January 2011

Estimating the Impact of Expanding Medicaid Eligibility For Family Planning Services: 2011 Update

Adam Sonfield, Jennifer J. Frost and Rachel Benson Gold

HIGHLIGHTS

- Over the past 15 years, 22 states have sought and received federal approval to extend Medicaid coverage for family planning services to residents solely on the basis of income under a complicated process known as a "waiver."
- A ground-breaking provision included in the March 2010 health care reform law greatly simplifies the process for a state seeking to expand Medicaid eligibility for family planning and allows for coverage of a larger population than currently included in any existing waiver program.
- This report provides a tool to help gauge the potential impact in each state of taking up this new authority.
- Twenty-eight states do not currently have an income-based family planning expansion. Nineteen states without an expansion could each serve at least 10,000 individuals, avert at least 1,500 unintended pregnancies and save at least $2.3 million in state funds in a single year, by expanding Medicaid eligibility under the new authority. Nine of these 19 states could each serve at least 50,000 individuals, avert at least 7,500 unintended pregnancies and save at least $17.4 million in state funds in a single year.
- Among the 22 states that already have a family planning expansion in place via the older waiver process, 11 could each serve at least 10,000 individuals, avert at least 1,300 unintended pregnancies and save at least $1.7 million in state funds in a single year, in addition to what their expansions achieve today.

January 2011

Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services: 2011 Update

Adam Sonfield, Jennifer J. Frost and Rachel Benson Gold

CONTENTS

Introduction 3

Methodological Overview 7

State Tables 10

Discussion 63

Methodoloical Appendix 65

Appendix Tables 72

References 79

ACKNOWLEDGMENTS

This report was written by Adam Sonfield, Jennifer J. Frost and Rachel Benson Gold, all with the Guttmacher Institute. The research was supported by the Centers for Disease Control and Prevention under contract 200-2010-M-89398.

The authors thank the following Guttmacher colleagues: Susheela Singh, Lawrence B. Finer and Cory L. Richards, for reviewing drafts of the report; Rachel K. Jones and Mia Zolna, for additional data analysis and tabulations; and Laura Jacobson, for important research support in the project's early phases. The report was edited by Jared Rosenberg. Kathleen Randall and Judith Rothman were responsible for layout and production.

Special thanks are due to the following individuals, who reviewed drafts of this work and provided invaluable comments: Diana Greene Foster, Bixby Center for Global Reproductive Health, University of California, San Francisco; Janet M. Bronstein, University of Alabama at Birmingham; and E. Kathleen Adams, Emory School of Public Health. Additionally, the authors thank officials from numerous states across the country who provided data and information about their Medicaid family planning expansions and their broader Medicaid programs.

The Guttmacher Institute gratefully acknowledges the general support it receives from individuals and foundations—including major grants from the William and Flora Hewlett Foundation, the David and Lucile Packard Foundation and the Ford Foundation—which undergirds all of the Institute's work.

© Guttmacher Institute, 2011

Suggested citation: 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

www.guttmacher.org

Introduction

The purpose of this report is to illustrate the potential of a small but important provision in the 2010 health reform legislation that gives states new authority to expand Medicaid eligibility for family planning services to women and men who are otherwise ineligible for the program. To do so, we have provided new estimates of what states could expect in terms of program participation, the numbers of unintended pregnancies, births and abortions that could be averted, and the resulting cost savings. These estimates are an update of a Guttmacher Institute study published in August 2006, which looked at the potential for similar expansions that many states had initiated under a different, more complicated process known as a "waiver."[1] The new estimates reflect both more recent data when available and specific provisions and requirements of the law. Among other things, the law allows for coverage of a larger population of individuals than currently covered under any existing waiver program, and requires states' expansions to cover adolescents and men—two populations that have been excluded under some waivers.

It should be emphasized up front that these estimates are merely that, estimates. The actual impact of expanded Medicaid family planning efforts would depend substantially on state-level factors, such as outreach efforts and provider capacity. In addition, although our methodology is based wherever possible on states' own reported data and on the experience of existing family planning expansions, policymakers and budget analysts may have access to additional state-specific information that was unavailable to us but that could provide a greater degree of precision. These findings should be viewed, therefore, as demonstrating the potential of expansions, rather than their definite impact. In that light, it is equally important to emphasize that given the options available at various stages of the analysis, we typically chose the analytical approach that would lead to the most conservative estimate.

History of the Expansions

When Medicaid was first established in 1965, the low-income families who in general were covered by the program were single mothers and their children receiving welfare cash assistance. In the 1980s, responding to research that showed both the importance and the 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 ($18,310 for a family of three in 2010),[2] which was far higher than most states' regular Medicaid eligibility ceilings.[3] 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 four in 10 births in the United States each year; in some states, the program funds more than half of all births.[5]

In recent years, about half the states have built on the eligibility expansions for pregnancy-related care by moving to expand eligibility for family planning services under Medicaid as well. 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, although Congress has provided funding for somewhat enhanced rates through June 2011 as an economic stimulus measure.[8] States are reimbursed by the federal government for the cost of pregnancy-related care at their regular reimbursement rates.

As of November 1, 2010, 22 states had sought and received federal approval 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.[9] Another three states had applications pending with the Centers for Medicare and Medicaid Services (CMS), the federal agency that

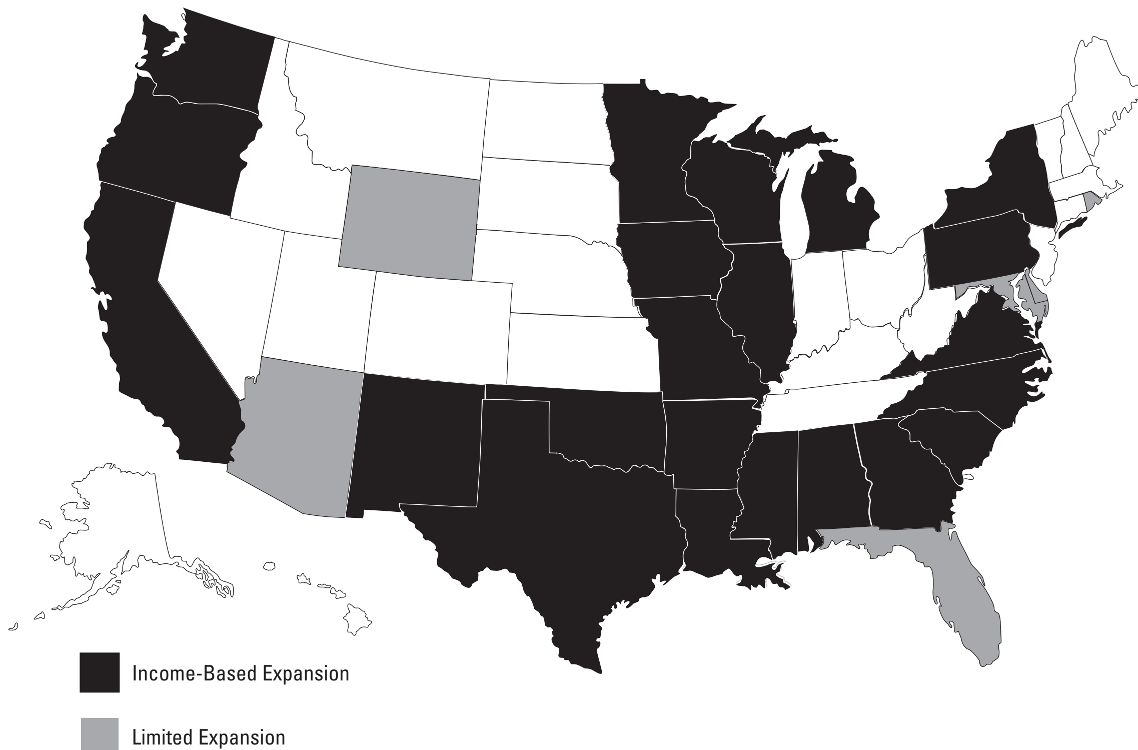
administers the program. This approach directly parallels the earlier expansions for pregnancy-related care. Most of these states extend coverage for family planning to women with incomes below 185% or 200% of poverty. Eight of these states limit their programs to individuals who are at least 19 years of age; three limit coverage to those who are at least 18. Nine include coverage for men in their programs. Six additional states had 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 (see map).

Evidence of Impact

According to a growing body of evidence from demonstration waiver evaluations and independent research studies, the broader, income-based programs are having a significant impact. Publicly funded family planning centers, including clinic sites that receive Title X funds and those that do not, in states with broad-based family planning expansions are able to meet more of the need than are those in other states. Centers in the expansion states served 48% of the women in need of publicly funded family planning services in 2006, compared with 36% in other states.* This gap is evidence that the expansions have increased family planning centers' ability to enable women to avoid unintended pregnancies and the abortions that follow.[10] California's Medicaid family planning expansion program, known as Family PACT, helped women in the state avoid 286,700 unintended pregnancies, including 79,200 to teenagers, according to the state's 2007 evaluation.[11] By doing so, the program helped women avoid 128,800 unintended births and 118,200 abortions. In Oregon, unintended pregnancy rates declined from 44 per 1,000 women of reproductive age in 1999, when the state's family planning expansion was implemented, to 38 per 1,000 in 2005.[12]

The expansion programs have helped women avoid unintended pregnancy by enabling them to improve their use of contraceptives. In Washington state, for example, the proportion of clients using a more effective method (defined as hormonal methods, IUDs and sterilization) increased from 53% at enrollment to 71% one year later,

States with Medicaid Family Planning Expansions



Notes: As of November 1, 2010. Income-based expansion refers to states with expansions for women (and sometimes men) whose family incomes do not exceed a specified level, most often at or near 200% of the federal poverty level. Limited expansion refers to states with expansions only for women who have left Medicaid either following a Medicaid-funded delivery or for any reason. *Source:* Reference 9.

according to the state's program evaluation.[13] Similarly, in California, Family PACT clients were both more likely to use any method and to use a more effective method than they were before enrolling in the program.[11]

Short intervals between births—a widely acknowledged risk factor for low-birth-weight deliveries and, therefore, infant mortality and morbidity—have become much less common in some states with family planning expansions. In Arkansas, repeat births within 12 months dropped 84% between 2001 and 2005 for women enrolled in the family planning expansion, and the proportion having a repeat delivery within 48 months fell by 31%.[14] In New Mexico, women accessing family planning services under the expansion were less likely to have a repeat delivery within 24 months than were women who did not access expansion services, 35% compared with 50%.[15] In Rhode Island, the proportion of mothers on Medicaid with birth intervals of less 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.[16] 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.[17] Specifically because of the demonstrated ability of these programs to increase spacing between births, the National Governors Association has taken the position that expanding Medicaid eligibility for family planning is an important step states can take to improve birth outcomes.[18]

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 just over two years over the same period.[14] In Wisconsin, birthrates for teens in the expansion program were substantially lower than those for all low-income teens from 2003 to 2006. Moreover, births to teens as a proportion of all state Medicaid births declined from 25% in 2000 to 18% in 2006.[19]

