

Health Outcomes and Lower Costs Associated with Medicaid Family Planning Waivers

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Twenty-six states have Medicaid §1115 family planning waivers to help promote reproductive health, help women avoid unintended pregnancies, and improve infant and maternal health outcomes. Family planning waivers – which allow states to provide services to individuals who are not otherwise eligible for coverage under Medicaid or the State Children’s Health Insurance Program (SCHIP) – have proven to be successful in reducing the social and economic costs associated with unintended pregnancies. This *State Health Policy Briefing* is the fourth in a series that examines the status of these waivers, and provides a brief overview of the positive health outcomes associated with expanding family planning coverage.¹

In the United States half of pregnancies are unintended.² Women whose pregnancies are unintended are likely to discover their pregnancies later and are less likely to adopt healthy behaviors at the beginning of the pregnancy, including entry into early prenatal care.³ Unhealthy behaviors during pregnancy and late and insufficient prenatal care can lead to low weight births and other health disadvantages. Because Medicaid pays for 41 percent of all births in this country, the federal and state governments are bearing an enormous share of the financial costs associated with unintended pregnancies.⁴ Family planning programs can significantly reduce unintended pregnancies and the associated social, individual, and financial costs. Moreover, because federal funds pay 90 percent of the cost of providing Medicaid family planning services, these programs are highly cost-effective for states.

Background

In the 1960s, understanding of the negative social and economic consequences of unintended pregnancies increased significantly.⁵ In 1972 Congress required all state Medicaid programs to make family planning services and supplies available to all Medicaid recipients of childbearing age.⁶ To aid states in this effort, the federal government began reimbursing states for these services at an enhanced 90 percent rate rather than the 50 to 77 percent federal match for most other Medicaid-covered services. Family planning services and supplies were also exempted from cost-sharing requirements.⁷

Under federal law, states are required to cover all pregnancy-related care for 60 days postpartum for all pregnant women with household incomes up to 133 percent of the federal poverty level. After 60 days postpartum, most

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women lose Medicaid coverage. Medicaid §1115 family planning waivers allow states to provide family planning services and supplies to women who lose Medicaid benefits after their pregnancies and to additional men and women who would not otherwise be eligible for such care.⁸ While there is variation among state programs, they generally provide contraceptive services and supplies; physical exams; lab tests, including screenings for sexually transmitted illnesses (STIs); and in some cases STI treatment.⁹

A clear relationship exists between unintended pregnancies and negative birth and maternal health outcomes.¹⁰ Medicaid family planning waivers have been shown to dramatically reduce the number of unintended pregnancies and to improve maternal health among program participants. For example:

- California's Medicaid family planning program, Family PACT, is estimated to have prevented between 205,000 and 213,000 unintended pregnancies in 2002 alone, about 45,000 of which would have been to teenagers.¹¹
- A study funded by the Centers for Medicare and Medicaid Services (CMS) and conducted by the CNA Corporation estimated that, among the six state family planning waiver programs evaluated, between 2.5 percent (New Mexico) and 10.2 percent (Oregon) of pregnancies were averted among program participants.¹²

In the past, Title X – the only federal program devoted exclusively to funding family planning services and clinics – provided the largest share of public funds for family planning.¹³ Yet today Medicaid provides more than six in ten public dollars for family planning services in the United States. Adjusted for inflation, Title X funding is 61 percent lower now than it was in 1980.¹⁴ As a result, Medicaid family planning waiver programs have become an increasingly important tool for states to meet the family planning needs of low-income men and women.

Health Benefits of Family Planning

Unintended pregnancies are associated with an increased health risk for women and their babies, due to behaviors during pregnancy (such as poor nutrition and tobacco, alcohol, and drug use) that are associated with adverse health effects.^{15,16} Additionally, women with unintended pregnancies are 1.6 times more likely to delay entry into prenatal care.¹⁷

Women with unintended or poorly timed pregnan-

cies are also more likely to deliver pre-term or have other pregnancy-related complications. Similarly, the proportion of infants born with health disadvantages, including low birth weight, is significantly higher if the pregnancy is unintended.^{18,19} Overall, unintended pregnancies result in a 30 percent greater likelihood that the infant's health will be compromised.²⁰ By helping women plan their pregnancies, Medicaid family planning waivers can reduce some of these negative birth outcomes.

