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Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future

Adam Sonfield and Rachel Benson Gold

HIGHLIGHTS

- Since the mid-1990s, 22 states had implemented a program to extend Medicaid coverage for family planning services to residents on the basis of income, regardless of whether they meet other requirements for Medicaid coverage, such as being a low-income parent.
- 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 streamline enrollment, states have used tactics such as 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.
- The expansion programs collectively serve about 2.7 million clients each year and have expanded the network of family planning providers and 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. They have also expanded access to related preventive care, such as screening for STIs and cervical cancer.
- Improved contraceptive use has translated into measurable declines in unintended and teen pregnancy and improvements in women's ability to space their pregnancies. In the process, the expansions have substantially reduced federal and state Medicaid expenditures on unplanned pregnancy.
- Taken collectively, the findings of state program evaluations and national analyses point to the undeniable value of publicly funded family planning services, both within state Medicaid programs and beyond. The programs' innovations and best practices in outreach and enrollment hold important lessons for the implementation of U.S. health reform efforts.

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Background

Between 1997 and the middle of 2011, 22 states expanded eligibility for family planning services under their Medicaid programs to broad populations of low-income Americans otherwise ineligible for Medicaid coverage.[1] Those 22 states account for two-thirds of women in need of publicly subsidized family planning services and supplies.[2] This report brings together nearly two decades' worth of evidence from state evaluations and national analyses about the impact of the expansion programs, with respect to increasing access to services, improving contraceptive use, avoiding unintended pregnancy and other key outcomes. It also lays out the ways in which state programs have advanced Medicaid programs' knowledge of how best to reach out to and enroll potential clients. The evidence gathered about the effectiveness of the services provided by the Medicaid expansions buttresses an already strong case about the value of improving access to publicly funded family planning services generally. And the lessons learned from this grand experiment will be especially relevant going forward, as the country moves toward larger-scale expansions to Medicaid under the new era of health reform.

History of the Expansions

When Medicaid was first established in 1965, the low-income families covered by the program generally were single mothers who received welfare cash assistance, and their children. In the 1980s, responding to research that showed the importance and cost-effectiveness of prenatal care, Congress broke the link between welfare and Medicaid for low-income pregnant women: It first allowed and later required states to extend eligibility for Medicaid-covered prenatal, delivery and postpartum care to all women with incomes below 133% of the federal poverty level ($18,530 for a family of three in 2011),[3] which was far higher than most states' regular Medicaid eligibility ceilings.[4] At their option, states could expand eligibility for pregnancy-related services to women with incomes up to 185% of poverty or beyond, and most states have done so.[4] As a result of such expansions, Medicaid pays for nearly half of all births in the United States each year.[5] In the 1990s, Congress continued this piecemeal, state-based expansion of public health coverage—most notably, by enacting the Children's Health Insurance Program (CHIP) in 1997 as a companion program for Medicaid to provide coverage for low-income children.

In recent years, almost half the states have sought and received permission from the federal government to similarly expand eligibility for family planning services under Medicaid. These programs include coverage for the package of family planning services and supplies covered for other Medicaid recipients in the state, which generally includes the full range of contraceptive methods, as well as associated examinations and laboratory tests.[6] A long-standing provision of the Medicaid statute allows states to claim federal reimbursement for 90% of the cost of these services and supplies.[7] Although states may include other, closely related care in their package of benefits, such as treatment for STIs diagnosed in the course of a family planning visit, the state must claim federal reimbursement for this care at its regular rate. These rates range from 50% to 76% of the cost, depending on the state.[8] States are reimbursed by the federal government for the cost of pregnancy-related care at their regular reimbursement rates.

As of October 2011, 22 states had implemented a program to extend Medicaid coverage for family planning services to residents solely on the basis of income, regardless of whether potential participants meet any of the other requirements for Medicaid coverage, such as being a low-income parent.[1] (Two additional states, Maryland and Ohio, have received approval for such an expansion from the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the program; those expansions are expected to start as soon as January 2012.) Most of these states extend coverage for family planning to women with incomes below 185% or 200% of poverty, typically the same income level used for pregnancy-related care (Table 1.1).[1,4] Eight of these states limit their programs to individuals who are at least 19 years of age; three limit coverage to those who are at least 18. Eleven include coverage for men in their programs.[1] Together, these 22 expansions serve roughly 2.7 million women and men annually.[9] California's Medicaid expansion alone served 1.8 million individuals (including 300,000

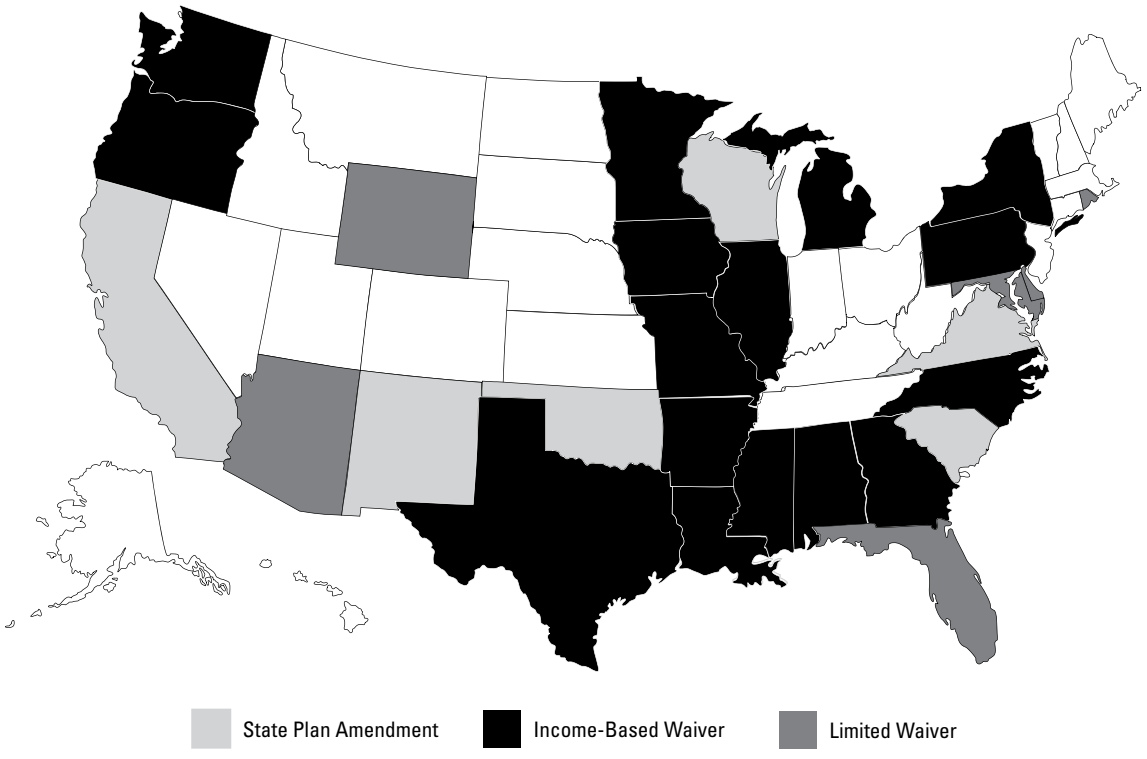
teenagers and 500,000 women in their early 20s) during its most recently evaluated program year (2009–2010).[10]

Six additional states have received federal approval for far more limited, non-income-based programs that extend eligibility for family planning services for some or all individuals who are otherwise leaving Medicaid, such as after the 60-day postpartum period (Figure 1.1).[1] (Notably, several of the states without family planning–specific expansions, including most of the New England states, have high income-eligibility ceilings under their broader Medicaid programs or other publicly subsidized insurance programs that include coverage for family planning services.)

In acknowledgement of the demonstrated effectiveness and cost-effectiveness of these programs, a ground-breaking provision included in the health reform legislation enacted in March 2010—the Patient Protection and Affordable Care Act—greatly simplifies the process for states seeking to expand eligibility for family planning services under Medicaid.[11] In the past, the only option states had was to obtain a research and demonstration waiver from CMS, which allows them to bypass standard Medicaid rules to provide a limited benefit package and to cover individuals who otherwise would not be eligible. Although no law or statute requires it, CMS has historically required that waivers be budget-neutral to the federal government—that is, they cannot cost the federal government more than it would spend in the absence of the waiver. Waivers also must have an extensive evaluation component, consistent with their role as demonstration initiatives. On average, it has taken roughly two years for a state to secure approval of a Medicaid family planning waiver.[12]

The provision included in the Affordable Care Act gives states a second option: It allows states to expand eligibility for family planning, up to the highest income-eligibility level for pregnant women in place under either the state's Medicaid or CHIP state plan, by amending their state Medicaid plan. Although a state must still obtain federal approval for a state plan amendment (SPA), the process for securing such approval is generally much faster and more streamlined than that for a waiver. Moreover, unlike a waiver, which is initially granted for a five-year period and then renewed in three-year increments, a SPA is a permanent change to a state's Medicaid program.

FIGURE 1.1. Twenty-two states—representing two-thirds of U.S. women of reproductive age—had implemented broad-based Medicaid family planning expansions, as of November 2011.



Note: As of November 1, 2011. *Source:* Reference 1.

CMS guidance specifies that states seeking to avail themselves of this option must include all individuals in the state who are not pregnant and who meet the income eligibility criteria established by the state.[13] As a result, family planning SPAs must cover males and adolescents, even if these individuals were not covered under a waiver previously obtained by the state.[14]

In addition, several restrictions that have been applied to family planning waivers in the past do not apply to SPAs. For example, states may use an enrollment strategy known as presumptive eligibility, through which an applicant may be granted immediate temporary eligibility by a qualified health care provider. Although documentation for various factors of eligibility—such as citizenship—is required to convert temporary eligibility into full enrollment, such documentation is not required for the presumptive determination. In addition, CMS does not limit coverage under SPAs to individuals who are uninsured, a requirement that had been imposed under waivers in the past. (However, as is the case for Medicaid generally, states are obligated to receive reimbursement from third-party payers.)

About This Report

This report explores three aspects of the Medicaid family planning expansions: outreach activities, enrollment practices and evidence of the expansions' impact. The chapters on outreach and enrollment update a prior Guttmacher Institute paper, published in 2008, on innovations in the design of states' expansion programs.[15] We have expanded and updated that information by surveying officials from the 22 states with income-based expansions, receiving responses from 19 of those states.[16] The chapter on the expansions' impact draws on a considerable body of research that has accumulated over the course of nearly two decades. The states have all been required to evaluate their individual programs, a task they have typically contracted out to state universities; as of August 2011, 19 of the 22 states with income-based expansions have made at least one such evaluation report available to the Guttmacher Institute.* In addition, CMS itself sponsored a multistate evaluation of the programs—conducted by the CNA Corporation along with the schools of public health at Emory University and the University of Alabama at Birmingham—that was completed in 2004.[17]

Three independent teams of economists have analyzed vital statistics records and other data to look at the impact of the expansions across the country.[18–20] And both the Guttmacher Institute and the Brookings Institution have released projections of the potential impact of further state expansions.[21,22]

*Of the remaining three states, Georgia's program was first implemented in 2011, too recently for an evaluation to be completed; Louisiana's first evaluation was not yet finalized as of this writing; and New York's family planning expansion is part of a much broader Medicaid eligibility expansion and has not, to our knowledge, been evaluated independently.

Outreach Activities

The Medicaid expansions for pregnant women in the 1980s pioneered many approaches to reaching out to new clients, such as targeted mailings and the establishment of telephone hotlines, in an effort to increase prenatal coverage.[23] In the late 1990s, CHIP programs took similar steps and tested additional practices. Family planning expansion programs have built upon this foundation in developing their own innovations.

Broad-Based Outreach

In order to first introduce a family planning expansion—when the need for outreach and internal support for conducting that outreach are typically at their peak—states have most commonly used broad outreach techniques. In some cases, this initial investment has included mass media campaigns, such as television, radio, billboards, transit ads, newspaper ads and mass mailings. States' experience with mass outreach has been decidedly mixed.

