WOMEN'S ISSUE BRIEF
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Medicaid's Role in Family Planning

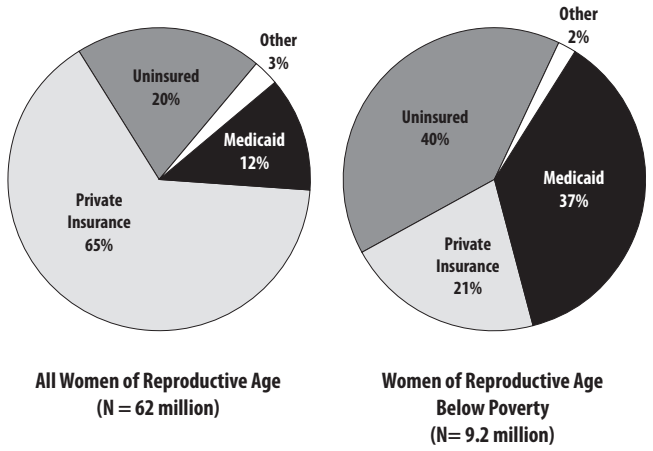
Medicaid is the joint federal-state program that finances health services for 55 million low-income individuals.[1] Over the years, the program has become increasingly important as a source of public funding for family planning. Since the mid-1980s, it has been the single largest source of public dollars supporting family planning services and supplies nationwide. As such, the policies set by Medicaid are central to the delivery of publicly supported family planning in the United States.

This *Issue Brief* reviews the role of Medicaid in financing and promoting access to family planning services for low-income women. Specifically, it examines the extent to which women of reproductive age rely on Medicaid for their care; the special status and range of services covered under the rubric of family planning; reviews the different approaches and the cost-effectiveness of the 26 state-initiated Medicaid family planning expansions as well as their impact in reducing unintended pregnancies and births, as well as abortions; and, highlights recent changes in Medicaid policy, particularly passage of the federal Deficit Reduction Act of 2005 (DRA) and their potential effects on provision of family planning services.

Women's Reliance on Medicaid

Medicaid finances care for millions of women of all ages. For women of reproductive age in particular, Medicaid plays an important role. Women are more likely to qualify for Medicaid than men because women tend to be poorer and more likely to meet the program's strict eligibility criteria (which largely limits coverage to dependent children, some of their parents, pregnant women, people with disabilities, and seniors). In fact, seven in 10 Medicaid beneficiaries older than age 14 are women.[2] In 2006, 12% of women of reproductive age—7.3 million women—ages 15–44 looked to Medicaid (and related public programs, including the State Children's Health Insurance Program) for their care. For poor women, the proportion is even higher: 37% of women of reproductive age in families with incomes below the federal poverty line ($16,600 for a family of three in 2006) were enrolled in Medicaid in 2006 (see Figure 1).[3]

Figure 1
Health Insurance Coverage of Women of Reproductive Age (15–44), 2006



Note: The federal poverty level was $16,600 for a family of three in 2006.
Source: Guttmacher Institute, special tabulations of data from the Current Population Survey, 2007.

The proportion of reproductive-age women enrolled in Medicaid varies by state, reflecting differences both in median income and in state-defined eligibility criteria (see Figure 2). Maine covers working parents up to an income level nearly four times as high as the limit in neighboring New Hampshire. As a result, the proportion of reproductive-age women enrolled in Medicaid in 2005–2006 ranged from 6% in New Hampshire to 24% in Maine. In nine states and the District of Columbia, at least 15% of reproductive-age women looked to Medicaid for their care; in 12 states, fewer than 10% were covered under the program.[4]

Figure 2
Percentage of Women of Reproductive Age (15–44), Enrolled in Medicaid and Uninsured, by State, 2005–2006

State	Medicaid	Uninsured	State	Medicaid	Uninsured
Alabama	13.6	20.8	Montana	9.8	21.6
Alaska	11.3	21.8	Nebraska	9.9	13.4
Arizona	15.9	26.5	Nevada	6.3	23.0
Arkansas	11.9	26.0	New Hampshire	5.9	14.3
California	13.3	22.8	New Jersey	7.5	19.0
Colorado	7.3	21.5	New Mexico	16.1	30.8
Connecticut	10.0	14.4	New York	18.3	17.7
Delaware	11.4	14.5	North Carolina	12.3	21.9
District of Columbia	19.1	13.5	North Dakota	10.0	13.1
Florida	7.4	27.6	Ohio	14.4	13.5
Georgia	10.3	22.5	Oklahoma	10.4	27.8
Hawaii	10.3	11.2	Oregon	11.7	23.5
Idaho	11.2	20.5	Pennsylvania	11.6	13.1
Illinois	11.3	16.7	Rhode Island	18.8	13.5
Indiana	11.3	18.6	South Carolina	12.3	20.0
Iowa	12.9	12.9	South Dakota	9.1	16.0
Kansas	7.3	16.5	Tennessee	17.2	15.2
Kentucky	13.2	19.1	Texas	8.1	31.3
Louisiana	12.9	27.5	Utah	8.5	21.0
Maine	23.6	12.1	Vermont	20.3	13.7
Maryland	6.8	17.6	Virginia	7.0	16.9
Massachusetts	15.4	11.9	Washington	11.2	14.9
Michigan	13.9	15.2	West Virginia	13.8	22.9
Minnesota	11.2	11.5	Wisconsin	13.9	10.8
Mississippi	16.0	24.1	Wyoming	8.5	21.9
Missouri	12.1	18.2			
U.S. Total (2006)				**11.7***	**20.4***

