

## State Efforts to Expand Medicaid-Funded Family Planning Show Promise

*In recent years, a number of states have sought and received federal permission to provide Medicaid-financed family planning services and supplies to lower income, uninsured residents whose incomes are above the state's regular Medicaid eligibility ceilings. These initiatives are beginning to show results, raising the question of whether states should be allowed to expand Medicaid eligibility for family planning on their own, as they already are allowed to do for maternity care.*

**By Rachel Benson Gold**

Half of all public dollars for family planning services and supplies in the United States are spent through the Medicaid program. Under this critically important source of family planning support, the federal government and the states share the cost of serving eligible individuals, with the federal government contributing nine dollars for each one dollar states spend on family planning—a higher federal match than is available for other Medicaid-funded care.

While the cost of serving Medicaid enrollees is shared, it is the states that generally determine eligibility for the program—and state income-eligibility ceilings vary widely across the country. Currently averaging 46% of the federal poverty level, these ceilings range from a low of 15% of poverty in Alabama to a high of 86% in California. (The federal poverty level in 1998 was \$13,650 for a family of three.)

Historically, states' income-eligibility ceilings for Medicaid were identical to those for welfare cash assistance. In fact, families were automatically enrolled in Medicaid by virtue of their qualifying for welfare (which, for adults, means being very poor *and* disabled, pregnant, elderly or in a family with dependents). Through a series of initiatives in the 1980s expanding Medicaid eligibility for maternity care, however, this historic link between Medicaid and welfare eligibility was broken; at least for maternity care, a woman's family income became the sole qualifying factor.

Eventually, Congress established a nationwide federal floor for Medicaid eligibility for pregnant women. In all states, pregnant women with incomes up to 133% of the federal poverty level became eligible for Medicaid-funded prenatal, delivery and postpartum care. States were given permission to extend eligibility to 185% of poverty at their discretion.

Under the maternity care expansions, an “expansion” woman (that is, a woman whose family income is too high to qualify her for regular Medicaid but below the ceiling for maternity care) remains eligible for care throughout her pregnancy and for 60 days postpartum, during which time family planning services may be provided. After that, the woman's coverage ceases.

Over the last several years, 12 states have built on this foundation to extend Medicaid coverage specifically for family planning beyond the 60-day postpartum period. To implement these initiatives, which have taken various forms, states have needed “permission” from the Health Care Financing Administration (HCFA). With data on these efforts starting to come in, some reproductive health advocates are beginning to wonder whether it is time to free states from the need to obtain these so-called federal waivers and give them the authority to establish these programs at their option.

### State Expansions

States have taken two major avenues to expanding eligibility for Medicaid-covered family planning services and supplies (see chart). The first approach, pioneered by Rhode Island and South Carolina in 1993, built directly on the Medicaid expansions for pregnant women.

So far, eight states have obtained federal approval to continue Medicaid coverage for family planning services beyond the regular 60-day postpartum period. Generally, these programs are for about two years postpartum, although Maryland's continues coverage for five years after childbirth. (Two other states, Missouri and Washington, have applications for similar programs pending at HCFA.) Delaware varied this approach somewhat when it received approval in 1996 to continue Medicaid coverage for family planning for two years for women who were losing regular Medicaid coverage for any reason, not just following childbirth.

More recently, some states have taken an entirely different, considerably bolder approach by seeking to extend Medicaid family planning coverage services to women *who had not previously been covered under Medicaid*. Four states have received waivers to bring their income-eligibility levels for Medicaid-covered family planning services up to the eligibility levels in place for Medicaid-covered maternity care. In 1996, HCFA approved a

waiver from Arkansas to provide family planning services to women in the state with family incomes up to 133% of poverty, far above the state's regular Medicaid eligibility level of 25%. More recently, New Mexico, Oregon and South Carolina have received approval to cover all state women with incomes up to 185% of poverty. (Kentucky has a similar application pending.)