In Virginia, for example, state officials gave radio and television interviews, and printed and distributed posters and pamphlets during the rollout of its income-based expansion. A later survey of participants found that only 12% had heard about the program through those types of sources; rather, the most common source of information about the program was the state social services department.[24]

Alabama, meanwhile, has run a statewide television commercial for its expansion program, Plan First, each year for one month during primetime, with limited success. The commercial has had a noticeable impact on the number of inquiries to the programs' telephone hotline. Nevertheless, surveys of actual enrollees have found that only about 1% had learned about the program from the television campaign, and far fewer from a radio campaign. Instead, about half learned about the program by referral from a provider and 14% via a postcard campaign.[16,25] Mississippi officials, on the other hand, have singled out movie theater ads as particularly effective.[16]

One common refrain among state officials is that mass media campaigns, whatever their impact, are not cost effective; in many cases—particularly during states' current fiscal crises—they are simply unaffordable. California, Michigan, North Carolina, Oklahoma and Washington all expressed specific concerns about cost effectiveness or limited outreach budgets.[16] According to Oregon officials, they have found their evaluation efforts to be most effective when multiple strategies—including transit, outdoor, cinema and print promotions—were run simultaneously as part of a coordinated social marketing campaign; on its own, each strategy has been less effective and cost effective.

Instead of proactive mass media campaigns, states have tended to rely on passive outreach techniques for mass audiences, including telephone hotlines (cited by 14 of the 19 states that responded to the 2011 survey), client referral programs (through which clients are provided with materials to pass along to their peers; cited by eight of the 19) and program Web sites (cited by 15 of the 19; Table 2.1).[16] The latter can be particularly helpful, for instance by allowing users to download applications, learn about covered services, ask questions about the program and locate providers in their area. Web sites can also help address the needs of women and men for whom English is not their primary language; California's Web site, for example, includes patient portals in six different languages: English, Spanish, Chinese, Vietnamese, Korean and Russian.[26]

Targeted Outreach

Some of the most common and most effective outreach methods have been those directed toward women and men who already have ties to publicly funded family planning. Medicaid expansion officials have partnered with family planning centers to sign up existing clients who meet the program's eligibility criteria. The influx of Medicaid reimbursement allows the family planning centers to expand access to additional clients and to conduct local outreach efforts to attract those new clients. In many states (eight of 19 in the 2011 survey; Table 2.2),[16] all community-based outreach is conducted by providers, rather than directly by the state, an approach that both saves the state money and takes advantage of family planning providers' knowledge of the local communities. This does not necessarily mean that the state plays no role in community outreach. In California, for example, the state provides free education and outreach materials to providers and has promoted best outreach practices through

its Web site, provider forums and webinars.[27,28] Client surveys in many states, including Alabama, Louisiana and Pennsylvania, have identified family planning providers as the most commonly cited source of information about the expansion program.[16,25,29]

States also commonly establish linkages between family planning expansions and other segments of their Medicaid and CHIP efforts. Women who are leaving Medicaid or CHIP after their 60-day postpartum period may have a particular need for family planning services, and most family planning expansions (13 of the 19) reach out to these women via mailings and phone calls.[16] Oklahoma officials say they have had success by reaching out to households with newborns as part of a broader initiative to educate families about available benefits. The state has similarly sent out program brochures to young adults aging out of their coverage in the state's broader Medicaid and CHIP efforts. Texas sent one million bilingual notices about their expansion program in 2009 alone to women whose children are enrolled in Medicaid.[30]

Also common are linkages with other health and social services programs. Illinois reports success collaborating not only with the Title X family planning program, but also with the state's family case management program (which links low-income families with health and socials services) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).[16] Outreach personnel in Alabama contact women receiving food stamps or WIC, and they include information on the state's Plan First program in the packets of information sent out at the beginning of each school year to parents of children enrolled in Head Start.[15] Pennsylvania's family planning expansion checks state databases for women who have been enrolled in any of the agency's other income-based programs, including food stamps, welfare and the school lunch program.[15] And Texas has conducted outreach via other state programs addressing birth defects, developmental disabilities and substance abuse.[30]

Most of the family planning expansions (13 of 19 in the survey) have made a particular effort to reach out to young adults, the age-group with the highest rate of unintended pregnancy.[16] Often this means working with community colleges and other colleges and universities, through their health clinics, health fairs and other venues, to provide students with information about the Medicaid expansion and local family planning providers. In several cases, states have worked to develop outreach materials designed specifically for young adults. For example, Virginia conducted a pair of focus groups to develop brochures, posters and other materials that would be appealing to young adults.[24] Illinois sponsored a project to assess the knowledge of college-age women about contraception and identify where students currently obtain health care information, in preparation for targeted social marketing initiatives.[31]

Fewer of the expansions (three of the 19) have tailored messages specifically for teenagers, in large part because half of them do not enroll minors.[16] California, however, requires that state-funded teen pregnancy prevention programs be formally linked with local family planning providers; in addition, many school and university health clinics are providers in Family PACT, the state's Medicaid family planning expansion.

Many states make a special effort to reach out to Latina women, because of their relatively high rates of unintended pregnancy, relatively low rates of private insurance coverage and potential language barriers. Texas, with its large Latina population, has been a leader on this front. To increase awareness among Latina women, Texas has produced bilingual outreach materials for potential enrollees and has conducted a series of bilingual regional billboard and transit ad campaigns.[30]

One well-established tactic—for the family planning expansions and for public health programs more broadly—has been the use of community health workers, known as *promotoras* in Latina communities, to assess the needs of and reach out to vulnerable members of their own community.[32] Drawing on their local roots and connections, promotoras provide information about available services and help clients navigate the system. Texas, for example, has worked with community colleges across the state to train and certify community health workers, and has included specific training about the state's family planning expansion. Arkansas has also reported some success with promotoras, who refer hundreds of people to state health clinics each year.[33]

States have varied in their approaches to community outreach. Some efforts are collaborative across the public health system, while other efforts are focused specifically on the family planning expansions and the existing clinic system. For instance, social workers and nurses in Alabama conduct assessments for family planning clients at county health departments and spread awareness about the program at physician's offices, colleges and other locations, particularly in areas where enrollment and participation in the program is low.[15] The venues states use to conduct outreach activities also are diverse, including schools and universities; hospitals, clinics, physicians' offices and pharmacies; recreation and community centers; local employers; and faith-based organizations. Community events such as health and job fairs are particularly important venues, cited by 11 of 19 states surveyed and highlighted in several state evaluations.[16]

Streamlining Enrollment

In addition to developing new outreach strategies for Medicaid, the pregnancy-care expansions of the 1980s also worked to streamline the eligibility and enrollment process, to help attract as many pregnant women as possible. They established simplified asset tests and allowed for applications to be completed by mail or on site at health clinics and hospitals.[23] Perhaps most notably, they pioneered an enrollment tactic known as presumptive eligibility, which allows health care providers, rather than government workers, to certify a client as eligible for temporary Medicaid coverage so that she can obtain prenatal care at her first visit.

CHIP programs have aimed to further simplify applications for eligible children. They have made use of universal applications for a range of government programs, as well as expedited, "express lane" enrollment for families that have established their income through programs with similar eligibility requirements (such as WIC or the school lunch program).[34] And many CHIP programs have allowed clients to self-declare their income with after-the-fact checks via government databases.[35,36]

Family planning expansion programs have built on these innovations and in some cases carried them a step further. They have worked to simplify the application process; automatically enroll certain groups of eligible individuals; facilitate applications at the point of service; and provide confidentiality protections to minimize disincentives to enrolling in and using the program.

Simplified Applications

Most states (including 17 of the 19 states in the 2011 survey) use simplified applications—typically one or two pages—that can be filled out quickly (Table 3.1).[16] These applications generally ask for a limited amount of information, including:

- contact information;
- age and gender;
- whether the client is sterile or pregnant;
- insurance and citizenship status;
- social security number;
- family size; and
- income.

This is much simpler than many Medicaid applications, which may require detailed information about a family's assets, income and financial obligations.

To make applying more convenient, most states (16 of the 19) allow applicants to start or complete the process remotely, by mail, fax or telephone or on the Internet, and without requiring an in-person interview.[16] Online application systems, in particular, have the potential to marry convenience with thoroughness by guiding applicants through the process and checking for missing information. Michigan officials believe their use of online applications has been the program's most effective strategy for enrolling teenagers and young adults. Oklahoma officials also tout the state's online enrollment system, which allows applicants to receive their eligibility determination in real time, as well as review a list of available providers.

Online application systems in some states also help residents to choose among multiple public programs for which they might be eligible. Wisconsin's system, for example, allows individuals and families to be screened simultaneously for eligibility for the family planning expansion, other types of health care coverage, and programs that provide long-term care, subsidize food and energy expenses, and provide state and federal tax credits.[37] Through the same Web site, those deemed eligible can then apply for several of the programs, including family planning, and check on the status of their benefits. Pennsylvania's online system works in a similar manner, and it allows a community-based organization or health care provider to assist with the application and screening process and to keep tabs on the application.[15,38]

For all types of applications—online or otherwise—most states are using state, federal and private databases to ease barriers related to documentation of clients' information. Notably, 16 of the 19 survey states are using this tactic to confirm applicants' citizenship status and social security number.[16] This option greatly mitigated problems caused by a 2006 law, which required officials to verify citizenship status via original documents of identification such as driver's licenses, birth certificates and passports.[39] Seven of the 19 states also help clients meet this documentation requirement by obtaining birth certificates for applicants born out of state.[16] Oregon officials note that

these strategies are particularly important for helping adolescents and young adults, who often have difficulty coming up with the necessary documents on their own; the state's evaluation highlights the fact that program staff are able to electronically confirm birth data for more than 80% of applicants.[16,40]

Databases also ease the burden on states of verifying an applicant's income, by making use of other state records—such as enrollment in other public programs with similar income eligibility ceilings—and privately run databases designed to help both government agencies and private companies verify employee incomes. Most of the states (13 of the 19) have adopted the CHIP-developed tactic of allowing clients to self-declare their income, with after-the-fact verification.[16] Using databases and government records to verify income is particularly helpful for streamlining the renewal process, because it is one of the few eligibility criteria that need to be checked on an ongoing basis. In fact, Missouri uses this information to automatically renew a woman's enrollment in the family planning expansion each year, contacting the woman only if information is missing.[41]

Automatic Enrollment

Many states (eight of the 19 states in the 2011 survey) have eliminated the application process entirely for certain groups of individuals losing full Medicaid coverage, by automatically enrolling them in the family planning expansion program.[16] Most commonly, this is done when women lose Medicaid coverage after giving birth. Typically, a woman will receive a letter or a phone call from her provider letting her know that she has been automatically enrolled in the program. This is often accompanied by a new enrollment card and information on participating clinics, available services and how to contact the program if the woman has questions.

Although this tactic ensures high enrollment into the family planning program, follow-up efforts in some states, including Alabama and Mississippi, have found that most auto-enrolled women do not make use of their new coverage.[16,25] When surveyed, many do not know or remember that they have been enrolled, or they do not understand what benefits are (and are not) available to them. At the same time, officials from Iowa and South Carolina have identified auto-enrollment as one of their most effective enrollment techniques.[16] And Virginia's evaluation notes that participation in the expansion declined by 55% over two years after the state discontinued automatic enrollment of postpartum women.[24]

To mitigate potential problems with automatic enrollment, some states have moved to repeatedly remind pregnant or postpartum women that they have been, or are about to be, enrolled in a family planning program, or to offer the women an opportunity to decline coverage. In Illinois, for example, family case managers are informed when a woman has been auto-enrolled for family planning coverage, so that the case manager can help her understand the program and find a family planning provider.[15] In Arkansas, all women enrolled in Medicaid because of a pregnancy are asked before they give birth whether they would like to be moved into the family planning program postpartum (effectively, an "opt in" approach).[15] In Oklahoma, that question is asked when a woman is enrolled in Medicaid for pregnancy care.[16] And, in Missouri, women losing eligibility postpartum receive two letters informing them they will be automatically enrolled in the family planning expansion and outlining covered benefits and their new term of eligibility.[41]

Illinois takes the concept of auto-enrollment further.[15] Its initial waiver program, approved in 2003, was limited to individuals losing full-fledged Medicaid coverage for any reason—including not only postpartum women, but also young adults who have aged out of their childhood coverage, and families whose earnings have risen above the Medicaid income ceiling. When the state's waiver was revised in 2006 to extend eligibility to individuals solely on the basis of income, the state held on to its earlier enrollment process, as well. Individuals who lose Medicaid coverage are automatically mailed a card providing them with three months of family planning coverage, along with an enrollment form to continue coverage after that.