Source: Guttmacher Institute, special tabulations of data from the Current Population Survey, 2006–2007.
*U.S. total is for 2006.

In the mid-1990s, the proportion of women ages 15–44 enrolled in Medicaid declined, a trend that most observers attribute both to the passage in 1996 of legislation overhauling the nation's welfare system and to the economic boom the country was experiencing during that period.[5] Although the welfare legislation included provisions aimed at preserving Medicaid coverage for families no longer eligible for welfare, these provisions proved confusing for beneficiaries and states alike, and were extremely difficult to implement. Since 2000, however, Medicaid enrollment—in general and among reproductive-age women—has increased again and leveled off, reflecting the economic climate of the early part of the decade and the long-term retreat of employer-sponsored insurance in the United States.

In 2003, 3.5 million Medicaid beneficiaries obtained a Medicaid-covered family planning service, which includes both reversible contraception and sterilization.[6] Three in 10 clients receiving services through publicly funded family planning clinics had their care paid for by Medicaid in 2003. In the same year, eight in 10 agencies providing publicly subsidized family planning services reported serving Medicaid beneficiaries.[7]

Special Status for Family Planning

Even though family planning has long enjoyed a special status in the Medicaid program, that was not the case when the program was enacted more than 40 years ago. At that point, each state had the authority to decide whether to cover the service or not.

Over the course of the 1960s, however, evidence began to emerge that unintended childbearing—especially among teenagers—could have serious social and economic consequences, including increased poverty and reliance on public assistance.[8] Similarly, researchers began to appreciate that repeated, closely spaced births or childbearing very early or late in the reproductive years could lead to adverse health outcomes for both mothers and their children.

Congress acknowledged the importance of family planning as well as the uneven coverage of the service across state Medicaid programs when it amended the program in 1972. These amendments established a legal entitlement to family planning for Medicaid beneficiaries nationwide by requiring that states include "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies."[9] Notably, although prescription drugs in general are covered at the states' option, contraceptives are included under the family planning mandate as family planning supplies and, therefore, are required for all state programs.

Enhanced Matching Rate

As an incentive to further encourage states to make family planning services widely available to Medicaid beneficiaries, the 1972 amendments also established a special matching rate of 90% for family planning services and supplies.[10] For most services, the cost of providing care to Medicaid beneficiaries is shared by the federal and

state governments based on a formula. States are assigned a "federal financial participation" rate, the proportion of the cost of providing services for which they will be reimbursed by the federal government. These "matching rates," which range from 50% to 76% of the cost of services, are inversely related to per capita income in the state, so that less-affluent states are reimbursed by the federal government at a higher rate.[11] For family planning, however, the federal government matches the cost of all services and supplies at 90% for all states, and this rate is a clear incentive for all states to extend family planning services to eligible beneficiaries.

Exempt from Cost-Sharing

The Medicaid statute includes two other key provisions aimed at improving access to family planning for beneficiaries. The first concerns the cost-sharing that may be required of Medicaid beneficiaries. For most services covered under Medicaid, states may require beneficiaries to incur "nominal" out-of-pocket costs. The federal statute, however, exempts family planning (and a small number of other services) from this requirement, regardless of the requirements placed on other services, drugs or supplies under the state program.[12] As a result, Medicaid beneficiaries are entitled to obtain family planning services and supplies without incurring any out-of-pocket costs. Research has demonstrated that cost-sharing requirements, such as deductibles and copayments can pose barriers to care and result in reduced use of health care services, particularly for low-income women.[13]

Some studies, however, have found that the prohibition on cost-sharing may not be adhered to universally. In a 1996 study of 27 Medicaid managed care plans in five states, two plans reported requiring a copayment for family planning. Nine percent of Medicaid managed care enrollees surveyed in those states reported having been charged fees for contraceptive services, and 3% indicated that they had discontinued use of a contraceptive method because of the cost.[14]

"Freedom of Choice" for Managed Care Beneficiaries

The second key provision relates to Medicaid managed care enrollees seeking family planning services. This is an important issue since the vast majority of women on Medicaid are enrolled in managed care plans[15] and the clinics from which many Medicaid beneficiaries traditionally have obtained their family planning have faced an array of challenges in pursuing arrangements with managed care plans.[16] Although states may require Medicaid beneficiaries to enroll in managed care plans and obtain care from providers affiliated with those plans, the federal statute makes an exception for family planning services and supplies in most cases.[17] Accordingly, most Medicaid managed care enrollees may obtain family planning services from any provider within their plan or, if they prefer, go outside of their plan to obtain services from the Medicaid-participating provider of their choice.

