California Program Shows Benefits of Expanding Family Planning Eligibility

By Rachel Benson Gold

In recent years, several states have moved to make large numbers of individuals whose incomes are above the very low, state-set levels for regular Medicaid enrollment eligible for Medicaid-funded family planning services. A newly released evaluation concludes that California's effort in that regard has been successful at increasing the use of effective contraceptive methods, as well as at improving access to other reproductive health services, such as sexually transmitted disease (STD) screening and treatment, among low-income women and men in the state.

Expanding Medicaid Eligibility

Medicaid was established in the 1960s to provide health care to the poorest of poor Americans, generally single mothers and their children who were receiving cash welfare assistance; because eligibility for Medicaid was linked very closely to eligibility for welfare, few families or individuals not on the welfare rolls were enrolled in the program. In the 1980s, Congress broke the welfare-Medicaid link for low-income pregnant women by first allowing and later requiring states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care to all women with incomes up to 133% of the federal poverty level—far above most states' regular Medicaid eligibility ceilings. (At their option, states may expand eligibility for pregnancy-related services to women with incomes up to 185% of poverty.)

Building on the expansions for pregnancy-related care, several states in recent years have moved to expand eligibility for family planning services as well. These expansions, however, require approval—commonly referred to as a "waiver"—from the Health Care Financing Administration (HCFA). Once approval of a family planning waiver is secured, the state can claim federal reimbursement for 90% of the costs.

MEDICAID FAMILY PLANNING WAIVERS

Extending coverage for women losing Medicaid postpartum	*Granting coverage solely on the basis of income*
Alabama* (2 years)	Alabama (133% of poverty)
Arizona (2 years)	Arkansas (133%)
Delaware† (2 years)	California (200%)
Florida (2 years)	New Mexico (185%)
Maryland (5 years)	Oregon (185%)
Missouri (2 years)	South Carolina (185%)
New York (22 months)	
Rhode Island (2 years)	
South Carolina (22 months)	

**Mobile County only. †Extends coverage to women losing Medicaid coverage for any reason.*

In general, the states' various family planning waivers have taken one of two routes. The first built directly on the expansions for pregnancy-related care, which allow states to provide Medicaid-funded family planning services and supplies, as part of postpartum care, for 60 days after a woman gives birth. Led by Rhode Island and South Carolina in 1993, eight states have now obtained federal approval to continue Medicaid coverage for family planing for periods ranging from two to five years postpartum (see box). (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.) Currently, Colorado, Georgia, Virginia and Washington have proposals pending with HCFA to expand postpartum family planning services and supplies for low-income women.

More recently, some states have taken a different—and considerably bolder—approach by seeking to extend Medicaid coverage for family planning services to women not previously covered under the program. Beginning with Arkansas and South Carolina, six states have received federal permission to expand their income eligibility levels for Medicaid-covered family planning services at least up to the eligibility levels in place for Medicaid-covered maternity care. An additional five states—Colorado, Kentucky, North Carolina, Washington and Wisconsin—have applications pending with HCFA for similar programs, although the proposal from North Carolina would only cover individuals who are at least 18 years old.

Significantly, two of the approved expansions include at least some services for men. In California, men can receive education and counseling, barrier methods, vasectomy, fertility assessment, HIV testing and

STD treatment. The Oregon program covers vasectomies, as well as counseling, referral and condoms for men. (Three of the five pending applications—from Colorado, North Carolina and Washington—would include at least some services for men as well.)

California State-Funded Effort

California's approach to expanding coverage was unique, building on a long tradition of using state funds for family planning services, especially for individuals for whom federal funding is unavailable. From 1974 to 1997, the state established a finite, albeit substantial, fund to pay for family planning services for low-income residents. Then, in 1997, it took a dramatic step by creating an open-ended legal entitlement to a package of state-funded family planning services and supplies for all residents, both male and female, with incomes up to 200% of poverty. Unlike the Medicaid-based efforts underway in other states, the new California program, known as the Family Planning, Access, Care and Treatment Program (Family PACT), was operated entirely with state dollars. In 1999, the state decided to seek federal reimbursement for part of the costs of the program and filed an application for federal approval with HCFA. The application was approved in December of that year, making the state eligible for federal reimbursement ("California's Expansion of Medicaid Family Planning Approved," *TGR*, February 2000, page 13).

Family PACT has three features that distinguish it from the efforts underway in other states. First, a client's eligibility is determined at the same site where services are obtained. This one-stop shopping approach not only permits an immediate eligibility determination but also obviates the need for a client to go to a welfare agency to apply, a step widely considered to be a deterrent to enrollment.

