carry out the provisions of this section shall be allotted to the States by the Secretary on the basis of the population and the financial need of the respective States.

"(c) For the purposes of this section, the term 'State' includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the District of Columbia, and the Trust Territory of the Pacific Islands. "State."

"(d) For the purpose of making grants under this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending Appropriation.

June 30, 1971; $15,000,000 for the fiscal year ending June 30, 1972; and $20,000,000 for the fiscal year ending June 30, 1973.

"TRAINING GRANTS AND CONTRACTS

"SEC. 1003. (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to provide the training for personnel to carry out family planning service programs described in section 1001 or 1002.

Appropriation. "(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1971; $3,000,000 for the fiscal year ending June 30, 1972; and $4,000,000 for the fiscal year ending June 30, 1973.

"RESEARCH GRANTS AND CONTRACTS

"SEC. 1004. (a) In order to promote research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population, the Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals for projects for research and research training in such fields.

Appropriation. "(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $50,000,000 for the fiscal year ending June 30, 1972; and $65,000,000 for the fiscal year ending June 30, 1973.

"INFORMATIONAL AND EDUCATIONAL MATERIALS

"SEC. 1005. (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials).

Appropriation. "(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $750,000 for the fiscal year ending June 30, 1971; $1,000,000 for the fiscal year ending June 30, 1972; and $1,250,000 for the fiscal year ending June 30, 1973.

"REGULATIONS AND PAYMENTS

"SEC. 1006. (a) Grants and contracts made under this title shall be made in accordance with such regulations as the Secretary may promulgate.

"(b) Grants under this title shall be payable in such installments and subject to such conditions as the Secretary may determine to be appropriate to assure that such grants will be effectively utilized for the purposes for which made.

"(c) A grant may be made or contract entered into under section 1001 or 1002 for a family planning service project or program only upon assurances satisfactory to the Secretary that—

"(1) priority will be given in such project or program to the furnishing of such services to persons from low-income families; and

"(2) no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge.

For purposes of this subsection, the term 'low-income family' shall be defined by the Secretary in accordance with such criteria as he may prescribe. "Low-income family."

"VOLUNTARY PARTICIPATION

"SEC. 1007. The acceptance by any individual of family planning services or family planning or population growth information (including educational materials) provided through financial assistance under this title (whether by grant or contract) shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.

"PROHIBITION OF ABORTION

"SEC. 1008. None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."

Approved December 24, 1970.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 91-1472 accompanying H.R. 19318 (Comm. on Interstate and Foreign Commerce) and No. 91-1667 (Comm. of Conference).
SENATE REPORT No. 91-1004 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 116 (1970):
July 14, considered and passed Senate.
Nov. 16, considered and passed House, amended, in lieu of H.R. 19318.
Dec. 8, House agreed to conference report.
Dec. 10, Senate agreed to conference report.

GPO 48-139

FIRST LADY HILLARY CLINTON AND VICE PRESIDENT GORE UNVEIL NEW INVESTMENT IN SAFE, EFFECTIVE FAMILY PLANNING SERVICES FOR AMERICAN WOMEN

January 22, 1999

Today, in honor of the 26th anniversary of Roe vs Wade, First Lady Hillary Rodham Clinton and Vice President Gore met with representatives from the reproductive health community to unveil a series of new steps to prevent unintended pregnancy, including a new multi million dollar initiative to ensure access to safe, high quality family planning services for American women.

MILLIONS OF AMERICAN WOMEN NEED FAMILY PLANNING SERVICES

More than 3 million unintended pregnancies occur every year in the United States. Women who use no contraceptives account for almost half of these pregnancies (47%), while the 39 million method users account for 53%. Unintended pregnancies among women who do not use contraception are almost as likely to end in abortion as they are in a birth.

NEW STEPS TOWARDS PROVIDING SAFE, EFFECTIVE FAMILY PLANNING SERVICES FOR AMERICAN WOMEN. This initiative reaffirms the Clinton-Gore Administration's committment to expanding and enhancing the quality of reproductive health services for all American women. Today, the First Lady and Vice President announced that the Administration is:

- **Unveiling the Largest Increase in Family Planning Services in 15 Years.** The Clinton/Gore Adminstration's FY 2000 budget includes $240 million for family planning, a $25 million increase, and the largest increase in 15 years. These grants fund family planning clinics providing reproductive health services and clinical care to over 5 million low income women. These new funds will be used to prevent over a million unintended pregnancies year by improving the delivery of comprehensive reproductive health services, including STD and cancer screening and prevention, and HIV prevention, education and counseling; providing educational programs that encourage adolescents to postpone of sexual activity; increase the accessibility of contraceptive counseling and services; increasing efforts to provide effective contraceptives to those in need; and developing partnerships with other community based providers to conduct outreach to adolescents at risk.

- **Preventing violence at women's health clinics.** In the wake of escalating violence against women's health clinics that provide abortions, the First Lady and the Vice President will announce the the FY 2000 budget includes $4.5 million for support additional security enhancements, such as including closed circuit camera systems, improved lighting, motion detectors, alarm systems and bullet-resistant windows for these clinics in order to protect their doctors and nurses. Under this proposal, the Department of Justice would make security assessments and enhancements available to clinics deemed to be at high risk of violence. This Administration is committed to fighting this form of domestic terrorism that has threatened so many clinics and providers. While emphasizing the importance of family planning services to prevent unintended pregnancies, the First Lady and Vice President also emphasized that those women who choose to have an abortion do not have to fear violence.

- **Contributing $25 million to the UNFPA.** Today, the First Lady and Vice President will announce that the President's FY 2000 budget proposes a $25 million voluntary contribution to the UNFPA, $5 million more than the President's FY 1999 budget proposal. The U.S. Contributions to the UN Population Fund is the largest multilateral donor organization in the population sector and concentrates its assistance to countries in the areas of reproductive health and voluntary family planning, population policy and advocacy.

- **Ensuring that Federal employees have access to comprehensive family planning services.** The FY 2000 budget also continues to ensure that the Federal government leads the way as a model health plan by assuring that Federal employees and their families participating in the 300 Federal Employees Health Benefit Program (FEHBP) have access to contraceptive coverage. This policy provides coverage to approximately 1.2 million women of childbearing age and reduces unwanted pregnancies and the need for abortions by requiring most FEHB plans to offer the full range of contraceptive services. Before this requirement, only 19% of federal health plans covered prescription contraceptives and 10% of the plans offered no contraceptive coverage at all.