There are several other examples of systems that automatically screen individuals without necessarily enrolling them. Under Michigan's electronic application system for Medicaid and CHIP, if a woman enrolls her child in Medicaid, the system will automatically determine whether she is eligible for the state's family planning program and will give her the opportunity to enroll.[15] Pennsylvania utilizes a similar screening system: When individuals apply for public programs online, the system determines whether they are also eligible for the state's family planning program. Individuals may decline to participate if they do not want family planning coverage, are pregnant or have been sterilized.

Point-of-Service Application

Despite the many options available for applying for a family planning expansion remotely, clients often choose to apply in person, often at their point of service, where so many potential enrollees first learn about the expansion programs. Fourteen of the 19 states responding to the 2011 survey allow at least some part of the application

process—such as verifying documents for applications submitted by mail, phone or the Internet—to be completed at the point of service, with 11 of the states allowing full on-site applications (Table 3.2).[16] This latter approach allows applicants to obtain family planning services and supplies immediately, without having to wait for their applications to be processed and without having to make a second visit. From the provider's perspective, another benefit is that it guarantees—or at least provides strong assurances—that the provider will be reimbursed for these services.

One of the most established tactics in the Medicaid program generally for achieving point-of-service application is presumptive eligibility: allowing health care providers, rather than government workers, to certify a client as eligible for temporary Medicaid coverage, with applications for ongoing coverage processed later by the state. Even if the application is later rejected, the provider is reimbursed for services that have been provided. Presumptive eligibility has been an important part of the family planning programs in several states, notably Minnesota, Missouri and Wisconsin,[16,42] and states were explicitly given the option to use presumptive eligibility under their new state plan amendment authority.

Despite its long-standing use elsewhere in Medicaid, CMS prohibited presumptive eligibility for several years during the Bush administration under states' family planning expansions. Instead, several states found ways to implement a system that seemed—from patients' and providers' perspectives—to be virtually identical. When CMS eliminated Wisconsin's use of presumptive eligibility at the beginning of 2008, the state continued its old practices with one key change: For clients who were eventually deemed ineligible, the state fully funded reimbursement to the provider.[15] Pennsylvania has taken a similar reimbursement approach for clients enrolled by one of the state's "community partners." These are organizations—including health care providers and community centers—that have been certified by the state to help women enroll in a state program, such as the family planning expansion, using the state's online application system. A community partner is able to check on the case status of clients they help enroll and is notified when clients' eligibility is finally determined (so providers will know when to file for reimbursement).

Perhaps the most ground-breaking enrollment technique pioneered by the family planning expansions is same-day point-of-service enrollment, which allows clients to sign up for coverage at the point of service, receive services and—for the first time in a Medicaid program—leave their provider's office officially enrolled in the program (rather than only presumptively or temporarily enrolled). California and Iowa both have some variation of this process.[15,43] Significantly, clinic staff do not make the actual eligibility determination. Rather, specially trained clinic personnel walk a client through the program application, verify whatever documentation is required and enter the client's information into the state's computer system. During the client's visit, the state's computer system is able to determine whether the client is eligible and issue a notice of decision.

In whatever form, point-of-service application has been an effective technique and one with a reportedly low error rate, because states make the effort to train and compensate providers for their efforts. Washington state officials reported in 2008 that only two or three out of 100 clients are ultimately rejected after initiating an application at a provider's office.[15] This high success rate may have been spurred in part by the fact that the state created a distinct code that providers were able to use to bill for application assistance to clients, such as answering applicants' questions, explaining the application process, entering application information into the database and verifying information. (In 2011, the state stopped reimbursing providers for application assistance because of budget constraints.[16]) Oregon also took application assistance services into account in setting its rates for a family planning visit, and updated its rates to account for the increased cost to clinics of helping clients meet citizenship documentation requirements in the application process.[15]

Protecting Client Confidentiality

States have taken steps to assure that enrollment in a family planning expansion and use of services under that expansion are kept confidential—protections needed to mitigate concerns that may keep many individuals from enrolling and participating in the program. Studies have shown that teens are likely to avoid seeking birth control and other reproductive health services—but to continue having sex—if a parent must be involved, be it through parental notification or required documentation that only a parent could provide.[44] This is not a concern just for teens: Other vulnerable family planning clients, such as victims of domestic abuse or undocumented immigrants, may avoid services out of their own pressing concerns, and clients may not want their partner to know about their contraceptive use. For these reasons, family planning providers and programs have a rich tradition of finding ways to preserve confidentiality. The Medicaid family planning expansions have had additional need for such protections, because the narrow scope of services provided means that the

very fact that someone is enrolled can be viewed as sensitive information.

Title X, as the only federal source of funding dedicated to family planning, has always required its providers to preserve patients' confidentiality, and its strategies have become the gold standard for the entire U.S. family planning system. Family planning centers funded in part through Title X, notably, allow teens to qualify for services based on their own income, rather than on their parents' income.[45]

Family planning expansion programs have generally adopted these standards. In every expansion program that includes teenagers, the teens are allowed to enroll on the basis of their own income. Following another procedure common within the family planning system, most states (16 of the 19 in the 2011 survey) allow program applicants to provide a second mailing address or phone number as a way for the state or a provider to contact them privately, and several states have started communicating with clients via e-mail or text messaging.[16]

Expansion programs have also had to be innovative to address additional confidentiality issues related to Medicaid broadly or the family planning expansions specifically. For example, states are usually required by Medicaid law to seek reimbursement whenever possible from private insurance. Yet, some clients with private insurance may fear that using their insurance will violate their privacy (e.g., a statement of benefits might be sent to the policy holder, who may be their husband or parent).[46] To get around this problem, most states (13 of the 19) maintain a "good cause" exception that allows clients to enroll in and make use of the family planning expansion, despite the usual restrictions related to private insurance.[16] This exception is often limited to cases where the client fears physical or emotional abuse. For instance, the Texas family planning application asks if filing a health insurance claim could cause physical, emotional or other harm and includes a space for a woman to elaborate.[47]

States' data systems can pose their own confidentiality challenges. As data for many different state programs are linked together (with the advantage of easing enrollment and renewal, and improving customer service), situations may occur in which another family member may inadvertently be informed that a woman is enrolled in the family planning expansion program. Some states (six of the 19) have responded to this potential problem by creating electronic "flags" for client records, such as messages reminding state caseworkers and health care providers when a woman has requested confidentiality or when changes to the client's record may affect her privacy.[16]

Impact of the Expansions

This chapter distills findings from a substantial body of state evaluations and national analyses to present the most complete picture to date of the evidence around the expansion programs' impact. It is organized in seven parts:

- access to family planning services, including expanding the number of family planning clients and providers;
- use of contraception, including use of more-effective methods and continuity of use;
- prevention of unintended pregnancies;
- improved spacing of pregnancies;
- prevention of teen pregnancy and delay of first births;
- government savings from helping women avoid unintended pregnancies and the Medicaid-funded births that would often follow; and
- use of other preventive care, including STI testing and cervical cancer screening.

Access to Services

By serving roughly 2.7 million women and men annually,[9] the 22 state Medicaid family planning expansions account for a sizable proportion of the 9.4 million women estimated to have received publicly supported contraceptive care during the most recently available year, 2006.[48]

New Family Planning Clients

The evidence leaves little doubt that the Medicaid expansions have helped increase the capacity of states' publicly funded family planning provider networks to serve new clients. In fact, the 2004 CMS-sponsored evaluation found that the number of Medicaid expansion participants in four of the states studied exceeded the total number of clients in the target population who had previously been served with *any* public dollars.[17] The evaluation also found that all of the states studied increased the total amount they were able to spend on family planning services per woman, sometimes by a significant margin.

Guttmacher Institute research has confirmed the finding that the expansion programs have helped increase the need met by publicly funded services: Publicly funded family planning centers in states with Medicaid expansions served 48% of the women in need of publicly funded family planning services* in 2006, compared with 36% in other states (Figure 4.1).[49] Moreover, the proportion of such women whose needs are met by family planning centers has grown in the expansion states (from 40% in 1994), while it has declined slightly in other states (from 39% in 1994).[49] The ability to serve more clients has been driven by the availability of new Medicaid funding: Over the same 12-year period, inflation-adjusted expenditures per woman in need grew by 81% in expansion states but by only 32% in other states, and expansion states spent over 70% more per woman in need than other states in 2006.[49]

Similarly, a nationwide analysis of Medicaid claims data over time, part of a broader study by economists Kearney and Levine, found that after controlling for state demographics and other state policies, the income-based expansions increased the share of the state's population of reproductive-age women receiving Medicaid family planning services by 5–10 percentage points.[19]

Evaluations from numerous individual states have generally come to a similar conclusion. Some have found that their expansion has increased the number of people receiving Medicaid-funded family planning services. In Minnesota, for example, use of Medicaid-funded family planning increased from 71,000 in 2004 (before the expansion) to 106,000 in 2009 (after the expansion).[50] In Washington, the number of Medicaid clients served by family planning clinics jumped from 23,000 before the expansion to 122,000 by the program's third year.[51] And in Oklahoma, the proportion of women using Medicaid family planning services within six months of a Medicaid-funded birth increased from 45% in 2004, before the expansion, to 55% in 2008.[52]

Other states have looked beyond Medicaid: Oregon's evaluation found that the total clients served by clinics affiliated with the state's health department grew from

*Women in need of publicly subsidized contraceptive services include those who are sexually active; are of reproductive age (13–44); are able to become pregnant; are not pregnant, postpartum or trying to become pregnant; and who either have a family income below 250% of the federal poverty level or are younger than age 20 and are therefore assumed to have a low personal income.

