Legislatures in Three States Seek to Expand Medicaid Family Planning Services Eligibility

Three additional states will be seeking permission from the federal government to expand Medicaid-funded family planning services within their borders under legislation passed this year in Connecticut, Indiana and Texas. If the applications are approved, almost half the states will have established family planning "waiver" programs—so called because they require a waiver of the normal Medicaid eligibility rules—over the past dozen years.

Since 1993, the Centers for Medicare and Medicaid Services (CMS) has approved the requests of 21 states to expand eligibility for Medicaid-covered family planning services and contraceptive supplies to groups of women (and in some cases men) who are otherwise ineligible for Medicaid coverage. Eight of these programs continue family planning coverage for women who are leaving the general Medicaid program, either because they were enrolled on the basis of their pregnancy and are reaching the end of the postpartum period or because for whatever reason they no longer meet the program's strict eligibility requirements. The remaining 13 states cover individuals based solely on their income. These programs typically extend family planning coverage to individuals with incomes under 185% or even 200% of poverty—far above most states' regular eligibility ceilings.

STATE MEDICAID FAMILY PLANNING ELIGIBILITY EXPANSIONS

State	Basis for Eligibility			Eligible Population Includes Men	Limited to Individuals 19 and Older	Waiver Expiration Date
	Losing Coverage Postpartum	Losing Coverage For Any Reason	Based Solely on Income (% of poverty)			
Alabama			133%		X	9/30/05
Arizona	2 years					9/30/06
Arkansas			200%			1/31/06
California			200%	X		9/30/05
Delaware		2 years				12/31/06
Florida	2 years					11/30/06
Illinois		5 years			X	3/31/09
Maryland	5 years					5/31/08
Minnesota			200%	X		*
Mississippi			185%			9/30/08
Missouri	1 year					3/1/07
New Mexico			185%		X	9/30/06
New York			200%	X		3/31/06
North Carolina			185%	X	X	†
Oklahoma			185%	X	X	4/1/10
Oregon			185%	X		10/31/06
Rhode Island	2 years					7/31/05
South Carolina			185%			6/30/05
Virginia	2 years					9/30/07
Washington			200%	X		6/30/06
Wisconsin			185%			12/31/07
TOTAL	**6**	**2**	**13**	**7**	**5**	

*Expansion was approved on 7/20/04 and will expire five years after the implementation date. †Expansion was approved on 11/5/04 and will expire five years after the implementation date. *Source:* Guttmacher Institute, State Medicaid family planning eligibility expansions, *State Policies in Brief,* July 1, 2005, <http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf>.

The state-initiated family planning eligibility expansions have been shown to have a significant and positive impact. A CMS-funded study of six of the income-based programs, completed in 2003, documented significant savings for both the state and federal governments ("Doing More for Less: Study Says State Medicaid Family Planning Expansions Are Cost-Effective, *TGR,* March 2004, page 1). Moreover, the researchers found direct evidence from individual programs of expanded access to care in the form of improved geographic availability of services, greater diversity of family planning providers or a measurable reduction in unintended pregnancy. A recent Guttmacher Institute study of publicly funded family planning services nationwide concluded that states with expansion programs in place in 2001 were able to meet more of the need for publicly subsidized family planning services than were other states.

While it is not new for a state to be directed by its legislature to apply for a family planning expansion, what is new is for the legislature to put restrictions on the application—as all three states have done this year. The Indiana measure, in an apparent attempt to exclude emergency contraception, includes a provision barring coverage for contraceptives "intended to terminate a pregnancy after fertilization." The provision misses the mark in two key respects, however, since neither emergency contraception nor any other birth control method is "intended" to act after fertilization and the potential modes of action for emergency contraception are virtually identical to those of other hormonal methods (see related story,

page 10, and "The Implications of Defining When a Woman Is Pregnant," *TGR,* May 2005, page 7). The Texas legislature took more direct aim at emergency contraception and explicitly excluded it from the expansion. (Interestingly, both states cover emergency contraception for other Medicaid recipients.)

The Texas legislation also requires that contraceptive counseling offered under the program emphasize sexual abstinence for unmarried women and, more troubling, bars participation in the program by any family planning provider that also provides abortion-related services with other funding. While both issues have been much debated in other forums, state Medicaid family planning eligibility expansions have never before been drawn into the fray.

Finally, the Texas measure, along with one adopted in Connecticut, would limit the expansion to adults. While five of the 21 existing state expansions also limit coverage to adults, this is the first time that the restriction has been imposed at the direct behest of the legislature.

Reproductive health advocates applaud the states' efforts to extend Medicaid eligibility for family planning services and supplies to individuals who otherwise would not be eligible. Nonetheless, they are dismayed by the restrictions imposed by these legislatures. By limiting the individuals covered, the services included or the providers who may offer care, the legislatures run the risk of undercutting the very goals they were seeking to achieve. Instead, they could end up with highly politicized programs that are less capable of either expanding access or generating significant cost savings.—*R. Gold*

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