While retaining freedom of choice for enrollees is important, it has proven to be difficult to achieve, for a variety of reasons.[18] First, freedom of choice is often allowed for only a limited package of services; this can cause difficulties both for the individuals seeking treatment and the providers seeking to meet their patients' needs. For example, providers may be reimbursed for diagnosing an STI, but not for providing treatment following diagnosis. Second, systems in which providers attempt to obtain reimbursement from a managed care plan, rather than directly from the state, have often resulted in a lack of timely and adequate payment. Third, enrollees are often not adequately informed or aware of their ability to go out of plan to obtain care.

Managed care poses other challenges as well in relation to the provision of family planning services.[19] Legislation enacted by Congress in 1997 allows a Medicaid managed care plan (whether or not religiously controlled, or even affiliated) to opt out of providing services under certain circumstances. Specifically, this provision gives plans the right to refuse "to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization objects to the provision of such service on moral or religious grounds."[20] In addition, expenditures for family planning services are often included in aggregate payments, known as capitation payments, to health plans, rather than as discrete payments for family planning. This makes it difficult to ascertain accurate expenditures for family planning services and supplies under the program, and for states to claim the enhanced 90% match from the federal government.

Recent Medicaid Policy Changes—The Deficit Reduction Act of 2005

In recent years, the Medicaid program has been subject to major policy changes that could affect access to family planning services and some of the special status that family planning has enjoyed within the program. In early 2006, Congress passed the Deficit Reduction Act of 2005 (DRA), which includes a number of provisions that allow states to change the basic structure of their Medicaid programs. This includes options for

states to increase cost-sharing levels (family planning services would remain exempt though), offer different sets of benefits to certain categories of enrollees, such as parents and some women who have recently had a Medicaid-funded birth, as well as design their own benefit package with approval from the Secretary of Health and Human Services. As a result, states could design benefits packages that do not include family planning services, but so far, very few states have altered their benefits packages at all and no state has scaled back family planning coverage.

There are several other DRA provisions that could have an impact on access to family planning services. For example, states now have the option to charge "nominal" cost-sharing for some drugs prescribed as part of a family planning visit. (Family planning "services" remain exempt from cost-sharing, but not necessarily drugs.) However, no state has yet adopted this policy. Furthermore, provisions in the DRA have affected the price of prescription contraceptives for some low-cost family planning providers. Historically, Medicaid law has allowed manufacturers to offer prescription drugs at nominal prices to certain entities, such as family planning clinics and college health centers, without it affecting the discount they must offer to Medicaid. These entities, in turn, have passed on those savings to beneficiaries by providing drugs at low or no cost. In the DRA, however, some types of family planning providers were excluded from the category of entities that qualify for this nominal pricing, effectively forcing drug manufacturers to increase significantly the prices they charge for prescription drugs, including contraceptives. Family planning proponents have argued that the affected clinics cannot keep up with these sharp price increases and that access to contraceptives could be compromised for the populations they serve.

Range of Services Covered as Family Planning

Federal guidelines describe the package of services considered family planning under Medicaid only in broad terms. According to the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program, states may claim the federal match for 90% of the costs of covering services that meet these broad guidelines (see Figure 3) and states "are free to determine the specific services and supplies which will be covered as Medicaid family planning services" within these broad parameters.[21]

Figure 3
Federal Guidelines for Medicaid Family Planning Benefit

Under the broad federal guideline that family planning services should "aid those who voluntarily choose not to risk an initial pregnancy," as well as those families with children who desire to control family size, states may cover:

- Counseling services and patient education
- Examination and treatment by medical professionals in accordance with applicable state requirements
- Laboratory examinations and tests
- Medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception
- Infertility services, including sterilization reversals

Source: State Medicaid Manual, Part 4: Services, www.cms.hhs.gov.

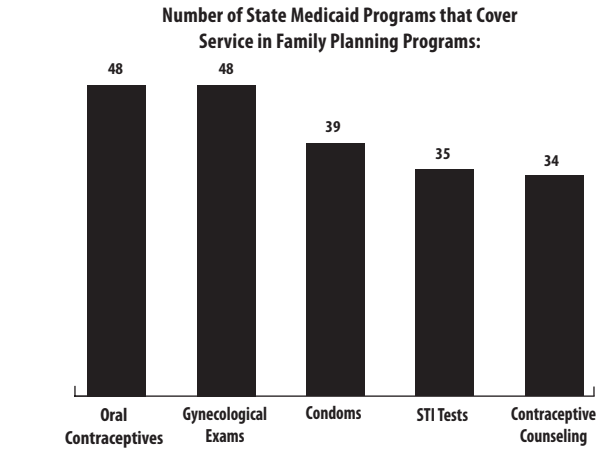
Under the CMS rules, services must be "expected to achieve a family planning purpose" in order to be reimbursed at the 90% rate. Tests to screen for STIs, for example, are covered at 90% "when performed routinely as part of an initial or regular or follow-up visit/examination for family planning." However, "if a routinely performed screening test indicates that the patient has a medical condition/problem which requires treatment," this treatment is not considered a family planning service and would not be eligible for the 90% federal matching rate. Rather, it would be covered under the state's regular matching rate.[22]