Date: 1.27.99

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Nicole Rabner
Fax: 6.2878

From: Jen Forshey

Number of Pages (excluding cover): 4

Subject:

The following was sent to HHS yesterday. We will be checking with them later today on their progress. Thanks for your help.

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840
Health Division (Room 7002)	202/395-5648

January 26, 1999

Health Division

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Route to: Richard Turman
Gwen Clark

Subject: **OMB Changes on HRSA Draft Congressional Justification & Performance Plan**

From: Jennifer Forshey
Barbara Menard

ACTION:
Decision_____
Signature_____
Comment_____
As requested XXX
Information_____

Phone: 202/395-4926
Fax: 202/395-7840
Room: NEOB #7001

Needed By:
Date:_____
Time:_____
Copies to:

Post this Document on HD Intranet? NO

cc: Barry Clendenin,
Diana Leland
Julio Everitt

Attached are our changes to the Family Planning - Title X section of the draft Congressional Justification. The changes to this section have been affirmed by Dan Mendelson and **must be** made to the document.

These changes are consistent with the guidance provided to ASMB last week. The FY 2000 Budget for family planning services (contraceptive and clinical) will increase at a rate at least commensurate with the increase to the program as a whole. In short, the program received a 11.6 ~~10.4%~~ budget increase for FY 2000, hence, the budget for family planning services must also rise by ~~10.4%~~ 11.6%.

So we can all have the same back-up material for this important issue area, we need to get a detailed budget breakdown for Family Planning for FY 1998 to FY 2000, containing the amounts spent on services, research, training, evaluation, management, etc. Since PHS staff must be using a table something like this as their own back-up for the CJ text, we request a copy of the table by 10:00 a.m. on Wednesday, January 27. Thanks.

If you have any questions or you are unable to read the faxed version, please call Jennifer Forshey at 202-395-4926.

Family Planning Program

Authorizing Legislation--Title X, Section 1001 of the Public Health Service Act.

	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Increase or Decrease
BA	$2,903,000	$215,000,000	$239,952,000	+$24,952,000
FTE	40	48	49	+4

FY 2000 Authorization.....Expired

Purpose and Method of Operation

The Family Planning Program, Title X of the PHS Act, is administered through the Office of Population Affairs/Office of Public Health and Science. This program provides grants to public and private non-profit agencies to provide voluntary family planning services. In FY 1998 approximately 4.5 million clients received family planning services through a network of 4,600 clinics nationwide. Approximately two percent of the clients served were males.

Family planning programs provide basic reproductive health services as well as screening for ancillary health problems, counseling, and information and education. In addition, Title X supports training for all levels of family planning personnel, including nurse practitioners. Title X also supports research which focuses on family planning service delivery improvements.

Although Medicaid is the largest source of funding for family planning services, Title X serves a population largely unserved by Medicaid which includes teens, nulliparous women, and the working poor. Title X is required to give priority to clients who are low-income, and approximately 85 percent of the clients served by the program are from low-income families. Approximately one-third of Title X clients are adolescents. For many clients, Title X has been the primary, or sole, point of contact with the health care system.

In FY 1998 there were 95 grantees, of which 33 were States or territorial health departments. Types of grantees funded include not-for-profit organizations and State and/or territorial health departments.

Funding for the family planning program during the last five years has been as follows:

	$	FTEs
1995	193,349,000	43
1996	192,592,000	39
1997	198,452,000	38
1998	202,903,000	40
1999	215,000,000	48

Rationale for the Budget Request

Funds targeted toward family planning services will increase at a rate at least commensurate with the increase to the program as a whole

The FY 2000 request of $239,952,000 is an increase of $24,952,000 and four FTEs over the FY 1999 appropriation. This budget request will enhance the ability of the Title X Program to address Departmental initiatives of assuring a healthy start for every child by increasing the proportion of pregnancies that are intended, promoting personal responsibility for healthy lifestyles, and eliminating racial and ethnic disparities as identified by the President's Initiative on Race, as well as addressing the health promotion and disease prevention objectives identified in Healthy People 2000 and 2010.

In FY 2000, the Title X Program will address the following Title X Program Priorities:

- Expansion and enhancement of the quality of clinical reproductive health services through partnerships with other entities that have related interests and that work with similar priority populations;
- Increased emphasis on services to adolescents, including emphasis on postponement of sexual activity and more accessible provision of contraceptive counseling and services;
- Increased services to hard-to-reach populations by partnering with community-based organizations and others that have a stake in the prevention of unintended pregnancy;
- Expansion of comprehensiveness of reproductive health services, including STD and cancer screening and prevention, HIV prevention, education and counseling, and substance abuse screening and referral;
- Increased services to males, emphasizing shared responsibility for preventing unintended pregnancy.

move bullet #4 to be bullet #1

Continued attention to these priorities is the best strategy we can adopt to ensure widespread recognition of the role which Title X plays in providing a vital service to a high need and often otherwise unserved population. The investment in family planning is essential in averting unintended pregnancies which are costly, in both human and dollar terms. Both the Administration and the Department have clearly targeted adolescent pregnancy prevention and male responsibility in preventing unintended pregnancy as ~~major~~ policy issues. Effective pregnancy prevention efforts must include men and adolescent boys, as well as women and adolescent girls. Although the program is already working in these areas, this budget request will ~~substantially expand~~ continue programmatic efforts on these priorities.

→ substantial progress have been made in reducing the numb of unintended teenage pregnancies, which are currently at a 23 yea low

important

In addition to the priorities listed above, there are other key issues the Title X program will address which impacts the current and future delivery of family planning services and require significant programmatic efforts and resources. These issues include: (1) Medicaid waivers and managed care; (2) implications of welfare reform and other issues that are affecting family planning services, such as Temporary Assistance to Needy Families (TANF) and Children's Health Insurance Program (CHIP) as well as other Federal and State initiatives; (3) electronic technology; (4) research findings, and (5) legislative mandates.

Outputs:

	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate
No. of Service Grantees	83	83	83
No. of Service Delivery Demonstration Grantees*			
Males	10	15	20
Hard-to-Reach Teens	2	8	15
Substance Abuse Populations	---	1	3
Incarcerated Populations	---	3	7
Clients Served	4,500,000	5,000,000	5,500,000

move

* Grantees may have multiple subcontractors or projects. Grantees may also be multi-funded, i.e., several departments or agencies working together to achieve a holistic service delivery approach.