52,000 in 1999, before the expansion, to 112,000 in 2008.[40] This included an increase among teen clients from 18,000 to 30,000. (The clinics served a high of 157,000 in 2005, before the enrollment in the expansion took a hit following the imposition of strict new federal rules on documenting citizenship, which were found to depress enrollment even among those who were eligible.) Evaluations in North Carolina, South Carolina and Wisconsin found similar, although less pronounced, growth.[42,53,54] And, in Pennsylvania, a survey of expansion enrollees found evidence that the expansion had increased the number of clients served in the state: Forty-three percent of expansion clients had never received family planning services prior to their enrollment.[29]

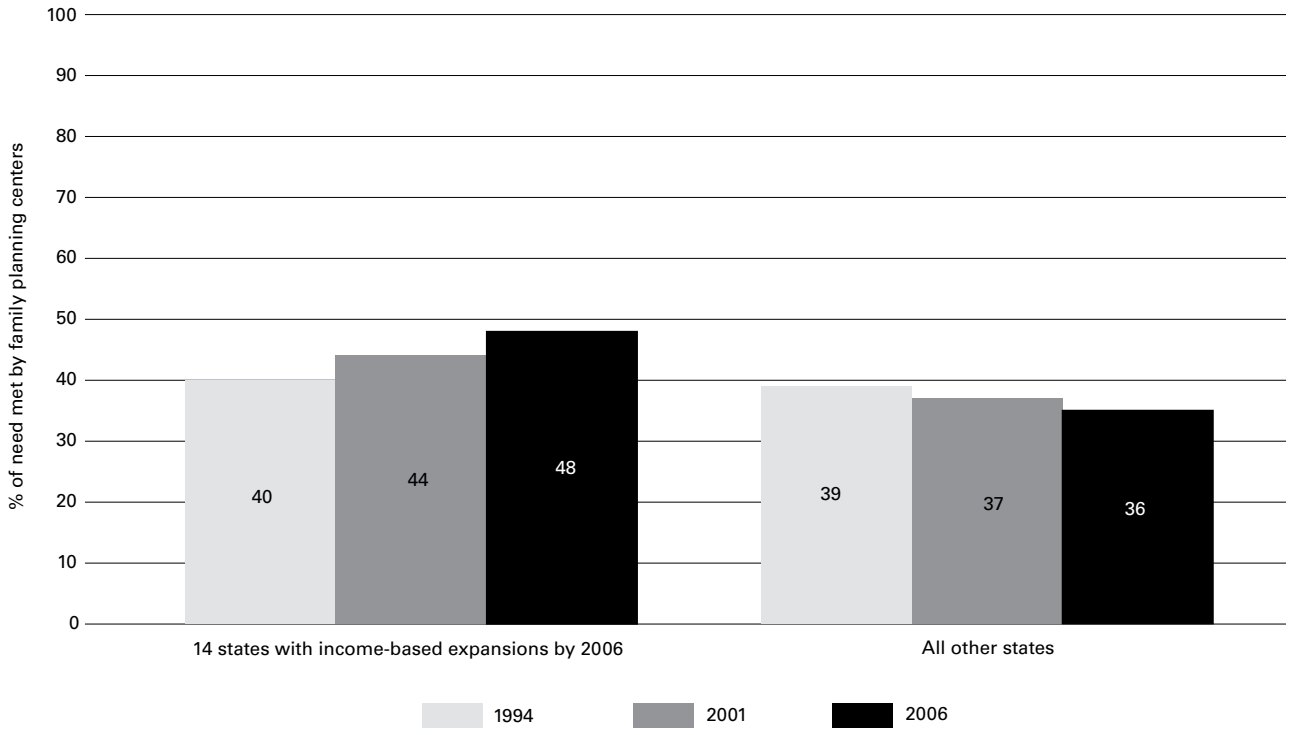
Network of Providers

Evaluation research also demonstrates that the expansions have made progress toward another goal: growing the network of family planning providers and improving the geographic availability of care.

Although many of the Medicaid expansions were organized around states' existing network of family planning clinics—typically those supported by Title X—some states have made it an explicit goal to increase the role of private-sector providers. California has been a leader on this front, with private providers accounting for 58% of the program's network.[10] However, because public-sector clinics tend to serve greater volumes of family planning clients than do private-sector providers, those private providers served only 32% of clients under Family PACT. In Oklahoma, similarly, the number of private clinicians and federally qualified health centers providing Medicaid-funded family planning services doubled between 2004 (before the expansion) and 2009 (after the expansion).[52]

The 2004 CMS-sponsored evaluation singled out California as successfully improving private-sector access.[17] Moreover, the researchers concluded that the geographic availability not only of physicians but also of non–Title X clinics increased with implementation of the Medicaid expansions in all six states that were studied. These increases were especially apparent in those geographic areas with fewer enrollees. This latter finding is tempered by the fact that geographic availability did not always translate into a measurable increase in the use of services, likely because many private practices serve few clients.

FIGURE 4.1. Family planning centers in states with Medicaid expansions have been able to meet more of the need for publicly supported contraceptive care than those in other states and to expand that share over time.

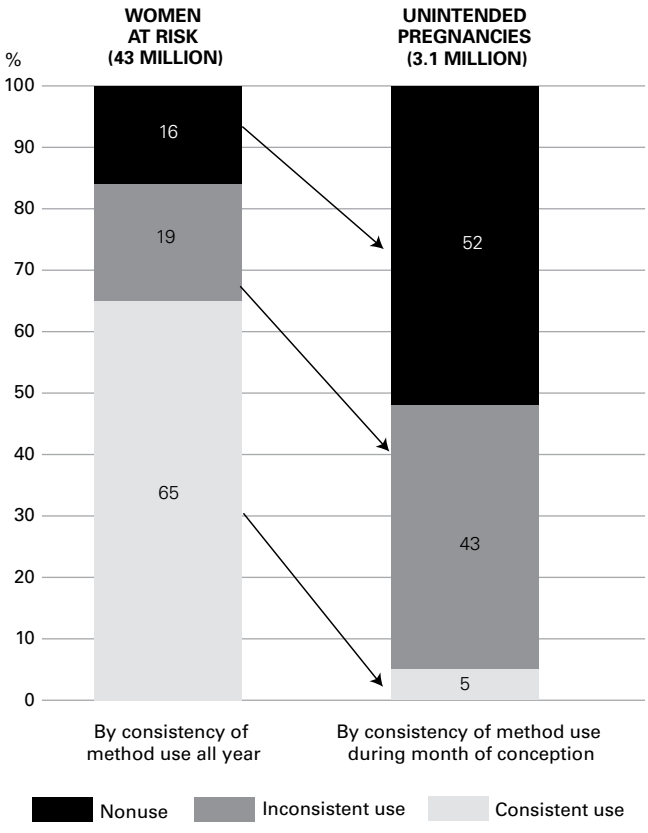


Source: Reference 49.

Contraceptive Use

Evidence from states' evaluations indicates that in addition to expanding access to contraceptive services, the Medicaid expansions have also improved contraceptive use in three ways: increasing the level of contraceptive use, increasing use of more-effective methods and improving continuity of contraceptive use. All three are highly important for reducing the incidence of unintended pregnancy. In fact, among all U.S. women at risk for unintended pregnancy, the 16% of women not using contraceptives for stretches of at least a month in a given year account for 52% of unintended pregnancies, and the 19% reporting inconsistent use account for 43% of unintended pregnancies.[49] The remaining two-thirds of women—those using contraception consistently and correctly—account for only 5% of unintended pregnancies (Figure 4.2).

FIGURE 4.2. The two-thirds of U.S. women at risk of unintended pregnancy who practice contraception consistently and correctly account for only 5% 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 49.

Use of Contraceptives

Several of the state evaluations attempted to gauge the impact of the expansion programs on levels of contraceptive use over time. For example, in Oregon, evaluators found that the proportion of sexually experienced high school students who used a method of contraception at last intercourse increased from 82% in 1997, before the expansion, to 87% in 2007.[40] In Washington, nonuse of contraception dropped by about 30% over the first four years of the program, based on surveys given to enrollees before and after enrollment.[51] Similarly, evaluators confirmed that in California, clients who were new to the Family PACT program were more likely to use a contraceptive method after they were served than before enrolling in the program, with use increasing from 67% to 89%; the effect was particularly pronounced among new adolescent clients, among whom use increased from 57% to 93%.[55]

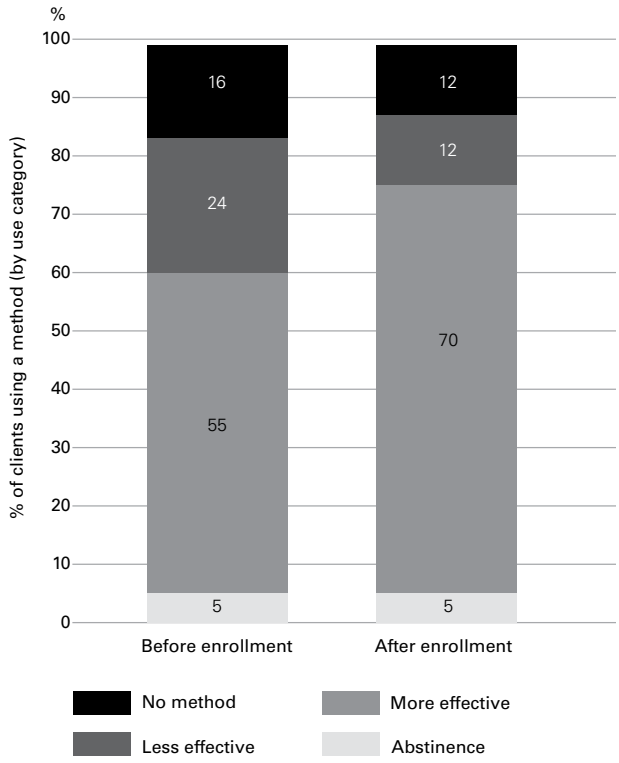
These findings were echoed by Kearney and Levine: Their analysis of data from the National Survey of Family Growth found that after controlling for other factors, the income-based family planning expansions were associated with measurable reductions in unprotected sex at either last intercourse or over the past three months.[19] (They also found no evidence that the expansions had increased sexual activity, as had been alleged by some family planning opponents.)

More-Effective Methods

State evaluations have also found an increase not only in use of any contraception, but also in the use of more-effective contraceptive methods. In Pennsylvania, for instance, the use of more-effective methods (defined by evaluators as hormonal methods, IUDs and sterilization) increased from 55% before enrollment to 70% after enrollment (Figure 4.3).[29] Use of these methods after enrollment was particularly high among young adults (84% among those aged 18–20 and 73% among 21–24-year-olds). In California, the proportion of new clients using these same methods increased from 28% before enrollment to 50% after their first office visit.[55]

Some of this shift undoubtedly comes from making more effective—and often more expensive—methods affordable for women. But the evaluations also make clear that counseling about method choice can increase use of more-effective methods. This was the case in California, where women were more than twice as likely to switch to a more effective method if their visit included counseling about their contraception options.[55] In North Carolina, an enhanced clinical counseling program was tested in six counties and showed modest success in increasing the use of more effective methods.[53]

FIGURE 4.3. Use of more-effective contraceptive methods increased from 55% before enrollment to 70% after enrollment in Pennsylvania's Medicaid family planning expansion.



Note: More effective methods are defined as hormonal methods, IUDs and sterilization; less effective methods are defined as condoms, withdrawal, diaphragm, spermicide and natural methods. The 1% who did not answer are not shown. *Source:* Reference 29.

And in Washington, a pilot program to provide intensive counseling and follow-up services for clients regarding their continued and correct use of contraceptives had a pronounced impact: Use of more effective methods increased from 51% before enrollment to 74% one year later at sites providing that follow-up, nearly twice the increase seen at control sites.[51] Providers in the pilot program "more frequently reported finding out about underlying client concerns and checking with clients to see if their birth control plan had been put into practice." Unfortunately, the pilot program was judged to be too expensive and was discontinued.

Continuity of Use

The Medicaid expansions have also been demonstrated to help women achieve improved continuity in their use of contraceptives. The most basic measures examined by several states relate to clients' return for follow-up care. California, for example, found that for the most recently evaluated year, 68% of clients had been retained from one of the prior four years.[10] In North Carolina, 76% of participants returned to renew their prescriptions for contraceptives, although only 24% returned for an annual exam.[53] And in South Carolina, the proportion of women who returned for services a year or so later increased from 21% in 1993, before the expansion, to 49% in 2005.[54]

North Carolina's enhanced counseling program had an impact here, as well: Recipients of the counseling, compared with a control group, had a 12% higher rate of continuous contraceptive use over 12 months and a 15% higher rate of return for an annual exam.[53] Similarly, a case management initiative in Alabama also helped on this front: About one-third of participants received case management in 2009, after being given a risk assessment to determine whether it would be helpful.[25] Those provided with case management were more likely to use any services, to use highly effective methods such as the pill or the injectable, and to have a return visit.

California's program tested another tactic designed to improve consistency of use: dispensing a full year's worth of pills at one time. Eleven percent of clients (including 34% of clinic clients) in January 2006 received a full year's supply, and their odds of pregnancy decreased by 30% and odds of abortion decreased by 46%, compared with women who received either one or three packs of pills at a time.[56] (Dispensing a full year's supply also saved the program $99 per woman per year, compared with costs for providing three cycles at a time, because of the costs of additional visits; that does not account for any additional cost savings from improvements in preventing unintended pregnancy.[57])

Unintended Pregnancy

Not surprisingly, perhaps the most extensively studied aspect of the Medicaid family planning expansions is their impact on preventing unintended pregnancies—particularly those that would otherwise have resulted in a Medicaid-funded birth. Measuring that effect has been a central component, required by CMS, of every state program evaluation, as well as all of the multistate analyses of the expansions.

