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New Federal Authority to Impose Medicaid Family Planning Cuts: A Deal States Should Refuse

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The joint federal-state Medicaid program has long been of central importance to low-income women's health care in general and to the provision of subsidized family planning services in particular. Since 1972, family planning has been one of a handful of services the federal government has required all state Medicaid programs to cover, and it is one of the very few services for which patient cost-sharing is prohibited. According to the most recent data available, nearly 12% of all women of reproductive age rely on Medicaid for their health care, and the program provides just over six in 10 public dollars spent on family planning across the country (see table).

However, a recently enacted federal law giving states significant new latitude to reshape their Medicaid programs could change all that. For the first time in more than three decades, states have the authority to exclude family planning from the package of benefits offered to some groups of enrollees under the program. In addition, they now may charge fees for at least some contraceptives or drugs used to treat sexually transmitted infections (STIs) that are prescribed as part of a family planning visit. In deciding whether to make changes to coverage of family planning in their Medicaid programs, state policymakers would be well served by looking at the experience of several states that, after examining the costs and benefits of Medicaid-covered family planning in recent years, have sought not to reduce but to increase coverage for their residents.

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States' Latitude

The Deficit Reduction Act signed into law earlier this year makes a number of wide-ranging changes to the federal Medicaid statute, including two that could directly impact the ability of some Medicaid enrollees to obtain the family planning services and contraceptive supplies they need. First, the law allows states to offer stripped-down benefit packages to certain categories of enrollees. In designing these packages, states have several models to choose from, and not all of these models include family planning. Moreover, states also have the option of designing their own package, which again would not have to include family planning.

These scaled-back packages could be offered to two groups of enrollees for whom access to family planning is critical. The first of these groups comprises parents enrolled in the program; there were 14 million nonelderly, nondisabled adults in Medicaid in 2003, almost all of whom were parents. While the language of the statute itself is ambiguous, a March 31 letter from the Centers for Medicare and Medicaid Services (CMS) to state Medicaid directors includes a broad interpretation of this provision. Under the CMS reading of the statute, states essentially are permitted to enroll almost all parents in stripped-down packages.

The second group that would be affected includes some women who have recently had a Medicaid-funded delivery and who, up to now, have been entitled to obtain family planning as part of postpartum care. Since 1989, the Medicaid statute has required states to cover all pregnant women with incomes up to 133% of the poverty line ($16,600 for a family of three in 2006); however, the statute also gives states the option to use a higher income ceiling. Nearly all states have availed themselves of this option, generally covering women with incomes at or close to 200% of poverty. Under the Deficit Reduction Act, states could exclude family planning from the package offered to postpartum women covered at a state's option.

Moreover, although the Deficit Reduction Act itself makes clear that enrollees not specifically targeted for a stripped-down package remain entitled to full Medicaid benefits, the March 31 letter from CMS says that states may offer one of these packages to such enrollees. Although the letter says that these individuals would have the option to retain their current full coverage, how that will play out in the implementation is obviously of great concern.

In addition to allowing states to scale back enrollees' benefit packages, the Deficit Reduction Act gives states the option to impose "nominal" cost-sharing for some drugs prescribed as part of a family planning visit. (Family planning "services" remain exempt from cost-sharing.) The legislation also removes a long-standing statutory protection that barred providers from denying care to enrollees unable to afford the cost-sharing that was required. Taken together, these two provisions of the new statute mean that, for the first time in more than 30 years, enrollees seeking family planning services may be charged for some of the care they receive and may be denied that care if they are unable to pay.

In structuring their Medicaid programs, states usually develop a list of so-called preferred drug—generally lower-cost generic drugs—that are not subject to cost-sharing; however, states could impose cost-sharing on nonpreferred drugs. Such a move could affect women using

CRITICAL ROLE OF MEDICAID

Medicaid contributes six in 10 public dollars for family planning in the United States and covers 12% of women of reproductive age.