THE CLINTON ADMINISTRATION:
STANDING UP FOR A WOMAN'S RIGHT TO CHOOSE

Today, the First Lady will keynote NARAL's 1999 celebration of the 26th anniversary of Roe v. Wade honoring those who have fought hard to preserve reproductive freedom. Mrs. Clinton's remarks will highlight the accomplishments of NARAL and the reproductive rights movement to protect the right to choose, while pressing for policies that prevent unintended pregnancies and ensure healthy childbirth. She will also call on everyone to double their efforts to educate the public about the need for expanded family planning services, an end to clinic violence, and comprehensive contraceptive coverage.

Her remarks, together with the new steps the Clinton Adminsistration took today, build on the Administration's longstanding commitment to provide American women with safe, high quality family planning services and assure access to choice. This Administration has worked hard to protect a woman's right to choose and to promote safe reproductive health services for women.

- **Creating of the National Task Force on Violence Against Health Care Providers.** Last November, the Justice Department's launched a National Task Force on Violence Against Health Care Providers to coordinate the investigation of violence against women's health care clinics nationwide. The Task Force works closely with local authorities and U.S. Attorneys investigating acts of violence against clinics by: coordinating national investigative efforts; creating an investigative clearinghouse for information related to clinic violence; and providing training to federal, state and local law enforcement personnel.

- **Provided Contraceptive Coverage to More than a Million Women.** The FY99 Omnibus Appropriations Act contains an important policy breakthrough on reproductive choice. The final bill requires the 300 Federal Employees Health Benefits Plans (FEHBP) to cover contraceptive drugs and devices, providing coverage to approximately 1.2 million women of childbearing age. Until now, only 19% of federal health plans covered prescription contraceptives and 10% of the plans offered no contraceptive coverage at all. The Republican Leadership tried to remove this measure, but President Clinton and pro-choice members remained firm.

- **Providing family planning services to low income women.** The Administration has granted Medicaid waivers to expand access to family planning services in 11 states in order to reduce the number of women with mistimed or unwanted pregnancies. These waivers extend family planning services to low-income women of childbearing age who would not otherwise be eligible for Medicaid family planning services, including low-income women who are eligible for Medicaid while pregnant but who lose their eligibility at the end of pregnancy, and low-income women who would become eligible for Medicaid if pregnant, even if they've never been pregnant or Medicaid eligible.

- **Stopped the Coburn Amendment Prohibiting the FDA from Approving RU-486.** On January 22, 1993, President Clinton reversed the ban on the importation of Mifepristone or RU-486; RU-486 is currently under review by the Food and Drug Administration (FDA). Unfortunately, the FDA's scientific drug approval process became under assault in the 105th Congress. President Clinton threatened to veto a provision that would have prevented the FDA from using government funds to test, develop or approve drugs that may induce medical abortion, including RU-486. Because of the President's veto threat, Republicans backed down and decided not to attach this provision to any funding bill.

- **Defeated Parental Consent Restrictions on Contraceptives for Minors.** The House voted to require minors to obtain parental consent prior to receiving any Title X family planning services (this has also been referred to as the Istook amendment). The President's veto threat helped to keep it out of the final bill.

- **Stopped the So-Called "Child Custody Protection" Act.** Senior Clinton Administration Advisers recommended a veto of this bill which would have made it illegal to transport a minor across State lines for the purpose of avoiding parental consent or notification laws. The Clinton Administration, as detailed in the Statement of Administration Policy, was very concerned that the bill did not protect close family members --including grandmothers, aunts and siblings --from criminal and civil liability. Family members could face criminal charges for aiding a relative in distress. The bill also did not protect persons that only provide information, counseling, referral or medical services to the minor from liability. Under a veto threat, the Senate failed to invoke cloture (or end debate) on the Child Custody Protection Act.

- **Upheld the Late Term Abortion Veto.** This year, the House of Representatives voted to override President Clinton's veto of a bill banning certain late-term abortions, known by proponents of the ban as "partial birth abortions." While the House voted to override the President's action, the Senate sustained the veto by a vote of 36-64 --just three votes short of the required two-thirds majority needed to override the veto. President Clinton vetoed the measure in October 1997 because it did not contain an exception that protected the health or life of the woman.

- **Continued to Fight Restrictions on International Family Planning.** The FY99 Omnibus Appropriations Act does not contain the so-called "Mexico City" policy, a provision that denies U.S. funds to international family planning organizations that use their own resources to perform abortions or lobby on abortion policy. The Mexico City restrictions were also included in the Foreign Affairs Reform and Restructuring Act. President Clinton vetoed this legislation because it contained these unacceptable restrictions.

Daniel N. Mendelson

01/14/99 04:31:40 PM

Record Type: Record

To: Sylvia M. Mathews/OMB/EOP

cc: Adrienne C. Erbach/OMB/EOP, Nicole R. Rabner/WHO/EOP, Richard J. Turman/OMB/EOP, Jennifer M. Forshey/OMB/EOP

Subject: Judy DeSarno

I spoke with Judy, and she is happy with our solution on male responsibility. It won't be mentioned in the budget, and we will discuss the issue in the context of CJs with an eye towards ensuring that contraceptive services receive a proportional increase in funds and that male involvement programs can be coordinated and run through the Title X clinics. We will meet with them to discuss the CJs before they go up. Let me know if you want more information, but you can feel free to announce.