Over time, CMS officials developed a standard methodology that states were required to follow for conducting their analysis of the number of Medicaid-funded births averted by the expansions. Essentially, it involves determining age-adjusted fertility rates for the expansion's target population before the expansion was implemented, then comparing them to actual fertility rates among expansion participants each year. The difference represents the impact of the program. All of the births averted

by contraception are, by definition, ones that would have resulted from unintended pregnancy. And because every woman participating in the expansions would also be eligible for Medicaid-funded pregnancy care, those averted births are considered ones that would have been paid for by Medicaid.

These before-and-after comparisons have yielded the expected result. For example, the birthrate in Michigan was 24 per 1,000 women among enrollees in their most recent program year, compared with 108 per 1,000 in the target population before the expansion.[58] In Missouri, the birthrate among enrollees was 33 per 1,000 in 2010, versus 79 per 1,000 among all Medicaid enrollees in the state in 2000.[41]

Many researchers have been unsatisfied with this approach, however, feeling that the methodology lacks a proper comparison group and that the impact of the expansion may be drowned out by other trends in the state and nation. In response, evaluations have used multiple approaches to demonstrate whether the expansions are having an effect. New Mexico, for example, has found that birthrates among women using expansion services are about 50% lower than among women enrolled but not using services.[59] Illinois has compared birthrates for expansion participants with low-income women generally during the same year, finding them to be more than 80% lower in 2009.[60] Oklahoma looked at population trends over time, finding that overall births among adults in the state has gone up over the course of the waiver, while births among women in the program's target income population started to decline by the program's third year.[52] And a few states have been able to look directly at rates of unintended pregnancy or birth, with Illinois, Oklahoma and Oregon measuring declines on that front during implementation of their expansion programs.[40,52,61]

Finally, California and Washington have taken an entirely different approach, using data on changes in enrollees' use of contraceptives and choice of method to project—based on the methods' failure rates—numbers of births averted. Evaluators in California estimate that by providing contraceptive methods to about one million women and 100,000 men in 2007, Family PACT helped them avert 296,000 unintended pregnancies.[57] In turn, that averted about 133,000 unplanned births, 122,000 abortions, 3,000 ectopic pregnancies and 38,000 miscarriages. In Washington, evaluators estimate that changes in contraceptive method choice have resulted in a 22% decrease in pregnancies.[51]

Several teams of economists have conducted independent, nationwide studies to gauge the impact of the Medicaid family planning expansions in averting unplanned births, and all have confirmed the programs' success. These researchers have drawn on vital statistics records for births in every state over multiple years, along with data on a wide range of other factors that might influence birthrates, from basic demographics to religious and political beliefs to state policies. The goal is to try to control for other possible explanations for changes to state birthrates—including overall national and regional trends—so as to isolate the impact of the Medicaid expansions.

In a 2007 article, Lindrooth and McCullough found that income-based expansions reduced statewide birthrates by about two births per 1,000 women.[18] They emphasize that their methodology accounts for the potential of Medicaid expansions to substitute for private insurance and private out-of-pocket spending. Lindrooth released an additional analysis a year later looking at Oregon's expansion specifically and found that it had a somewhat stronger impact, a reduction of about four births per 1,000 women; the effect of the expansion in Oregon, and in many others states, increased over time as more women were enrolled.[62]

Kearney and Levine's analysis came to a similar conclusion: They estimated that having an income-based expansion reduces births among adults statewide by about 2%.[19] Looking specifically at birthrates among women who would be eligible for the program—as opposed to all women in the state—they estimated that births fell by about 9% among these eligible women and by nearly 15% for eligible women aged 20–24.

Because of the demonstrated potential of these Medicaid family planning expansions, researchers have estimated the impact they would make if additional states adopted them. A 2011 Guttmacher Institute analysis indicates that the adoption of expansions by states that do not already have one could help 19 states each serve at least 10,000 new individuals each year and each prevent at least 1,500 unintended pregnancies; nine of those 19 states could each serve at least 50,000 new clients and each avert at least 7,500 unintended pregnancies.[21] And an analysis from Brookings Institution researchers projects that states that have not yet implemented an expansion could reduce overall pregnancies in those states by almost 2%.[22]

Pregnancy Spacing

Many of the state expansions have also set an explicit goal of helping women improve their pregnancy spacing. Again, measuring the impact of the expansion programs specifically in this regard has been a challenge, in part because it requires several years of data and in part because other factors may drive broader trends in pregnancy spacing, nationally and regionally. Minnesota, Mississippi and Wisconsin are among the states that have found

only marginal changes over time and little evidence of an impact from their family planning expansions.[42,50,63]

Nevertheless, a number of states have been able to identify promising trends on this front by comparing expansion enrollees with other groups of women. In Arkansas, repeat births within 12 months dropped 84% between 2001 and 2005 among women enrolled in the family planning expansion, and it has dropped more quickly among expansion enrollees than among all women on Medicaid.[33] In Iowa, 11% of expansion participants gave birth within 24 months of their last delivery; in comparison, repeat births were experienced by 15% of women who had a Medicaid-funded birth but who did not use family planning services under the expansion.[64] The difference was even larger for young adults aged 18–21: 13% vs. 21%, respectively. In New Mexico, women obtaining family planning services under the expansion were less likely to have a repeat delivery within 24 months than were women who were enrolled but did not access expansion services (35% vs. 50%).[59] In South Carolina, the proportion of expansion participants having a repeat conception within 18 months decreased from 7% in 1995 to 4% in 2003, a substantially lower rate than was found among all women enrolled in Medicaid (13% in 2003).[54] And, in Texas, 18% of expansion participants had a repeat birth within 24 months, compared with 29% of Medicaid-eligible women who did not participate in the program.[65]

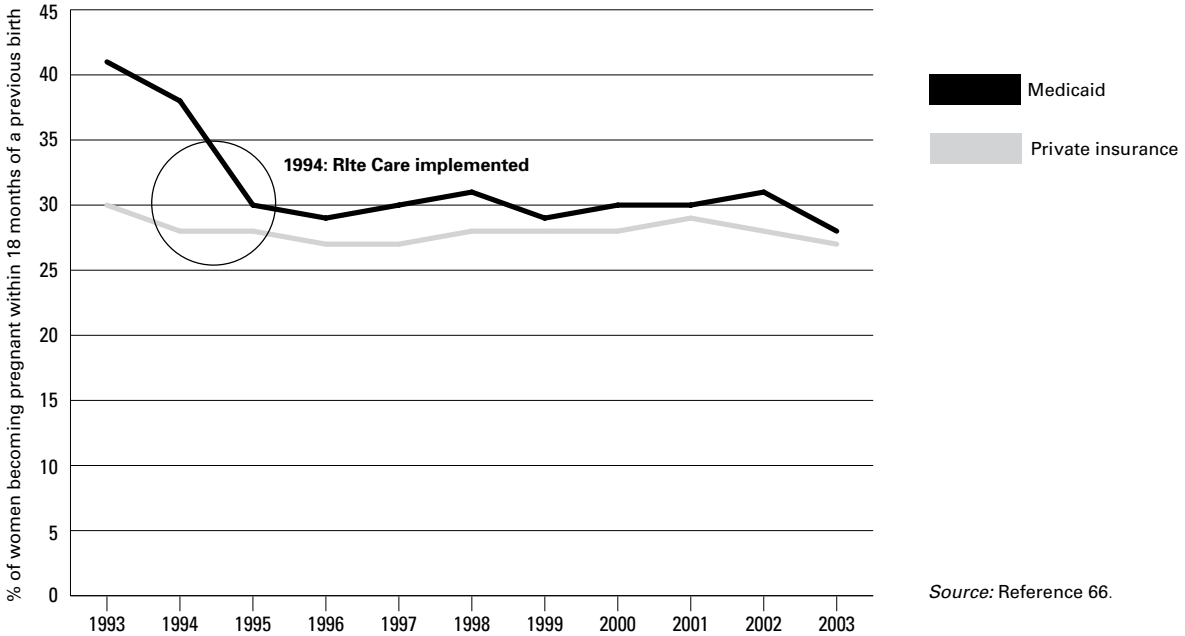
Even in Rhode Island—a state with a far smaller family planning expansion that is limited to women leaving Medicaid postpartum—evaluators found an impact: The proportion of mothers on Medicaid with birth intervals shorter than 18 months fell from 41% in 1993 to 28% in 2003, and the gap between privately insured and publicly insured women narrowed from 11 percentage points to less than one point (Figure 4.4).[66]

South Carolina has attempted to go further and assess whether the expansion's effect on helping women plan and time their pregnancies has had a measurable impact on subsequent health outcomes. After controlling for demographic and behavioral variables, evaluators found that greater use of expansion services improved the odds that a woman had adequate prenatal care.[67] Evaluators did not find a direct association between use of expansion services and preventing low birth weight and preterm birth, but adequacy of prenatal care did lower the odds of low birth weight.

Teen Pregnancy

Some of the state evaluations and national analyses have looked specifically at issues related to teen pregnancy. Oregon and Wisconsin, for example, have studied teen birthrates in their states: Oregon has found that declines in teen pregnancy accelerated in the years following implementation of its expansion.[40] In Wisconsin, the birthrate

FIGURE 4.4. In Rhode Island, the difference in the prevalence of short pregnancy intervals between Medicaid enrollees and women with private insurance virtually disappeared with the implementation of RIte Care.



Source: Reference 66.

for teen participants was four per 1,000, vs. 124 per 1,000 for all low-income teens.[42] Iowa's evaluation found that the expansion had a particularly pronounced effect on pregnancy spacing among teenagers: Eleven percent of expansion participants aged 13–17 had a repeat birth within 24 months, compared with 20% for those in the same age-group who had had a Medicaid-funded birth but were not using family planning services under the expansion.[64]

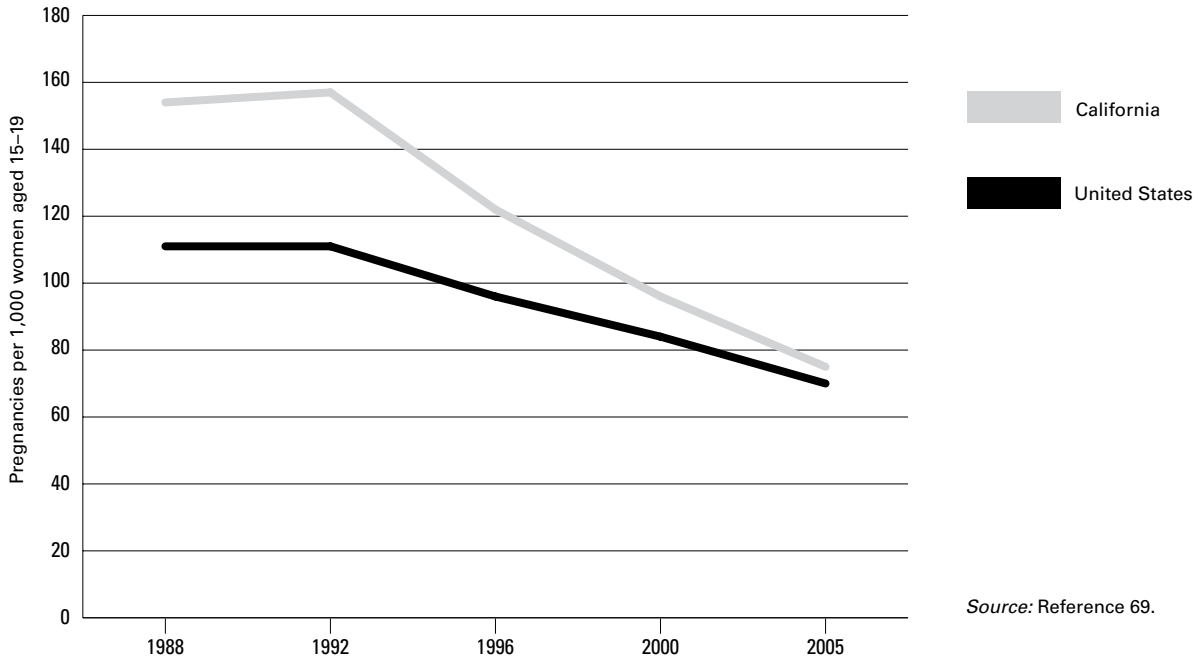
Evaluators in California were able to estimate the impact of the expansion on teen pregnancies and their subsequent outcomes: By providing contraception to 233,000 adolescent clients in 2007, Family PACT helped them avert 81,000 unintended pregnancies, which would have resulted in about 41,000 unplanned births, 28,000 abortions, 800 ectopic pregnancies and 12,000 miscarriages.[57] In combination with a series of other interventions to reduce teen pregnancy, including an expansion of comprehensive sex education, Family PACT helped California to dramatically reduce teen pregnancy.[68] Between 1992 and 2005, the state made more headway in reducing teen pregnancy than any other state, a 52% decline that nearly closed what had been a substantial gap between the rate for California and that for the entire United States (Figure 4.5).[69] Teen births in the state dropped 47% over that time period, and teen abortions declined 66% from their peak in 1988 to 2005.

