The National Campaign to Prevent Teen and Unplanned Pregnancy

Briefly...

Policy Brief: The Benefits of Medicaid Coverage of Contraception

Background

Medicaid family planning is the largest source of public funding for contraceptive services, accounting for 75% of all publically funded family planning; the need for such services is great. In 2010, 19.1 million women were in need of publicly funded contraceptive services and supplies, an increase of 17%, or nearly 3 million women, since 2000.[1] Since 1972, family planning services and supplies have been required services covered under Medicaid. Family planning services and supplies are also exempted from cost-sharing requirements. This remains the case despite recent regulations allowing for new cost sharing in Medicaid. Additionally, family planning services and supplies also receive a special "match rate." The federal government assumes 90% of costs; states cover 10%.

Key Data

- Medicaid finances 45% of all births in the United States; in 15 states, the District of Columbia, and Puerto Rico at least half of all births are Medicaid-funded.
- In 2010, the average cost for one Medicaid-covered birth was $12,770, whereas the annual cost of providing publicly funded contraception for a woman was $239.
- For every dollar spent, public funding for contraception saves the nation approximately $6 that otherwise would have been spent on pregnancy-related care.
- In 2010, publicly funded contraception helped women prevent 2.2 million unplanned pregnancies, 1.1 million of which would have resulted in unplanned births and 760,000 in abortions

Cost Savings

Medicaid finances 45% of all births in the United States and at least half of all births in a number of states (AL, AK, AZ, AR, DC, IL, LA, ME, MS, NM, NC, OK, PR, SC, TN, WV, and WI).[2,a] It is well documented that expanding access to Medicaid family planning services reduces unplanned pregnancy and produces substantial cost savings for state and federal budgets.[3] In 2010, the average national cost for one Medicaid-covered birth (including prenatal care, delivery, postpartum care, and infant care for one year) was $12,770. In comparison, the annual per-client cost for contraceptive care was an estimated $239.[4] For every dollar spent, public funding for contraception saves the nation approximately $6 that otherwise would have been spent on pregnancy-related care.[5] In fact, a Congressional Budget Office analysis that reviewed the cost implications for the expansion of Medicaid family planning eligibility in all 50 states to match Medicaid eligibility for pregnancy-related services showed a cost savings of at least $700 million over 10 years.[6]

Broader Benefits of Medicaid Coverage of Contraception

Unplanned pregnancy lies behind the vast majority of the nation's abortions. Among unmarried women in their twenties, 44% of unplanned pregnancies result in abortion, underscoring the importance of ensuring access to effective and affordable contraception.

In 2010, publicly funded contraception helped women prevent 2.2 million unplanned pregnancies, 1.1 million of which would have resulted in unplanned births and 760,000 in abortions.[7]

Unplanned pregnancy is also linked to a number of negative consequences for parents and children. Women experiencing an unplanned pregnancy are less likely than women who have an intended pregnancy to obtain early prenatal care, and their babies are at increased risk of low birth weight, premature birth, and infant mortality. Births resulting from unplanned pregnancies lead to higher levels of chaos and relationship turmoil between the parents and within the family.[8] Because most births to unmarried women are unplanned (57%), unplanned pregnancy is also closely linked to the well-documented burdens associated with non-marital childbearing, especially for the children, who are more likely to be poor, have lower academic achievement, and drop out of high school.[9]

Half of unplanned pregnancies occur to the approximately one in 10 women who are using no contraception and half occur to women who either are using an ineffective method of contraception or are using an effective method incorrectly or inconsistently.[10] This means that in order to significantly reduce unplanned pregnancy, it is essential to both encourage and support more women who are not currently pregnant and not using contraception to do so and to help those who are using contraception to do so more effectively by ensuring they have access to the full range of methods so they can choose one that works best for them. This includes ensuring access to long acting reversible contraceptives (LARCs) such as IUDs and the implant. Both have higher up-front costs but are less expensive over their lifetime and more effective at preventing unplanned pregnancy. Research shows that when women have good information about these low maintenance, highly effective methods and are given no-cost access to them, many select them. In turn, the use of these effective methods leads to less unplanned pregnancy and less abortion.[11,12]

A key benefit of Medicaid coverage of contraception is that most state Medicaid programs cover LARCs.[13] In fact, LARC use among women obtaining publicly funded contraceptive services increased from 4% in 2002 to 11% in 2006-2010. This resulted in a decrease in the number of unplanned pregnancies in this population, from 67 per 1,000 women to 62 per 1,000 in this time period. As more states expand Medicaid, more women will now have access to contraception, including the most effective, low maintenance methods. Helping to prevent unplanned pregnancy among low income women will in turn reduce Medicaid-funded births.