Within these general guidelines, state Medicaid programs cover an array of services under the rubric of family planning.* All state programs cover a range of Food and Drug Administration–approved contraceptive methods, often including over-the-counter methods. All 47 states and the District of Columbia responding to a survey as of January 2000 indicated that they covered the IUD, injectable contraceptives and oral contraceptives, and a slightly lower number reported covering the diaphragm.[23] Forty-two states and the District of Columbia indicated that they covered at least one over-the-counter method, such as condoms, spermicides and the contraceptive sponge. Thirty-four states covered contraceptive counseling as a separate family planning service (see Figure 4).

* Under CMS policy, abortion "may not be claimed as a family planning service" under any circumstances. However, federal law allows abortion to be covered under Medicaid when the woman's life would be endangered if the pregnancy were carried to term and in cases of rape or incest; states may obtain reimbursement for these procedures under their regular federal reimbursement rates, rather than the special 90% family planning rate. Furthermore, individual states remain free to use their own funds to pay for other "medically necessary" abortions for Medicaid beneficiaries, and 17 do so as of May 2007.

Figure 4

Select Family Planning Services Offered by State Medicaid Programs, 2000



Note: 47 states and the District of Columbia responded to this survey.
Source: Schwalberg, R., et al., *Medicaid Coverage of Family Planning Services,* Kaiser Family Foundation, 2001.

The survey also found that 27 states and the District of Columbia covered emergency contraception, although the method was relatively new to the market at that point. A subsequent study found that 10 states that had not reported covering emergency contraception in 2000 were providing coverage in 2001.[24] In addition, nearly all states responding to the survey had begun covering two newer methods, the contraceptive patch and the contraceptive ring.

All 47 states and the District of Columbia responding to the 2000 survey reported covering gynecological exams as of January 2000. Similarly, nearly all programs indicated that they covered testing for cervical cancer and STIs, as well as STI treatment. Nonetheless, whether these related services are considered family planning or must be provided at the state's regular Medicaid matching rate depends on the specific service and the circumstances in which it is delivered. This distinction is significant for states, because of the preferential federal matching rate. But it is important to beneficiaries as well, because the ban against cost-sharing and the freedom to choose providers applies only to those services considered family planning.

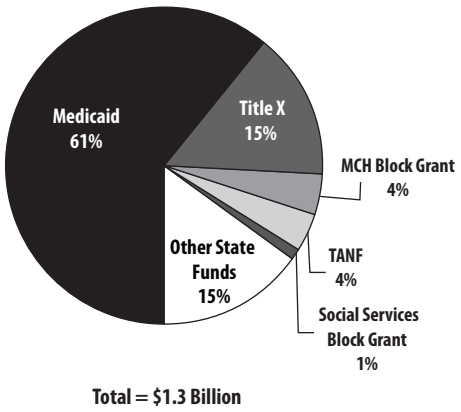
Nearly all Medicaid programs cover tubal ligation for women and vasectomy for men. (Regulations promulgated in 1978 govern the provision of federally funded sterilizations; they specify a procedure for obtaining informed consent, require a 30-day waiting period and prohibit sterilization of anyone younger than 21 or mentally incompetent.)[25] A sterilization performed primarily for contraceptive purposes is within the definition of family planning, although a sterilization performed for the treatment of a medical condition is not.[26]

A Major Source of Public Funding

Although expenditures for family planning services and supplies comprise only one-third of one percent of overall Medicaid program expenditures,[27] Medicaid is a significant source of financing for family planning services for low-income women. Over the course of the last quarter-century, Medicaid's importance in financing family planning has been increasing. In 1980, Medicaid contributed approximately 20% of all public funds spent to provide contraceptive services and supplies. By the mid-1980s, Medicaid had become the single largest source of public funding. In 2001, the program provided six in 10 of all public dollars spent, far surpassing the Title X national family planning program (15%), and other programs (see Figure 5).[28] This reflects the fact that from 1980 to 2007, appropriations for Title X, the only federal program focused solely on family planning services, had declined by 61%, when inflation is taken into account.[29] While Congress is considering a significant increase to Title X funding for 2008, Medicaid will clearly continue to be the major source of family planning funds for some time to come.

