Medicaid Success Story: Family Planning Initiatives

BY JENNIFER SILVERMAN
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WASHINGTON — Twenty-one states have found alternatives to extend eligibility for family planning services while saving money for the Medicaid program, a health policy expert said during a Kaiser Family Foundation briefing on women and Medicaid.

This is encouraging news at a time when everyone's so concerned about budget cuts and, specifically, cuts to Medicaid, Rachel Gold, director of policy analysis at the Alan Guttmacher Institute, a health policy research organization in Washington, said during the briefing.

One-third of U.S. women of reproductive age who are under the poverty level depend on Medicaid for their health care, putting it "front and center of providing critical reproductive services," Ms. Gold said.

Under one cost-saving approach, 13 of the 21 states have extended Medicaid eligibility for family planning to women based solely on their income. Women who never had any association with Medicaid would be eligible for this benefit, she said. Of the 13 states, 7 extended the coverage to men, providing them with access to condoms, testing and diagnosis for sexually transmitted diseases, and vasectomies.

In authorizing these experimental eligibility expansions, the federal government requires that these programs remain budget neutral—"meaning they can't cost the government any more than what it would have spent in the absence of one of these programs," Ms. Gold said.

In a study of six of these income-based Medicaid expansions, the Centers for Medicare and Medicaid Services found that the programs met the budget neutrality requirement. In addition, the programs also saved money for the Medicaid program as a whole, because "the cost of providing family planning under these programs is far less than the cost of providing the maternity services that would have been necessary in the absence of these programs," Ms. Gold said.

Although Medicaid has covered newborns through a 60-day postpartum period, that coverage has never been extended to the mother, Ms. Gold said. "Many states have thought this didn't make sense, and six have tried experiments where you leave the woman on Medicaid for generally up to 2 years for family planning only." Two states, Illinois and Delaware, went so far as to extend Medicaid coverage for family planning to women who would be losing full Medicaid coverage for any reason.

Since the establishment of these programs, data show that more women with expanded coverage have been getting family planning services than when these services were offered in clinics, Ms. Gold said.

Family planning is one of a handful of services that state programs must cover under a federal mandate. "The federal government reimburses states 90 cents on the dollar for their expenditures for family planning. That's a higher reimbursement rate than for any other medical service under Medicaid," she said. In 2001, Medicaid contributed $770 million for family planning services and supplies.

Medicaid recipients who obtain family planning services cannot be charged any copays or incur out-of-pocket costs.

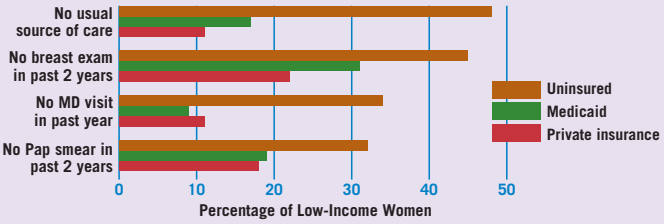
Individuals enrolled in Medicaid managed care plans can obtain family planning services with the provider of their choice, "regardless of whether that provider is affiliated with the person's managed care plan," she said. Most states cover a fairly wide range of contraceptive methods, including condoms, "even though condoms are a nonprescription method."

Tubal ligation and vasectomies are covered as family planning services in all state Medicaid programs. By comparison, gynecologic exams and tests and treatment for STDs are covered by Medicaid, although they're not always considered family planning services. "This is important from the woman's perspective, because then you might have to pay copays or not have the freedom to choose your provider" for these services, Ms. Gold said.

Eligibility for maternity care has greatly increased because of a series of expansions granted by Congress and the states. Medicaid currently pays for 4 in 10 births nationwide, and in four states—Alaska, Mexico, West Virginia, and Mississippi—the program pays for more than half the births.

Abortion funding no longer applies to Medicaid unless the woman's life is in danger or she's the victim of rape or incest. "The federal government pays for just a handful of abortions under these restrictions every year, and most states have adopted parallel restrictions," she said.

