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The Central Role of Medicaid in the Nation's Family Planning Effort

By Adam Sonfield

Since the Republican takeover of the House of Representatives in 2010, fiscal and social conservatives have found common cause in curbing public spending for a range of programs supporting low-income Americans. One of the highest priority targets, because of its roughly $400 billion annual cost and its central place in state budgets, has been the joint federal-state Medicaid program. The new House's first two budgets, for FY 2012 and FY 2013—both of which were authored by Rep. Paul Ryan (R-WI) and passed by the House on party-line votes—proposed converting Medicaid into a block grant controlled by the states. That concept has long been promoted by conservatives as a way to devolve considerable power to state governments while simultaneously restricting federal spending on the program. The latest proposal, according to the Center on Budget and Policy Priorities, would save over $800 billion in federal spending over 10 years, and trillions of dollars more in subsequent decades, by capping states' allotments well below their currently projected level of growth—cuts that would inevitably lead to far fewer Medicaid enrollees.[1]

Medicaid has also been attacked specifically in its central role as a source of public funding for family planning services. In 2011, one of the final points of contention in a budget showdown that nearly shut down the federal government was House Republicans' insistence on prohibiting Planned Parenthood affiliates from receiving any federal funds—which primarily come in the form of reimbursements for the provision of contraception, Pap tests, STI tests and similar services to low-income women and men who rely on Medicaid as their health insurance. President Obama and the Senate's Democratic leadership stood firm against that proposal, but several states have continued the fight with considerably more success, in legislatures if not in the courts.[2]

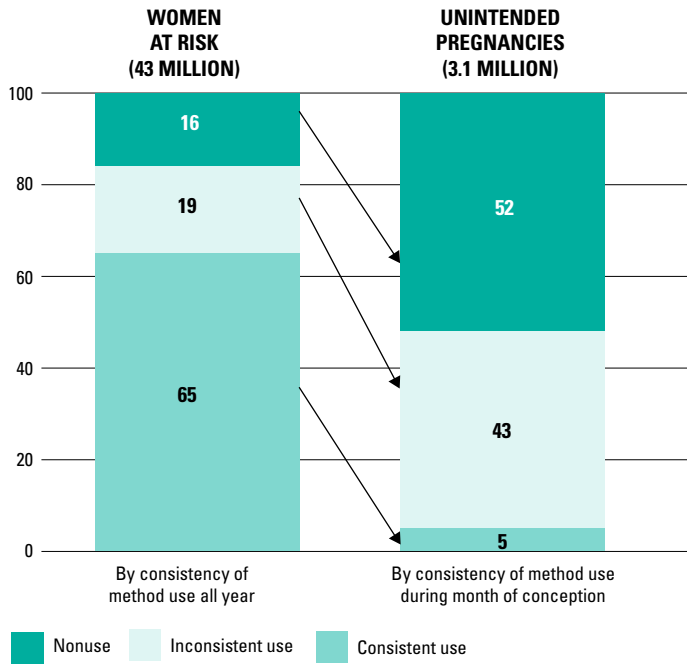
The Medicaid agenda of progressive policymakers has been in many ways the polar opposite: They have sought to expand Medicaid's reach by setting stronger eligibility and coverage standards that all states must adhere to in their programs. Their goals have been to reduce the number of low-income Americans who are uninsured and close gaping disparities across states in program quality and eligibility requirements. After several incremental expansions during the 1980s and 1990s, progressives had their most important success to date with the March 2010 enactment of the Patient Protection and Affordable Care Act (ACA).

Proponents of the law extolled its move to raise and standardize income eligibility ceilings for Medicaid, opening its doors to all Americans with incomes at or below 138% of the federal poverty level, far above current levels in most states. That expansion of Medicaid is slated to begin in 2014 if it is not blocked by the U.S. Supreme Court as part of the larger constitutional challenge to the ACA.