PRENATAL AND PRECONCEPTION CARE

Early prenatal care allows pregnant women and their health care providers to identify and potentially treat health problems and behaviors that could compromise fetal development or the health of the mother.²¹ Women with unintended and mistimed pregnancies are more likely to delay entry into prenatal care,²² which may be associated with negative health outcomes such as low birth weight.²³ Additionally, babies born to mothers who received no prenatal care are three times more likely to be born at a low birth weight than those born to mothers who received prenatal care.²⁴

Family planning also allows for counseling and care before conception, which is essential to maximize the likelihood of healthy pregnancies and positive infant health outcomes. When pregnancies are anticipated, women can take steps to improve their health and reduce risk factors that might affect their future pregnancies.²⁵

Women of childbearing age can suffer from a wide variety of conditions that may lead to negative birth outcomes. For example:

- In the United States, 9.3 percent of women ages 15 to 44 are diabetic.²⁶ Infants born to women with unmanaged diabetes are three times more likely to be born with birth defects. The risks to both mother and baby are substantially reduced by proper management of the disease.²⁷
- One out of three women of childbearing age is obese.²⁸ Maternal obesity is associated with many adverse birth outcomes, including pre-term delivery and neural tube

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defects (birth defects of the brain and spinal cord).

Weight loss before pregnancy reduces these risks.²⁹

- Untreated sexually transmitted illnesses can lead to a wide range of poor birth outcomes including physical and developmental disabilities. Early screening and treatment can prevent them.³⁰
- Use of daily folic acid supplements before conception has been shown to reduce the incidence of neural tube defects by two-thirds.³¹

Family planning waivers can give women access to providers who can discuss reproductive health information with them at every visit; states are required to make referrals to community health centers to provide primary care to individuals enrolled in family planning programs.³² Additionally, many waiver programs provide screenings and treatment for STIs and screenings for breast and cervical cancers.^{33,34} By providing preconception education, screenings, and in some limited cases care, family planning waiver programs can help decrease risk factors and improve the chances for healthy births.

REDUCTION IN LOW BIRTH WEIGHT AND PRE-TERM BIRTHS

By providing coverage for family planning services, states can reduce low birth weight and pre-term births.

Pre-term births account for 12.5 percent of all births in the United States. Infants born prematurely are at greater risk for many potential complications, including respiratory, gastrointestinal, immune system, central nervous system, hearing, and vision problems. As pre-term infants grow older, longer-term problems may arise, including cerebral palsy, mental retardation, behavior and social-emotional concerns, learning difficulties, and poor health and growth.³⁵ While the causes of prematurity are unknown for half of premature births,³⁶ it is clear that unintended pregnancies are more likely to result in pre-term births than intended ones.³⁷

An additional goal of family planning waivers is to promote healthy spacing between births. Several studies have shown that closely spaced births are associated with a higher risk of low birth weight and prematurity.³⁸ One study concluded that “interpregnancy intervals shorter than 18 months and longer than 59 months are significantly associated with increased risk of adverse perinatal outcomes. These data suggest that spacing pregnancies appropriately could help prevent such adverse perinatal outcomes.”³⁹

Evidence suggests that family planning waivers can increase birth spacing among program participants.⁴⁰ For example, Rhode Island’s RIte Care program focused on length-

ening birth spacing. In 1993, before the state’s waiver was implemented, 41 percent of women in Rhode Island who had Medicaid-funded births became pregnant within 18 months of their previous delivery. By 1996 (post-waiver) that number had been reduced dramatically to 29 percent, essentially closing the gap in short interpregnancy intervals between women enrolled in Medicaid and those with commercial health coverage. Rhode Island also saw dramatic improvements in infant health outcomes among program participants, including a 36 percent drop from 1990 to 1999 in infant mortality for infants with publicly funded coverage.⁴¹

Return on Investment and Cost Savings

Through family planning waivers, states have the potential to dramatically lower the financial costs associated with unintended pregnancies and unhealthy birth outcomes. Poor birth outcomes are expensive. For example:

- Average hospital costs for pre-term or low birth weight infants have been shown to be 25 times higher than for uncomplicated births.⁴²
- Approximately 8 percent of infant hospitalizations include a diagnosis of pre-term birth or low birth weight, yet account for 47 percent of all infant hospital costs and 27 percent of all pediatric hospital stays, or \$5.8 billion dollars annually.⁴³
- By comparison, uncomplicated newborn births account for 42 percent of infant hospital stays but only 10 percent of all infant hospital costs, or \$1.2 billion annually.⁴⁴
- Additionally, hospitalization costs have been shown to decrease with increased birth weight and gestational age. Costs are highest for extremely pre-term infants, or those with less than 28 weeks gestation or birth weight below 1000 grams. These costs average \$65,600 per infant.⁴⁵

Among pre-term and low birth weight infant hospitalizations, 42 percent of stays are paid for by Medicaid.⁴⁶ By reducing low weight and premature births, states have the potential to save millions of dollars.