Figure 5

Sources of Public Funding for Family Planning Services, 2001



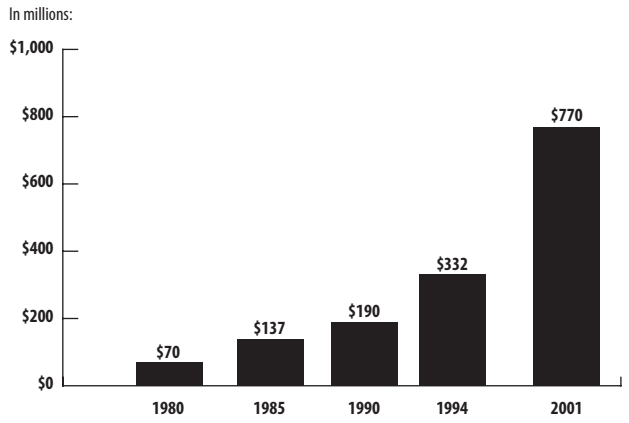
Source: Sonfield, A. and Gold, R.B., *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001,* New York: Guttmacher Institute, 2005, http://www.guttmacher.org/pubs/fpfunding/index.html.

Medicaid spending on family planning services and supplies has grown dramatically in recent years, from about $100 million in the early 1980s, to nearly $350 million in 1994 to $770 million in 2001^ (see Figure 6). This increase parallels growth

^ This figure underestimates the amount spent on family planning as it only includes those reimbursements that were for fee for service. Managed care payments that were capitated for enrollees were not included in this estimate.

in overall Medicaid spending. Total Medicaid expenditures for medical services grew by 75% from 1995 to 2002.[30] However, the rate of increase for family planning has been considerably slower than the rate of growth for prescription drug expenditures overall, which rose on average by 16.4% between 2000 and 2004.[31]

Figure 6
Medicaid Expenditures for Family Planning Services and Supplies, Selected Fiscal Years 1980–2001



Sources: Sollom, T., Gold, R.B., and Saul, R., "Public Funding for Contraceptive, Sterilization and Abortion Services, 1994," *Family Planning Perspectives,* July/August 1996, pp. 166–173; and Sonfield, A. and Gold, R.B., *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001,* New York: Guttmacher Institute, 2005, www.guttmacher.org/pubs/fpfunding/index.html.

The growth in Medicaid spending for contraceptive services is due to a combination of factors, including sharply increasing costs of providing care across the health care system. Furthermore, as discussed below, state Medicaid family planning eligibility expansions have extended Medicaid eligibility for family planning services to new individuals who otherwise would not have been able to enroll, or remain enrolled, in the program; the seven states that had broadly expanded eligibility through such programs by 2001 accounted for two-thirds of the increase in Medicaid family planning expenditures between 1994 and 2001.[32] Today, 26 states have these family planning expansion program. While there has been much discussion about recent increases in Medicaid spending, Medicaid cost inflation seems to parallel increases evident throughout the health sector, and is driven in large part by rising enrollment in Medicaid and rapid growth in health care inflation.[33]

In 2001, all but seven states and the District of Columbia spent more than $1 million for family planning services and supplies through their Medicaid programs (see Figure 7). Rapid growth in the cost of providing family planning spending is not only limited to Medicaid. The cost to clinics of providing services to clients is rising as well. A recent survey of agencies receiving grants under the Title X program found that the cost of an initial clinic visit for family planning rose by an average of 24% from 2001 to 2004.[34]

Figure 7
Medicaid Expenditures on Family Planning Services, by State, FY 2001 (in thousands of dollars)

State	Expenditures ($)	State	Expenditures ($)
Alabama	15,258	Montana	1,513
Alaska	153	Nebraska	1,809
Arizona	12,717	Nevada	2,541
Arkansas	12,769	New Hampshire	722
California	260,636	New Jersey	14,200
Colorado	4,606	New Mexico	3,861
Connecticut	13,777	New York	57,925
Delaware	2,532	North Carolina	11,909
District of Columbia	113	North Dakota	733
Florida	18,865	Ohio	12,973
Georgia	11,584	Oklahoma	12,162
Hawaii	178	Oregon	19,211
Idaho	972	Pennsylvania	30,183
Illinois	14,948	Rhode Island	2,034
Indiana	17,169	South Carolina	26,607
Iowa	2,409	South Dakota	417
Kansas	1,047	Tennessee	23,622
Kentucky	4,389	Texas	31,144
Louisiana	8,836	Utah	1,484
Maine	4,079	Vermont	3,384
Maryland	11,920	Virginia	13,671
Massachusetts	21,430	Washington	8,986
Michigan	11,936	West Virginia	1,089
Minnesota	2,919	Wisconsin	5,193
Mississippi	4,492	Wyoming	712
Missouri	21,811		
U.S. Total			**769,627**

Source: Sonfield, A. and Gold, R.B., *Public Funding for Contraceptive, Sterilization and Abortion Services, FY 1980–2001,* New York: Guttmacher Institute, 2005, http://www.guttmacher.org/pubs/fpfunding/index.html.