	Expenditures on Contraceptive Services, FY 2001		% of women 15–44 covered by Medicaid, 2003–2004
	Medicaid (in 000s of dollars)	% attributable to Medicaid	
U.S. TOTAL	**$769,627**	**61.0**	**11.9***
Alabama	15,258	57.4	11.7
Alaska	153	3.6	12.9
Arizona	12,717	76.2	14.3
Arkansas	12,769	78.2	13.1
California	260,636	80.9	14.1
Colorado	4,606	52.5	6.9
Connecticut	13,777	81.2	11.4
Delaware	2,532	61.5	11.3
Dist. of Columbia	113	8.8	19.9
Florida	18,865	40.9	9.2
Georgia	11,584	27.9	8.8
Hawaii	178	13.3	9.6
Idaho	972	31.3	9.8
Illinois	14,948	56.3	9.9
Indiana	17,169	72.3	10.4
Iowa	2,409	34.7	10.7
Kansas	1,047	33.5	8.7
Kentucky	4,389	33.7	13.8
Louisiana	8,836	42.7	12.3
Maine	4,079	58.5	23.9
Maryland	11,920	56.5	5.8
Massachusetts	21,430	72.5	12.6
Michigan	11,936	43.1	12.9
Minnesota	2,919	25.5	10.4
Mississippi	4,492	43.3	15.1
Missouri	21,811	70.6	13.1
Montana	1,513	53.5	10.4
Nebraska	1,809	58.9	9.8
Nevada	2,541	52.7	6.7
New Hampshire	722	25.5	5.6
New Jersey	14,200	53.1	6.7
New Mexico	3,861	57.9	14.9
New York	57,925	60.3	17.8
North Carolina	11,909	43.7	11.0
North Dakota	733	46.4	10.4
Ohio	12,973	56.3	12.3
Oklahoma	12,162	50.5	8.8
Oregon	19,211	83.6	10.4
Pennsylvania	30,183	59.5	11.2
Rhode Island	2,034	76.0	18.4
South Carolina	26,607	60.9	14.9
South Dakota	417	24.2	11.1
Tennessee	23,622	74.4	16.6
Texas	31,144	47.4	8.6
Utah	1,484	37.8	7.9
Vermont	3,384	82.7	20.6
Virginia	13,671	44.9	6.2
Washington	8,986	52.2	13.4
West Virginia	1,089	16.5	12.7
Wisconsin	5,193	35.8	14.1
Wyoming	712	51.6	9.4

*2004 data. *Sources:* Guttmacher Institute, 2005, and Guttmacher Institute tabulations from Current Population Survey, 2004–2005.

brand-name contraceptive methods such as the Ortho Tri-Cyclen Lo pill, the Ortho Evra patch or the Depo-Provera injectible. It could also affect drugs that are used to treat sexually transmitted or urinary tract infections, such as Zithromax.

Learning from Experience

In short, states now have authority to decide whether to cover family planning for some enrollees and whether to impose cost-sharing for some drugs prescribed as part of a family planning visit. As they consider these options, states would do well to look at the experience of the states that have considered the impact of Medicaid-covered family planning in recent years and, as a result, have decided to increase rather than reduce coverage. Moreover, the experience of these states demonstrates that reducing Medicaid coverage of family planning runs directly counter to three of the major goals often articulated by the most ardent supporters of the legislation: reducing Medicaid costs, promoting personal responsibility and improving enrollees' health.

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Reducing Medicaid costs. The major goal of the Medicaid provisions of the statute is to cut costs. Here the data are clear: The way to reduce Medicaid costs is to expand coverage of family planning, not cut it. In fact, every dollar spent to provide publicly funded family planning services and supplies saves $3 that otherwise would be spent to provide Medicaid-funded pregnancy-related and newborn care.

In recent years, 23 states have received federal permission to expand coverage of family planning to individuals who otherwise would not be eligible. A recent, federally funded evaluation of several of these programs was conducted by the CNA Corporation along with the schools of public health at Emory University and the University of Alabama at Birmingham (related article, March 2004, page 1). This effort found that by helping thousands of women each year prevent unplanned pregnancies that would have resulted in Medicaid-funded births, the family planning expansions resulted in millions of dollars in savings to both the federal and state governments (see table).

Encouraging personal responsibility. A second, often-mentioned goal of the Deficit Reduction Act is to promote "personal responsibility" on the part of program enrollees. The notion is that if enrollees are required to shoulder a part of the cost of their care, they will cut back on unnecessary care, which, in turn, will lower Medicaid costs. This argument, however, is counterproductive when it comes to family planning, because enrollees are acting responsibly when they utilize contraceptives, not when they forego them. Any cost-sharing that would discourage use would, therefore, be counter to the goal of personal responsibility. Moreover, any cost-sharing imposed on a prescription medication that would discourage enrollees from treating an STI would likewise be counterproductive, resulting not only in a more serious medical situation for the enrollee, but possibly in the transmission of the disease to someone else.

Extensive research shows that imposing cost-sharing reduces utilization of services, including preventive care. According to the federally

COST SAVINGS

Medicaid family planning eligibility expansions result in significant cost savings to the federal and state governments.

