Medicaid Family Planning Expansions Hit Stride

Over the last decade, 18 states have expanded eligibility for Medicaid-covered family planning services to large numbers of their residents who would otherwise not be eligible for such care. These states have taken a variety of approaches in their expanded programs, both in regard to the populations they cover and to the specific services they provide. Together, these expanded programs provided critical contraceptive services as well as testing for cervical cancer, sexually transmitted diseases and HIV to 1.7 million clients in FY 2001, with 1.3 million served in California alone.

By Rachel Benson Gold

In the early years of the joint federal-state Medicaid program, eligibility was limited largely to low-income, single mothers and their children who were receiving welfare. In the 1980s, however, Congress broke the welfare-Medicaid link for pregnancy-related services by first allowing and later requiring states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care to women with incomes up to 133% of the federal poverty level—far above most states' regular Medicaid income-eligibility ceilings. At their option, states could expand eligibility for pregnancy-related services to women with incomes up to 185% of poverty and even beyond.

Over the last decade, several states have built on this history to expand Medicaid eligibility for family planning services as well. Unlike the increases for pregnancy-related care, which are specifically provided for in the federal statute, these expansions require approval—generally referred to as a "waiver"—from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid.

Medicaid waivers are generally given to allow for research and demonstration efforts that test innovative approaches to Medicaid coverage. As such, they entail a lengthy federal review process and include extensive evaluation components. Waivers are usually granted for five years, although they may be renewed at CMS's option.

Evolving Federal Requirements

Under the Medicaid statute, waivers must be "budget neutral" to the federal government (that is, federal spending under a waiver cannot exceed what federal spending would have been without a waiver). States that have obtained these waivers have successfully argued that the cost of providing family planning services and supplies to individuals under the program pales in comparison to the cost of providing pregnancy-related services to recipients who would otherwise become pregnant and eligible for Medicaid-funded prenatal, delivery and postpartum care. This is particularly striking since the federal government pays 90% of the cost of providing family planning services and supplies under Medicaid, compared with 50–77% of the cost of other medical services, including pregnancy-related care.

In 2001, the Bush administration instituted a new requirement that family planning waiver programs facilitate access to primary care services. Specifically, states are required to establish formal arrangements with community health centers to provide primary care services to individuals enrolled in the family planning program. In addition, any materials or counseling provided to these enrollees must include information on how to access primary care services from community health centers. The impact of providing these referrals must be included in the state's evaluation of its family planning waiver program ("Administration Softens Stance on Medicaid Family Planning Waivers," *TGR,* October 2001, page 13). Since that policy change became effective, five waivers have been approved, including one that had been submitted by Department of Health and Human Services Secretary Tommy G. Thompson when he was governor of Wisconsin.

Varied Approaches

In general, the states' various family planning waivers have taken one of three approaches. The first built directly on the expansions for pregnancy-related care, which allow states to provide Medicaid-funded family planning services and supplies for 60 days after a woman gives birth as part of postpartum care. Led by Rhode Island and South Carolina in 1993, six states have obtained federal approval to continue family planning, generally for two years postpartum, although Maryland provides coverage for five years after delivery (see table, page 12).

Delaware and Illinois (the latest state to have a waiver approved by CMS) varied this approach somewhat and continued Medicaid coverage for family planning for individuals leaving the Medicaid program for any reason, not just following childbirth.

Some states have taken a considerably bolder approach by seeking to extend Medicaid coverage for family planning services to residents not previously covered under the program. Beginning with Arkansas and South Carolina, 10 states have received federal permission to expand their income-eligibility levels for Medicaid-covered family planning services up to at least the eligibility level in place for Medicaid-covered maternity care.

Waiver programs provide a broad package of services to enrolled individuals. For example, Alabama's program, known as Plan First, covers an initial visit, periodic visits, counseling and education, testing for cervical cancer and sexually transmitted diseases (STDs), pregnancy testing, HIV counseling, contraceptive services and supplies, and sterilization services. According to the state, the direct services are augmented with psychosocial assessment for all enrollees and case coordination for high-risk or at-risk women.