Notwithstanding the political maelstrom, the fact remains that Medicaid is—and will remain—a critical component of the U.S. health care system. Even now, the program is the single largest payer for health care services in the country, providing care to 49 million citizens and legal residents.[3]

CONTRACEPTION WORKS

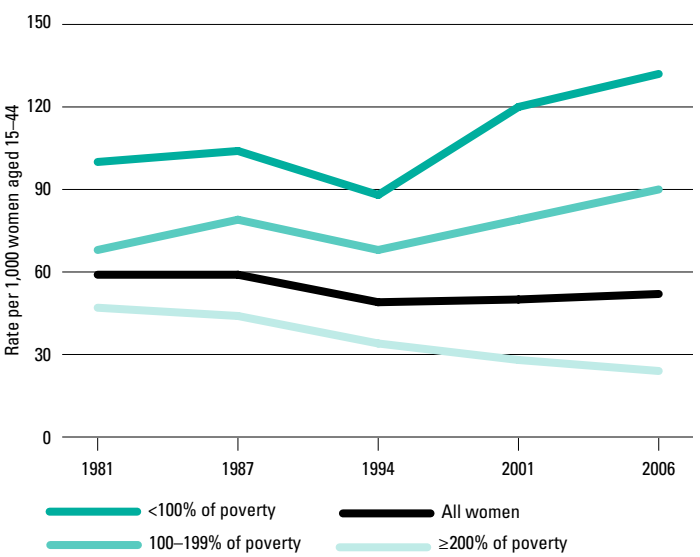
The one-third of U.S. women at risk for unintended pregnancy who do not practice contraception consistently and correctly—or at all—account for 95% of unintended pregnancies.



Note: Nonuse includes women not using a method all year (6%) and those with a gap in use of at least one month (10%). *Source:* Reference 6.

DIVERGING TRENDS

Unintended pregnancy has become increasingly concentrated among poor and low-income women.



Source: Reference 8.

And because every Medicaid enrollee is guaranteed coverage for a strong package of family planning services and supplies, the program has become the financial fulcrum for the U.S. family planning effort, accounting for three-quarters of public funding.[4] That investment, according to numerous studies, is addressing a range of needs for women and couples and is paying considerable dividends for individuals, families, government and society.

Medicaid and the U.S. Family Planning Effort

Family planning services provide substantial benefits for the health and well-being of women and families, primarily by helping them to plan and space their pregnancies.[5] Correct and consistent contraceptive use dramatically reduces the risk of unintended pregnancy: Women who are not using contraceptives, or who are using them inconsistently, represent one-third of women at risk for unintended pregnancy but account for 95% of all unintended pregnancies (see chart).[6] Unintended pregnancy and inadequate pregnancy spacing, in turn, have been linked with a range of negative maternal and child health outcomes.[5] For example, numerous studies demonstrate a causal link between pregnancies that are too close together and key birth outcomes, such as low birth weight and preterm birth, that influence the future health of the child. Similarly, unintended pregnancy is linked with negative maternal behaviors, such as delayed initiation of prenatal care and reduced breast-feeding. In addition, women's ability to rely on contraception and plan their families enables them to invest in higher education and to be full participants in the nation's workforce.

Despite the well-documented benefits of contraception, many women face problems using contraceptives consistently over several decades—something that is necessary for the average U.S. woman to meet her childbearing goal of two children. The result is that half of U.S. pregnancies—3.2 million annually—are unintended, and about 5% of reproductive-age women have an unintended pregnancy each year.[7] The challenges women face in terms of knowledge, motivation and access to services are particularly salient for lower-income women. In fact, in 2006, the rate of

unintended pregnancy among women in poverty was more than five times the rate among women at or above 200% of poverty and had increased by 50% since 1994 (see chart).[8]

The federal and state governments have worked for decades to help women meet these challenges. At last count, in 2006, publicly funded family planning services in the United States helped serve 9.4 million female contraceptive clients. That included 2.2 million clients served by private doctors and clinicians and 7.2 million served by the nation's network of more than 8,000 family planning centers.[9] All told, these services helped women and couples avoid 1.94 million unintended pregnancies, which would have resulted in 860,000 unplanned births and 810,000 abortions. Without these services, unintended pregnancy, teen pregnancy and abortion in the United States would be nearly two-thirds higher among women overall and close to twice as high among poor women. The subset of services provided by publicly supported family planning centers resulted in almost 1.5 million unintended pregnancies averted in 2008 at a net savings to taxpayers of $5.1 billion.[10] This amounted to nearly $4 saved for every $1 spent providing contraceptive care. (For state-specific data of the impact of the services provided at publicly funded family planning centers, see table.[6–7,10–13])