Some states have also found that their family planning expansion program enables young women to delay a first birth. For example, in Arkansas, the average age at first birth for women enrolled in the Medicaid family planning expansion rose by nearly three and a half years between 1998 and 2005; for all Medicaid enrollees in the state, the average age at first birth increased by a little more than two years over the same period.[33] In Wisconsin, births to teens as a proportion of all state Medicaid births declined from 25% in 2000 to 18% in 2006.[42]

Economists have also identified an impact of the Medicaid family planning expansions on teen births. Kearney and Levine estimate that income-based expansions reduce births among teens by about 4%.[19] And Yang and Gaydos—using a similar methodology as the other two teams of economists, but with an exclusive focus on teen birthrates—found that the Medicaid expansions had reduced teen births by two per 1,000 teens on average, with a particularly large impact among black and Hispanic teens.[20] (The same analysis looked at several other state policies and provided evidence that abstinence-only education programs actually led to an increase in teen birthrates.)

The 2011 Guttmacher Institute analysis projects that adopting a new expansion could help 12 states each serve at least 5,000 new clients younger than age 19 annually.[21] Each state would thus prevent at least 700 unintended pregnancies that would otherwise result in at least 240 abortions and at least 370 unplanned births; in Florida, an expansion could serve nearly 50,000 new adolescents

FIGURE 4.5. Between 1992 and 2005, California reduced its teen pregnancy rate by more than 50%, bringing it to just above the national average.



Source: Reference 69.

and help avert 7,100 unintended pregnancies each year. The Brookings Institution analysis projects that states that have not yet implemented an expansion could reduce teen pregnancies in those states by 1.4%.[22]

Government Savings

Almost half (48%) of all births in the country were paid for by Medicaid or CHIP in 2006.[5] But because unintended pregnancy is far more prevalent among low-income women than among higher income women, Medicaid pays for almost two-thirds (64%) of births that result from unintended pregnancy. The cost to Medicaid of unintended pregnancies alone amounted to $11 billion in 2006, according to a pair of estimates from the Guttmacher Institute and the Brookings Institution.[5,70] That figure is a conservative estimate that is limited to publicly funded medical care for pregnancy and the first year of an infant's life; the true cost would be many times higher if other expenses, such as social supports or ongoing medical care, were considered. The role of Medicaid in covering the cost of unintended births is even greater in many states, particularly in the South, and it is no coincidence that many Southern states—despite conservative politics that often disfavor family planning—pioneered the Medicaid family planning expansions.

States had ample reason to expect that expanding eligibility for family planning under their Medicaid programs would save money. Publicly funded contraceptive services and supplies have been demonstrated repeatedly to be highly cost-effective. Every dollar invested by the government for contraception saves $3.74 in Medicaid expenditures for pregnancy-related care related to births from unintended pregnancies.[71] In total, the services provided at publicly funded family planning clinics resulted in a net savings of $5.1 billion in 2008. Significantly, these savings do not account for any of the broader health, social or economic benefits to women and families that accrue from using contraceptive services and supplies, and thus being able to time, space and prepare for pregnancies.

Numerous state evaluations and national analyses have confirmed that this logic holds true for the Medicaid family planning expansions specifically. In fact, CMS recently noted that states have been allowed to expand eligibility for family planning under Medicaid precisely because of the cost-effectiveness of the expansions.[13] For example, according to the CMS-sponsored multistate evaluation, all of the programs studied yielded significant savings to the federal and state governments. States as diverse as Alabama, Arkansas, California, Oregon and South Carolina each saved more than $15 million in a single year by helping women avoid unintended pregnancies that would have resulted in Medicaid-funded births.[17] More recent data are available from some of the evaluations conducted by states, with net savings of $14 million in Iowa in 2009,[64] $45 million in Missouri in 2010,[41] $18 million in North Carolina in 2009,[53] $46 million in Texas in 2009[72] and $159 million in Wisconsin in 2006.[42]

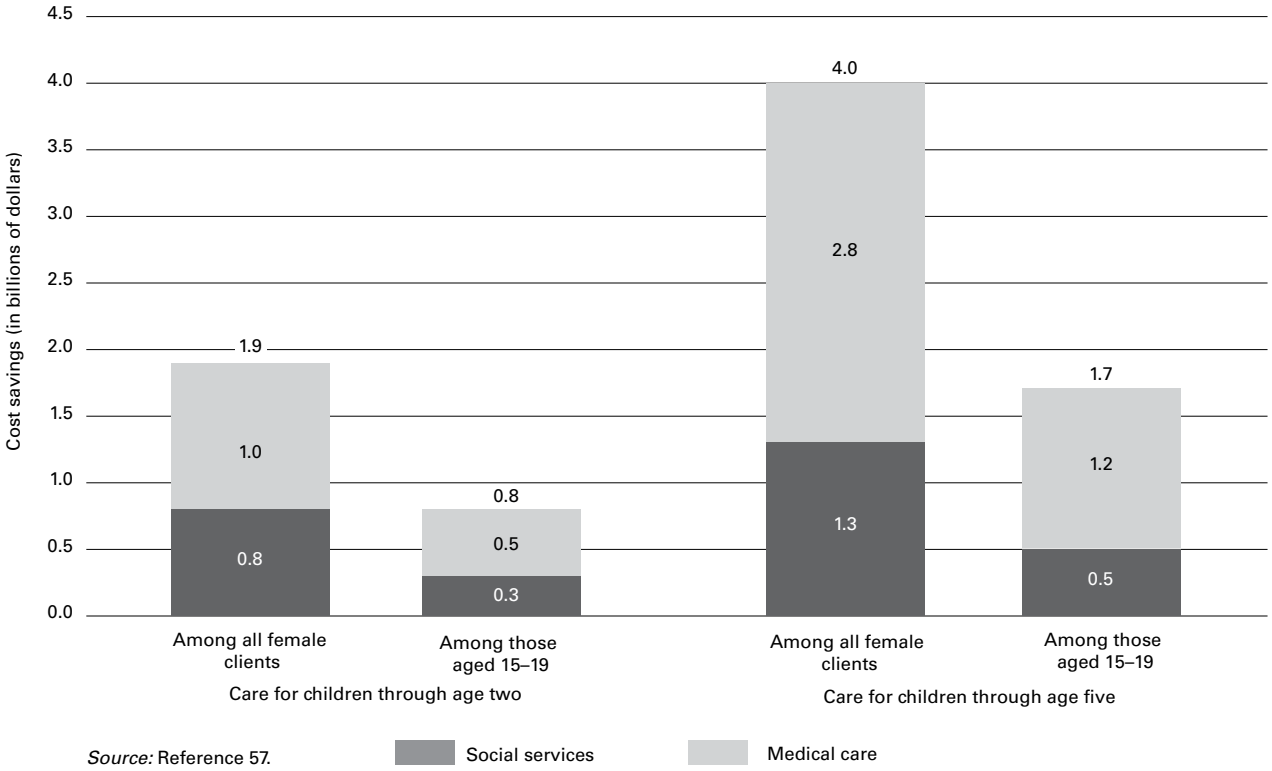
California has conducted the most extensive cost-benefit analyses among the states with Medicaid family planning expansions, going well beyond what has been required by CMS to demonstrate that its program is budget neutral for the federal government. By factoring in welfare and other social services costs and the cost of children's medical care until age two (instead of age one, as required by CMS), California evaluators found that pregnancies averted among female Family PACT clients in 2007 saved $1.9 billion, including more than $800 million for adolescent clients.[57] That figure rose to more than $4 billion, including $1.7 billion for adolescent clients, when evaluators accounted for the savings resulting from reduced social services and medical care for children through age five (Figure 4.6, page 20) . Although adolescents account for 27% of pregnancies averted, they account for 44% of the cost-savings because, compared with older women, they are more likely to carry a pregnancy to term, have a higher risk of maternal and infant health complications and tend to be eligible for a wider range of publicly funded services. All told, every dollar spent on Family PACT saved $4.30 in government costs from conception to age two and $9.25 to age five.

These findings of substantial cost savings have been confirmed by all of the national evaluations that have looked at the issue. Lindrooth and McCullough found the income-based family planning expansions to produce net government savings from both a state and federal perspective.[18] The Kearney and Levine analysis also concluded that these expansions were cost-effective, compared with other interventions to reduce unplanned pregnancies and births.[19] Moreover, the 2011 Guttmacher Institute projections find that adopting a new expansion could help 19 states each save at least $2.3 million in state funds annually, with nine of the 19 states each saving at least $17.4 million in state funds.[21] And the Brookings Institution paper projects that states that have not yet implemented an expansion could save $1.1 billion overall and $4.26 per dollar spent.[22]

Additional Preventive Care

Finally, although the primary focus of the family planning expansions has been on helping women avert unplanned pregnancies and births, the expansions have also provided millions of women with other, related family planning ser-

FIGURE 4.6. In California, pregnancies averted among female Family PACT clients in 2007 saved an estimated $4 billion in health care and social services expenses for children through age five.



Source: Reference 57.

vices. Most notably, they have funded testing for sexually transmitted infections (STIs), including HIV, and screenings for reproductive cancer and precancerous conditions.

Sexually Transmitted Infections

Screening for HIV and other STIs has become standard practice for family planning providers and is typically integrated into contraception-related visits. Screening is particularly important for the populations targeted by the family planning expansions, young and low-income women and men, because they are at highest risk of STIs.

Because screening is a routine part of family planning visits, the Medicaid expansions have paid for millions of STI tests and helped to diagnose large numbers of STI cases. In Alabama, for example, 56% of clients in 2009 reported on an evaluation survey that they had received counseling and testing for HIV and 65% for STIs more broadly.[25] Those attending health department clinics more frequently reported receiving STI counseling and testing than did clients of private providers (72% vs. 57%). In Wisconsin, over 2,000 expansion clients were diagnosed with chlamydia in 2006; considerably smaller numbers of expansion clients were diagnosed with gonorrhea or trichomoniasis.[42]

The most extensive data on STI testing and diagnosis come from California, where Family PACT has placed a particular emphasis on STI care for both women and men. During the program's most recently evaluated 12-month period, 67% of clients received an STI test, for a total of 3.6 million tests.[10] Testing was especially high among male clients, with 80% receiving an STI test. Almost all of those who received any testing were tested for chlamydia and gonorrhea, and most were also tested for HIV and syphilis. Evaluators did not have access to diagnosis results for all of these tests, but data from one major laboratory provider found that 4.5% of chlamydia tests among women aged 25 or younger were positive, as were 1.8% among women aged 26–30. The same study found that 32% of women diagnosed with chlamydia were retested within 1–6 months, a practice consistent with national standards to identify repeat infection, which often occurs via untreated partners.