Significantly, four waiver programs—in California, New York, Oregon and Washington—provide coverage to men as well as women. (The pending waiver application from Minnesota also includes men.) For the fiscal year 2001–2002, 12% of the California program's clients were men, compared with 4% during the program's first year of operation, according to statistics provided by the state Office of Family Planning.

Whereas most of the waivers cover all recipients of reproductive age, the programs in Alabama and Illinois only cover women who are 19 or older. The waiver application pending from North Carolina would also only cover individuals who are at least 19. Legislation to restrict the Wisconsin waiver to individuals 19 and older was soundly defeated by both houses of the state legislature in late September.

MEDICAID FAMILY PLANNING WAIVERS

State	Basis for Eligibility			Target Population Includes Men	Limited to Individuals ≥19	Waiver Expiration Date
APPROVED	Losing Coverage Postpartum (length of extension)	Losing Coverage For Any Reason (length of extension)	Based Solely on Income (eligibility ceiling as % of poverty)			
Alabama			133%		X	9/30/2005
Arizona	2 Years					9/30/2006
Arkansas			133%			1/31/2006
California			200%	X		11/30/2004
Delaware		2 Years				12/31/2003
Florida	2 Years					8/31/2003
Illinois		5 Years			X	*
Maryland	5 Years					5/31/2005
Mississippi			185%			*
Missouri	1 Year					3/1/2004
New Mexico			185%			6/30/2003
New York			200%	X		3/31/2006
Oregon			185%	X		9/30/2003†
Rhode Island	2 Years					7/31/2005
South Carolina			185%			12/31/2004
Virginia	2 Years					9/30/2007
Washington			200%	X		6/30/2006
Wisconsin			185%			12/31/2007
Total in Effect	**6**	**2**	**10**	**4**	**2**	
PENDING						
Colorado			150%			
Minnesota			275%	X		
North Carolina			185%		X	
Oklahoma			185%			
Total Pending			**4**	**1**	**1**	

Waiver has been recently approved; expiration will be five years from date of implementation. †Extension pending with Centers for Medicare and Medicaid Services.

The California Story

Family planning waivers have brought coverage for family planning to many in need. Of the 13 states that had waiver programs operating in FY 2001, 12 were able to provide data to The Alan Guttmacher Institute on the number of enrollees served. Together, these states reported 1.7 million clients, nearly 1.3 of whom were served in California (see table). The seven states that could provide expenditure data reported spending $71 million under their waiver programs, two-thirds of which was spent in California.

The California program, known as Family PACT, is unique among the state waiver efforts. It was initiated in 1997, when the state created an entitlement to family planning for all residents with incomes up to 200% of poverty. Initially, the effort was funded entirely with state dollars, but in 1999, California submitted and received approval for a Medicaid waiver, making the program eligible for federal reimbursement.

In addition to its generous eligibility and the fact that it serves both women and men, Family PACT includes a unique feature designed to address a long-standing and widely acknowledged problem in Medicaid—its cumbersome and time-consuming enrollment process. Historically, enrolling in Medicaid often entailed applying in person at the local welfare agency, something that has long been considered a significant deterrent. Under Family PACT, enrollment occurs at the point of service, obviating the need for a client to make multiple visits and avoiding the stigma of an association with welfare. Instead, family planning providers use information from the client to determine eligibility; eligible clients are then issued a Health Access Program card that enables them to access services.

Clients served through Family PACT also receive a wide range of services. According to the state Office of Family Planning, more than seven in 10 clients served through the program in FY 2001–2002 received contraceptive services, six in 10 received STD testing and over half were tested for cervical cancer. In that year, the program provided 3.4 million STD tests.