In addition, expanding eligibility for family planning under Medicaid permits a woman to establish a relationship with a health care provider prior to pregnancy. This, as recognized by the March of Dimes, increases her likelihood of obtaining the timely prenatal care needed if and when she eventually does become pregnant.[20]

Because the cost of providing Medicaid-covered, pregnancy-related care greatly outstrips the cost of providing contraceptive services, giving women access to the contraceptive services they need and want generates significant state and federal savings. In fact, CMS recently noted that states have been allowed to expand eligibility for family planning under Medicaid precisely because of the cost-effectiveness to the program.[21] For example, according to a federally funded evaluation of state Medicaid family planning expansions completed in 2003, 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.[22] More recent data are available from some of the evaluations conducted by states. Wisconsin estimates that its program generated net savings of $159 million in 2006.[19] Moreover, data from the Texas Health and Human Services Commission show that by serving 75,800 women in 2008,[17] the state's Medicaid family planning expansion yielded net savings of $42 million.[23]

New State Authority

In acknowledgement of the effectiveness and cost-effectiveness of these programs, a ground-breaking provision included in the omnibus health care reform legislation that was enacted in March 2010 greatly simplifies the process for a state seeking to expand eligibility for family planning under Medicaid.[24] In the past, the only option for a state seeking to expand was through approval of a research and demonstration waiver from CMS, which allows a state to bypass standard Medicaid rules to provide a limited benefit package and to cover individuals who otherwise would not be eligible. Although not required by law or statute, 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 otherwise have spent in the absence of the waiver. Even though states have been able to meet this threshold, the process of demonstrating budget neutrality was a time-consuming one. Waiver applications are given extensive review within CMS, and are examined by the Office of Management and Budget as well. CMS also requires that waivers have an extensive evaluation component, consistent with their role as demonstration initiatives. On aver-

*Women in need of publicly subsidized contraceptive services include those who are sexually active, of reproductive age (13–44), able to become pregnant and not pregnant, postpartum nor 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.

age, it has taken roughly two years for a state to secure approval of a Medicaid family planning waiver.[25]

The provision included in the health care reform legislation gives states a second option: It allows states to expand eligibility for family planning by amending their state Medicaid plans, a far simpler process than that which states needed to endure to secure approval of a waiver. A state must still obtain federal approval for a state plan amendment (SPA), but that is generally a faster and more streamlined process than that for a waiver. Moreover, a SPA is a permanent change to a state's Medicaid program, unlike a waiver, which is initially granted for a five-year period and then renewed in three-year increments.

The legislation permits states to set the eligibility level for family planning up to the highest level for pregnant women in place under either the state's Medicaid or Children's Health Insurance Program (CHIP) state plan. Subsequent guidance issued by CMS 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.[21] As a result, states may not exclude individuals based on age or gender, even if these individuals would not have been eligible for coverage under a waiver previously obtained by the state.[26]

As described by the Energy and Commerce Committee of the House of Representatives, the statutory provision was designed to enable state Medicaid programs to cover family planning services and supplies for any individual who would be eligible for Medicaid or CHIP coverage of pregnancy-related care.[27] To reach this goal of true parity in eligibility, the CMS guidance makes clear that a state may use the same methodology for determining income eligibility under a family planning SPA as it uses for pregnancy-related care.[21] This includes counting each applicant as two people in the household when determining income eligibility, a methodology not previously permitted by CMS under a family planning waiver that will allow coverage for a greater number of individuals. States choosing to use the same methodology for determining eligibility for family planning as they use for pregnancy-related care would need to apply that methodology to both women and men. In addition, in making eligibility determinations, states have the option to consider only the income of the applicant and not the income of other family members.

In addition, several restrictions that had been applied to family planning waivers in the past are not applicable to SPAs. For example, states may utilize an enrollment strategy known as presumptive eligibility, through which an applicant may be granted immediate but temporary eligibility by a qualified health care provider. Although documentation for various factors of eligibility—such as citizenship—is not required for the presumptive determination, applicants must provide that documentation to convert that temporary eligibility into full enrollment. 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.)

A family planning SPA must provide coverage for all family planning services and supplies covered under the state's full-benefit Medicaid program; these services may be reimbursed at the special 90% federal reimbursement rate for family planning. In addition, states must cover at least some—but not necessarily all—family planning–related services, which are defined as "medical diagnosis and treatment services that are…provided in a family planning setting as part of or as follow-up to a family planning visit." Related services may include drugs for treating STIs when diagnosed during a family planning visit, rescreening for STIs based on guidelines from the Centers for Disease Control and Prevention, an annual visit for men, colposcopy services, repeat Pap tests or the human papillomavirus vaccine. States may be reimbursed for these related services at their regular federal reimbursement rate. As under full-benefit Medicaid, states must cover transportation services needed by individuals enrolled under a family planning SPA, a requirement not applicable under a family planning waiver.

All of these options and requirements under a SPA apply equally to every state, whether it be a state looking to expand Medicaid eligibility for family planning services for the first time or one that has an existing family planning waiver but is looking to transition to a SPA. This report provides estimates for what taking up the SPA authority could mean for both types of states.

Methodological Overview

Basic Overview

In this report, we examine the potential of states' new authority to implement a family planning SPA by presenting estimates of program participation; the numbers of pregnancies, births and abortions that could be averted; and the resulting cost savings. The estimates are updates of estimates originally presented in an August 2006 Guttmacher Institute report,[1] and the methodology for the current report closely follows that of the prior one. Specifically, for each state and the District of Columbia, we draw on a wide array of data sources to:

- estimate the number of women who would be likely participants in the family planning expansion;
- predict how many of those women would make use of services, as well as the number of men;
- predict the net change in contraceptive use and method mix among female program participants;
- estimate the number of unintended pregnancies, abortions and unintended births that would be averted as a result of this net change in users and methods used;
- estimate the cost of a birth under Medicaid and the total cost of Medicaid births averted;
- estimate the cost per user of Medicaid family planning services and the total cost of the expansion; and
- compare the two total costs to arrive at net savings, both overall and for the state only.

In addition to incorporating more recent data when available, this report differs from its 2006 predecessor to address changes since that time in states' authority and in the policy environment surrounding the family planning expansions. Details on the updates and changes may be found in the Methodological Appendix of this report. In brief:

Eligibility scenarios

Under the authority that Congress gave to states in March 2010, states now have two likely options regarding eligibility levels for a family planning SPA, and this report presents estimates for both scenarios:

- States may establish parity between the SPA eligibility level and the percentage of poverty used to determine eligibility for pregnancy-related care. This option is referred to in this report as "Nominal Parity" because it fails to account for the fact that for pregnancy-related care, a woman is counted as two people in weighing whether her income is low enough to qualify for Medicaid.

- Alternatively, states may set the SPA eligibility procedures so that they mirror those used for pregnancy-related care. This option is referred to in this report as "True Parity" because it means that any woman who would be eligible for coverage of pregnancy-related care would also be eligible for family planning coverage.

New requirements

Under the 2010 law and its interpretation by CMS, a state that initiates a family planning SPA must follow several requirements that do not apply to existing Medicaid family planning expansions. Most notably for these estimates, states may not exclude adolescents or men (two groups that are currently excluded in many of the waiver programs) and must pay for transportation services for expansion participants under a SPA (a category of services not included in waiver programs). Our estimates in this report, therefore, include adolescent and male participants for all programs and additional costs for transportation services. (The estimates include costs for male participants, but we were not able to estimate their potential impact on averting unintended pregnancies.) States are also required to cover at least some family planning–related services, but because they are given broad discretion about what to cover, we were unable to include their costs or benefits of such services in our estimates.

First-year estimates

Our estimates for states without existing waiver programs include projections for the first year of a new program, as state policymakers are often concerned with the immediate, single-year budgetary impact of a policy change. These estimates account for an initial ramp-up period where participation is relatively low, and include only

those births prevented that would have occurred during the given year. In other words, for the first-year estimates, we counted only one-quarter of the total number of projected averted births, to account for the nine-month duration of pregnancy.

Scope of the Analysis

Predicting the impact of new or expanded Medicaid family planning efforts is an uncertain endeavor, and much depends on decisions by state policymakers and other state-specific factors, such as the capacity of the provider network. It is best, therefore, to view these findings as demonstrating the potential of Medicaid family planning expansions, rather than their definite impact. In particular, these estimates cannot provide the same level of precision that could be obtained by using state-specific information that might be accessible to policymakers and budget analysts in an individual state, but was not available to us. That said, we have attempted to address numerous issues that could affect program participation, impact and costs, and our methodology is based wherever possible on states' own reported data and on the experience of existing family planning expansions. Moreover, given the options available at various stages of the analysis, we typically chose the analytical approach that would lead to the most conservative estimate.

For example, according to state officials who have worked on existing waiver programs, one key factor behind levels of program participation is the effort put into the program's implementation, particularly outreach to potential participants and providers.[28] In the absence of strong outreach efforts, a program's impact would likely be muted considerably. Accordingly, we have assumed that a robust investment in outreach, enrollment and related efforts is integral to a successful program, and we have included such an investment in our estimates of program costs (a 10% increase in family planning costs per user). Nevertheless, it is possible that some states will have even greater initial start-up costs if, for example, they require major changes to their enrollment systems.

Another key factor in program participation is the level of insurance coverage—Medicaid, CHIP or private insurance—among low-income individuals in the state; less coverage means more demand for the program. Although individuals eligible or enrolled in other coverage may still enroll in a family planning SPA, our estimates of likely participants focus on individuals uninsured for at least part of the year. It should be noted, however, that some individuals may apply for a family planning SPA and discover that they are eligible for broader Medicaid or CHIP; if such individuals enroll in those broader programs rather than the family planning SPA, our estimates still give the SPA "credit" for pregnancies averted as a result of the new coverage.

In terms of estimating the impact on participants' contraceptive practices, we incorporated the fact that for some new program participants, the program would merely be taking on costs that would have been paid by other public or private sources, because many eligible women are already using contraceptives. Our methodology accounts for this so-called substitution effect by comparing the mix of contraceptive methods used by all likely participants (including those who may have already received recent family planning care) with the mix of contraceptive methods used by women who received publicly funded contraceptive care in the past year. In this way, we evaluate the impact of these programs as the net effect of some nonusers becoming contraceptive users and some current users switching to more effective methods. We do not try to estimate any improvement in how effectively contraceptives are used, nor do we account for the potential impact of services to male clients. Because this part of our methodology draws exclusively on national-level data, we cannot account for the fact that family planning efforts may be more successful in some states than others in terms of encouraging women's use of more-effective methods or assisting them in using their chosen method consistently and correctly.