In the meantime, 17 states continue to use their own funds to provide abortion services to Medicaid enrollees, she said. ■



Note: Based on women aged 18-64 with incomes below 200% of poverty level, defined as $14,255 for a family of three in 2001.
Source: Kaiser Family Foundation

Snapshot of Women Who Get Medicaid

The vast majority of women on Medicaid are in their reproductive years, but they're not the most expensive population to treat, Alina Salganicoff, Ph.D., vice president and director of women's health policy for the Kaiser Family Foundation, said at the briefing.

"The elderly and disabled account for two-thirds of the spending because of [their] greater health needs and more costly medical and long-term care," Ms. Salganicoff said. On average, a low-income adult on Medicaid, typically a mother, costs about $2,000 a year to treat, whereas a disabled elderly beneficiary costs about $12,000 a year to treat.

Women comprise more than 70% of the adult Medicaid population and are more likely than men to qualify because of their lower incomes and status as single, low-income parents of children, she said.

"Forty percent of poor women are still uninsured," Ms. Salganicoff said.

Nearly half of the women on Medicaid have children under the age of 18 in the household; 1 in 5 of these women are over the age of 65, and the remaining third don't have children in the household but often qualify based on a disability. Those without children or a disability may never qualify for the program "no matter how poor they get," she said.

Although women of color are more likely to be low income, half of all women on Medicaid are white.

"Women on Medicaid are more than four times as likely to report their health as fair or poor," because low-income people tend to have more health issues, Ms. Salganicoff said.

Medicaid covers half of the women in the United States with a permanent physical or mental impairment who live in a community setting. This percentage is even higher among institutionalized women—Medicaid pays for the care of nearly three-fourths of the residents in nursing homes.

Relatively new to Medicaid assistance are uninsured women with breast and cervical cancer, she said. In 2000, treatment was extended as an optional Medicaid benefit for women screened under a program established by the Centers for Disease Control and Prevention in 1990, she said. "In California alone, 10,000 women got treatment under this program."

Most N.J. Welfare Recipients Are Unaware of Family Planning Rule

BY JOYCE FRIEDEN
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WASHINGTON — Many current and former welfare recipients in New Jersey are not aware that their welfare payments do not increase if they have more children, but they say that the rule would not affect their family planning decisions, Hannah Fortune-Greeley said at the annual meeting of the American Public Health Association.

New Jersey is 1 of 24 states that have a so-called "family cap" law, wherein women who have additional children while receiving Temporary Assistance to Needy Families (TANF) benefits will not have their benefits raised. The law is designed to discourage TANF recipients from having more children at a time when they don't have the means to support them.

In a pilot study, Ms. Fortune-Greeley, a graduate student at Columbia University School of Public Health, New York, and her colleagues interviewed 32 female current and former TANF recipients in New Jersey. Of those, 9 were black, 12 were Latino, 9 were white, and 2 were biracial. Respondents' average age was 31, and they had an average of 2.4 children. Seven did not have a high school diploma, and 14 were married; 75% of recipients had some form of health insurance.

Slightly less than half the respondents reported that they were using contraception, and one-third of those said they were doing so primarily to prevent STDs.

More than half had had at least one abortion. The average number of abortions per recipient was 2.8; the highest was 6. Reasons given for having abortions included being in an abusive relationship, being an incest victim, and spacing children.

Only two respondents said they were aware of the family planning cap, and neither could describe it accurately, Ms. Fortune-Greeley said. When asked whether awareness of the cap would influence future decisions about childbearing, three-fourths said it wouldn't influence them at all. Most of the women said the policy wouldn't affect their use of contraception. As to what would happen if they became pregnant while on TANF, almost all respondents said they would keep the baby; two said they would give it up for adoption.

There's clearly a need for better communication of the policy from the social services' offices to clients, she said. "The policy doesn't appear to be impacting women's reproductive decision making. … They're having more children without receiving this incremental increase, and it is posing additional economic hardship on already poor families." ■