Medicaid Family Planning Expansions

Over the past decade and a half, over half of the states have sought and received permission from CMS to extend Medicaid eligibility for family planning services to large numbers of individuals whose incomes are above the state-set income eligibility levels to qualify for Medicaid enrollment or who do not meet the other categorical requirements. These programs have extended coverage to many who otherwise would be ineligible for Medicaid coverage (see Figure 8).

Figure 8
State Medicaid Family Planning Eligibility Expansions as of October 2007

State	Basis for Eligibility			Eligible Population Includes Men	Limited to Individuals ≥19	Expiration Date
	Losing Coverage Postpartum	Losing Coverage for Any Reason	Based Solely on Income (% of Poverty)			
Alabama			133%		X	9/30/2008
Arizona	2 Years					10/25/2009
Arkansas			200%			1/31/2009
California			200%	X		10/31/2007
Delaware		2 Years				12/21/2009
Florida		2 Years				11/30/2009
Illinois	*		200%		X	3/31/2009
Iowa	*		200%			1/31/2011
Louisiana			200%		X	7/1/2011
Maryland	5 Years					5/31/2008
Michigan			185%		X	3/1/2011
Minnesota			200%	X		6/30/2011
Mississippi			185%			9/30/2008
Missouri	1 Year					10/15/2007
New Mexico			185%		X (18 to 50)	9/30/2009
New York	*		200%	X		9/30/2011
North Carolina			185%	X	X	9/30/2010
Oklahoma			185%	X	X	3/31/2010
Oregon			185%	X		10/31/2009
Pennsylvania			185%		X (18+)	2/1/2013
Rhode Island	2 Years					7/31/2008
South Carolina			185%			12/31/2007
Texas			185%		X (18+)	12/11/2011
Virginia	*		133%	X		9/30/2010
Washington			200%	X		6/30/2009
Wisconsin			185%			12/31/2007
Total in Effect	**4**	**2**	**20**	**8**	**9**	

*State also extends Medicaid eligibility for family planning services to women following a Medicaid-funded delivery.
Source: Guttmacher Institute, "State Medicaid Family Planning Eligibility Expansions," *State Policies in Brief,* October 1, 2007, http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.

When Medicaid was first established, the low-income families covered generally were single mothers and their children receiving welfare cash assistance. 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 (specifically including postpartum family planning services) for up to 60 days postpartum 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 could expand eligibility for pregnancy-related services to women with incomes up to 185% of poverty or beyond.[35]

Building on the expansions for pregnancy-related care, several states moved to expand eligibility for Medicaid family planning services as well. Because these expansions limit the scope of coverage of Medicaid benefits to family planning supplies, services and some related care, states seeking to adopt these programs must obtain approval—generally through a research and demonstration "waiver"—from CMS. Waivers are one avenue for states to make program alterations that go beyond federal Medicaid guidelines. These waivers are limited both in scope—in this case to family planning—and in time—to an initial five-year period, although states may apply for an extension. Once approval of a family planning waiver is secured, the state may claim federal reimbursement for 90% of the costs of providing family planning services and supplies under the effort.

States can design waivers using different approaches, but the proposal must be "budget neutral" to the federal government over the five-year span of the effort; that is, it cannot cost the federal government more than it would have spent in the absence of the waiver. States that have obtained these waivers have 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 beneficiaries who would otherwise become pregnant and eligible for Medicaid-funded prenatal, delivery and postpartum care.

A newer requirement, instituted in 2001 by the Bush administration, is that family planning waiver programs must facilitate access to primary care. To meet this requirement, states must generally have arrangements with primary care providers to whom clients may be referred when needed. States must develop written materials for clients explaining how they can access primary care services and the impact of providing these referrals must be included in the state's evaluation of its family planning waiver.[36]

Varied Approaches to Coverage

In general, the states' Medicaid family planning eligibility expansions have taken one of three routes.[37] 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. Under this provision, unless a woman qualifies for Medicaid under a different eligibility pathway, she would lose her Medicaid coverage after the 60-day postpartum period. Led by Rhode Island and South Carolina in 1993, four states currently have federal approval to continue coverage for family planning services, generally for two years postpartum, although Maryland provides coverage for five years after delivery.

Delaware and Florida varied this approach somewhat and continue Medicaid coverage for family planning for individuals leaving the Medicaid program for any reason, not just following childbirth.

The third approach has been to extend Medicaid coverage based on income rather than historical participation in the program. This opens the possibility for family planning services to residents who had not been previously covered under the program at all. Beginning with Arkansas and South Carolina, 20 states currently have federal permission to expand their income-eligibility levels for Medicaid-covered family planning services, with most states extending coverage to individuals with an income at or near 200% of poverty.[†]

In general, when approving states' applications for family planning waivers, CMS allows the programs to cover services—including office visits, tests, laboratory procedures and contraceptive supplies—whose "primary purpose" is family planning.[38] The program may also cover treatment of a condition, such as an STI, diagnosed in the course of a family planning visit, although the state will be reimbursed at its regular reimbursement rate for the care, not at the special 90% reimbursement rate for family planning. However, testing or treatment for STIs that are not diagnosed as part of a family planning visit is not covered under the programs recently approved by CMS.