Reproductive Cancers

Screening for cervical cancer through such technology as Pap smears and human papillomavirus testing is also a standard practice for family planning providers, and several states have documented providers' screening efforts un-

der the expansion programs. In Alabama, 75% of clients surveyed said they had received a Pap test or pelvic exam in 2009.[25] In California, 43% of female clients received at least one cervical cytology test; those aged 35–55 were screened at a higher rate (61%).[10] Nine percent of Pap tests came back with abnormal results.[55]

Evaluators in Wisconsin attempted to assess linkages between the Medicaid family planning expansion and another Medicaid program devoted to treating cervical cancer, precancerous cervical conditions and breast cancer. They found that 18% of women in the cancer-treatment program had used family planning expansion services in the past.[42]

Conclusions

For nearly two decades, until the enactment of the Affordable Care Act in 2009, state Medicaid family planning expansions had been operating as experiments under which states were obliged to demonstrate that expanded eligibility for family planning and related services under Medicaid would be beneficial on many fronts: for the women and men seeking services; for states' networks of publicly supported family planning providers; and for state and federal budgets. That experiment has come to an end, with Congress concluding that expansions have, indeed, been successful.

As demonstrated in this report, the evidence of that success from state evaluations and national analyses is bountiful. The expansion programs collectively are serving about 2.7 million women and men each year and have enabled family planning providers in states with expansions to substantially increase the proportion of the need for services that they are able to meet. These services have helped reduce levels of unprotected sex, increase use of more-effective contraceptive methods and improve continuity of contraceptive use. They have also expanded access to related preventive care, such as screening for HIV and other STIs and for cervical cancer and precancerous cervical conditions.

Improved contraceptive use has translated into measurable declines in unintended pregnancy 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 the expansions are limited to a small segment of each state's population. State evaluations have also pointed to improvements in women's ability to space their pregnancies.

All of this has positive implications for the health of pregnant women and newborns, as well as the social and economic health of families. Numerous studies point to a causal link between pregnancy spacing and three negative birth outcomes: low birth weight, preterm birth and small size for gestational age.[73] Unintended pregnancy has been linked to delayed initiation of prenatal care and to reduced breast-feeding after a child is born. These types of maternal behavior, in turn, can influence outcomes throughout a child's life. Moreover, unintended pregnancy can hinder women's educational and financial success and deprive women and couples of the ability to have children when they feel best prepared.

The family planning expansions have also paid impressive dividends for federal and state budgets. These findings echo prior research demonstrating that investments in publicly funded family planning services save billions of dollars each year and have the clear potential to reduce the toll on federal and state taxpayers of unplanned pregnancy—$11 billion annually, according to conservative estimates.

Taken collectively, the findings of this sizable body of research point to the undeniable value of publicly funded family planning services, both within state Medicaid programs and beyond. At the same time, an examination of state outreach and enrollment practices—and the high level of creativity and innovation they collectively embody—makes it clear that when the government teams up with family planning providers, the synergies can be considerable.

In the process of making these expansion programs successful, state officials have improved their knowledge of how to reach out to and enroll women and men in public insurance programs such as Medicaid. For example, the family planning expansions have advanced a range of techniques to allow women to apply for coverage and receive services on the same day. The expansions have also helped to blaze a trail in coordinating outreach and enrollment among a wide range of public programs, and states have streamlined the application process through online application systems, confirmation of applicants' information via government and private databases, and automatic enrollment of some eligible individuals.

These types of innovations and best practices have implications well beyond the family planning expansions themselves. Rather, they hold important lessons about outreach and enrollment for the implementation of the Affordable Care Act, the most ambitious attempt since the 1960s to expand health insurance coverage and improve health care delivery in the United States.

One of the centerpieces of the Affordable Care Act is a massive expansion to Medicaid. Starting in January 2014, all states will be required to extend eligibility under the

program to all citizens (and legal residents after a five-year bar) with incomes up to 133% of poverty, far higher than the eligibility levels in place in most states today. As a result of this change, Medicaid, by 2019, is expected to serve 16 million people who would otherwise be uninsured, according to estimates from the Congressional Budget Office. That amounts to half of health reform's projected expansion of U.S. insurance coverage.[74]

To make enrollment as seamless as possible, the Affordable Care Act standardizes income eligibility guidelines across programs and pushes states to design a joint enrollment system for Medicaid, CHIP and many private insurance plans, so as to ensure that there is, as many experts call it, "no wrong door" for applicants. And to make this work, the federal government has pointed to many of the same techniques that states have been testing in their family planning expansion programs, such as online applications, confirmation of enrollees' information via electronic data sources and coordination in enrollment among public programs.[75] If states can build on their successes in expanding access to family planning care, they can improve the odds that the Affordable Care Act meets its full potential.

TABLE 1.1. Eligibility ceilings for Medicaid and related coverage, and participation in Medicaid family planning expansions, by state, 2011

State	Income eligibility ceilings			Expansion participants	
	Family planning expansion	Pregnancy-related care	Full-benefit coverage	Year	Number
Total	—	—	—	—	2,701,281
Alabama	133%	133%	24%	2009	60,381
Arkansas	200%	200%	17%	2005	48,735
California	200%	200%	106%	2010	1,820,850
Georgia	200%	200%	50%	—	—
Illinois	200%	200%	191%	2011	56,277
Iowa	200%	300%	83%	2010	29,168
Louisiana	200%	200%	25%	2011	55,424
Michigan	185%	185%	64%	2009	37,125
Minnesota	200%	275%	215%	2009	30,112
Mississippi	185%	185%	44%	2010	28,170
Missouri	185%	185%	25%	2010	30,968
New Mexico	185%	235%	67%	2010	11,118
New York	200%	200%	150%	2006	30,520
North Carolina	185%	185%	49%	2010	29,900
Oklahoma	185%	185%	53%	2010	25,295
Oregon	185%	185%	40%	2010	75,478
Pennsylvania	185%	185%	46%	2008	43,129
South Carolina	185%	185%	93%	2010	39,195
Texas	185%	185%	26%	2010	103,281
Virginia	200%	200%	31%	2010	3,044
Washington	200%	185%	74%	2010	74,225
Wisconsin	300%	300%	200%	2006	68,886

Notes: Eligiblity ceilings are defined as a percentage of the federal poverty level (FPL) and represent the highest ceiling in the state under Medicaid, CHIP or other public programs with similar benefits and cost-sharing. Full-benefit coverage is for parents with dependent children; of the 22 states, only New York provides full Medicaid coverage for adults without dependent children (up to 100% FPL). Data on participation are for the most recent 12-month period available; most data span two calendar years, with the second of the two years listed. *Sources:* References 1, 4 and 9.

TABLE 2.1. Broad-based outreach strategies in use by Medicaid family planning expansions, by state, 2011

State	Mass media campaign	Telephone hotline	Program Web site	Social media	Materials for peer-to-peer referral
Total	14	14	15	5	8
Alabama	X	X	X	X	
California	X	X	X		X
Georgia	X	X	X		X
Illinois	X	X	X		X
Iowa	X	X			X
Louisiana		X	X		
Michigan	X	X		X	X
Minnesota	X		X		
Mississippi	X	X	X	X	X
Missouri					
New Mexico			X		
North Carolina	X	X	X		
Oklahoma	X	X	X	X	
Oregon	X	X	X	X	
Pennsylvania		X	X		X
South Carolina	X	X	X		X
Texas	X		X		
Virginia	X		X		
Washington		X			

Note: Arkansas, New York and Wisconsin did not respond to the survey. *Source:* Reference 16.

TABLE 2.2. Targeted outreach strategies in use by Medicaid family planning expansions, by state, 2011

State	Coordinated outreach		Tailored outreach		Community outreach		
	For postpartum women	Via Medicaid or other public programs*	For young adults	In languages other than English	At community events	At educational institutions	Conducted only by local providers
Total	13	12	13	14	11	8	8
Alabama	X	X	X	X	X	X	
California		X	X	X			X
Georgia	X	X		X			X
Illinois	X	X	X	X	X	X	
Iowa	X		X	X			X
Louisiana	X	X	X	X	X	X	
Michigan	X	X	X		X	X	
Minnesota							X
Mississippi	X	X	X	X	X	X	
Missouri							X
New Mexico							X
North Carolina	X		X	X	X	X	
Oklahoma	X	X	X	X	X		
Oregon		X	X	X	X	X	
Pennsylvania	X	X	X	X			X
South Carolina	X	X		X	X	X	
Texas	X	X	X	X	X		
Virginia	X		X	X	X		
Washington							X

*Not including other family planning programs. *Note:* Arkansas, New York and Wisconsin did not respond to the survey. *Source:* Reference 16.

TABLE 3.1. Enrollment strategies in use by Medicaid family planning expansions, by state, 2011

State	Simplified forms	Applications submitted remotely	Joint application or screening for other public programs	Data verification		Assistance obtaining birth certificates	Automatic enrollment
				Citizenship	Income		
Total	17	16	12	16	13	7	8
Alabama	X	X	X	X	X	X	X
California	X				X		
Georgia	X	X		X		X	
Illinois		X	X	X	X		X
Iowa	X	X	X	X			X
Louisiana	X	X	X	X	X		
Michigan	X	X	X	X	X		
Minnesota	X	X					
Mississippi	X	X		X	X		X
Missouri	X	X	X	X	X		
New Mexico	X	X	X	X	X		X
North Carolina		X	X	X	X		
Oklahoma	X	X	X	X	X	X	X
Oregon	X			X	X	X	
Pennsylvania	X	X	X	X		X	X
South Carolina	X	X	X	X	X	X	X
Texas	X	X		X			
Virginia	X	X	X	X			
Washington	X				X	X	

Note: Arkansas, New York and Wisconsin did not respond to the survey. *Source:* Reference 16.

TABLE 3.2. Point-of-service enrollment assistance strategies in use by Medicaid family planning expansions, by state, 2011

State	Providers may verify documents	Clients may apply on site	State pays for application assistance
Total	11	11	3
Alabama	X	X	
California		X	
Georgia			
Illinois	X	X	
Iowa	X	X	
Louisiana	X		
Michigan	X		
Minnesota		X	X
Mississippi			
Missouri	X	X	
New Mexico			
North Carolina	X		
Oklahoma	X	X	
Oregon		X	X
Pennsylvania	X	X	
South Carolina	X	X	X
Texas	X	X	
Virginia			
Washington			

Note: Arkansas, New York and Wisconsin did not respond to the survey. *Source:* Reference 16.

References

1. Guttmacher Institute, Medicaid family planning eligibility expansions, *State Policies in Brief (as of November 1, 2011),* 2011, <http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf>, accessed Nov. 9, 2011.

2. Special tabulations of data from the Guttmacher Institute and the 2010 and 2011 U.S. Census Bureau Current Population Surveys.

3. *Federal Register*, 76:3637, 2011.

4. Heberlein M et al., *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010–2011,* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2011, <http://kff.org/medicaid/upload/8130.pdf>, accessed Aug. 8, 2011.

5. Sonfield A et al., The public costs of births resulting from unintended pregnancies: national and state-level estimates, *Perspectives on Sexual and Reproductive Health*, 2011, 43(2):94–102.

6. Ranji U et al., *State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings*, Menlo Park, CA: Kaiser Family Foundation; and Washington, DC: The George Washington University Medical Center School of Public Health and Health Services, 2009, <http://www.kff.org/womenshealth/upload/8015.pdf>, accessed Nov. 21, 2010.

7. U.S. Social Security Act 1903(a)(5).

8. *Federal Register*, 75:69082, 2010.

9. Special tabulations of data from state Medicaid family planning waiver evaluations, 2011.

10. Bixby Center for Global Reproductive Health, *Family PACT Program Report Fiscal Year 2009-10*, San Francisco: Bixby Center for Global Reproductive Health, University of California, 2010, <http://www.familypact.org/Files/Provider/Research%20Reports/2011-0725_FamPACT2011AR_508.pdf>, accessed Nov. 1, 2011.

11. P.L. 111–148, Sec. 2303, Mar. 23, 2010.

12. Special tabulations of data from state Medicaid family planning waiver approvals, 2010.

13. Centers for Medicare and Medicaid Services, Family planning services option and new benefit rules for benchmark plans, *State Medicaid Director Letter*, July 2, 2010, SMDL #10-013, ACA #4, <http://www.cms.gov/smdl/downloads/SMD10013.pdf>, accessed July 15, 2010.