Medicaid is at the center of the U.S. family planning effort. Altogether, Medicaid provided $1.8 billion toward family planning services in FY 2010, amounting to 75% of total public funding for family planning.[4] That includes all of the public funding for family planning services provided by private doctors and clinicians and for most of the services provided at subsidized family planning centers. (For state-specific data on Medicaid family planning expenditures, see table, page 10.[4]) Indeed, the program has been responsible for almost all of the growth in family planning funding since the early 1990s. That growth largely mirrors broader trends throughout the program, with enrollment in Medicaid and its companion, the Children's Health Insurance Program (CHIP), increasing by nearly 75% between 2000 and 2010, because of eligibility expansions and growth in enrollment during the economic downturn.[3]

IMPACT OF FAMILY PLANNING CENTER SERVICES

	Impact of services at publicly funded centers, 2008		% increase in events in the absence of these services		
	Unintended pregnancies averted	Cost savings (in millions of dollars)	Unintended pregnancies	Abortions	Teen pregnancies
U.S. TOTAL	**1,476,300**	**$5,099**	**46**	**51**	**52**
Alabama	28,200	$60	36	106	40
Alaska	6,800	$53	96	140	83
Arizona	18,600	$58	36	43	34
Arkansas	17,100	$62	77	125	92
California	317,900	$924	52	60	57
Colorado	26,700	$75	59	73	59
Connecticut	16,600	$71	47	39	66
Delaware	4,800	$21	42	34	71
Dist. of Columbia	7,000	$15	43	54	40
Florida	65,500	$183	32	31	45
Georgia	34,800	$191	32	43	38
Hawaii	4,200	$15	18	32	34
Idaho	7,600	$34	70	112	74
Illinois	44,000	$153	32	38	40
Indiana	22,700	$87	50	76	54
Iowa	16,400	$71	82	102	98
Kansas	9,500	$30	38	70	37
Kentucky	25,300	$128	79	173	58
Louisiana	14,700	$65	28	49	24
Maine	7,400	$17	83	102	127
Maryland	20,100	$88	28	29	53
Massachusetts	25,800	$105	52	41	84
Michigan	31,200	$79	45	36	57
Minnesota	21,000	$54	46	65	80
Mississippi	16,600	$31	41	88	54
Missouri	20,800	$78	39	57	44
Montana	7,000	$18	82	137	104
Nebraska	5,000	$10	52	84	57
Nevada	9,300	$23	28	29	30
New Hampshire	6,600	$21	77	94	176
New Jersey	30,100	$156	27	23	37
New Mexico	15,100	$56	82	86	75
New York	98,000	$396	35	28	48
North Carolina	34,000	$133	34	47	39
North Dakota	3,900	$16	84	176	100
Ohio	34,500	$122	34	44	50
Oklahoma	24,800	$76	54	139	56
Oregon	29,400	$37	87	99	108
Pennsylvania	67,700	$209	50	67	86
Rhode Island	5,800	$21	43	54	45
South Carolina	23,700	$99	46	72	45
South Dakota	4,800	$16	83	208	88
Tennessee	31,200	$137	28	83	38
Texas	98,700	$348	32	51	28
Utah	9,600	$38	38	102	70
Vermont	5,700	$19	116	140	150
Virginia	20,100	$93	25	26	38
Washington	40,500	$138	77	68	100
West Virginia	11,900	$56	79	163	83
Wisconsin	24,300	$94	55	102	86
Wyoming	3,200	$20	78	111	93

Note: Percentage increase in the absence of services provided at publicly supported centers is calculated by dividing the number of events (unintended pregnancies, abortions or teen pregnancies) averted by the total number of events in the state. *Sources:* Columns 1 and 2 and abortions averted (2008)—reference 10; unintended pregnancies and teen pregnancies averted (2006)—reference 6; total number of unintended pregnancies (2006)—references 7 and 11; total number of abortions by state of residence (2007)—reference 12; and total number of teen pregnancies (2005)—reference 13.