Data from the program's first year alone show a dramatic impact ("California Program Shows Benefits of Expanding Family Planning Eligibility," *TGR,* October 2000, page 1). In the last year in which the program was funded entirely with state dollars (FY 1997–1998), Family PACT provided contraceptive services and supplies to 642,000 women and 28,000 men. Prior to their first Family PACT visit, a third of contraceptive clients were either using a low-efficacy contraceptive method (such as withdrawal or periodic abstinence) or no method at all; after their visit, 95% were using an effective contraceptive method (such as barrier or hormonal methods). Four in 10 clients left with a more reliable contraceptive method than the one they had been using before their Family PACT visit.

CLIENTS SERVED IN MEDICAID FAMILY PLANNING WAIVER PROGRAMS, 2001

State and Type of Waiver	Number Served
Postpartum	
Arizona	15,131
Florida	18,854
Maryland	23,301
Missouri	u
Rhode Island	935*
Leaving Medicaid for Any Reason	
Delaware	879
Income Based	
Alabama	63,767
Arkansa	44,773
California	1,270,000
New Mexico	21,951*
Oregon	81,610
South Carolina	62,238
Washington	73,108
Total	**1,676,547**

*Data are number of clients enrolled in program, not actually served. *Note:* u=unavailable. *Source:* Unpublished data from FY 2001 Survey of State Medicaid Agency Expenditures on Reproductive Health Services, AGI: New York, 2003; and data from Florida are from Centers for Medicare and Medicaid Services.

By comparing the contraceptive methods used prior to Family PACT with those obtained through Family PACT, researchers from the University of California at San Francisco estimate that in its first year of operation, the program prevented 108,000 unintended pregnancies, 24,000 of which would have been to teens. By preventing these pregnancies, the program helped women in California avoid a total of 41,000 abortions, 9,000 of which would have been to teens.

In that year, Family PACT spent $114.4 million on direct client services, including pregnancy prevention, as well as on other care provided under the program; however, the pregnancies averted as a result of the program's operation would have cost $511.8 million in medical, social services and education costs. Thus, every dollar spent through Family PACT saved an estimated $4.48 in public expenditures, according to the researchers.

Next Steps

In 1999, then-Sen. John Chafee (R-RI) and several of his colleagues introduced legislation that would give states the authority to expand Medicaid eligibility for

family planning without having to go through the cumbersome process of obtaining a federal waiver. Chafee had been impressed by data from the Rhode Island waiver program showing that in addition to being highly cost effective, the program helped reduce the number of women becoming pregnant shortly after giving birth—a well-established risk factor for low birth weight that is itself a major cause of infant mortality. According to health officials, the proportion of women in Rhode Island with Medicaid-funded deliveries becoming pregnant within nine months of a previous birth was cut nearly in half following the program's implementation. In addition, the difference between the proportion of privately insured women and of Medicaid enrollees with short birth intervals was almost eliminated ("State Efforts to Expand Medicaid-Funded Family Planning Show Promise," *TGR,* April 1999, page 8).

Four years later—and armed with the more recent and equally compelling data from California—Sens. Lincoln Chafee (R-RI), son of the former senator, and Dianne Feinstein (D-CA) are taking the position that these programs have outgrown the waiver system, which is intended to test out innovative approaches and demonstrate their potential impact. That demonstration, they argue, has already been made. To that end, they have reintroduced the Family Planning State Empowerment Act, which would give states the authority to expand Medicaid eligibility for family planning on their own, just as they have had since the 1980s for maternity care. A similar provision is included in the Improving Women's Health Act, which was introduced by Sen. Blanche Lincoln (D-AR) in June.

Chafee and Feinstein contend that their legislation—which has been referred to the Finance Committee—would help level the playing field for lower-income women by providing increased access to family planning to help them prevent an unintended pregnancy and to prenatal and maternity services if they do become pregnant. Chafee and Feinstein also contend that this level playing field would help the federal and state governments—which shoulder much of the cost of the reproductive choices these women make.

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