Conclusion

Research has clearly demonstrated that unintended pregnancies are associated with an increased health risk for both women and infants, and they significantly increase the rate of low weight and premature births. These consequences can dramatically increase health care costs and decrease quality of life for the mother and the child, and they are expensive for state Medicaid programs. Family planning waivers have proven to be a successful tool for states to help women prevent unintended pregnancies and increase inter-birth intervals, while also reducing state costs and improving maternal and child health outcomes.

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Notes

- 1 Medicaid 1115 Family Planning Demonstration Waiver Programs (Aug. 2007); *Cost-Effectiveness of Medicaid Family Planning Demonstrations* (Sept. 2007); *Medicaid Family Planning Demonstrations: Design Issues and Resources for States* (Dec. 2007), available on www.nashp.org.
- 2 Lawrence B. Finer and Stanley K. Henshaw, "Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001," *Perspectives on Sexual and Reproductive Health* 38, no. 2 (2006): 90-96. See also Adam Sonfield, "Preventing Unintended Pregnancy: The Need and the Means," *The Guttmacher Report on Public Policy* 6 no. 5 (Dec. 2003): 7-10.
- 3 Jennifer O'Brien, *PRAMS 1999 Surveillance Report* (Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2003). See also LeaVonne Pulley et al., "The Extent of Pregnancy Mistiming and Its Association with Maternal Characteristics and Behaviors and Pregnancy Outcomes," *Perspectives on Sexual and Reproductive Health* 34, no. 4 (2002): 206-211.
- 4 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *National Vital Statistics Reports* 51, no. 11 (June 25, 2003).
- 5 The Henry J. Kaiser Family Foundation and the Guttmacher Institute, "Medicaid's Role in Family Planning," *Issue Brief* (Oct. 2007): 2.
- 6 Rachel Benson Gold et al, "Medicaid: A Critical Source of Support for Family Planning in the United States," *Issue Brief*, The Henry J Kaiser Family Foundation and The Guttmacher Institute (April 2005): 3. See also Rachel Benson Gold, "Medicaid Family Planning Expansions Hit Stride," *The Guttmacher Report on Public Policy* 6, no. 4 (Oct. 2003): 11-14.
- 7 The Henry J Kaiser Family Foundation and the Guttmacher Institute, "Medicaid's Role in Family Planning," 3.
- 8 Rachel Benson Gold, "Doing More for Less: Study Says State Medicaid Family Planning Expansions are Cost-Effective," *The Guttmacher Report on Public Policy* 7, no. 1 (March 2004).
- 9 The Henry J. Kaiser Family Foundation and the Guttmacher Institute, "Medicaid's Role in Family Planning."
- 10 Joe L. Holliday, "Expanding Medicaid Income Eligibility for Family Planning: An Opportunity to Improve Reproductive Outcomes and Lower Medicaid Costs," *North Carolina Medical Journal* 65, no. 3 (May/June 2004): 170.
- 11 Diana Greene Foster et al, "Estimates of Pregnancies Averted Through California's Family Planning Waiver Program in 2002," *Perspectives on Sexual and Reproductive Health* 38, no. 3 (2006): 126-131. See also The Henry J. Kaiser Family Foundation and the Guttmacher Institute, "Medicaid: A Critical Source of Support for Family Planning in the United States," *Issue Brief* (April 2005).
- 12 J. Edwards, J. Bronstein, and K. Adams, *Evaluation of Medicaid Family Planning Demonstrations* (The CNA Corporation, Nov. 2003), CMS Contract No. 752-2-415921: 22.
- 13 J.J. Frost et al., *Estimating the Impact of Serving New Clients by Expanding Funding for Title X*, Occasional Report no. 33 (New York: the Guttmacher Institute, 2006): 5.
- 14 Rachel Benson Gold, "Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort," *Guttmacher Policy Review* 1, no. 2 (Spring 2007): 14.
- 15 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Unintended Pregnancy Prevention. Retrieved