In evaluating program costs, our examination assumes that the package of services provided to women who participate in a family planning expansion program will include those family planning services and supplies reimbursed at the 90% federal matching rate. Per-user costs have also been inflated (by 1%) to account for the transportation services required for Medicaid recipients, based on states' current expenditures among women of reproductive age. As noted above, although states provide a broader range of reproductive and preventive health services as part of their programs, estimation of the costs—or benefits—of such services is beyond the scope of this analysis. Nevertheless, almost all of the existing waiver programs have included some related services, such as drugs for the treatment of STIs diagnosed during a family planning visit, without a substantial increase to their program costs.

The savings estimated in this report are the direct, short-term maternity and infant care costs related to an averted Medicaid birth. Those include the costs of prenatal care, labor and delivery, and postpartum care, as well as one-year of Medicaid costs for an infant. These are the standard set of costs included by states in evaluating the existing waivers, in accordance with requirements set by CMS. No savings are included from averted Medicaid-

funded abortion services or those related to miscarriages, nor are longer-term or indirect potential impacts related to families' use of health care and social services. Similarly, we do not account for any savings to states that are switching from a waiver program to a SPA, and that as a result, are no longer required to conduct extensive evaluations of their programs or apply for a renewal every three years.

In addition, this analysis does not address critical issues related to the capacity of the provider network to meet the expected increase in demand for services under these programs. The experience of existing expansions demonstrates both that this is an important determinant of success and that achieving it is feasible. Similarly, the analysis does not account for such national influences as the political controversy over immigration or the broader expansions to Medicaid required as part of health care reform. Such factors could have a positive or negative influence on the impact of states' family planning expansions.

State Tables

This chapter includes 51 tables, one for every state and the District of Columbia. The information presented is different depending on whether the state currently has a family planning expansion in place.

For states that do not have an existing family planning expansion (or have only a limited expansion, such as for women otherwise losing Medicaid coverage postpartum), the data presented are estimates of the potential impact if a family planning SPA were initiated. The table first shows the state's highest current eligibility level for pregnancy-related care under Medicaid or CHIP. Next, the table presents the findings for both an expansion to Nominal Parity and for an expansion to True Parity. Within each of those scenarios, the table presents the potential impact during the first year of program operation and for a "mature" year of an expansion, reflecting the fact that the first year differs from subsequent years in two key respects: First, expansion participation goes through an initial ramp-up period and second, the savings for most births averted to first-year participants do not accrue until the second year.

For each column, data presented include the number of projected expansion participants, which ranges from 4,200 in the less populous states of North Dakota and Wyoming to 259,300, in the much more populous state of Florida for a mature program under Nominal Parity, and from 5,200 in North Dakota and Vermont to 293,000 in Florida under True Parity. The table then presents numbers of unintended pregnancies, abortions and unintended Medicaid births averted; estimates for unintended pregnancies averted range from 600 in North Dakota and Wyoming to 36,840 in Florida for a mature program under Nominal Parity and from 730 in North Dakota and Vermont to 41,620 in Florida under True Parity. Next, it presents the total Medicaid savings from births averted, expenditures on expansion services and net savings, as well as the state government's share of these costs and savings. (The federal government's share is not presented, but may be calculated by subtracting the state's share from the total.)

Notably, because the savings for most births averted to first-year participants do not accrue until the second year, a new expansion may have an overall net budgetary cost in the first year. Yet, because states pay only 10% of the costs of family planning services but a greater share for maternity care, states themselves—as opposed to the federal government—would in almost all cases see a net budgetary savings even in year one. For a mature program, the state's share of the net savings range from $1.3 million in the District of Columbia to $73.8 million in Florida under Nominal Parity and $1.4 million to $83.3 million in the same states under True Parity.

For those states with an existing family planning expansion, we present estimates of the potential impact of switching to a SPA. The table begins by listing out three key parameters for the states' existing expansions: their current eligibility level and whether they cover men and adolescents. It then lists the state's eligibility level for pregnancy-related care. Then, it presents two columns of findings, one for each scenario (Nominal Parity and True Parity). Because these states have already initiated an expansion, no first-year estimates are included.

The estimates for these states include any additional participation that could be expected from a change in income eligibility, either at the Nominal Parity level, if their waiver is not yet at that level, or at the True Parity level, which is above the current eligibility level for all states with waivers. It also includes new costs and savings (if applicable) from covering adolescents, men and transportation services. Because for many states with existing expansions, the Nominal Parity scenario would entail no increase in female participation—and therefore no Medicaid births averted in our estimates—that scenario may simply represent the additional costs from transportation services and, possibly, from adding male participants. (Although serving men presumably does avert some unintended pregnancies, that is not captured in our estimates.) The True Parity scenario, by contrast, would always entail a substantial expansion in female participation, reducing unintended pregnancy and resulting costs. Net cost-savings for the states range from $206,000 in Mississippi to $36.6 million in California under True Parity.

All estimates are in 2008 dollars, and all are for a one-year period. This report includes only state-level estimates, reflecting the fact that Congress has played its role, and the most pressing decisions now are at the state level: whether individual states will choose to take up the new authority that Congress has granted them. Adolescent and

male participants are included in the findings presented in the 51 state tables; two additional tables, breaking out the data specifically for these subgroups, are included in the appendix (Appendix Tables B and E).

As noted previously, the ultimate impact of an expansion would depend greatly on state-level decisions and factors, including the full package of services covered, the quality of care provided, the capacity of the provider network and the level of investment needed to the state's Medicaid systems. Moreover, state-level policymakers may have access to additional, state-specific data not available to us for these estimates. For these reasons, these findings demonstrate the potential of Medicaid family planning SPAs, rather than a definite statement of their impact. To assist states in estimating the impact of this variation, Appendix Table D includes estimates of events averted, costs and savings for each additional 1,000 adult female program participants.

Alabama

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **133%**
  - ▫ **Men** — **Not covered**
  - ▫ **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **133%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	9,000	25,500
No. of events averted		
Unintended pregnancies	1,140	3,470
Abortions	390	1,160
Medicaid births	600	1,810
Total costs and savings		
Savings from Medicaid births averted	$5,601,000	$16,969,000
Expenditures on expansion services	$2,906,000	$9,805,000
Net savings (or loss)	$2,694,000	$7,163,000
State costs and savings		
Savings from Medicaid births averted	$1,813,000	$5,494,000
Expenditures on expansion services	$488,000	$1,451,000
Net savings (or loss)	$1,326,000	$4,043,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Alaska

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **175%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	2,300	7,600	2,800	9,200
No. of events averted				
Unintended pregnancies	330	1,090	390	1,310
Abortions	110	360	130	430
Medicaid births	40	570	50	680
Total costs and savings				
Savings from Medicaid births averted	$1,021,000	$13,614,000	$1,229,000	$16,389,000
Expenditures on expansion services	$1,391,000	$4,636,000	$1,710,000	$5,699,000
Net savings (or loss)	–$370,000	$8,978,000	–$481,000	$10,690,000
State costs and savings				
Savings from Medicaid births averted	$485,000	$6,470,000	$584,000	$7,788,000
Expenditures on expansion services	$194,000	$647,000	$239,000	$796,000
Net savings (or loss)	$291,000	$5,823,000	$345,000	$6,992,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Arizona

- **Has only a limited family planning expansion**
- **Pregnancy care eligiblity level** **150%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	20,700	69,100	25,300	84,400
No. of events averted				
Unintended pregnancies	2,940	9,810	3,600	11,990
Abortions	980	3,270	1,200	3,980
Medicaid births	380	5,110	470	6,240
Total costs and savings				
Savings from Medicaid births averted	$4,097,000	$54,627,000	$5,004,000	$66,717,000
Expenditures on expansion services	$8,903,000	$29,676,000	$11,003,000	$36,676,000
Net savings (or loss)	–$4,806,000	$24,951,000	–$5,999,000	$30,041,000
State costs and savings				
Savings from Medicaid births averted	$1,385,000	$18,464,000	$1,691,000	$22,551,000
Expenditures on expansion services	$1,243,000	$4,144,000	$1,536,000	$5,121,000
Net savings (or loss)	$142,000	$14,320,000	$155,000	$17,430,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Arkansas

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **200%**
  - ▫ **Men** — **Not covered**
  - ▫ **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	700	4,000
No. of events averted		
Unintended pregnancies	0	470
Abortions	0	160
Medicaid births	0	250
Total costs and savings		
Savings from Medicaid births averted	$0	$2,938,000
Expenditures on expansion services	$302,000	$1,224,000
Net savings (or loss)	–$302,000	$1,715,000
State costs and savings		
Savings from Medicaid births averted	$0	$795,000
Expenditures on expansion services	$80,000	$208,000
Net savings (or loss)	–$80,000	$587,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

California

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **200%**
  - ▫ **Men** — **Covered**
  - ▫ **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	0	142,400
No. of events averted		
Unintended pregnancies	0	17,930
Abortions	0	5,920
Medicaid births	0	9,300
Total costs and savings		
Savings from Medicaid births averted	$0	$90,050,000
Expenditures on expansion services	$4,795,000	$48,229,000
Net savings (or loss)	–$4,795,000	$41,821,000
State costs and savings		
Savings from Medicaid births averted	$0	$45,025,000
Expenditures on expansion services	$2,397,000	$8,463,000
Net savings (or loss)	–$2,397,000	$36,563,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Colorado

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	19,600	65,200	20,900	69,500
No. of events averted				
Unintended pregnancies	2,780	9,260	2,960	9,880
Abortions	920	3,070	980	3,280
Medicaid births	360	4,820	390	5,130
Total costs and savings				
Savings from Medicaid births averted	$3,748,000	$49,971,000	$3,996,000	$53,279,000
Expenditures on expansion services	$10,856,000	$36,188,000	$11,623,000	$38,744,000
Net savings (or loss)	–$7,108,000	$13,783,000	–$7,627,000	$14,535,000
State costs and savings				
Savings from Medicaid births averted	$1,874,000	$24,986,000	$1,998,000	$26,640,000
Expenditures on expansion services	$1,516,000	$5,053,000	$1,623,000	$5,410,000
Net savings (or loss)	$358,000	$19,933,000	$375,000	$21,230,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Connecticut

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **250%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	7,400	24,800	8,200	27,300
No. of events averted				
Unintended pregnancies	1,060	3,530	1,160	3,880
Abortions	350	1,170	390	1,290
Medicaid births	140	1,830	150	2,020
Total costs and savings				
Savings from Medicaid births averted	$1,968,000	$26,241,000	$2,166,000	$28,883,000
Expenditures on expansion services	$1,319,000	$4,398,000	$1,452,000	$4,840,000
Net savings (or loss)	$649,000	$21,843,000	$714,000	$24,043,000
State costs and savings				
Savings from Medicaid births averted	$984,000	$13,120,000	$1,083,000	$14,441,000
Expenditures on expansion services	$184,000	$614,000	$203,000	$676,000
Net savings (or loss)	$800,000	$12,506,000	$880,000	$13,765,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Delaware