While most of the expansions cover beneficiaries for the full span of their reproductive lives, nine of the programs—in Alabama, Illinois, Louisiana, Michigan, New Mexico, North Carolina, Oklahoma, Pennsylvania and Texas—only cover women who are at least 18 or 19 years old.

Significantly, eight programs—in California, Minnesota, New York, North Carolina, Oklahoma, Oregon, Virginia and Washington—provide coverage to men as well as women. For FY 2004/2005, California reported that 11% of the program's clients were men.[39]

California has made a special effort 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 the California program, 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 card that enables them to access services.[40]

Several other states have also taken steps to simplify enrollment procedures in their Medicaid programs. However, these efforts could be affected by a provision in the DRA requiring that Medicaid enrollees who claim citizenship provide documentary proof. (Immigrants eligible for Medicaid had already been required to document their status.) Health care advocates and many state officials are worried that millions of low-income American citizens could be forced to delay needed care or even lose Medicaid coverage because of the time, expense and difficulty of obtaining acceptable documentation.[41] Initial reports indicate that citizens—not immigrants—are the ones at risk of lost or delayed coverage and care.[42] In some states, providers have reported an increase in the number of individuals coming to family planning clinics with no source of third-party reimbursement because of the documentation requirement. And some states are seeing enrollment in their Medicaid family planning eligibility expansion programs begin to fall.[43]

A Significant Impact

With the recent federal approval of expansion proposals from Illinois, Pennsylvania and Texas, three-quarters of women estimated to be in need of publicly subsidized family planning in the United States live in one of the 26 states with some

[†] California began its effort in 1997 by creating an entitlement to family planning for residents with incomes up to 200% of poverty. Initially, the effort was funded entirely with state dollars. In 1999, California submitted and received approval for a Medicaid waiver, making the program eligible for federal reimbursement.

form of a Medicaid family planning eligibility expansion.[‡] These programs have assisted large numbers of low-income people who otherwise might have had no source of coverage for family planning.[44] Together, expansion programs serve almost two million enrollees annually, with the massive California program, known as Family PACT, serving twice as many clients as all the other state expansion programs combined. More than seven in 10 clients served through Family PACT in FY 2004/2005 received a contraceptive method and more than six in 10 received one or more STI tests. More than half the women served were tested for cervical cancer.[45]

Research on the impact of these efforts is accumulating. A national evaluation of Medicaid family planning waivers conducted by the CNA Corporation along with the schools of public health at Emory University and the University of Alabama at Birmingham, under a contract with CMS, has provided important evidence of the impact of the waivers.[46] The researchers found evidence that some of the programs expanded access to care, improved the geographic availability of services, expanded the diversity of family planning providers and resulted in a measurable reduction in unintended pregnancy.

Guttmacher Institute data from 2001 demonstrated that clinics in states with income-based expansions were able to meet more of the need for services: clinics in the expansion states served half of the women in need, while clinics in states without expansions served 40%.[47] Most recently, a study by researchers from the Medical University of South Carolina published in *Women's Health Issues* in 2007 found that Medicaid family planning expansions result in lower birthrates, with the broad, income-based programs having the greatest impact.[48]

Several studies have found that by providing contraceptive services to women who would become eligible for Medicaid if they experienced an unintended pregnancy, family planning waiver programs generate substantial cost savings. The federally funded evaluation of programs in six states found that all yielded significant savings to both the federal government and the states (see Figure 9).[49] Similarly the evaluations of programs conducted by several of the states, as required by CMS as part of the federal waiver, have found that the savings generated by the programs by reducing the number of Medicaid-funded deliveries far outstrip the costs of providing family planning services to program enrollees.[50]

Figure 9
Impact of State Medicaid Family Planning Eligibility Expansions

			Net Savings from Expansion Program		
State	**Year**	**Births Averted**	**Total**	**State Share***	**Federal Share**
Alabama	2000–2001	3,612	$19,028,783	$6,981,721	$12,047,062
Arkansas	1998–1999	4,486	$29,748,208	$9,411,954	$20,336,254
California	1999–2000	21,335	$76,182,694	$64,314,302	$11,868,392
New Mexico	2000–2001	1,528	$6,510,909	$2,650,439	$3,860,470
Oregon	2000	5,414	$19,756,294	$11,077,646	$8,678,648
South Carolina	1996–1997	3,769	$23,066,926	$7,403,462	$15,663,464

Source: Edwards, J., Bronstein, J., and Adams, K., *"Evaluation of Medicaid Family Planning Demonstrations,"* The CNA Corporation, CMS Contract No. 752-2-415921, November 2003.
* State share of savings calculated by Guttmacher Institute, based on the total savings and the federal share of savings in the final report by the CNA Corporation.