TITLE X LANGUAGE TO ACCOMPANY THE PASSBACK

The funding increase for the Title X family planning program should, first and foremost, be spent on contraceptive services to reduce unintended pregnancy With any remaining funds, priority will be given to education, counseling, and medical services to males within the clinical service delivery system, or through community-based programs directly linked to Title X service providers.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. list	Invited Participants for Pro-Choice Group Meeting (partial) (3 pages)	01/20/1997	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
OA/Box Number: 15421

FOLDER TITLE:
Title X

2012-1035-S
kc1089

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[002]

Invited Participants for Pro-Choice Group Meeting
January 20, 1997 5:00 pm
Vice President's Ceremonial Office - OEOB Rm 276

1) Susan Cohen, Senior Public Policy Associate — President ?
Alan Guttmacher Institute
DOB
SSN P6/(b)(6)
State MD

2) Nancy Zirkin, Director of Government Relations
American Association of University Women
DOB
SSN P6/(b)(6)
State MD

3) ~~Patricia~~ Ireland, President
National Organization for Women ← Kim Gandy NOW
DOB
SSN P6/(b)(6)
State ~~DC~~

P6/(b)(6)

4) Marcia Greenberger, Co-President
National Women's Law Center
DOB
SSN P6/(b)(6)
State DC

5) Anita Perez-Ferguson, President
National Women's Political Caucus
DOB
SSN P6/(b)(6)
State CA

6) Gloria Feldt, President
Planned Parenthood
DOB
SSN P6/(b)(6)
State NY

P6/(b)(6)

[002]

7) Kate Michelman, President
National Abortion and Reproductive Rights Action League
DOB
SSN P6/(b)(6)
State PA & DC

8) Vicki Saporta, Executive Director
National Abortion Federation
DOB
SSN P6/(b)(6)
State DC

9) Eleanor Smeal, President
Fund for Feminist Majority
DOB
SSN P6/(b)(6)
State VA

10) Judy Desarno, President/CEO
National Family Planning and Reproductive Health Organization
DOB
SSN P6/(b)(6)
State MD

11) Judith Lichtman, President
Women's Legal Defense Fund
DOB
SSN P6/(b)(6)
State DC

12) Beverly Stripling, Public Policy Director
YWCA of the U.S.A.
DOB
SSN P6/(b)(6)
State DC

13) Craig Lasher, Senior Policy Analyst/Legislative Assistant for Political Affairs
Population Action International
DOB
SSN P6/(b)(6)
State MD

14) Brian Dixon, Director of Government Relations
Zero Population Growth
DOB P6/(b)(6)

[002]

SSN P6/(b)(6)
State PA

15) ~~Kathy Bryant~~, Associate Director Government Relations President?
American College of OBGYN
DOB
SSN P6/(b)(6)
State MA

16) Sarah Brown,
National Campaign to PreventTeen Pregnancy
DOB
SSN P6/(b)(6)
State DC

17) Brenda C. Romney
Center for Reproductive Law and Policy
DOB
SSN P6/(b)(6)
State DC

18) James Wagner, Executive Director
Advocates for Youth
DOB
SSN P6/(b)(6)
State VA

19) Rev. Carlton W. Veazey
Religious Coalition for Reproductive Choice
DOB
SSN P6/(b)(6)
State MD

NURSES

From groups

December 9, 1998

Ms. Sylvia Mathews
Deputy Director, Office of Management and Budget
Room 252
Old Executive Office Building
Washington, DC 20503

Dear Sylvia:

Thank you again for meeting with the undersigned representatives of national women's organizations on November 25th. We are writing to express our continued concern that the Administration's budget request for Title X remains low. Further, we would like to call your attention to an additional problem involving family planning funding that we have learned of since our meeting.

As you recall, we discussed the proposed funding level for the Title X family planning program and learned that the Office of Management and Budget had included an increase of $14.9 million for the program for FY 2000, for a total proposed funding level of just under $230 million. This falls far short of the HHS requested increase of $38 million, which itself did not meet the needs of the program. We request that you find additional funds to support these basic clinical reproductive health services for women funded by the Title X program before the President's Budget is finalized.

Since our meeting, we have learned that the OMB passback also included language drafted by HHS which directs that the *entire* proposed increase be spent on programs other than clinical reproductive health services. Specifically, language contained in the passback calls for every penny of that increase to be spent on programs to involve males or to promote abstinence among non-sexually active teens. Even given low inflation, this proposal to level fund women's health services effectively constitutes a cut.

Moreover, the impact of this proposed cut would be compounded by increasing service costs, further hampering clinics' abilities to effectively serve women. Right now, rates of chlamydia are skyrocketing among teens and excellent but expensive urine-based tests to screen for certain sexually transmitted diseases have come onto the market. In addition, new technologies such as the ThinPrep Pap test, and long-acting methods of contraception, such as Depo-Provera and Norplant have the potential to expand the health care options of women served at Title X clinics, but still remain out of the reach of many Title X providers. We believe that this proposal will therefore weaken the clinic

infrastructure and reduce access to basic health care services for the growing ranks of low-income Americans who are uninsured or underinsured.

Although supporters of Title X recognize the value of additional programs dedicated to involving males, as well as the value of postponing sexual involvement, we question the wisdom of funding these programs at the expense of Title X—an already cash-strapped program that is one of the vital safety nets for health care in this country. In the case of male involvement, many Title X providers *already* operate such programs. However, the separate programs funded in recent years through the Office of Family Planning have not even required linkage to the existing clinic system to provide reproductive health services to those who need them. In addition, it is our understanding that a proposal is being developed with HHS that calls for a vastly expanded new male involvement program that would establish an entirely *separate* health care system within community-based organizations that have not historically provided health services.

Title X is, first and foremost, a *family planning* program. While Title X providers discuss abstinence with patients when appropriate, abstinence-specific dollars are made available through the Adolescent Family Life program. In addition to the $17 million allocated for FY 1999 for the Adolescent Family Life program, the federal government will spend close to $50 million per year to implement the abstinence-only programs required by the 1996 welfare reform legislation.

We would like to schedule a meeting as soon as possible to continue our discussion on how best to advance a women's health agenda for the coming year.

Sincerely,

Judith M. DeSarno, National Family Planning and Reproductive Health Assn.

Marsha Greenberger, National Women's Law Center

Jacquelyn Lendsey, Planned Parenthood Federation of America

Kate Michelman, National Abortion and Reproductive Rights Action League

Cory Richards, The Alan Guttmacher Institute

Nancy Zirkin, American Association of University Women

NATIONAL
FAMILY
PLANNING &
REPRODUCTIVE
HEALTH
ASSOCIATION

December 9, 1998

Denese Shervington, M.D., M.P.H.
Deputy Assistant for Population Affairs
4340 East West Highway, Suite 200
Bethesda, MD 20814

Dear Dr. Shervington:

Thank you for meeting with representatives from the National Family Planning and Reproductive Health Association on November 18, 1998. As a first step in our mutual commitment to ongoing communication, we are requesting information regarding implementation of legislative language included in the introductory paragraphs to section 101(f) of the omnibus spending bill (P.L. 105-277) passed by Congress on October 19. This language incorporates by reference a provision included in Senate Report 105-300 that mandates the following:

> In order to assure that all low-income women have access to comprehensive family planning services, the Committee expects that no less than 90 percent of the total Title X appropriation must be allocated to the regional offices to be awarded to grantees who provide clinical family planning services as defined by law.