- **Has only a limited family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	2,100	6,900	2,300	7,600
No. of events averted				
Unintended pregnancies	300	980	320	1,080
Abortions	100	330	110	360
Medicaid births	40*	510	40*	560
Total costs and savings				
Savings from Medicaid births averted	$515,000	$6,873,000	$564,000	$7,518,000
Expenditures on expansion services	$489,000	$1,630,000	$536,000	$1,786,000
Net savings (or loss)	$26,000	$5,243,000	$28,000	$5,732,000
State costs and savings				
Savings from Medicaid births averted	$258,000	$3,436,000	$282,000	$3,759,000
Expenditures on expansion services	$68,000	$228,000	$75,000	$249,000
Net savings (or loss)	$190,000	$3,208,000	$207,000	$3,510,000

* Actual numbers differ slightly but appear the same due to rounding. *Definitions:* Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

District of Columbia

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **300%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	1,500	5,000	1,600	5,400
No. of events averted				
Unintended pregnancies	220	720	230	770
Abortions	70	240	80	260
Medicaid births	30*	370	30*	400
Total costs and savings				
Savings from Medicaid births averted	$360,000	$4,801,000	$386,000	$5,152,000
Expenditures on expansion services	$390,000	$1,299,000	$420,000	$1,401,000
Net savings (or loss)	–$30,000	$3,502,000	–$34,000	$3,751,000
State costs and savings				
Savings from Medicaid births averted	$108,000	$1,440,000	$116,000	$1,546,000
Expenditures on expansion services	$54,000	$181,000	$59,000	$196,000
Net savings (or loss)	$54,000	$1,259,000	$57,000	$1,350,000

* Actual numbers differ slightly but appear the same due to rounding. *Definitions:* Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Florida

- **Has only a limited family planning expansion**
- **Pregnancy care eligiblity level** **185%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	77,800	259,300	87,900	293,000
No. of events averted				
Unintended pregnancies	11,050	36,840	12,490	41,620
Abortions	3,680	12,260	4,150	13,840
Medicaid births	1,440	19,170	1,620	21,650
Total costs and savings				
Savings from Medicaid births averted	$14,482,000	$193,097,000	$16,359,000	$218,121,000
Expenditures on expansion services	$20,572,000	$68,572,000	$23,405,000	$78,015,000
Net savings (or loss)	–$6,090,000	$124,525,000	–$7,046,000	$140,106,000
State costs and savings				
Savings from Medicaid births averted	$6,252,000	$83,360,000	$7,062,000	$94,163,000
Expenditures on expansion services	$2,873,000	$9,575,000	$3,268,000	$10,894,000
Net savings (or loss)	$3,379,000	$73,785,000	$3,794,000	$83,269,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Georgia

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **200%**
  - ▫ **Men** — **Not covered**
  - ▫ **Adolescents** — **Limited to ages 18 and older**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	14,900	23,900
No. of events averted		
Unintended pregnancies	1,800	3,090
Abortions	620	1,040
Medicaid births	950	1,610
Total costs and savings		
Savings from Medicaid births averted	$13,477,000	$22,956,000
Expenditures on expansion services	$4,647,000	$8,093,000
Net savings (or loss)	$8,830,000	$14,863,000
State costs and savings		
Savings from Medicaid births averted	$4,973,000	$8,471,000
Expenditures on expansion services	$803,000	$1,284,000
Net savings (or loss)	$4,170,000	$7,186,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Hawaii

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **185%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	1,600	5,400	1,900	6,400
No. of events averted				
Unintended pregnancies	230	760	270	900
Abortions	80	250	90	300
Medicaid births	30	400	40	470
Total costs and savings				
Savings from Medicaid births averted	$341,000	$4,550,000	$404,000	$5,382,000
Expenditures on expansion services	$460,000	$1,532,000	$545,000	$1,817,000
Net savings (or loss)	–$119,000	$3,018,000	–$141,000	$3,565,000
State costs and savings				
Savings from Medicaid births averted	$148,000	$1,979,000	$176,000	$2,341,000
Expenditures on expansion services	$64,000	$214,000	$76,000	$254,000
Net savings (or loss)	$84,000	$1,765,000	$100,000	$2,087,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Idaho

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **133%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	4,500	15,200	5,800	19,300
No. of events averted				
Unintended pregnancies	650	2,150	820	2,740
Abortions	210	710	270	910
Medicaid births	80	1,120	110	1,420
Total costs and savings				
Savings from Medicaid births averted	$1,312,000	$17,494,000	$1,670,000	$22,265,000
Expenditures on expansion services	$1,062,000	$3,539,000	$1,354,000	$4,512,000
Net savings (or loss)	$250,000	$13,955,000	$316,000	$17,753,000
State costs and savings				
Savings from Medicaid births averted	$395,000	$5,271,000	$503,000	$6,708,000
Expenditures on expansion services	$148,000	$494,000	$189,000	$630,000
Net savings (or loss)	$247,000	$4,777,000	$314,000	$6,078,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Illinois

- **Existing family planning waiver**
  - **Eligibility level** — **200%**
  - **Men** — **Not covered**
  - **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	5,300	8,300
No. of events averted		
Unintended pregnancies	700	1,120
Abortions	240	380
Medicaid births	370	590
Total costs and savings		
Savings from Medicaid births averted	$3,943,000	$6,342,000
Expenditures on expansion services	$1,342,000	$2,378,000
Net savings (or loss)	$2,601,000	$3,963,000
State costs and savings		
Savings from Medicaid births averted	$1,971,000	$3,171,000
Expenditures on expansion services	$215,000	$360,000
Net savings (or loss)	$1,756,000	$2,811,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Indiana

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	20,200	67,300	22,000	73,300
No. of events averted				
Unintended pregnancies	2,870	9,560	3,130	10,420
Abortions	950	3,170	1,040	3,450
Medicaid births	370	4,970	410	5,420
Total costs and savings				
Savings from Medicaid births averted	$4,487,000	$59,827,000	$4,891,000	$65,208,000
Expenditures on expansion services	$3,215,000	$10,717,000	$3,517,000	$11,723,000
Net savings (or loss)	$1,272,000	$49,110,000	$1,374,000	$53,485,000
State costs and savings				
Savings from Medicaid births averted	$1,674,000	$22,322,000	$1,825,000	$24,329,000
Expenditures on expansion services	$449,000	$1,496,000	$491,000	$1,637,000
Net savings (or loss)	$1,225,000	$20,826,000	$1,334,000	$22,692,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Iowa

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **200%**
  - ▫ **Men** — **Not covered**
  - ▫ **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **300%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	6,300	10,800
No. of events averted		
Unintended pregnancies	830	1,480
Abortions	280	490
Medicaid births	430	770
Total costs and savings		
Savings from Medicaid births averted	$6,784,000	$12,009,000
Expenditures on expansion services	$1,954,000	$3,302,000
Net savings (or loss)	$4,831,000	$8,707,000
State costs and savings		
Savings from Medicaid births averted	$2,596,000	$4,596,000
Expenditures on expansion services	$298,000	$486,000
Net savings (or loss)	$2,298,000	$4,109,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Kansas

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **150%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	7,000	23,400	8,600	28,700
No. of events averted				
Unintended pregnancies	1,000	3,320	1,220	4,080
Abortions	330	1,100	410	1,350
Medicaid births	130	1,730	160	2,120
Total costs and savings				
Savings from Medicaid births averted	$1,398,000	$18,644,000	$1,716,000	$22,879,000
Expenditures on expansion services	$2,503,000	$8,345,000	$3,107,000	$10,356,000
Net savings (or loss)	–$1,105,000	$10,299,000	–$1,391,000	$12,523,000
State costs and savings				
Savings from Medicaid births averted	$567,000	$7,564,000	$696,000	$9,282,000
Expenditures on expansion services	$350,000	$1,165,000	$434,000	$1,446,000
Net savings (or loss)	$217,000	$6,399,000	$262,000	$7,836,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Kentucky

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **185%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	17,700	58,900	19,900	66,400
No. of events averted				
Unintended pregnancies	2,510	8,370	2,830	9,430
Abortions	830	2,780	940	3,120
Medicaid births	330	4,350	370	4,900
Total costs and savings				
Savings from Medicaid births averted	$4,717,000	$62,900,000	$5,311,000	$70,812,000
Expenditures on expansion services	$5,668,000	$18,893,000	$6,389,000	$21,298,000
Net savings (or loss)	–$951,000	$44,007,000	–$1,078,000	$49,514,000
State costs and savings				
Savings from Medicaid births averted	$1,426,000	$19,008,000	$1,605,000	$21,399,000
Expenditures on expansion services	$791,000	$2,638,000	$892,000	$2,974,000
Net savings (or loss)	$635,000	$16,370,000	$713,000	$18,425,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Louisiana

- **Existing family planning waiver**
  - **Eligibility level** — **200%**
  - **Men** — **Not covered**
  - **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	1,400	1,900
No. of events averted		
Unintended pregnancies	170	250
Abortions	60	90
Medicaid births	90	130
Total costs and savings		
Savings from Medicaid births averted	$1,418,000	$2,069,000
Expenditures on expansion services	$400,000	$604,000
Net savings (or loss)	$1,018,000	$1,464,000
State costs and savings		
Savings from Medicaid births averted	$390,000	$570,000
Expenditures on expansion services	$67,000	$96,000
Net savings (or loss)	$323,000	$474,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Maine

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	2,200	7,400	2,600	8,700
No. of events averted				
Unintended pregnancies	320	1,060	370	1,230
Abortions	110	350	120	410
Medicaid births	40	550	50	640
Total costs and savings				
Savings from Medicaid births averted	$392,000	$5,229,000	$457,000	$6,093,000
Expenditures on expansion services	$461,000	$1,538,000	$538,000	$1,792,000
Net savings (or loss)	–$69,000	$3,691,000	–$81,000	$4,301,000
State costs and savings				
Savings from Medicaid births averted	$144,000	$1,919,000	$168,000	$2,235,000
Expenditures on expansion services	$64,000	$215,000	$75,000	$250,000
Net savings (or loss)	$80,000	$1,704,000	$93,000	$1,985,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Maryland

- **Has only a limited family planning expansion**
- **Pregnancy care eligiblity level** **250%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	15,400	51,300	16,800	56,100
No. of events averted				
Unintended pregnancies	2,180	7,280	2,390	7,980
Abortions	730	2,420	790	2,650
Medicaid births	280	3,790	310	4,150
Total costs and savings				
Savings from Medicaid births averted	$3,978,000	$53,039,000	$4,356,000	$58,084,000
Expenditures on expansion services	$4,863,000	$16,211,000	$5,348,000	$17,828,000
Net savings (or loss)	–$885,000	$36,828,000	–$992,000	$40,256,000
State costs and savings				
Savings from Medicaid births averted	$1,989,000	$26,519,000	$2,178,000	$29,042,000
Expenditures on expansion services	$679,000	$2,264,000	$747,000	$2,489,000
Net savings (or loss)	$1,310,000	$24,255,000	$1,431,000	$26,553,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Massachusetts