14. Gold RB, Summers R and Frachele R, CMS guidance on family planning state plan amendments, memo to interested parties, New York: Guttmacher Institute; Washington, DC: National Family Planning & Reproductive Health Association; and Portland: Oregon Public Health Division, 2010, <http://www.guttmacher.org/pubs/Family-planning-SPA.pdf>, accessed Dec. 23, 2010.

15. Sonfield A, Alrich C and Gold RB, *State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions,* New York: Guttmacher Institute, 2008.

16. 2011 Guttmacher Medicaid Family Planning Eligibility Expansion Survey.

17. Edwards J, Bronstein J and Adams K, *Evaluation of Medicaid Family Planning Demonstrations*, Alexandria, VA: CNA, 2003.

18. Lindrooth RC and McCullough JS, The effect of Medicaid family planning expansions on unplanned births, *Women's Health Issues,* 2007, 17(2):66–74.

19. Kearney MS and Levine PB, Subsidized contraception, fertility, and sexual behavior, *Review of Economics and Statistics*, 2009, 91(1):137–151.

20. Yang Z and Gaydos LM, Reasons for and challenges of recent increases in teen birth rates: a study of family planning service policies and demographic changes at the state level, *Journal of Adolescent Health*, 2010, 46(6):517–524.

21. Sonfield A, Frost JJ and Gold RB, *Estimating the Impact of Expanding Medicaid Eligibility For Family Planning Services: 2011 Update*, New York: Guttmacher Institute, 2011.

22. Sawhill I, Thomas A and Monea E, An ounce of prevention: policy prescriptions to reduce the prevalence of fragile families, *Future of Children*, 2010, 20(2):133–155.

23. Gold RB, Singh S and Frost J, The Medicaid eligibility expansions for pregnant women: evaluating the strength of state implementation efforts, *Family Planning Perspectives,* 1993, 25(5):196–207.

24. Virginia Department of Medical Assistance Services, *Evaluation: Virginia Family Planning Expansion Project*, Richmond: Virginia Department of Medical Assistance Services, 2010.

25. Bronstein JM, *Alabama's Plan First Medicaid Demonstration Program Evaluation, Demonstration Year Nine, October 2008–September 2009*, Birmingham: School of Public Health, University of Alabama, 2010.

26. Family PACT, Client home, Sep. 29, 2008, <http://www.familypact.org/en/Clients.aspx>, accessed Oct. 4, 2011.

27. Bixby Center for Global Reproductive Health, *Reaching Out for Success: Family PACT Provider Guide to Effective Outreach*, San Francisco: Bixby Center for Global Reproductive Health, University of California, 2006, <http://familypact.org/_Resources/Documents/061117%20Best%20Outreach%20Practices%20-%20%20submitted%20to%20OFP.PDF>, accessed Nov. 1, 2011.

28. Family PACT, Ask the experts: in reach and outreach strategies to market your Family PACT program, Feb. 8, 2011, <http://familypact.org/en/Providers/provider-training/family-pact-previously-recorded-webcasts/ATE-In-Reach-and-Outreach-Strategies.aspx>, accessed Nov. 1, 2011.

29. Office of Medical Assistance Programs, Pennsylvania Department of Public Welfare, *2010 SelectPlan for Women: Recipient Survey Analysis,* Harrisburg: Pennsylvania Department of Public Welfare, 2011.

30. Texas Health and Human Services Commission, *Annual Savings and Performance Report for the Women's Health Program*, Austin: Texas Health and Human Services Commission, 2010.

31. Illinois Healthy Women Program, Illinois Department of Healthcare and Family Services, *Illinois Health Women Annual Progress Report – Waiver Year 6, April 1, 2009 – March 31, 2010*, Springfield: Illinois Department of Healthcare and Family Services, 2010.

32. Gold RB, 'I am who I serve'—community health workers in family planning programs, *Guttmacher Policy Review*, 2010, 13(3):8–13.

33. Fay W. Boozman College of Public Health, University of Arkansas for Medical Services (UAMS), *Evaluation of the Women's Health Waiver*, Little Rock, AR: UAMS, 2007.

34. Perry M and Paradise J, *Enrolling Children in Medicaid and SCHIP: Insights from Focus Groups with Low-Income Parents,* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2007.

35. Horner D, Lazarus W and Morrow B, *Express Lane Eligibility: How to Enroll Large Groups of Eligible Children in Medicaid and CHIP,* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1999.

36. Horner D and Morrow B, *Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance,* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2006.

37. State of Wisconsin, Access, Sep. 30, 2011, <https://access.wisconsin.gov/>, accessed Oct. 4, 2011.

38. Pennsylvania Department of Public Welfare, Compass, Oct. 4, 2011 <https://www.humanservices.state.pa.us/Compass.Web/CMHOM.aspx>, accessed Oct. 4, 2011.

39. Ross DC, *New Citizenship Documentation Option for Medicaid and CHIP Is Up and Running: Data Matches with Social Security Administration Are Easing Burdens on Families and States*, Washington, DC: Center on Budget and Policy Priorities, 2010, <http://www.cbpp.org/files/4-20-10health.pdf>, accessed Oct. 4, 2011.

40. Office of Family Health, Oregon Health Authority, *Family Planning Expansion Project: Project Evaluation Report for the Life of the Program 1999–2009*, Portland: Oregon DHS Public Health, 2009.

41. Alicia Smith & Associates, *Evaluation of the Women's Health Services Program*, Jefferson City: State of Missouri Department of Social Services, 2011.

42. Office of Policy Initiatives and Budget, Wisconsin Department of Health and Family Services, *The Wisconsin Family Planning Waiver: Final Evaluation Report for 2003–2007*, 2008, <http://www.dhs.wisconsin.gov/aboutdhs/opib/policyresearch/FamilyPlanningWaiverFinalEvaluationReport2003-2007.pdf>, accessed Dec. 15, 2010.

43. Brindis CD et al., Meeting the reproductive health care needs of adolescents: California's family planning access, care, and treatment program, *Journal of Adolescent Health,* 2003, 32(6):79–90.

44. Jones R and Boonstra H, Confidential reproductive health services for minors: the potential impact of mandated parental involvement for contraception, *Perspectives on Sexual and Reproductive Health,* 2004, 36(5):182–191.

45. Gold RB, Title X: three decades of accomplishment, *Guttmacher Report on Public Policy,* 2001, 4(1):5–8.

46. Gold RB, Unintended consequences: how insurance processes inadvertently abrogate patient confidentiality, *Guttmacher Policy Review,* 2009, 12(4):12–16.

47. Texas Health and Human Services Commission, Women's health program Medicaid application, no date, <http://www.hhsc.state.tx.us/WomensHealth/Application_English.doc>, accessed Oct. 5, 2011.

48. Guttmacher Institute, *Contraceptive Needs and Services, 2006*, 2009, <http://www.guttmacher.org/pubs/win/allstates2006.pdf>, accessed Oct. 5, 2011.

49. Gold RB et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, New York: Guttmacher Institute, 2009.

50. Minnesota Department of Human Services, *Minnesota Family Planning Program §1115 Waiver: Interim Report of Evaluation Findings, June 2010*, St. Paul: Minnesota Department of Human Services, 2010.

51. Cawthorn L et al., *Take Charge Final Evaluation: First Five Years: July 2001–June 2006*, Seattle: Washington State Department of Social and Health Services, 2006.

52. Oklahoma Health Care Authority, *Final Evaluation of Oklahoma's SoonerPlan*, Oklahoma City: Oklahoma Health Care Authority, 2010.

53. Navigant Consulting, *North Carolina Medicaid Be Smart Family Planning Waiver: Waiver Year Five Annual Report*, Raleigh: North Carolina Department of Health and Human Services, 2011.

54. Center for Health Services & Policy Research, *Interim Evaluation of Project No. 11–00057/4 SC Family Planning Waiver: Expansion of Medicaid Benefits for Women Below 185% FPL (SFYs 1995–2005)*, Columbia: Arnold School of Public Health, University of South Carolina, 2007.

55. Thiel de Bocanegra H et al., *The 2007 Family PACT Medical Record Review: Assessing the Quality of Services*, Sacramento: Bixby Center for Global Reproductive Health, University of California, San Francisco, 2009.

56. Foster DG et al., Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies, *Obstetrics & Gynecology*, 2011, 117(3):566–572.

57. Biggs MA et al., *Cost-Benefit Analysis of the California Family PACT Program for Calendar Year 2007,* San Francisco: Bixby Center for Global Reproductive Health, University of California, 2010, <http://bixbycenter.ucsf.edu/publications/files/FamilyPACTCost-BenefitAnalysis2007_2010Apr.pdf>, accessed Nov. 21, 2010.

58. Michigan Department of Community Health, *PLAN FIRST! Michigan's Family Planning Waiver: July 1, 2009–June 30, 2010 Annual Report*, Lansing: Michigan Department of Community Health, 2010.

59. New Mexico Medical Review Association, *Family Planning Waiver Evaluation: July 1, 1998 – June 30, 2006*, Albuquerque: New Mexico Human Services Department, 2006.

60. Illinois Healthy Women Program, unpublished data, 2011.

61. Division of Medical Programs, Illinois Department of Healthcare and Family Services, *Report to the General Assembly, January 2010: Public Act 93-0536*, Springfield: Illinois Department of Healthcare and Family Services, 2010.

62. Lindrooth RC, Measuring the effect of Oregon's family planning Medicaid waiver, *Policy Brief*, Charleston: Medical University of South Carolina, 2008.

63. HealthSystems of Mississippi, *Final Family Planning Waiver Assessment*, Jackson: HealthSystems of Mississippi, 2008.

64. Momany ET and Carter KD, *Iowa Family Planning Demonstration Evaluation Final Report*, Iowa City: University of Iowa Public Policy Center, 2011.

65. Texas Health and Human Services Commission, *Women's Health Program Annual Report 2008: January 1, 2008–December 31, 2008*, Austin: Texas Health and Human Services Commission, 2009.

66. RIte Care Research and Evaluation Project, unpublished data, 2005.

67. Center for Health Services & Policy Research, *Supplemental Report: Interim Evaluation of Project No. 11–00057/4 SC Family Planning Waiver: Expansion of Medicaid Benefits for Women Below 185% FPL (SFYs 1995-2005)*, Columbia: Arnold School of Public Health, University of South Carolina, 2007.

68. Boonstra H, Winning campaign: California's concerted effort to reduce its teen pregnancy rate, *Guttmacher Policy Review,* 2010 13(2):18–24.

69. Guttmacher Institute, *U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity*, 2010, <http://www.guttmacher.org/pubs/USTPtrends.pdf>, accessed Oct. 5, 2011.

70. Monea E and Thomas A, Unintended pregnancy and taxpayer spending, *Perspectives on Sexual and Reproductive Health,* 2011, 43(2):88–93.

71. Frost JJ, Henshaw SK and Sonfield A, *Contraceptive Needs and Services, National and State Data, 2008 Update,* New York: Guttmacher Institute, 2010.

72. Texas Health and Human Services Commission, *2010 Annual Savings and Performance Report for the Women's Health Program*, Austin: Texas Health and Human Services Commission, 2011.

73. Guttmacher Institute, Testimony of Guttmacher Institute, submitted to the Committee on Preventive Services for Women, IOM, 2011, <http://www.guttmacher.org/pubs/CPSW-testimony.pdf>, accessed Oct. 5, 2011.

74. Elmendorf DW, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010,* Washington, DC: Congressional Budget Office, 2011, <http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf>, accessed Aug. 8, 2011.

75. Department of Health and Human Services, *Affordable Insurance Exchanges; Simple, Seamless and Affordable Coverage: Exchange Eligibility and Employer Standards and the Affordable Care Act*, 2011, <http://www.healthcare.gov/news/factsheets/2011/08/exchanges08122011b.html>, accessed Oct. 4, 2011.

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