The language further provides that all funds available for family planning services be made available no later than 60 days (December 18, 1998) after passage of the bill. This timely release is especially vital to grantees whose funding cycles begin on January 1.

For FY 1999, total funding for the Title X family planning program is $215 million, with 90% totaling $193.5 million. We would appreciate receiving, prior to the Congressional deadline of December 18, 1998, a funding breakdown reflecting the dollars actually allocated to each of the ten regions. If that total is less than $193.5 million, we would like to know the release date for the remaining funds.

Thank you very much for your assistance with this matter which is of critical importance to the provision of family planning to low-income clients.

Sincerely,

Judith M. DeSarno
President/CEO

Margie Fites Seigle
Chairperson
National Family Planning and
Reproductive Health Association

Gloria Feldt
President, Planned Parenthood
Federation of America

Joanne Baker
Chair, State Family Planning Administrators

Frank Bonati
Chair, Family Planning Councils of America, Inc.

Enclosures
cc: The Honorable Donna Shalala

Background on Title X Funding
FY98 and FY99 increases

Our national rate of unintended pregnancy is on the decline, in part due to the availability of clinical reproductive health services to low-income Americans through the title X family planning clinic network and in part because of the introduction of long-acting methods of contraception. At the same time however, our national rate of sexually transmitted disease remains extraordinarily high. The Title X system is facing severe financial pressures and continues to serve as a critical provider of primary care services to uninsured and underinsured Americans. Title X clinics are increasingly unable to make long-acting methods of contraception available to all women who need them, to use new pap technologies critical for services to at-risk populations nor new urine-based screening tests for sexually transmitted infections for men and women. For example, chlamydia, remains the most commonly reported infectious disease in the U.S. and it is assumed that half of new cases occur among men. In addition, it is critical to retain the nurse practitioners who serve as the backbone of the system.

For the past two fiscal years, overall increases to the Title X program have not translated into the same percentage increase in funding for clinical services. While the providers of family planning and reproductive health services did not expect to receive the entire program increase, there was widespread expectation both among the Title X providers, the advocates of women's health and Congressional supporters that this key infrastructure would see some relief from the escalating costs of providing clinical services. In addition, as Title XX of the SSBG was drastically cut, it was hoped that for those states which relied heavily on Title XX funds to provide family planning services, that the increase would help offset those devastating cuts. (This was particularly true in Pennsylvania as articulated by Senator Specter.)

In FY98, Title X funding was $203 million - a $5 million increase over FY97. the clinical service delivery program did not receive the same increase as the program increase. At that time, a nearly $2 million new male involvement program was introduced that with few exceptions ignored the male-oriented programs that were sponsored by the Title X provider network with or without the use of Title X funds. No requirement was made that these new male involvement grants be linked with Title X clinical service programs.

Thus far in FY99, the federal health regions have only a 3% increase, despite the program overall increase of 5%, with no provision that even the 3% increase be passed along to the clinical service program.

Therefore, while the program has received increases over the past two appropriation cycles, the clinical provider network has been effectively level-funded and when the increased costs of contraceptives, better screening devices for cervical cancer and sexually transmitted infections are taken into account, they have actually lost ground.

Conference agreement compared with:	
New budget (obligational) authority, fiscal year 1998	−3,842,000
Budget estimates of new (obligational) authority, fiscal year 1999	−162,506,000
House bill, fiscal year 1999	+616,147,000
Senate bill, fiscal year 1999	+447,945,000

SECTION 101(f): DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 1999

The conferees on H.R. 4328 agree with the matter inserted in this subsection of this conference agreement and the following description of this matter. This matter was developed through negotiations on the differences in the House and Senate versions (H.R. 4274 and S. 2400) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, by members of the appropriations subcommittee of both the House and Senate with jurisdiction over H.R. 4274 and S. 2440.

In implementing this agreement, the Departments and agencies should comply with the language and instructions set forth in House Report 105–635 and Senate Report 105–300. In the case where the language and instructions specifically address the allocation of funds, the Departments and agencies are to follow the funding levels specified in the Congressional budget justifications accompanying the fiscal year 1999 budget or the underlying authorizing statute and should give full consideration to all items, including items allocating specific funding included in the House and Senate reports. With respect to the provisions in the House and Senate reports that specifically allocate funds, each has been reviewed and those which are jointly concurred in have been included in this joint statement.

The Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act, FY 1999, put in place by this bill, incorporates the following agreements of the managers:

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

The conference agreement appropriates $5,272,324,000, instead of $4,000,873,000 as proposed by the House and $5,409,375,000 as proposed by the Senate.

The agreement includes language inserting a legal citation to the Workforce Investment Act of 1998 as proposed by the Senate to fund a specific project authorized by the new law. It also includes language proposed by the Senate modified to identify funds for youth job training activities, making the funds available for the period April 1, 1999 through June 30, 2000, and specifying an amount and a legal citation for youth opportunity grants. It includes language proposed by the Senate providing that job training funds may be used for transition to, and implementation of, the provisions of the Workforce Investment Act of 1998. The House had no similar provisions.

The agreement also i
demonstration funds unde
Act (dislocated workers) fo
entrants in the workforce
the Senate. It also include
ing service delivery areas t
training and summer youth
ernor. The House had no si

The conference agreem
priation of $250,000,000 fo
ate for youth opportunity g
$250,000,000 for fiscal yea
proposed by the Senate and
Funding for fiscal year 20
2000 appropriations bill.

The Labor Department
and provide technical assist
emy Demonstration Progra

The conference agreeme
the following projects and ac

Dislocated Workers

—$5,000,000 for Special
—$1,500,000 for Special
—$500,000 for a high-te
land of Maui in Hawaii
—$500,000 for the Bethe
to provide high technology
Natives
—$1,000,000 for U. of
retraining
—$1,000,000 for the Iow
—$1,000,000 for Twin C
Worklink to plastics employ
—$1,000,000 for the Yor
—$1,000,000 to continue
—$300,000 ($900,000 o
quate performance), for a d
the University of Wisconsin-
Studies Center.