Because several different approaches could be taken to expanding Medicaid eligibility, Guttmacher Institute researchers in 2006 projected the cost-effectiveness of four scenarios for expanding eligibility for Medicaid-covered contraceptive services: establishing parity in all states between contraceptive services and pregnancy-related care; instituting a nationwide eligibility expansion to women with incomes of either 200% or 250% of poverty; and giving each state the option to extend eligibility to women with an income up to 200%.[51]

Under each of these scenarios, some women who were unable to access services at all would be able to obtain them, and some women who were using less effective contraceptive methods would be able to use more effective methods. Accordingly, all four of these expansion approaches would improve women's ability to avoid unplanned pregnancy and birth, as well as abortion (See Figure 10).

[‡] Women are defined as being in need of contraceptive services and supplies if they are of reproductive age (13–44), have ever had sexual intercourse, and are able to become pregnant but do not wish to do so. Those with an income below 250% of the federal poverty level or who are younger than 20 (and thus presumed to have a low personal income) are considered in need of publicly funded contraception.

Similarly, all of the expansion scenarios would result in significant cost savings to the federal and state governments, and researchers found that the most cost-effective approach, however, would be to establish parity between the income ceiling a state uses to determine eligibility for Medicaid-funded pregnancy-related care and the state's income ceiling for family planning. Of the 20 states to have adopted an income-based family planning expansion, all but Minnesota has taken this approach.

Figure 10
Estimated Impact of Scenarios for Expanding Eligibility for Medicaid Coverage of Contraceptive Services

	Nationwide, women up to 200% FPL	Optional, women up to 200% FPL	Nationwide, women up to 250% FPL	Nationwide, parity with eligibility for pregnancy-related care
Unplanned Pregnancies Averted				
Number	521,700	375,100	722,600	471,100
Percent	16.7%	12.0%	23.2%	15.1%
Abortions Averted				
Number	210,300	151,200	291,200	189,900
Percent	16.3%	11.7%	22.5%	14.7%
Unplanned Births Averted				
Total	248,900	178,900	344,700	224,700
Medicaid-funded	238,200	174,300	271,300	224,700
Costs and Savings				
Medicaid costs averted (in billions of $)	$2.47 B	$1.76 B	$2.81 B	$2.34 B
Cost of expansion (in billions of $)	$0.91 B	$0.63 B	$1.25 B	$0.82 B
Net savings (in billions of $)	$1.56 B	$1.13 B	$1.56 B	$1.53 B
Cost savings ($ saved per $1 spent)	$2.70	$2.80	$2.20	$2.90

Notes: FPL=federal poverty level. The federal poverty level in 2006 was $16,600 for a family of three. Estimates are for the annual impact in the third year of program operation.
Source: Frost, J.J., Sonfield, A. and Gold, R.B., Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services, Occasional Report, Guttmacher Institute, 2006, No. 28, p. 6.

Conclusion

Family planning is a central component of preventive care for reproductive-age women, and Medicaid has played an increasingly large role in financing these services for low-income women. Today, 26 state expansion programs have extended Medicaid family planning services to women who do not qualify for full Medicaid. Some policymakers have proposed that states be given broader authority to expand family planning coverage in the future without federal waivers. A decade of evaluations of these programs has shown that the investment has prevented unintended pregnancies and abortions, and generated substantial cost savings for the program.

In addition, several key policies have strengthened Medicaid's ability to promote access to family planning for low-income women. The exemption from cost-sharing has ensured that family planning services are affordable for low-income women. Medicaid's freedom of choice provision allows women to maintain relationships with their family planning providers, even when they are enrolled in managed care networks and has helped to promote continuity of care and confidentiality. Finally, the 90% federal match has given states an incentive to facilitate and broaden access to family planning services. The enhanced match has enabled several states to expand the range of family planning services covered, promote greater beneficiary education about family planning, and extend coverage to women who may not otherwise qualify for Medicaid.

Recent moves in Congress and in state capitals across the nation have put the role of Medicaid on the front burner. The DRA has given states considerable new flexibility to restructure their Medicaid programs. While few states have adopted the DRA's general options, understanding how states could use these new choices and assessing the impact of subsequent changes on access to family planning services will be important. Furthermore, several states have implemented or are considering health coverage expansions to reduce the number of uninsured, with Medicaid as a primary vehicle for expanding coverage. Successful expansion initiatives could provide access to health care, including family planning services, to many low-income women who do not currently qualify for Medicaid.

There is a large and growing body of research that demonstrates the significance of Medicaid-funded family planning services to low-income men and women. As policymakers at both the federal and state level grapple with the future of the Medicaid program, it will be important for them to consider how program changes could affect access to these key preventive services for the millions women who rely on Medicaid for their health coverage and reproductive care.

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