State Landscape

At present, 31 states have expanded Medicaid eligibility specifically for family planning services to individuals who would otherwise not be eligible for full health coverage under Medicaid. They have done this either through demonstration waivers or state plan amendments (SPAs).[14] The number and diversity of states that have expanded Medicaid coverage of family planning is recognition that doing so is a smart and cost-effective policy. In addition to family planning specific expansions of Medicaid coverage, states also have the option as part of the Affordable Care Act (ACA) to expand their Medicaid programs to all those with incomes up to 133% of the federal poverty level (FPL).[b] Ten states that currently do not have family planning waivers or SPAs are expanding Medicaid coverage under this ACA option. Therefore, this leaves nine states (AK, ID, KS, ME, NE, NH, SD, TN, and UT) that do not have a family planning

TABLE 1. Medicaid Expansion and State Family Planning Expansions as of October 2013

ACA Medicaid Expansion AND Family Planning Expansion	ACA Medicaid Expansion and NO Family Planning Expansion	NO ACA Medicaid Expansion and Family Planning Expansion	NO ACA Medicaid Expansion and NO Family Planning Expansion
Arizona	Colorado	Alabama	Alaska
Arkansas	DC	Florida	Idaho**
California	Hawaii	Georgia	Kansas
Connecticut	Kentucky	Indiana	Maine**
Delaware	Massachusetts	Louisiana	Nebraska
Illinois	Nevada	Mississippi	New Hampshire
Iowa	New Jersey	Missouri	South Dakota
Maryland	North Dakota	Montana	Tennessee
Michigan	Vermont	North Carolina	Utah**
Minnesota	West Virginia	Oklahoma	
New Mexico		Pennsylvania	
New York		South Carolina	
Ohio		Texas*	
Oregon		Virginia	
Rhode Island		Wisconsin	
Washington		Wyoming	

* Texas operates an entirely state-funded family planning expansion program that provides family planning services to women at least 18 years of age with coverage up to 185% of the federal poverty level (FPL).

** Idaho, Maine, and Utah have waivers expanding coverage to limited numbers of childless adults but coverage is generally not equivalent to a full Medicaid expansion up to 133% of FPL.

waiver or SPA and are unlikely to expand their Medicaid programs up to 133% of the FPL in 2014 as the ACA offers. Of these, three states (ID, ME, and UT) offer waivers expanding coverage to limited numbers of childless adults (such waivers typically cover childless adults up to a higher income level than otherwise would be offered in that state, but coverage is generally not equivalent to a full Medicaid expansion up to 133% of FPL. These waivers also have other varying criteria such as caps on the number of enrollees or higher cost-sharing provisions).[15] In the six states that lack either a family planning or income-based waiver and are not expanding as the ACA offers, the old eligibility criteria for Medicaid will still apply. Typically those criteria preclude covering able-bodied childless adults even if they meet the income criteria for their state, which is often significantly lower than the FPL. Women who make over 100% of FPL will qualify for subsidies to purchase private insurance through health exchanges. However, women in these six states, and likely some in ID, ME, and UT, who make more than the current Medicaid eligibility level in their state (and/or do not meet the other qualification criteria) but less than 100% of the FPL will find themselves caught without contraceptive coverage or any Medicaid coverage for that matter.

Recommendation

Expanding access to Medicaid family planning services reduces unplanned pregnancy, improves health outcomes, and produces substantial cost savings for state and federal budgets. By reducing unplanned pregnancies, it also reduces abortion, and produces a host of health and social benefits for women and families. States should expand Medicaid coverage of family planning through a waiver, SPA, or through the option to expand their full Medicaid program to 133% of FPL. This is particularly important for the nine states that currently do not plan to expand their full Medicaid programs as the ACA allows and do not have a Medicaid family planning waiver or SPA. By expanding coverage of family planning through Medicaid, states will reap both fiscal and social benefits.

NOTES

a. Data were rounded to the nearest whole number.

b. Some sources say that states can expand Medicaid up to 133% FPL and some say 138%, both are right. While the ACA says 133%, it also simplifies the way in which eligibility is determined across states and ties it to the Modified Adjusted Gross Income (MAGI) tax rules. MAGI allows for 5% of a person's income to be disregarded, meaning that someone who makes 138% FPL would have 5% deducted when using MAGI to calculate income, bringing that person's income to 133% FPL and eligible for Medicaid in states that expand.

SOURCES

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