Native Americans

—$4,000,000 for co-loca
Workforce Investment Act of

Pilots and Demonstrations

—$3,000,000 for Samoa
—$675,000 for the Sout
Job Training Program
—$2,500,000 for trainir
adults in Hawaii
—$1,250,000 for Ilisaqui
—$250,000 for Koahni
Alaska

and to ensure, as much as possible, that no individual with HIV receives suboptimal therapy due to the lack of health care provider information.

Family planning

The Committee recommends $215,000,000 for the title X family planning program. This is $3,077,000 below the administration request and $12,097,000 above the 1998 level. Title X grants support primary health care services at more than 4,000 clinics nationwide. About 85 percent of family planning clients are women at or below 150 percent of poverty level.

Title X of the Public Health Service Act, which established the family planning program, authorizes the use of a broad range of acceptable and effective family planning methods and services. The Committee believes this includes oral, injectable, and other preventive modalities.

The Committee remains concerned that programs receiving title X funds ought to have access to these resources as quickly as possible. The Committee, therefore, again instructs the Department to distribute to the regional offices all of the funds available for family planning services no later than 60 days following enactment of this bill.

The Committee is pleased with recent data indicating a reduction in the rate of teenage pregnancy in the United States. In order to assure that all low-income women have access to comprehensive family planning services, the Committee expects that no less than 90 percent of the total title X appropriation must be allocated to the regional offices to be awarded to grantees who provide clinical family planning services as defined by law.

Rural health research

The Committee recommends $11,713,000 for the Office of Rural Health Policy. This is $57,000 more than the fiscal year 1998 level and $22,000 above the administration request. The funds provide support for the Office as the focal point for the Department's efforts to improve the delivery of health services to rural communities and populations. Funds are used for rural health research centers, grants to telemedicine projects, the National Advisory Committee on Rural Health, and a reference and information service.

Health care facilities

The Committee provides $30,000,000 for health care facilities, which is $2,043,000 above the 1998 level and $30,000,000 above the administration request. Funds are made available to public and private entities for construction and renovation of health care and other facilities.

Sufficient funds are available to contribute to the construction of a pediatric dental facility serving medically underserved inner city neighborhoods. The Committee is aware that the University of Pennsylvania School of Dental Medicine has many meritorious characteristics that make it well-suited for this important task, and urges the full and fair consideration of its proposal.

Funds are also available to contribute to the upgrade of existing facilities dedicated to women's health that emphasize support of homeless and medically underserved women. The Committee is aware that Magee-Womens Hospital of Pittsburgh, PA, is one of a few specialty hospitals in the country providing services exclusively for women and infants, and urges that its proposal receive full and fair consideration.

Funds are available to contribute to the upgrading of an osteopathic facility dedicated to medically underserved areas in an inner city area. The Committee is supportive of the efforts of the Philadelphia College of Osteopathic Medicine and urges its proposal receive high priority in funding.

Funds are available to contribute to the modernization and upgrade of a medium-sized medical facility that coordinates health services within a county. The Committee is supportive of the proposal by the Fulton

Title X mtg

- regns: 10 – 4,500 clinics 1970 created
- 5 mil clients/yr.
- 30% under 20 | 220-224

since 1985 – unauthorized

means testing/evaluative/block granting attempts

C. 50/50 → State run/CBO

Purpose of Act

1. services
2. research – fam plan. – population research
3. admin supervision of services/research
4. public – non profit planning
5. info/materials – pop growth/fam plan
6. evaluation
7. training manpower
8. central ofc

Ofc of Public Health & Science

organizationally – research no research on methods – NIH

budgetarily – HRSA

5 yr strategic plan –

Make improvement –

6 priorities of strategic plan: (1) assure healthy start (2) pers. resp (3) elim racial disparities (4) enhance mental health (5) awareness – global health concerns (6) safety and health supply (6) [illegible]

OPA:

- research
- networking, coalition, partnership
- communication

Methods: Health - child:

Health stat - ↑ % w/m - programs are intended

tighten research - natl policy - delivery of repro health services

partnerships

Personal resp:

↑ opp - role red. educat - hard to reach target and - males, young people.

strengthening infrastructure

Elim. racial disparities:

↓ incl HIV / AIDS - disp. affect racial minorities

Male initiative:

resurgence of interest

leg demand - males - more resp

STD / HIV infection rates - male control strategy

research - limited - role of male imp.

Carter - male

fed attention - welfare leg

fatherhood initiative - promote father w/ info, resp fatherhood

postpone it - until ready to risk

Teen pregnancy reduction - adolescent boys / men.

state level - fatherhood initiative

male involvement in US - less than optimal
where to deliver
· traditional clinics - hasn't been so effective
· male repro health - question remain.

OFP in OPA
male initiative - 3 yrs ago -
small amount - to 10 regions - demos
↑ male resp - repro health - enhance futures.
① hire 1 or more male interns. in a clinic -
regional admin
② 1½ ago RFA - 10 involvement research grants
· research authority
- just gone into 2nd yr - funding
dev, imp. & test approaches. - how to deliver & what.
emph - dev services in settings that
provide other services → CBO - bring fam planning to where
males already
③ longer range plans - planning stages -
w/ outside grps.
explore current research/
expand fam plan networks
sup community based networks - males
partnering w/ them.

Boston - T.Rex
4 of CA - grant
direct linkage
Something - CBO - health based
linkage

10 and above pastor

239, sr

Internal Budget Documents
HHS Request / OMB passback

Family Planning Program

Authorizing Legislation--Title X, Section 1001 of the Public Health Service Act.