(Of these states, South Carolina has shown particular interest in expanding its family planning coverage. In 1993, it became one of the first states to obtain federal approval to extend postpartum coverage. In 1997, it was among the first to expand coverage for all women with incomes up to 185% of poverty, far above its regular level of 18%.)

Meanwhile, building on its long-standing tradition of using *state* funds to serve individuals for whom federal funding is unavailable, California, in 1996, took the dramatic step of creating an entitlement to family planning services for both women and men whose incomes are below 200% of poverty. Unlike the other states' programs, the California effort is funded entirely with state dollars, which made federal approval unnecessary.

### Outreach Efforts and Eligibility Systems

Finding and enrolling eligible individuals in need of family planning services is key to these programs' success, and, clearly, this is much easier in programs designed to serve postpartum women. These women, after all, are already in the Medicaid system and receiving Medicaid-funded care; "converting" their eligibility at the end of the 60-day postpartum period can be a relatively uncomplicated task. In Maryland, for example, the process is seamless, according to Rosemary Murphey of the Department of Health and Mental Hygiene; when a woman's postpartum eligibility is about to lapse, she says, an enrollment card for the family planning system is automatically generated and sent.

States that have adopted purely income-based eligibility standards are likely to find outreach a much more complex issue. Here, they need to locate and enroll individuals who are not currently in the system; some of these women may be resistant to participation in a program because they perceive it to be related to "welfare." This problem is similar to the ones faced by states during the maternity care expansions of the 1980s, as well as under the new State Children's Health Insurance Program (CHIP), which seeks to provide coverage to children in families with incomes well above the usual state-set Medicaid ceilings.

States have taken different approaches to meeting this challenge. New Mexico, for example, decided to incorporate outreach for the new family planning

expansion into a comprehensive media campaign on health care for children and families, according to Gigitte Nieto of the New Mexico Human Services Department. With the assistance of a professional marketing agency and several corporate sponsors, she reports, the state embarked on a large-scale effort that includes television, billboards and materials printed in both Spanish and English.

In contrast, state health officials in Oregon, Arkansas and California say they have relied, at least initially, largely on their current provider network to "get the word out" both to current clients who may not have a source of payment for the care they receive and, via word of mouth, to other potential enrollees as well. In addition, Oregon is designing a large-scale social marketing campaign to be rolled out in the later years of the program. To bolster its outreach efforts, Arkansas is hoping to begin to provide grants to a wide array of existing community groups.

Throughout the design and early implementation phases of its effort, California has worked to make the eligibility and enrollment process as simple as possible and one that, unlike Medicaid eligibility generally, does not require the potential enrollee to have any contact with the state social services agency. Eligibility is determined by the health care provider at the point of service. Any provider who participates in Medicaid (known in California as Medi-Cal) may be involved in the family planning program after being trained by the state. According to the state Office of Family Planning, of the nearly 2,000 providers participating in the program in

#### STATES WITH MEDICAID WAIVERS EXTENDING FAMILY PLANNING COVERAGE

<i>TO WOMEN WHO LOSE MEDICAID COVERAGE...</i>		<i>TO WOMEN SOLELY ON THE BASIS OF INCOME</i>
<i>...AT THE END OF POSTPARTUM PERIOD</i>	<i>...FOR ANY REASON</i>	
ALABAMA (2 YEARS)*	DELAWARE (2 YEARS)	ARKANSAS (133%)
ARIZONA (2 YEARS)		NEW MEXICO (185%)
FLORIDA (22 MONTHS)		OREGON (185%)
ILLINOIS (10 MONTHS)		SOUTH CAROLINA (185%)
MARYLAND (5 YEARS)		
NEW YORK (22 MONTHS)		
RHODE ISLAND (2 YEARS)		
SOUTH CAROLINA (22 MONTHS)		

\**Mobile County only.*

early 1998, about 70% were private physicians in individual or group practices; the remainder were clinics or county health departments.