MEDICAID FAMILY PLANNING FUNDING

	Medicaid expenditures on family planning services, FY 2010	
	dollars spent, in millions	as % of all public spending
U.S. TOTAL	**$1,770.0**	**74.7**
Alabama	34.3	72.8
Alaska	2.1	38.7
Arizona	58.5	90.4
Arkansas	25.6	85.0
California	518.9	85.7
Colorado	11.4	46.4
Connecticut	7.6	66.3
Delaware	5.6	77.8
District of Columbia	4.6	86.1
Florida	66.0	64.0
Georgia	78.6	85.3
Hawaii	6.1	71.9
Idaho	3.1	39.7
Illinois	40.7	71.4
Indiana	14.6	65.1
Iowa	16.5	82.7
Kansas	2.6	24.2
Kentucky	37.7	70.5
Louisiana	34.5	87.8
Maine	4.4	57.8
Maryland	38.5	81.0
Massachusetts	40.7	79.8
Michigan	39.0	72.1
Minnesota	13.6	61.7
Mississippi	20.1	79.5
Missouri	40.2	88.0
Montana	1.5	34.0
Nebraska	5.7	76.0
Nevada	4.1	57.1
New Hampshire	2.1	45.2
New Jersey	20.6	56.6
New Mexico	10.4	83.5
New York	83.0	65.1
North Carolina	32.5	41.1
North Dakota	0.7	31.1
Ohio	31.0	74.4
Oklahoma	22.2	71.5
Oregon	35.8	86.6
Pennsylvania	75.6	84.6
Rhode Island	2.2	58.3
South Carolina	25.0	74.2
South Dakota	2.0	61.5
Tennessee	42.7	76.7
Texas	92.1	62.1
Utah	4.1	66.5
Vermont	4.2	80.3
Virginia	28.2	86.6
Washington	41.7	62.0
West Virginia	5.7	48.9
Wisconsin	30.2	64.1
Wyoming	1.5	62.6

Source: Reference 4.

Medicaid's role as an insurance program for low-income Americans, and as the primary source of public funding for family planning services, is expected to expand further if the ACA is fully implemented. According to projections from the Kaiser Family Foundation, 10 million currently uninsured American women aged 18–64, 55% of all uninsured women in that age-group, could qualify for Medicaid in 2014 under the new, expanded eligibility criteria.[14]

Medicaid Family Planning Expansions

Although Medicaid as a whole has been a key component of the U.S. family planning effort in every state, it has become particularly vital in about half the states. Since the mid-1990s, 24 states have initiated broad income-based expansion programs providing family planning services under Medicaid to women (and, in some states, men) with incomes well above the cut-off for Medicaid eligibility overall and regardless of whether they meet other requirements for Medicaid coverage, such as being a low-income parent (see map).[15] These states have usually sought to match the eligibility level they have set for pregnant women under Medicaid, typically 185% or 200% of the federal poverty level. Five additional states have implemented more limited expansions for individuals losing full-benefit Medicaid coverage (most often after giving birth).

These programs were pioneered not only in states like California and Oregon that are seen as traditionally supportive of reproductive rights, but also in conservative southern states such as Arkansas and South Carolina. In those states, Medicaid may pay for 60% or more of all births in the state, and health officials have been particularly concerned about preterm births and other maternal and child health issues. Family planning services were seen—in conservative, moderate and liberal states alike—as having the potential to address these concerns while supporting the choices of women and families.

Initially, states seeking to implement a Medicaid family planning expansion program were required to receive federal approval under a long and complicated process known as a waiver.