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	6,700	22,300	7,200	24,000
No. of events averted				
Unintended pregnancies	950	3,170	1,020	3,420
Abortions	320	1,060	340	1,140
Medicaid births	120	1,650	130	1,780
Total costs and savings				
Savings from Medicaid births averted	$1,718,000	$22,913,000	$1,851,000	$24,686,000
Expenditures on expansion services	$1,717,000	$5,723,000	$1,863,000	$6,211,000
Net savings (or loss)	$1,000	$17,190,000	–$12,000	$18,475,000
State costs and savings				
Savings from Medicaid births averted	$859,000	$11,456,000	$926,000	$12,343,000
Expenditures on expansion services	$240,000	$799,000	$260,000	$867,000
Net savings (or loss)	$619,000	$10,657,000	$666,000	$11,476,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Michigan

- **Existing family planning waiver**
  - **Eligibility level** — **185%**
  - **Men** — **Not covered**
  - **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	5,100	10,900
No. of events averted		
Unintended pregnancies	640	1,460
Abortions	220	490
Medicaid births	340	760
Total costs and savings		
Savings from Medicaid births averted	$3,196,000	$7,270,000
Expenditures on expansion services	$684,000	$1,485,000
Net savings (or loss)	$2,512,000	$5,784,000
State costs and savings		
Savings from Medicaid births averted	$1,339,000	$3,046,000
Expenditures on expansion services	$112,000	$224,000
Net savings (or loss)	$1,227,000	$2,822,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Minnesota

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **200%**
  - ▫ **Men** — **Covered**
  - ▫ **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **275%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	2,600	5,100
No. of events averted		
Unintended pregnancies	370	720
Abortions	120	240
Medicaid births	190	370
Total costs and savings		
Savings from Medicaid births averted	$1,911,000	$3,710,000
Expenditures on expansion services	$832,000	$1,561,000
Net savings (or loss)	$1,079,000	$2,148,000
State costs and savings		
Savings from Medicaid births averted	$956,000	$1,855,000
Expenditures on expansion services	$136,000	$238,000
Net savings (or loss)	$819,000	$1,617,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Mississippi

- **Existing family planning waiver**
  - **Eligibility level** — **185%**
  - **Men** — **Not covered**
  - **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	700	5,300
No. of events averted		
Unintended pregnancies	0	660
Abortions	0	220
Medicaid births	0	340
Total costs and savings		
Savings from Medicaid births averted	$0	$2,262,000
Expenditures on expansion services	$374,000	$2,031,000
Net savings (or loss)	–$374,000	$230,000
State costs and savings		
Savings from Medicaid births averted	$0	$536,000
Expenditures on expansion services	$99,000	$330,000
Net savings (or loss)	–$99,000	$206,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Missouri

- **Existing family planning waiver**
  - **Eligibility level** — **185%**
  - **Men** — **Not covered**
  - **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	10,000	18,000
No. of events averted		
Unintended pregnancies	1,290	2,420
Abortions	440	820
Medicaid births	680	1,260
Total costs and savings		
Savings from Medicaid births averted	$7,828,000	$14,596,000
Expenditures on expansion services	$2,529,000	$4,964,000
Net savings (or loss)	$5,299,000	$9,632,000
State costs and savings		
Savings from Medicaid births averted	$2,942,000	$5,485,000
Expenditures on expansion services	$408,000	$748,000
Net savings (or loss)	$2,534,000	$4,738,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Montana

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **150%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	2,800	9,400	3,300	11,100
No. of events averted				
Unintended pregnancies	400	1,340	470	1,580
Abortions	130	450	160	530
Medicaid births	50	700	60	820
Total costs and savings				
Savings from Medicaid births averted	$642,000	$8,555,000	$757,000	$10,090,000
Expenditures on expansion services	$1,399,000	$4,665,000	$1,688,000	$5,628,000
Net savings (or loss)	–$757,000	$3,890,000	–$931,000	$4,462,000
State costs and savings				
Savings from Medicaid births averted	$202,000	$2,692,000	$238,000	$3,175,000
Expenditures on expansion services	$195,000	$651,000	$236,000	$786,000
Net savings (or loss)	$7,000	$2,041,000	$2,000	$2,389,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Nebraska

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **185%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	5,300	17,600	5,900	19,500
No. of events averted				
Unintended pregnancies	750	2,500	830	2,780
Abortions	250	830	280	920
Medicaid births	100	1,300	110	1,440
Total costs and savings				
Savings from Medicaid births averted	$1,418,000	$18,910,000	$1,578,000	$21,037,000
Expenditures on expansion services	$1,526,000	$5,088,000	$1,706,000	$5,686,000
Net savings (or loss)	–$108,000	$13,822,000	–$128,000	$15,351,000
State costs and savings				
Savings from Medicaid births averted	$595,000	$7,938,000	$662,000	$8,831,000
Expenditures on expansion services	$213,000	$710,000	$238,000	$794,000
Net savings (or loss)	$382,000	$7,228,000	$424,000	$8,037,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Nevada

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **185%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	9,800	32,800	11,300	37,600
No. of events averted				
Unintended pregnancies	1,400	4,660	1,600	5,350
Abortions	460	1,550	530	1,780
Medicaid births	180	2,420	210	2,780
Total costs and savings				
Savings from Medicaid births averted	$1,817,000	$24,221,000	$2,086,000	$27,812,000
Expenditures on expansion services	$1,912,000	$6,374,000	$2,206,000	$7,352,000
Net savings (or loss)	–$95,000	$17,847,000	–$120,000	$20,460,000
State costs and savings				
Savings from Medicaid births averted	$860,000	$11,471,000	$988,000	$13,172,000
Expenditures on expansion services	$267,000	$890,000	$308,000	$1,027,000
Net savings (or loss)	$593,000	$10,581,000	$680,000	$12,145,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

New Hampshire

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **185%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	2,800	9,400	3,200	10,700
No. of events averted				
Unintended pregnancies	400	1,330	460	1,530
Abortions	130	440	150	510
Medicaid births	50	690	60	790
Total costs and savings				
Savings from Medicaid births averted	$671,000	$8,945,000	$770,000	$10,268,000
Expenditures on expansion services	$1,060,000	$3,533,000	$1,224,000	$4,079,000
Net savings (or loss)	–$389,000	$5,412,000	–$454,000	$6,189,000
State costs and savings				
Savings from Medicaid births averted	$335,000	$4,472,000	$385,000	$5,134,000
Expenditures on expansion services	$148,000	$493,000	$171,000	$570,000
Net savings (or loss)	$187,000	$3,979,000	$214,000	$4,564,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

New Jersey

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	24,300	81,000	26,300	87,700
No. of events averted				
Unintended pregnancies	3,450	11,510	3,740	12,460
Abortions	1,150	3,830	1,240	4,140
Medicaid births	450	5,990	490	6,480
Total costs and savings				
Savings from Medicaid births averted	$6,840,000	$91,194,000	$7,407,000	$98,754,000
Expenditures on expansion services	$5,477,000	$18,257,000	$5,942,000	$19,806,000
Net savings (or loss)	$1,363,000	$72,937,000	$1,465,000	$78,948,000
State costs and savings				
Savings from Medicaid births averted	$3,420,000	$45,597,000	$3,703,000	$49,377,000
Expenditures on expansion services	$765,000	$2,549,000	$830,000	$2,766,000
Net savings (or loss)	$2,655,000	$43,048,000	$2,873,000	$46,611,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

New Mexico

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **185%**
  - ▫ **Men** — **Not covered**
  - ▫ **Adolescents** — **Limited to ages 18 and older**
- **Pregnancy care eligiblity level** — **235%**

	Potential impact of state plan amendment	
	Nominal Parity	True Parity
No. of new expansion participants	3,200	4,400
No. of events averted		
Unintended pregnancies	420	600
Abortions	140	200
Medicaid births	220	310
Total costs and savings		
Savings from Medicaid births averted	$2,414,000	$3,430,000
Expenditures on expansion services	$1,371,000	$1,936,000
Net savings (or loss)	$1,043,000	$1,494,000
State costs and savings		
Savings from Medicaid births averted	$699,000	$993,000
Expenditures on expansion services	$211,000	$289,000
Net savings (or loss)	$489,000	$704,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

New York

- **Existing family planning waiver**
  - **Eligibility level** — **200%**
  - **Men** — **Covered**
  - **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	0	3,400
No. of events averted		
Unintended pregnancies	0	480
Abortions	0	160
Medicaid births	0	250
Total costs and savings		
Savings from Medicaid births averted	$0	$3,615,000
Expenditures on expansion services	$71,000	$941,000
Net savings (or loss)	–$71,000	$2,674,000
State costs and savings		
Savings from Medicaid births averted	$0	$1,807,000
Expenditures on expansion services	$36,000	$157,000
Net savings (or loss)	–$36,000	$1,650,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

North Carolina

- **Existing family planning waiver**
  - **Eligibility level** — **185%**
  - **Men** — **Covered**
  - **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	3,700	7,100
No. of events averted		
Unintended pregnancies	520	1,010
Abortions	180	340
Medicaid births	270	530
Total costs and savings		
Savings from Medicaid births averted	$3,820,000	$7,382,000
Expenditures on expansion services	$1,060,000	$2,344,000
Net savings (or loss)	$2,761,000	$5,037,000
State costs and savings		
Savings from Medicaid births averted	$1,373,000	$2,654,000
Expenditures on expansion services	$179,000	$358,000
Net savings (or loss)	$1,195,000	$2,296,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

North Dakota

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **133%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	1,300	4,200	1,500	5,200
No. of events averted				
Unintended pregnancies	180	600	220	730
Abortions	60	200	70	240
Medicaid births	20	310	30	380
Total costs and savings				
Savings from Medicaid births averted	$369,000	$4,923,000	$449,000	$5,990,000
Expenditures on expansion services	$405,000	$1,351,000	$499,000	$1,665,000
Net savings (or loss)	–$36,000	$3,572,000	–$50,000	$4,325,000
State costs and savings				
Savings from Medicaid births averted	$134,000	$1,785,000	$163,000	$2,171,000
Expenditures on expansion services	$57,000	$189,000	$70,000	$232,000
Net savings (or loss)	$77,000	$1,596,000	$93,000	$1,939,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Ohio

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	32,000	106,700	34,500	115,000
No. of events averted				
Unintended pregnancies	4,550	15,160	4,900	16,340
Abortions	1,510	5,030	1,630	5,420
Medicaid births	590	7,880	640	8,490
Total costs and savings				
Savings from Medicaid births averted	$7,078,000	$94,374,000	$7,628,000	$101,701,000
Expenditures on expansion services	$8,134,000	$27,112,000	$8,806,000	$29,354,000
Net savings (or loss)	–$1,056,000	$67,262,000	–$1,178,000	$72,347,000
State costs and savings				
Savings from Medicaid births averted	$2,775,000	$37,004,000	$2,991,000	$39,877,000
Expenditures on expansion services	$1,136,000	$3,786,000	$1,230,000	$4,099,000
Net savings (or loss)	$1,639,000	$33,218,000	$1,761,000	$35,778,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Oklahoma