- 3 Dec. 2007. <http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm>.
- 16 J. Edwards, J. Bronstein, and K. Adams, 6.
- 17 J.P. Mayer, "Unintended Childbearing, Maternal Beliefs, and Delay of Prenatal Care," *Birth* 24, no. 4 (1997). See also Marsha Regenstein et al., *Barriers to Prenatal Care: Findings from a Survey of Low-Income and Uninsured Women Who Deliver at Safety Net Hospitals* (Washington, D.C.: The National Public Health and Hospital Institute, 2005).
- 18 K. Kost et al., "The Effects of Pregnancy Planning Status on Birth Outcomes and Infant Care," *Family Planning Perspectives* 30, no. 5 (1998): 223-230.
- 19 The National Campaign. *Unplanned Pregnancy: Consequences of Unplanned Pregnancy Fact Sheet*. Retrieved 3 Dec. 2007. <http://www.thenc.org/resources/pdf/FactSheet-Consequences.pdf>.
- 20 Jeanette M. Conner and James E. Dewey, "Reproductive Health" in *Well Being: Positive Development Across the Life Course*, Marc Bornstein et al., editors (Mahwah, N.J.: Lawrence Erlbaum Associates, 2003): 100.
- 21 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Trends in the Well-Being of America's Children & Youth* (1997): section HC 3.2.a.
- 22 Susan A. Cohen, "The Broad Benefits of Investing in Sexual and Reproductive Health," *The Guttmacher Report on Public Policy* 7, no. 1 (March 2004): 5-8.
- 23 Cameron A. Mustard and Noralou P. Roos, "The Relationship of Prenatal Care and Pregnancy Complications to Birthweight in Winnipeg, Canada," *American Journal of Public Health* 84, no. 9 (Sept. 1994): 1450.
- 24 U.S. Department of Health and Human Services. *Fact Sheet: Preventing Infant Mortality*, Jan. 13, 2006. Retrieved 3 Dec. 2007 <http://www.hhs.gov/news/factsheet/infant.html>.
- 25 Kay Johnson et al., "Recommendations to Improve Preconception Health and Health Care—United States," *Morbidity and Mortality Weekly Report* (April 21, 2006).
- 26 Hani K. Atrash et al., "Preconception Care for Improving Perinatal Outcomes: The Time to Act," *Maternal and Child Health Journal* 10, supplement 1, (Sept. 2006): S4.
- 27 Atrash et al., S7.
- 28 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "Folate Status in Women of Childbearing Age, by Race/Ethnicity—United States, 1999-2000, 2001-2002, and 2003-2004," *Morbidity and Mortality Weekly Report* 55, no. 51 (Jan. 5, 2007): 1377-1380.
- 29 Atrash et al., S7.
- 30 Johnson et al.
- 31 Atrash et al., S7. See also Johnson et al.
- 32 Gold, "Medicaid Family Planning Expansions Hit Stride."
- 33 Gold, "Doing More for Less."
- 34 Henry J. Kaiser Foundation and the Guttmacher Institute, "Medicaid: A Critical Source of Support for Family Planning in the United States," 5.
- 35 Institute of Medicine, *Preterm Birth: Causes, Consequences, and Prevention* (Washington, D.C.: National Academies Press, 2006).
- 36 National Governors Association Center for Best Practices, *Healthy Babies: Efforts to Improve Birth Outcomes and Reduce High Risk Births* (Washington, DC: National Governors Association, 2004).
- 37 The National Campaign.
- 38 Elinor Hall and Michelle Berlin, "Using Medicaid to Support Preterm Birth Prevention: Five Case Studies" (prepared for March of Dimes, May 2004): 34.
- 39 Agustin Conde-Agudelo et al., "Birth Spacing and Risk of Adverse Perinatal Outcomes, a Meta-analysis," *Journal of the American Medical Association* 295, no. 15 (April 19, 2006).
- 40 J. Edwards, J. Bronstein, and K. Adams, 6.
- 41 Infant mortality dropped from 10.7 per 1,000 births to 6.8 per 1,000 births from 1990-1999. See RI Medicaid Research and Evaluation Reports, "Rhode Island's Infant Mortality Rate Drops Significantly in 1990s," Issue Brief no. 3 (Dec. 2002). Also Hall and Berlin: 38.
- 42 Rebecca B Russell, et al., "Cost of Hospitalization for Preterm and Low Birth Weight Infants in the United States," *Pediatrics* 120, no. 1 (July 2007): 7.
- 43 Russell et al., 4.
- 44 Ibid.
- 45 Russell et al., 1.
- 46 Agency for Healthcare Research and Quality, 2001 NIS. Cited in Russell et al., 6.