To become eligible in California, a potential enrollee provides information on income, family size and whether he or she has any other available source of coverage for family planning services. Following the provider's determination of eligibility, an enrollment card is automatically activated on-site; this card may then be used to obtain services or supplies from other participating family planning providers, laboratories or pharmacies. Eligibility is certified annually.

## Rhode Island: A Case in Point

*As one of the earliest programs to begin operation, Rhode Island's is also one of the first efforts to generate data not only on the number of clients enrolled but on the impact of the initiative on pregnancies and births—and costs. The Rhode Island family planning effort was part of a reconfiguration of its entire Medicaid program, known as RIte Care, which expanded income eligibility levels and mandated enrollment in managed care. Birth certificate data allow the state to monitor maternal and child health indicators both before and after the implementation of RIte Care in August 1994.*

*Among these indicators, according to Christine Ferguson, director of human services for the state, was the percentage of women who had private, employment-related health insurance or who received publicly subsidized care who became pregnant again shortly after having given birth. Interbirth interval is a key variable, since having a short interval between births is a well-established risk factor for low birth weight, a major cause of infant mortality in the United States.*

*RIte Care, including the expanded family planning program, appears to be having a dramatic impact on this important variable. In 1993, before RIte Care, 20% of women having Medicaid-funded deliveries in the state had become pregnant within nine months of a previous birth. In 1997, after RIte Care, that percentage was cut almost in half to 11%.*

*Even more striking, according to Ferguson, is the virtual elimination of the difference between privately insured women and Medicaid women experiencing a short interbirth interval. One year before RIte Care, 42% of women having a Medicaid-funded birth became pregnant within 18 months of a previous delivery, compared with 31% of women with private insurance coverage (see chart). Within two years, says Ferguson, the difference between the two populations "virtually collapsed. The speed with which it happened was awesome."*

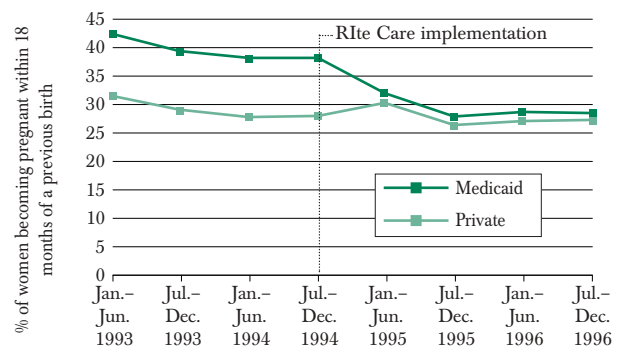
## Program Enrollment

With several of these initiatives operational for a number of years now, data are becoming available on the number of clients served. Although preliminary in many cases, these data indicate that the various state efforts have the potential to reach large numbers of enrollees.

The first programs to be up and running were those designed to extend the time postpartum family planning may be provided to women who were already enrolled in Medicaid as a result of their pregnancies, and data are available from at least two of these states. In Rhode Island, 5,400 women have participated in the program

## IMPROVED BIRTHSPACING

*Difference in interbirth intervals between Medicaid enrollees and women with private insurance virtually disappeared with the implementation of RIte Care*



Source: Rhode Island Department of Human Services.

*Further, the RIte Care experience also demonstrates the cost-effectiveness of providing Medicaid-covered family planning services. From the program's beginning in 1994 through the end of 1997, Rhode Island spent \$5.7 million on RIte Care family planning services, including the expansion program. The state estimates that this effort helped prevent 1,443 deliveries to Medicaid-eligible women during this time period.*

*With the state paying \$5,000 per publicly funded delivery, as well as \$400 per month for each newborn in the first year, prevention of these births avoided an expenditure of \$14.3 million. These data, says Patricia Leddy, administrator of the RIte Care program, "clearly show that our investment in family planning services, which provided mothers in RIte Care with the ability to choose whether and when to have more children, was very cost-effective in saving more than two and one-half times our investment."*

since it began operation in mid-1994, with approximately 1,300 enrolled at any point in time (see box). During the first year of its similar effort, Maryland provided services to nearly 5,000 women, with enrollment increasing by nearly 900 women per month during the first two years of operation.