- **Existing family planning waiver**
  - **Eligibility level** — **185%**
  - **Men** — **Covered**
  - **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	5,400	8,900
No. of events averted		
Unintended pregnancies	780	1,270
Abortions	270	430
Medicaid births	410	660
Total costs and savings		
Savings from Medicaid births averted	$4,167,000	$6,769,000
Expenditures on expansion services	$1,225,000	$2,002,000
Net savings (or loss)	$2,942,000	$4,767,000
State costs and savings		
Savings from Medicaid births averted	$1,371,000	$2,227,000
Expenditures on expansion services	$188,000	$297,000
Net savings (or loss)	$1,182,000	$1,930,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Oregon

- **Existing family planning waiver**
  - **Eligibility level** — **185%**
  - **Men** — **Covered**
  - **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	0	10,800
No. of events averted		
Unintended pregnancies	0	1,550
Abortions	0	510
Medicaid births	0	810
Total costs and savings		
Savings from Medicaid births averted	$0	$5,528,000
Expenditures on expansion services	$169,000	$2,796,000
Net savings (or loss)	–$169,000	$2,732,000
State costs and savings		
Savings from Medicaid births averted	$0	$2,164,000
Expenditures on expansion services	$85,000	$452,000
Net savings (or loss)	–$85,000	$1,712,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Pennsylvania

- **Existing family planning waiver**
  - **Eligibility level** — **185%**
  - **Men** — **Not covered**
  - **Adolescents** — **Limited to ages 18 and older**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	7,300	14,600
No. of events averted		
Unintended pregnancies	930	1,970
Abortions	320	660
Medicaid births	490	1,030
Total costs and savings		
Savings from Medicaid births averted	$5,077,000	$10,605,000
Expenditures on expansion services	$1,571,000	$2,949,000
Net savings (or loss)	$3,506,000	$7,655,000
State costs and savings		
Savings from Medicaid births averted	$2,331,000	$4,870,000
Expenditures on expansion services	$246,000	$439,000
Net savings (or loss)	$2,085,000	$4,431,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Rhode Island

- **Has only a limited family planning expansion**
- **Pregnancy care eligiblity level** **250%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	3,200	10,700	3,500	11,800
No. of events averted				
Unintended pregnancies	460	1,530	500	1,680
Abortions	150	510	170	560
Medicaid births	60	790	70	870
Total costs and savings				
Savings from Medicaid births averted	$741,000	$9,878,000	$815,000	$10,870,000
Expenditures on expansion services	$572,000	$1,907,000	$632,000	$2,108,000
Net savings (or loss)	$169,000	$7,971,000	$183,000	$8,762,000
State costs and savings				
Savings from Medicaid births averted	$352,000	$4,691,000	$387,000	$5,162,000
Expenditures on expansion services	$80,000	$266,000	$88,000	$294,000
Net savings (or loss)	$272,000	$4,425,000	$299,000	$4,868,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

South Carolina

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **185%**
  - ▫ **Men** — **Not covered**
  - ▫ **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	1,100	10,600
No. of events averted		
Unintended pregnancies	0	1,340
Abortions	0	440
Medicaid births	0	700
Total costs and savings		
Savings from Medicaid births averted	$0	$7,931,000
Expenditures on expansion services	$635,000	$4,326,000
Net savings (or loss)	–$635,000	$3,605,000
State costs and savings		
Savings from Medicaid births averted	$0	$2,396,000
Expenditures on expansion services	$168,000	$683,000
Net savings (or loss)	–$168,000	$1,713,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

South Dakota

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **133%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	1,700	5,800	2,200	7,200
No. of events averted				
Unintended pregnancies	250	830	310	1,030
Abortions	80	280	100	340
Medicaid births	30	430	40	530
Total costs and savings				
Savings from Medicaid births averted	$451,000	$6,018,000	$561,000	$7,474,000
Expenditures on expansion services	$462,000	$1,541,000	$580,000	$1,935,000
Net savings (or loss)	–$11,000	$4,477,000	–$19,000	$5,539,000
State costs and savings				
Savings from Medicaid births averted	$180,000	$2,406,000	$224,000	$2,987,000
Expenditures on expansion services	$65,000	$215,000	$81,000	$270,000
Net savings (or loss)	$115,000	$2,191,000	$143,000	$2,717,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Tennessee

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **250%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	21,300	71,000	23,100	77,000
No. of events averted				
Unintended pregnancies	3,020	10,080	3,280	10,940
Abortions	1,000	3,340	1,090	3,630
Medicaid births	390	5,240	430	5,680
Total costs and savings				
Savings from Medicaid births averted	$4,958,000	$66,107,000	$5,378,000	$71,702,000
Expenditures on expansion services	$5,790,000	$19,299,000	$6,293,000	$20,977,000
Net savings (or loss)	–$832,000	$46,808,000	–$915,000	$50,725,000
State costs and savings				
Savings from Medicaid births averted	$1,799,000	$23,990,000	$1,952,000	$26,021,000
Expenditures on expansion services	$808,000	$2,695,000	$879,000	$2,929,000
Net savings (or loss)	$991,000	$21,295,000	$1,073,000	$23,092,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Texas

- **Existing family planning waiver**
  - ▫ **Eligibility level** — **185%**
  - ▫ **Men** — **Not covered**
  - ▫ **Adolescents** — **Limited to ages 18 and older**
- **Pregnancy care eligiblity level** — **185%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	12,900	26,400
No. of events averted		
Unintended pregnancies	1,620	3,540
Abortions	560	1,190
Medicaid births	850	1,850
Total costs and savings		
Savings from Medicaid births averted	$8,977,000	$19,453,000
Expenditures on expansion services	$1,895,000	$4,541,000
Net savings (or loss)	$7,081,000	$14,912,000
State costs and savings		
Savings from Medicaid births averted	$3,543,000	$7,678,000
Expenditures on expansion services	$320,000	$689,000
Net savings (or loss)	$3,223,000	$6,989,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Utah

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **133%**

	Potential impact of state plan amendment			
	Nominal Parity		**True Parity**	
	First year	**Mature year**	**First year**	**Mature year**
No. of expansion participants	6,900	23,100	8,400	28,100
No. of events averted				
Unintended pregnancies	990	3,280	1,200	4,000
Abortions	330	1,100	400	1,330
Medicaid births	130	1,710	160	2,080
Total costs and savings				
Savings from Medicaid births averted	$1,452,000	$19,363,000	$1,767,000	$23,558,000
Expenditures on expansion services	$2,933,000	$9,777,000	$3,703,000	$12,342,000
Net savings (or loss)	–$1,481,000	$9,586,000	–$1,936,000	$11,216,000
State costs and savings				
Savings from Medicaid births averted	$412,000	$5,493,000	$501,000	$6,683,000
Expenditures on expansion services	$410,000	$1,365,000	$517,000	$1,723,000
Net savings (or loss)	$2,000	$4,128,000	–$16,000	$4,960,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Vermont

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **200%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	1,400	4,600	1,500	5,200
No. of events averted				
Unintended pregnancies	200	650	220	730
Abortions	60	220	70	240
Medicaid births	30*	340	30*	380
Total costs and savings				
Savings from Medicaid births averted	$373,000	$4,969,000	$420,000	$5,596,000
Expenditures on expansion services	$355,000	$1,182,000	$401,000	$1,335,000
Net savings (or loss)	$18,000	$3,787,000	$19,000	$4,261,000
State costs and savings				
Savings from Medicaid births averted	$153,000	$2,036,000	$172,000	$2,292,000
Expenditures on expansion services	$50,000	$165,000	$56,000	$186,000
Net savings (or loss)	$103,000	$1,871,000	$116,000	$2,106,000

* Actual numbers differ slightly but appear the same due to rounding. *Definitions:* Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Virginia

- **Existing family planning waiver**
  - **Eligibility level** — **133%**
  - **Men** — **Covered**
  - **Adolescents** — **Not covered**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	3,500	4,100
No. of events averted		
Unintended pregnancies	500	590
Abortions	170	200
Medicaid births	260	310
Total costs and savings		
Savings from Medicaid births averted	$4,138,000	$4,866,000
Expenditures on expansion services	$776,000	$909,000
Net savings (or loss)	$3,361,000	$3,958,000
State costs and savings		
Savings from Medicaid births averted	$2,069,000	$2,433,000
Expenditures on expansion services	$111,000	$130,000
Net savings (or loss)	$1,958,000	$2,304,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Washington

- **Existing family planning waiver**
  - **Eligibility level** — **200%**
  - **Men** — **Covered**
  - **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **200%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	0	2,700
No. of events averted		
Unintended pregnancies	0	370
Abortions	0	120
Medicaid births	0	190
Total costs and savings		
Savings from Medicaid births averted	$0	$2,531,000
Expenditures on expansion services	$112,000	$747,000
Net savings (or loss)	–$112,000	$1,784,000
State costs and savings		
Savings from Medicaid births averted	$0	$1,227,000
Expenditures on expansion services	$56,000	$145,000
Net savings (or loss)	–$56,000	$1,082,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

West Virginia

- **No existing family planning expansion**
- **Pregnancy care eligiblity level** **150%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	5,600	18,600	6,600	22,100
No. of events averted				
Unintended pregnancies	790	2,640	940	3,150
Abortions	260	870	310	1,040
Medicaid births	100	1,370	120	1,630
Total costs and savings				
Savings from Medicaid births averted	$1,226,000	$16,343,000	$1,460,000	$19,464,000
Expenditures on expansion services	$1,934,000	$6,446,000	$2,310,000	$7,699,000
Net savings (or loss)	–$708,000	$9,897,000	–$850,000	$11,765,000
State costs and savings				
Savings from Medicaid births averted	$316,000	$4,208,000	$376,000	$5,012,000
Expenditures on expansion services	$270,000	$900,000	$323,000	$1,075,000
Net savings (or loss)	$46,000	$3,308,000	$53,000	$3,937,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Wisconsin

- **Existing family planning waiver**
  - **Eligibility level** — **200%**
  - **Men** — **Covered**
  - **Adolescents** — **Covered**
- **Pregnancy care eligiblity level** — **300%**

	Potential impact of state plan amendment	
	Nominal Parity	**True Parity**
No. of new expansion participants	10,600	18,800
No. of events averted		
Unintended pregnancies	1,510	2,660
Abortions	500	880
Medicaid births	780	1,380
Total costs and savings		
Savings from Medicaid births averted	$9,277,000	$16,422,000
Expenditures on expansion services	$2,244,000	$3,876,000
Net savings (or loss)	$7,033,000	$12,546,000
State costs and savings		
Savings from Medicaid births averted	$3,932,000	$6,960,000
Expenditures on expansion services	$359,000	$586,000
Net savings (or loss)	$3,573,000	$6,373,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Notes:* These figures represent the estimated impact of transitioning to a state plan amendment, which requires coverage of men, adolescents and transportation services. For states that include adolescents or men in their existing waiver programs, the Nominal Parity scenario may not result in additional participation, events averted or savings, but would still entail new transportation costs.