	FY 1998 Budget	FY 1999 President's Budget	FY 1999 House	FY 2000 Estimate
BA	$202,903,000	$218,077,000	$202,903,000	$253,113,000
FTE	42	42	42	46

FY 2000 Authorization.....Expired

RATIONALE FOR BUDGET REQUEST

The FY 2000 request of $253,113,000 is an increase of $35,036,000 over the FY 1999 President's budget and $50,210,000 over the FY 1999 House level. This proposed increment will further strengthen the Title X health infrastructure for families, women and adolescents, as well enable the program to continue providing a comprehensive range of family planning services and to better meet the increasing demand for these services. The proposed increment will enhance partnerships with other health and social service organizations. It will allow an expansion of services to hard to reach populations, including males and adolescents, as well as research on the mix of services most appropriate and effective for these populations. The program will continue its quest for newly developed technologies aimed at improving its ability to function efficiently and effectively.

cont↑-cut-

Investment in family planning services is essential in averting unintended pregnancies which are costly, in both human and dollar terms, to society. Both the Administration and the Department have clearly targeted adolescent pregnancy prevention and male responsibility in preventing unintended pregnancy as major policy issues. Effective pregnancy prevention efforts must include men and adolescent boys, as well as women and adolescent girls. Moreover, particularly in the case of adolescents, these efforts should not only provide education and services but also expand opportunities for their futures. Although the program is already working in these areas, this proposed increment will substantially expand existing initiatives.

- Increasing the program's ability to reach adolescents before they become sexually active and providing interventions to encourage continued postponement greatly enhance the potential for reducing adolescent pregnancy.

- Further expanding male involvement initiatives which provide family planning/reproductive health education and services to young men:

  Supporting additional demonstration projects designed to employ young men from the surrounding community while providing them with job training, career counseling and family planning education, counseling and services.

Supporting community-based organizations in developing, implementing and testing family planning education and service components for inclusion in programs that provide other health, education and social services to young males.

- Current and ongoing advances in electronic communication technologies (distance learning) will be used to increase the efficiency and effectiveness of the Title X health infrastructure.

The Title X Family Planning Program will continue its focus on providing family planning and reproductive health services through existing program priorities:

- increasing outreach to persons not likely to seek services, including males and adolescents;

- emphasis on comprehensiveness of reproductive health services, including STD and cancer screening and prevention, HIV prevention, education and counseling,
increased involvement of male partners, substance abuse screening and referral;

- emphasis on services to adolescents, including community education, emphasis on postponement of sexual activity, and more accessible provision of contraceptive counseling and services for those adolescents who are sexually active;

- elimination of disincentives to provide high cost but effective contraceptives to serve high risk (and high unit cost) clients, and to provide non-revenue generating services such as community education and prevention services; and

- emphasis on activities involving women's health nurse practitioners particularly minority nurse practitioners and nurse practitioners serving disadvantaged and medically underserved communities.

Outputs:

	FY 1998 Enacted	FY 1999 President's Budget	FY 2000 Estimate
No. of Service Grantee	83	83	95
No. of Clinics	4,790	4,790	4,950
Clients Served	5,050,000	6,135,000	7,135,000
Community Partnership Projects:			
No. Male Initiative Grants	10	15	25
No. Other Hard to Reach Population Grants	25	35	50
Service Delivery Improvement Grants	4	8	12

OMB PASSBACK NOTES -- FAMILY PLANNING

Family Planning. OMB staff stated that the FY 2000 passback level for HRSA includes $229.952 million for Family Planning activities at HRSA, an increase of $14.952 million (+7%) over the FY 1999 enacted level. OMB concurred with HHS' proposal to expand and augment the following two existing initiatives: 1) reaching adolescents before they become sexually active; and 2) expanding "male involvement" grants that provide family planning services to young men.

December 10, 1998

MEMORANDUM

TO: **Elena**
FROM: **Nicole**
SUBJECT: **Title X Update**

Following my e-mail to you yesterday about funding for Title X in the FY 2000 budget, I spoke with Judy Appelbaum at the National Women's Law Center, who raised a recent concern shared by a variety of women's advocates and outlined in an attached letter to Sylvia Matthews. In the letter, the advocates state that it is their understanding that the Administration intends to devote the entirety of our FY 2000 Title X increase of $15 million to programs other than clinical reproductive health services, planning instead to expand efforts that involve males or promote abstinence among non-sexually active teens. The advocates naturally object strongly to this strategy, but it is not in fact our position.

In its budget justification document, HHS did single out these programs as warranting added dollars, but also recommended that the increase be used to augment the delivery of clinical reproductive health services. In its passback notes, OMB concurred with HHS' recommendation, writing:

> OMB staff stated that the FY 2000 passback level for HRSA includes $229.952 million for Family Planning activities at HRSA, an increase of $14.952 million (+7%) over the FY 1999 enacted level. OMB concurred with HHS' proposal to expand and augment the following two existing initiatives: 1) reaching adolescents before they become sexually active; and 2) expanding "male involvement" grants that provide family planning services to young men.

It is clear that the women's groups obtained this passback language and read it as targeting the totality of our recommended increase to these two programs. I spoke with the Title X budget examiner at OMB, who stressed that this was not OMB's intention. OMB then spoke with the HHS budget staff, who said that they also did not read the passback language in that way.

The women's groups, however, may oppose targeting any new dollars to these purposes, given the great need for the basic services that Title X provides and given that these other efforts are supported through a number of other funding streams. Further, the women's groups will likely urge a greater budget commitment to Title X. OMB points out, however, that HRSA, which administers Title X, was cut as a whole, and Title X was one of only two programs that received any increase in HRSA's budget.

I called Marsha Greenberger to discuss this, but have not yet reached her. My view is that

we should touch base soon with one of the signatories to the letter, explain that the advocates misunderstood the passback language, and gauge their level of opposition to targeting any of the new funding to the programs suggested by HHS. Please let me know if you would like to handle this; otherwise, I will try to reach Marsha next week.

Attachments
12/9/98 letter to Matthews
HHS Title X budget justification
OMB Title X passback
12/9/98 e-mail

December 9, 1998

Ms. Sylvia Mathews
Deputy Director, Office of Management and Budget
Room 252
Old Executive Office Building
Washington, DC 20503

Dear Sylvia:

Thank you again for meeting with the undersigned representatives of national women's organizations on November 25th. We are writing to express our continued concern that the Administration's budget request for Title X remains low. Further, we would like to call your attention to an additional problem involving family planning funding that we have learned of since our meeting.

As you recall, we discussed the proposed funding level for the Title X family planning program and learned that the Office of Management and Budget had included an increase of $14.9 million for the program for FY 2000, for a total proposed funding level of just under $230 million. This falls far short of the HHS requested increase of $38 million, which itself did not meet the needs of the program. We request that you find additional funds to support these basic clinical reproductive health services for women funded by the Title X program before the President's Budget is finalized.