Data are also just starting to become available from some of the newer, income-based expansions. During just the first three months of 1998, the Arkansas program, which is available to women in the state with incomes up to 133% of the poverty line, served nearly 12,000 enrollees. And in the first six months of its effort, New Mexico served nearly 5,500 women.

The state-funded program in California has enrolled nearly 780,000 individuals since it began in 1997, according to Janet Treat of the state's Office of Family Planning. Unlike many of the other efforts, the California program is open to both men and women, and approximately 5% of enrollees are men. (Under its newly approved waiver, Oregon will also provide services to men, and Washington State is developing a proposal that would include men as well.)

Because nonprofit family planning clinics likely had been providing free or partially subsidized services to many, if not most, of these previously uninsured individuals, the various state expansion programs provide an important source of payment for a clinic system struggling to provide high-quality medical care to their low-income clientele and continue to make available a broad range of contraceptive choices, including the newer, long-lasting—but more expensive—methods (see story, page 1). But, as Jeanne Atkins of the Oregon health department points out, the waiver programs have important, direct benefits for the clients as well.

Prior to the approval of Oregon's waiver, Atkins says, uninsured women with incomes above the federal poverty level were required to pay fees for their care on a sliding scale. By enrolling these women in Medicaid, under which enrollees may not be charged for the family planning services and supplies they receive, the program "will remove the financial barrier of that sliding-fee scale," with significant implications for the client. "People who had been picking up only one or two packs of pills at a time because that's all they can afford will now be able to get 13 packs at a time. That should help reduce gaps in pill use." In addition to facilitating better use of a client's current method, Atkins hopes that by eliminating patient copays while providing a source of payment for the provider, the program will put within patients' reach some of the highly effective, long-lasting methods that would have involved sizable up-front costs to the patient—or that some clinics might not have been able to make available at all.

## Next Steps

The potential of these state efforts is leading some reproductive health advocates to conclude that steps should be taken to encourage other states to follow suit, or at least to allow states to do so on their own initiative.

At present, however, the only way for states to expand coverage is by obtaining a federal waiver. Increasingly, the waiver process is being seen as part of the problem, rather than part of the solution. "Obtaining a waiver can be cumbersome," says Susan Tucker of the Maryland Department of Health and Mental Hygiene, "often including months of negotiation between the state agency and HCFA. It's a process that can be both time-consuming and expensive for all the parties involved." (The New Mexico waiver, for example, was pending for nearly three years before HCFA gave final approval.) Moreover, as Tucker points out, "designing a program and preparing an application are just the first steps in a complex process." Roy Jeffis of the Arkansas Medicaid agency agrees, noting that even after approval, voluminous paperwork is still required. "These reporting requirements are a real burden to the states," says Jeffis.

Others contend that simply requiring a governor to seek "permission" from an administration that may be of another political party may be enough to chill a state's enthusiasm. Katherine Kneer of Planned Parenthood Affiliates of California says this may have been the case in her state, where former Gov. Pete Wilson, a Republican, opted to forgo seeking a federal waiver from the Clinton administration in favor of expanding coverage for family planning using exclusively state dollars. Newly elected Democratic Gov. Gray Davis, by contrast, recently announced that he intends to seek a waiver in order to access federal dollars to pay much of the cost of the program.

One answer, some advocates argue, would be for Congress to give states the authority to expand Medicaid eligibility for family planning on their own, just as they have had for 15 years for maternity care. That would help level the playing field for lower income women, these advocates say, by providing increased access to family planning to help them prevent an unintended pregnancy as well as access to prenatal and maternity services if they do become pregnant. It also, they point out, would help level the playing field for the states—which shoulder much of the cost of the reproductive choices these women make. 🌱

*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 no. FPR000057. The conclusions and opinions expressed in this article, however, are those of the authors and The Alan Guttmacher Institute.*