Wyoming

- **Has only a limited family planning expansion**
- **Pregnancy care eligiblity level** **133%**

	Potential impact of state plan amendment			
	Nominal Parity		True Parity	
	First year	Mature year	First year	Mature year
No. of expansion participants	1,300	4,200	1,600	5,300
No. of events averted				
Unintended pregnancies	180	600	230	750
Abortions	60	200	80	250
Medicaid births	20	310	30	390
Total costs and savings				
Savings from Medicaid births averted	$499,000	$6,652,000	$625,000	$8,329,000
Expenditures on expansion services	$815,000	$2,718,000	$1,050,000	$3,501,000
Net savings (or loss)	–$316,000	$3,934,000	–$425,000	$4,828,000
State costs and savings				
Savings from Medicaid births averted	$249,000	$3,326,000	$312,000	$4,165,000
Expenditures on expansion services	$114,000	$380,000	$147,000	$489,000
Net savings (or loss)	$135,000	$2,946,000	$165,000	$3,676,000

Definitions: Nominal Parity—eligibility level for family planning set at same percentage of poverty level used for pregnancy-related care. True Parity—eligibility procedures for family planning expansion use same methodology used for pregnancy-related care, under which a woman is counted as two people in weighing whether her income is low enough to qualify. *Note:* The First Year numbers include only one-quarter of the expected numbers of averted births and their resulting costs, because three-quarters of those births averted would occur during the following year, after nine months of pregnancy.

Discussion

Since the mid-1990s, more than 20 states have trail-blazed efforts to expand eligibility for Medicaid-covered family planning services and supplies to women and men who otherwise would not be covered. In response to those states' demonstrated success, Congress acted in 2010 to give all states the authority to take this step without the delays, costs and red-tape that come with seeking a waiver from Medicaid law and regulations. In this report, we have attempted to provide state policymakers with a tool to help them gauge the potential impact in their own state of taking up this new authority, both for states that are already running a waiver program and for states that have never taken such a step.

Indeed, our estimates indicate that a Medicaid family planning SPA would have a substantial, positive impact for most states. Among the 28 states that do not currently have an income-based family planning expansion, 19 of them would each serve at least 10,000 individuals under the True Parity scenario, once the program has a chance to mature. Each of these 19 states would enable women to prevent at least 1,500 unintended pregnancies and save at least $2.3 million in state funds in a single year. Nine of them would each serve at least 50,000 individuals, avert at least 7,500 unintended pregnancies and save at least $17.4 million in state funds.

Taking up the new SPA authority could have a sizable impact even among the states that already have a family planning expansion in place via the waiver process. Among the 22 states with waivers, 11 of them would each serve at least 10,000 new participants under the True Parity scenario. Each of these 11 states would help women avert at least 1,300 unintended pregnancies and save at least $1.7 million in state funds. All of these results would be in addition to what their expansions achieve today.

This choice for states comes at a time of crisis. The so-called Great Recession has driven millions of additional Americans into the ranks of the unemployed, and for many, the fallout has included the loss of their employer-sponsored health insurance. The number of women of reproductive age covered by private insurance fell by 2.3 million from 2008 to 2009. Many of them have sought assistance from the government in the form of public insurance coverage, and the number of reproductive-age women on Medicaid or CHIP rose by one million over the same period. Yet, for many more, the safety net failed them: The number of women of reproductive age without any insurance increased by 1.3 million.[29]

These trends echo a series of other findings on how the recession is affecting women's reproductive health preferences, decisions and access to care. According to a 2009 Guttmacher Institute study, nearly half of low- and middle-income women surveyed wanted to delay pregnancy or limit the size of their family because of the economy, and large numbers said they were being more careful about consistently using contraceptives or were considering sterilization or using a long-acting reversible contraceptive, such as the IUD. But for many, economic hardship means having to skimp and even take risks to save money, by doing things like trying to stretch a monthly supply of pills or putting off a health care visit. After losing their insurance and running low on money, many women have turned to safety-net providers for free or subsidized care.[30]

A separate 2009 study of Title X–supported family planning centers found that nearly nine in 10 had seen an increase in poor and low-income clients and in those without insurance between the first quarter of 2008 and the first quarter of 2009. Yet, more than half of those providers reported serious challenges in meeting their clients' needs, such as staff layoffs, hiring freezes and cutbacks in the range of contraceptive methods they offer. One in four providers said that waiting times had increased, typically doubling from less than a week to about two weeks.[31]

The challenges these safety-net clinics are facing are tied to cutbacks in public funding, as state and federal governments struggle with their own severe budgetary crises. State tax revenue has declined dramatically during the recession, and almost every state faced a budget shortfall at the start of fiscal year 2011.[32] State expenses for Medicaid and CHIP, meanwhile, have climbed, as more Americans become eligible and enroll. And because states are legally required to balance their budgets, they are contemplating cuts in all areas, including in health care programs such as Medicaid and in family planning funding.

Even though it may seem counter-intuitive to some policymakers, the findings in this report show that even in an immensely challenging fiscal environment, expanding access to family planning services under Medicaid would benefit both states and their residents substantially. For states, family planning expansions can help address the social goals of reducing unintended pregnancy and abortion, while also helping to control public costs, even in the initial budget year, by reducing the number of pregnant women and newborns who will be eligible for coverage under public insurance programs. For safety-net providers, the expansions can mean that more of their clients will be reimbursed by Medicaid, freeing up Title X and other grant funding to help them maintain or expand their capacity to provide quality care. And for individuals and couples, the expansions can assist them in planning the size of their families and enable them to have children when they are in a position to care for them.

Methodological Appendix

This report presents estimates of the numbers of pregnancies, births and abortions that could be averted, and the resulting cost savings, if a state were to take up its new authority to implement a family planning state plan amendment (SPA). These estimates are updates of estimates originally presented in an August 2006 Guttmacher report,[1] and the methodology for the current report closely follows that of the prior one.

For each state and the District of Columbia, we:

- estimate the number of women who would be likely participants in the family planning expansion;
- predict how many of those women would make use of services, as well as the number of men;
- predict the net change in contraceptive use and method mix among female program participants;
- estimate the number of unintended pregnancies, abortions and unintended births that would be averted as a result of this net change in users and methods used;
- estimate the cost of a birth under Medicaid and the total cost of Medicaid births averted;
- estimate the cost per user of Medicaid family planning services and the total cost of the expansion; and
- compare the two total costs to arrive at net savings, both overall and for the state only.

For states with existing family planning expansions (implemented via the waiver process), we estimate the changes that could be expected from expanding coverage to new participants.

In this chapter, we summarize the methodology step by step and highlight areas in which the data or methods have changed from the 2006 analysis. Readers interested in additional methodological details should reference Appendix A of the 2006 report.

The data used in this analysis are drawn from a wide range of sources, including:

- the Guttmacher Institute's 2006 and 2008 estimates of women aged 13–44 in need of contraceptive services and supplies;
- state-level data on income and insurance coverage from the Current Population Survey (CPS), combining the most recent two or three years of data (2007–2009) for all state estimates;
- national-level data on contraceptive use, insurance coverage and contraceptive failure rates from or based on the 2002 National Survey of Family Growth (NSFG), and on the outcomes of unintended pregnancies from the 2006–2008 NSFG;
- state-level data on Medicaid family planning use and costs from the Medicaid Statistical Information System (MSIS) for 2007 or 2008;
- data for 24 states from available family planning waiver applications and evaluations;
- state-level indices of Medicaid fee-for-service costs and managed care capitation rates;
- government data on the federal poverty level and the Consumer Price Index; and
- data on states' eligibility ceilings for Medicaid-covered pregnancy care and for existing Medicaid family planning expansions.

Likely Participants Under the Expansion

The first step in our study was to estimate how many women would be newly eligible for and likely to use Medicaid coverage for family planning. In doing so, we made three assumptions based on the nature of the proposed expansions, the rules by which Medicaid generally is governed and the way most of the existing expansions operate.

- Family planning services would be used by women in need of contraceptive services and supplies—defined as those who were sexually active, of reproductive age (13–44), able to become pregnant and not pregnant, postpartum nor trying to become pregnant during the last 12 months.
- Women enrolled for the entire past year in private insurance or public health coverage (including regular Medicaid) would be unlikely to seek services in a family planning expansion and should thus be excluded from estimates of likely program participants.
- Women younger than 19 (considered minors under Medicaid) would be eligible for a family planning expansion on the basis of their own income, rather than their family's income, and their own income would be low enough for them to qualify for services.

Following these assumptions, we identified the number of women aged 13–18 and 19–44 in each state who were in need of family planning services in 2008, drawing on the most recent Guttmacher Institute estimates of women in need of contraceptive services and supplies at the state level.[33,34] Next, we estimated how many of the adult women had a family income below the state's income-eligibility level for pregnancy-related care, assuming an even distribution of women within income levels when the available data did not match up with the eligibility level. Finally, we estimated the proportions of in-need, income-eligible adults and of in-need adolescents who were uninsured for some period during the past year (i.e., they had neither public nor private health insurance). For that last step, we drew on state-level data on the percentage of women of reproductive age who were uninsured (using the 2008–2010 CPS)[35] and adjusted these data (using national data from the NSFG)[36] to estimate the proportion who were uninsured for some period during the past year.

It should be noted that our estimates of likely participants under each scenario may include some women who were eligible for, but had not yet applied for, regular Medicaid or CHIP benefits. In effect, we are giving "credit" to the expansion for the costs and the savings incurred by the addition of these women, regardless of whether they are newly included through the expansion or through regular Medicaid or CHIP.

Notable changes since 2006:

Updated data: More recent data were available for women in need of family planning services (2008 data, supplemented with 2006 data for estimating distributions of women in need by poverty status) and from the CPS for the proportions of reproductive-age women who were uninsured (2007–2009 data) and for the income distribution of adult women 20–24[35] (used to approximate the income distribution of 19-year-olds). Income-eligibility levels for pregnancy-related care and for existing waivers were also updated to reflect current levels, as was the federal poverty level.[2,4,9]

Scenarios for expansion: The 2006 report included four different potential scenarios for expansion, based on potential decisions by Congress as to what states might be required or allowed to do. Under the authority that Congress gave to states in March 2010, states now have two likely options regarding eligibility levels for a family planning SPA:

- They can set the SPA eligibility level at the same percentage of poverty used for pregnancy-related care—referred to in this report as "Nominal Parity"; or
- they can set the SPA eligibility level so that it accounts for the fact that a pregnant woman is counted as two people in weighing whether her income is low enough to qualify for Medicaid—referred to in this report as "True Parity."