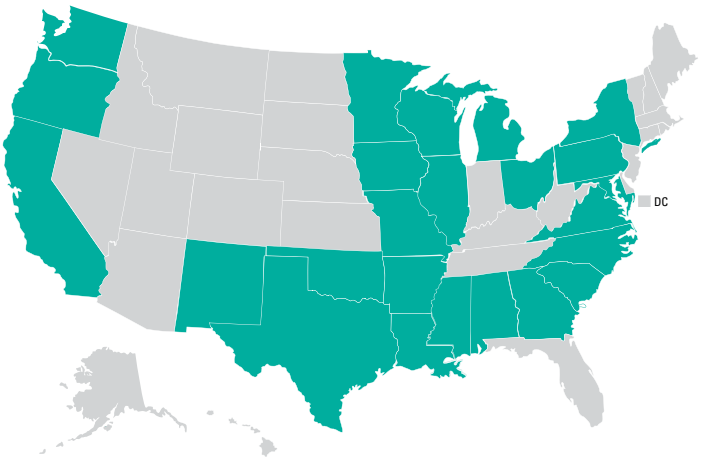
States are required to demonstrate the effectiveness and cost-effectiveness of these waiver programs. Because those evaluations over nearly two decades showed that the programs have clear health benefits and generate significant government cost savings, Congress included a provision in the ACA designed to facilitate states' adoption of an expansion program. States were given new authority, known as a State Plan Amendment, to set the eligibility level for family planning up to the highest level for pregnant women in place under Medicaid or CHIP; the state may not exclude individuals based on age or gender. The provision also greatly simplifies the process for a state seeking to implement an expansion program and allows the program to be permanent (rather than having to be renewed periodically, as is the case for waivers).

States' long experience in implementing these programs has made it clear that maximizing a program's impact requires serious efforts to ensure that potential clients learn about the program and to streamline Medicaid's often complicated enrollment process.[16] To reach out to new clients, state agencies have established program Web sites and telephone hotlines, linked up with other health and social services programs, and used tailored messages and tactics to reach young adults, Latinas and other groups in need. To address enrollment barriers, states have used tactics such as simplifying application forms, offering online applications, using databases to verify citizenship status and income, automatically enrolling certain groups of potential clients, and facilitating applications and enrollment at the point of service. Many of these tactics are expected to be duplicated as states work to implement the broader Medicaid expansion under health reform.[17]

National analyses and state evaluations provide considerable evidence of the impact of these expansion programs. Collectively, the income-based Medicaid expansion programs spent $626 million on family planning services in FY 2010.[4] The limited expansion programs spent $3.7 million that year. Together, spending under the expansions constitutes 36% of total Medicaid family planning expenditures in the United States.

STATE MEDICAID EXPANSIONS

Twenty-four states have implemented broad-based Medicaid family planning expansions for individuals who are not eligible for full-benefit Medicaid coverage.



Note: As of April 1, 2012. *Source:* Reference 15.

With these resources, the expansion programs serve about 2.7 million clients over the course of a year.[16] They have expanded the network of family planning providers and increased their capacity to meet the need for services. The services provided have helped reduce levels of unprotected sex, increase use of more-effective contraceptive methods and improve continuity of contraceptive use. Expansion programs have also increased access to related preventive care, such as screening for STIs and cervical cancer. Improved contraceptive use has translated into measurable improvements in women's ability to space their pregnancies, as well as declines in unintended and teen pregnancy, and the births, abortions and miscarriages that otherwise would have resulted. Indeed, three independent teams of economists have identified significant effects on statewide birthrates, despite the fact that each expansion is limited to a small segment of the state's population. In the process, the expansions have substantially reduced federal and state Medicaid expenditures on unplanned pregnancy.

Winning Medicaid's Future

Medicaid appears to be at its most important turning point since the program was enacted by Congress in 1965. In June, the Supreme Court is

expected to issue its ruling on the constitutionality of the Medicaid expansion. Only a few months later is a national election.

Regardless of the outcome of either event, Medicaid will not disappear. What is not clear is the direction the program will take. A stronger, expanded Medicaid program should mean more and better coverage for the reproductive health needs of low-income Americans. A scaled-back Medicaid, reshaped to restrict costs, enrollment and care, would weaken the family planning safety net and imperil the health and well-being of the women and families who rely upon it.

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Editor's Note: State-by-state fact sheets about Medicaid and family planning can be found on the Guttmacher Institute's Web site at: <www.guttmacher.org/statecenter/medicaid>.

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