Second, the delivery system, which had comprised only clinics under the original state program, was expanded to include private physicians as a means of increasing access to services, since in a state as large as California, the distance between clinics can be considerable. According to Charlotte Newhart of the state office of the American College of Obstetricians and Gynecologists, providing a wider choice of providers increases the likelihood that a woman will be able to choose a provider that meets her individual needs. It will allow an enrollee to chose a provider, Newhart says, "that is in her neighborhood, speaks her language, provided her obstetrical care during her last pregnancy or is sensitive to her cultural needs."

Third, Family PACT also expanded the delivery system to include pharmacies. Under the original state program, an enrollee was required to obtain her contraceptive supplies from the clinic. With only 450 clinic sites statewide, services were not always easily accessible, especially in the more rural areas. Under Family PACT, an enrollee is given a card allowing her to renew a prescription at the pharmacy of her choice between clinic visits. In addition, providers may write prescriptions for supplies such as condoms that are often purchased over the counter, a process that allows pharmacies to claim reimbursement from the state.

Initial Program Evaluation

The statute authorizing the creation of Family PACT requires the state Office of Family Planning, which administers the program, to evaluate the effort. An evaluation report by the Institute for Health Policy Studies and the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California at San Francisco, completed earlier this year and recently made available by the state, documents the accomplishments of the first year of Family PACT's operation, FY 1997–1998. In that year, when the program was still funded entirely with state dollars, Family PACT provided services to 749,572 clients. Six in 10 Family PACT clients already had at least one child, and 61% were Hispanic.

Family PACT provided contraceptive services and supplies to 642,000 women and 28,000 men in FY 1997–1998. Prior to their first Family PACT visit, a third of contraceptive clients were either using an ineffective contraceptive method or no method at all; after their visit, 95% were using an effective contraceptive method (see chart). Four in 10 clients left with a more reliable contraceptive method than the one

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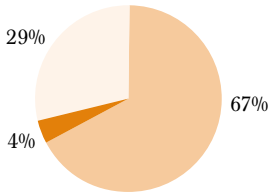
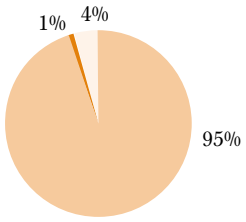
Clear Impact

While two-thirds of Family PACT contraceptive clients used an effective method before their first visit...



Method use before first visit

...almost all of them were using an effective method after that first visit.



Method use after first visit

Effective methods | Low-efficacy methods | No method

Note: Low-efficacy methods are defined as withdrawl, periodic abstinence and spermicides alone; effective methods include barrier methods, oral contraceptives, injectables, implants, IUDs and sterilization. *Source:* State of California, Department of Health Services, Office of Family Planning, Family PACT Program Evaluation Report, January 2000.

California Program…

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they had been using before their Family PACT visit.

By comparing the contraceptive methods used prior to Family PACT with the methods obtained through Family PACT, the researchers 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 in direct client services, including pregnancy prevention, as well as 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 evaluation team.

Based on the program's record as an important primary-prevention strategy that emphasizes the delivery of high-quality, comprehensive care, the evaluators concluded that Family PACT "represents an important investment in the state's future." They did so even as they stressed that because of methodological difficulties, their initial evaluation concentrated solely on documenting the impact of the contraceptive services and supplies that were delivered. The evaluators hope to develop methods of examining the impact of other components of the program, such as the almost 750,000 STD and HIV tests it provided, in future evaluation reports. According to Claire Brindis of the evaluation team, while quantifying the benefits of preventing unintended pregnancy is all that is possible now, "the importance of the full range of services provided under Family PACT—including screening for cervical cancer, STDs and HIV—is indisputable and very real for the women, men and families of California."

Mounting Evidence

The California data are an important addition to similarly encouraging reports from Rhode Island's expansion effort, which currently provides family planning services and supplies to women with incomes up to 250% of poverty for up to two years following a Medicaid-funded delivery. Data released last year show that in addition to being highly cost effective, the Rhode Island program is helping to reduce the number of women who become pregnant shortly after giving birth, a well-established risk factor for low birth weight that is itself a major cause of infant mortality in the United States. According to state health officials, the proportion of women with Medicaid-funded deliveries becoming pregnant within nine months of a previous birth has been cut nearly in half since the program's implementation. In addition, the difference between the proportion of privately insured women and of Medicaid enrollees with short birth intervals has almost been eliminated ("State Efforts to Expand Medicaid-Funded Family Planning Show Promise," *TGR*, April 1999, page 8). Together, the data from Rhode Island and California are beginning to form a persuasive body of evidence on the important benefits to individual women and their families, to public health in general and to the public purse of expanding eligibility for subsidized family planning services and supplies.