Since our meeting, we have learned that the OMB passback also included language drafted by HHS which directs that the *entire* proposed increase be spent on programs other than clinical reproductive health services. Specifically, language contained in the passback calls for every penny of that increase to be spent on programs to involve males or to promote abstinence among non-sexually active teens. Even given low inflation, this proposal to level fund women's health services effectively constitutes a cut.

Moreover, the impact of this proposed cut would be compounded by increasing service costs, further hampering clinics' abilities to effectively serve women. Right now, rates of chlamydia are skyrocketing among teens and excellent but expensive urine-based tests to screen for certain sexually transmitted diseases have come onto the market. In addition, new technologies such as the ThinPrep Pap test, and long-acting methods of contraception, such as Depo-Provera and Norplant have the potential to expand the health care options of women served at Title X clinics, but still remain out of the reach of many Title X providers. We believe that this proposal will therefore weaken the clinic

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infrastructure and reduce access to basic health care services for the growing ranks of low-income Americans who are uninsured or underinsured.

Although supporters of Title X recognize the value of additional programs dedicated to involving males, as well as the value of postponing sexual involvement, we question the wisdom of funding these programs at the expense of Title X—an already cash-strapped program that is one of the vital safety nets for health care in this country. In the case of male involvement, many Title X providers *already* operate such programs. However, the separate programs funded in recent years through the Office of Family Planning have not even required linkage to the existing clinic system to provide reproductive health services to those who need them. In addition, it is our understanding that a proposal is being developed with HHS that calls for a vastly expanded new male involvement program that would establish an entirely *separate* health care system within community-based organizations that have not historically provided health services.

Title X is, first and foremost, a *family planning* program. While Title X providers discuss abstinence with patients when appropriate, abstinence-specific dollars are made available through the Adolescent Family Life program. In addition to the $17 million allocated for FY 1999 for the Adolescent Family Life program, the federal government will spend close to $50 million per year to implement the abstinence-only programs required by the 1996 welfare reform legislation.

We would like to schedule a meeting as soon as possible to continue our discussion on how best to advance a women's health agenda for the coming year.

Sincerely,

Judith M. DeSarno, National Family Planning and Reproductive Health Assn.

Marsha Greenberger, National Women's Law Center

Jacquelyn Lendsey, Planned Parenthood Federation of America

Kate Michelman, National Abortion and Reproductive Rights Action League

Cory Richards, The Alan Guttmacher Institute

Nancy Zirkin, American Association of University Women

[redacted]

Nicole R. Rabner

12/09/98 03:14:47 PM

Record Type: Record

To: Elena Kagan/OPD/EOP

cc:
Subject: Title X

Title X family planning seems to be in fairly good shape. First, the history:

FY98 Enacted	FY99 Request	FY99 Enacted
$203 mil	$218 mil	$215 mil

This year's OMB/HHS budget negotiations:

FY00 HHS Request	FY00 Passback
$253 mil	$230 mil

While OMB did not grant HHS its full requested increase for Title X, the passback does represent a 7 percent increase over the FY99 enacted level and the same dollar increase ($15 million) that we requested for FY99. HHS has not appealed the passback -- in large measure because the Health Resources and Services Administration (HERSA), which administers Title X, was cut in other, unrelated areas. In fact, Ryan White and family planning were the only two HERSA programs that were given any increase in passback. HHS/HERSA plans to spend any Title X increase in three areas: (1) augmenting current programs; (2) targeting adolescents before they become sexually active, and (3) strengthening male responsibility.

I understand that Sylvia Mathews met with the women's groups the day after passback, and the women's groups were already aware of the passback level. While they did press Sylvia for a larger increase for family planning, they were pleased with our continued commitment to increasing the program.

- CTs piece
- PRC memo
- Metzenbaum ltr
- Title X

→ $ for monitoring –
- set aside for monitoring NPRM (?)

IV E - defined concept / funding channels *

98
99

won those increases
5% increased each

clinic health services
80% – spent on services
to men & wm → not received 5%
last yr – didn't
to health region 2 or 3 %

not w/ sup of fund / advocacy community
function

delib. decision not to give those $ – using other $

male services
sep clinic services – for males – excludes Title X – fam planning

abstinence –

38 mil

new projection -
1 mil told → 2 mil ended up.

25 - esoteric
about.

Hr. this year.

\# language
- enormous problem -
incl. males - ufo
Title X. …

98 - new male involvement

not reg- to[illegible].

Title X - dollars
Office of F Planning -
new DAS.
move forward - 4 yrs -
build male involvement
system
excludes Title X clinical comp.

wage a fight knowing
lang. that is in there -
sets us up
1 mil - self-esteem - mentoring -

link w/
Title X -
some clinical
services
(some)

language -
find some
creative here.

services to men & women -
Title X framework.

lower unintended pre.
morbidity

deliver
first rate
care

reprod. healthy … choose to become
pregnant

Specter - 90% - regions by Sec 18 & 90% - clinical
services

purpose of program -
wk to do
STD - women & men, $ used to assure
mmm - make sure males are
included.

- Dr. Satcher
- Sam Taylor Fam Planning.

abstinence - is not one.

where dollars given out
Dr Shirrington - v. devoted - Cancer home -
looks at it like dev prog.

beating down - successes -
Advance with health.

ex fam - decide if & when to become politically

talking about - budget justify
approach I say

recog the higher costs of care

Sup staff qualityservices for men & women within
Title X system

1998

203 mil ; 10 regional

89% - services to grantees clinical an
left to their discretion contrac

11% w/in ofc of Pop Affairs
1% - evaluate
2.5% - pop operations (grantees o
.5% - info & ed.
rest - training & research
less than 1% - young adolescents
less than 1% - male resp

99

% to regions - 91% regionals

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION

FACSIMILE TRANSMITTAL SHEET

TO: Nicole Rabner

FROM: Judith DeSano, Pres/CEO

COMPANY: Office of the First Lady

DATE: 12/14/98

FAX NUMBER:

TOTAL NO. OF PAGES INCLUDING COVER:

PHONE NUMBER:

RE: Title X FY2000 Request

☒ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY

NOTES/COMMENTS:

Marcia Greenberger asked that I share this with you.

NFPRHA 122 C Street, NW • Suite 380 • Washington, DC 20001-2109 • TEL: 202-628-3535 • FAX: 202-737-2690 • E-MAIL: info@nfprha.org