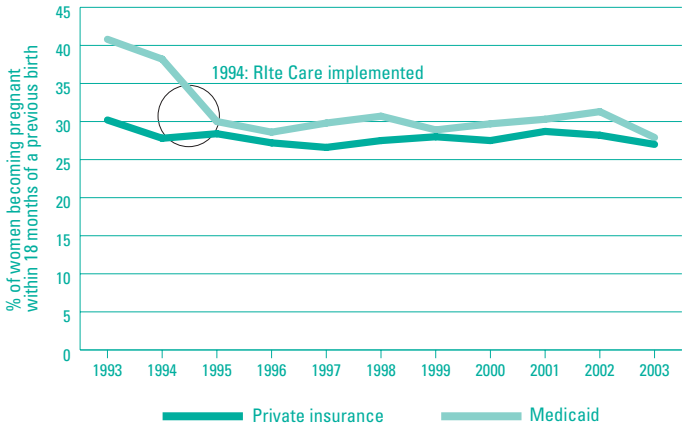
State	Year	Net Savings (in 000s)		
		Total	State	Federal
Alabama	2000	$19,029	$6,982	$12,047
Arkansas	1998–1999	29,748	9,412	20,336
California	1999–2000	76,183	64,314	11,868
New Mexico	2000–2001	6,511	2,650	3,860
Oregon	2000	19,756	11,078	8,679
South Carolina	1996–1997	23,067	7,403	15,663

Source: CNA Corporation, 2003.

funded RAND Health Insurance Experiment (widely seen as one of the most important and rigorous health policy studies ever conducted), low-income individuals reduced their use of effective medical care by as much as 44% when required to make copayments. More recently, a study in Quebec found that imposing prescription-drug fees resulted in low-income enrollees foregoing drugs necessary for preventive care. But perhaps most troubling, when Utah began charging copayments of $2–3 (the range that would be permitted under the Deficit Reduction Act), nearly one in five enrollees said they dealt with the situation by "stretching out" their prescriptions. The implications for family planning are particularly problematic: If copayments result in gaps in use of oral contraceptives, for example, that would sharply increase the risk of unintended pregnancy.

IMPROVED BIRTHSPACING

The difference in interpregnancy intervals between Medicaid enrollees and women with private insurance virtually disappeared with the implementation of RIte Care.



Source: RIte Care Research and Evaluation Project, 2005.

Meeting enrollees' health needs. A third major goal of the legislation is to allow states to improve enrollees' health care and, by extension, their health. This would be accomplished by offering "coverage that better meets each patient's needs," according to Rep. Joe Barton (R-TX), one of the leading sponsors of the measure in the House. Clearly, reducing coverage for family planning runs counter to achieving that goal. The federal Centers for Disease Control and Prevention identified family planning as one of the top 10 public health achievements of the 20th century, and in 2000, the federal government set a public health goal to reduce unintended pregnancy by 40% over 10 years, and recognized family planning as the key to achieving that national objective.

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Moreover, California's experience with its family planning expansion, which provides services to state residents with incomes up to 200% of poverty, shows the potential of Medicaid family planning in reaching that ambitious goal. In 2002 alone, the state's Medicaid family planning expansion prevented 213,000 unintended pregnancies, 45,000 of which would have been to teenagers. By preventing these pregnancies, the program helped women in California avoid a total of 82,000 abortions, 16,000 of which would have been to teenagers.

Family planning is also important in reducing the risk of infant mortality. After Rhode Island instituted a comprehensive expansion that included extended family planning coverage for women following a Medicaid-funded birth, the proportion of women with Medicaid-funded deliveries who became pregnant within 18 months of a previous birth—a well-established risk factor for low birth weight, itself a major risk factor for infant mortality—was cut dramatically (see chart). Moreover, the disparity between Medicaid enrollees and privately insured women in the state was almost eliminated. Family planning expansions in Arkansas and South Carolina report similar findings.

Because of the impact of family planning programs on extending intervals between pregnancies, the National Governors Association consid-

ers expanding Medicaid eligibility for family planning an important step states can take to improve birth outcomes and reduce high-risk births. These findings of the importance of providing family planning as a way to improve childspacing are critical because women who have recently had a Medicaid-funded delivery are one of the populations of women targeted to receive a potentially stripped-down package of benefits that does not include family planning. Clearly, any package designed to meet the heath needs of these women would include postpartum family planning.

A Process with Little Daylight

Although reducing coverage of, or imposing cost-sharing for, family planning would contravene the stated goals of the Deficit Reduction Act, that in no way guarantees that changes along these lines will not be proposed. Therefore, it is critical for reproductive health advocates to monitor the implementation of the legislation in each state. This task will be made all the more difficult by virtue of the process established for states to make the changes permitted under the legislation.

In contrast to the process for expanding family planning, a state seeking to implement the provisions of the Deficit Reduction Act is not required to go through the complex process of obtaining a federal waiver. Instead, it need merely submit to the CMS regional office a proposed amendment to its state Medicaid plan. There is no requirement for public notice or input before the fact. Often, the only public notification that a state's Medicaid plan has been changed comes when the state proposes regulations to implement an amendment that has already been approved. The lack of a public process for the review of a plan amendment makes it critical that reproductive health advocates establish close ties both to their Medicaid agencies and to the larger Medicaid community in their states. This may be the only way to ensure that they have a voice in determining whether vitally important health benefits offered to Medicaid recipients in that state will continue to be guaranteed or will be reduced. www.guttmacher.org