This report includes estimates for both of these income-eligibility options. Because the impact of the pregnancy on poverty-level status varies according to the size of the family (the smaller the family size, the larger the effect), we assumed in making estimates for the True Parity scenario that, on average, a likely participant would be in a family of two. By that standard, for example, the effective eligibility level for family planning under a True Parity scenario would be 251% in a state that covers pregnant women up to 200% of poverty. (See Appendix Table A for details of this adjustment.) This appears to be a conservative assumption: Data from the largest existing family planning expansion, in California, indicate that 50% of clients were in a family of one in 2009.[37]

States with existing expansions: As was the case in the 2006 report, the estimates presented here for the 22 states with existing income-based expansions reflect only the expected increase in participation under each scenario, by comparing eligibility for the current expansions with their Nominal Parity and True Parity eligibility levels. (Also as was the case in the 2006 report, we did not account for participants in the six limited family planning expansions—typically limited to women leaving Medicaid after giving birth—because the number of women participating in such expansions is quite small.)

In addition, under the 2010 law, a state that initiates a family planning SPA may not exclude adolescents (or anyone else on the basis of age). Because 12 of the 22 states with existing expansions are limited to adults, the estimates for those states account for adding adolescents. For four of those 12 states, current eligibility includes those age 18 and older. We assumed that in those states, 18-year-olds were currently included based on family income, rather than their own income, and the estimates for new likely participants include higher-income 18-year-olds, on the assumption that the state would shift to a policy of enrolling all adolescents based on their own income. (Appendix Table B includes findings specifically for adolescents.)

Women above 200% of poverty: Because of recent increases in several states' eligibility levels for pregnancy-related care and because of relatively high eligibility levels under the True Parity scenario, the question of potential participation among women with incomes above 200% of poverty was more salient in this update than it was in the

original 2006 report. Notably in that regard:

- In estimating numbers of in-need adult women with a family income above 250% of poverty, we applied the distribution observed among in-need women with a family income of 200–250% of poverty. For example, the number of in-need women with a family income of 250–300% of poverty was estimated as equal to the number of in-need women with a family income of 200–250% of poverty. (This methodology was used for a few states with high eligibility levels for the 2006 report, but was more frequently applicable for the current report. No data on the actual distribution of in-need women are available for groups above 250% of poverty. A review of the actual distribution of all women by poverty group suggests a fairly even distribution between 200 and 400% of poverty.)
- In estimating the proportion of in-need, income-eligible adults who were uninsured, we used data from the CPS for two income groups: those with a family income below 200% of poverty and those whose income is at or above 200%. Insurance levels are considerably higher among the latter group, meaning that fewer in-need women in that income group are deemed likely participants in this study. Because no state family planning expansion as yet includes women with an income above 200% of poverty, we have no data to gauge whether this adjustment would appropriately predict actual participation among higher-income women.

Women Who Would Use Services

To estimate how many likely participants would actually use family planning services under an expansion program, we drew on data from 20 of the 22 states with existing income-based Medicaid family planning expansions, collected from program evaluations and from the responses to requests for data that we made to state officials.[38]

We divided the actual number of female program users reported by each state for which we had data by the number of women we estimated to be likely participants for the state's existing expansion (a figure generated following the methodology described in the previous section). This provided us with an estimate of the rate of use among likely participants for each state in a given year of its expansion. For these states, we used the calculated rate of use among likely participants for the most recent available year to make predictions about additional use under both of the eligibility scenarios.

For other states (and for the two states with a waiver but no available data, Georgia and Missouri), we needed to make an estimate of the rate of use. To do so, we examined the calculated rates among the expansion states during the first full year of the expansion (based on the data available for 17 states) and the most recent "mature" full year (third year or later; based on data for 14 states). In doing so, we came to a national estimate of the rate of use that approximates the average rate of use among states with existing expansions—30% for year one and 50% for mature programs. (See Appendix Table C for details of the comparisons, including averages.) To model the phenomenon that first-year participation ramps up over the course of the year, we cut participation in half for the first year, to 15%.

Finally, we multiplied the applicable rate for each state by the number of likely participants for that state under each scenario to estimate the number of expansion participants.

Notable changes since 2006:

Variation: Far more extensive data were available in 2010 for numbers of program users than was the case in 2006, as more states had implemented expansions and had evaluated their programs. Based on the broader available data, it became clear that states' experience with implementing family planning expansions has varied considerably more than was apparent in 2006. Rates of use among likely participants ranged from 5% to 77% for the first full year of an expansion, and from 9% to 135% for the most recent mature year, without any clear patterns to the distribution. The estimates in this report for states without current expansions, therefore, are based on the average experience of states with existing programs, and real-world experience can be expected to vary. States' efforts at outreach to both likely participants and potential providers would likely be one critical factor in determining actual levels of program use. To assist states in estimating the impact of this variation, Appendix Table D includes estimates of events averted, costs and savings for each additional (or fewer) 1,000 female adult program participants.

The more extensive data also indicated that even among long-established programs, rates of use could fluctuate over time, perhaps in response to external influences (e.g., other changes in Medicaid policy, such as those related to documentation of citizenship status). For that reason, our estimates for "mature" programs were based on the most recent year of data available, rather than exclusively relying on data from the third full year.

Note that rates of use among likely participants can top 100%, because our estimates of likely participants exclude some women who are nonetheless eligible for and may make use of a Medicaid family planning expansion. Privately insured women, for example, may participate in a Medicaid expansion because they have limited benefits or substantial out-of-pocket costs. Women older than 44 also participate in some states' programs. Because some women in the numerator are not included in the denomi-

nator, this calculation could be more accurately described as a ratio, rather than a rate. Nevertheless, what we refer to as "rate of use among likely participants" should accurately predict the number of participants in future expansions, because the comparison of actual to likely participants is being made consistently across all states. (As noted above, a more detailed explanation of this methodology can be found in the 2006 report.[1])

States with existing expansions: For this report, we estimated levels of new participation for states with existing expansions using state-specific rates of use, rather than the average rate of use (used in 2006). This change made sense given the wider variation in use rates found among states for this report, and given that this report is designed to provide information for state-level policymakers and advocates, rather than those at the federal level, as was the case in 2006.

Male participants: Under the 2010 law, a state that initiates a family planning SPA may not exclude anyone on the basis of gender. Therefore, the estimates for this report, unlike those for 2006, include potential male participants. (The estimates also include costs for male participants, but not their potential impact on averting unintended pregnancies, as described in subsequent sections of this chapter.)

Data were available on male participation in existing expansions from six of the nine states that currently include men. Male participation was generally low: For five of those six states, male participation ranged from 9–39 males per 1,000 females, with an average of 17 males per 1,000 females. (California's program was the outlier, with 148 males for every 1,000 females; that program includes a broader range of services for men than is required by CMS guidance for family planning SPA programs and seems unlikely to be a model for many new expansions.)

For the six states with available data on male participation, we estimated the number of new male participants using state-specific ratios. For all other states, we made estimates using the 17 males per 1,000 females average. For the 13 states with existing expansions that exclude men, estimates of new participation under a family planning SPA include adding men. Male participants are incorporated into the estimates reported in the state tables, starting on page 12. (Appendix Table E includes findings specifically for male participants.)

Contraceptive Use Among Program Participants

To measure program impact, we first estimated the improvement in contraceptive use among female expansion participants by comparing the contraceptive method mix for two national subgroups that represent women before and after receipt of expansion services. By examining the actual current contraceptive method mix of women who would be likely participants in the expansion—some of whom are already receiving publicly subsidized services, such as through clinics supported by the Title X program—we were able to measure the impact of the program above and beyond that which would result from contraceptive services already used by these women. This allowed us to account for any substitution effects by excluding the impact on contraceptive use and unintended pregnancy among women who would simply move from one payment source to another (e.g., Title X to Medicaid) and would continue to use the same contraceptive method prior to and after program implementation.

We used the 2002 NSFG to examine the contraceptive method mix of two national subpopulations of women that, in our estimation, best represent women before and after an expansion:

- The method use of likely participants before the expansion was represented by the method mix of a nationally representative sample of women (NSFG respondents) who met the characteristics of likely participants described above (i.e., uninsured, income- and age-eligible women who are sexually active, able to get pregnant and not currently pregnant, postpartum or seeking pregnancy).
- The expected method use of these women after joining the expansion was represented by the method mix of a nationally representative sample of women (NSFG respondents) who reported receiving one or more publicly funded contraceptive service (including services from publicly funded clinics of all types and Medicaid-funded contraceptive care from private providers) during the prior 12 months and who were current reversible contraceptive users or had received a publicly funded tubal sterilization in the prior year.

Compared with current clients of publicly funded providers (the second group above), lower proportions of likely program participants (the first group) used effective contraceptive methods (e.g., 26% vs. 39% used the pill, and 14% vs. 24% used the injectable); a higher proportion used no method (22% vs. none). However, most likely participants were using some method of contraception, and many were already using effective methods.

Notable changes since 2006:
None. Note that male participants are not included in these estimates, as they are based exclusively on contraceptive use among women. It was not possible from the available data to gauge the potential impact of providing contraceptive services to men on either the contraceptive

behavior of women or on the likelihood that women would be more successful in avoiding unintended pregnancy.

Pregnancies, Abortions and Births Averted

Next, we estimated the number of unintended pregnancies that increased use of effective contraceptives would prevent. We applied method-specific failure rates to the method mix used by the two national subpopulations that represent women before and after program implementation and calculated the number of expected unintended pregnancies that would occur in one year among women in each group. We then subtracted the number of unintended pregnancies expected among women after joining the program from those expected among likely participants without the program expansion to estimate the net impact upon a hypothetical population of expected users. (Note that this methodology also includes further adjustments for method users and nonusers separately that are calculated by comparing the numbers of unintended pregnancies predicted with the number of actual unintended pregnancies experienced by method users and nonusers nationally in the United States. See Appendix A of the 2006 report for more details on this adjustment and its calculation.[1])

Finally, we used the net number of unintended pregnancies averted among the women in the hypothetical population to estimate a national-level number of unintended pregnancies averted per 1,000 female expansion participants of 144.5. This figure was then applied to the estimated number of participants in each state under each scenario to estimate total unintended pregnancies averted by the program.

Of the unintended pregnancies averted, we assumed that among adult women, 51.9% would have resulted in a birth and 33.0% in an abortion, given the actual national distribution of unintended pregnancy outcomes among women with incomes below 200% of poverty in 2006. Among adolescents, we assumed 52.6% would have resulted in a birth and 34.4% in an abortion, based on the 2006 distribution among women age 19 and younger.[39] (The remainder of the pregnancies would result in fetal losses.) This methodology accounts for national variation in the outcomes of unintended pregnancy by poverty status and age. Although additional variation may occur by other characteristics of women and by state, data to make further adjustments are not available.

Notable changes since 2006:

Failure rates: More recent data on contraceptive failure rates were available for most methods.[40] That resulted in a slight change in the number of unintended pregnancies averted per 1,000 female participants.

Events averted: More recent data were available on the distribution of outcomes for unintended pregnancies (from the 2006–2008 NSFG). Because a number of states with existing expansions would be required to extend eligibility to adolescents under a SPA, we have included adolescent-specific findings in this report. To enhance the accuracy of those estimates, we used a distribution of outcomes specific to that age-group.

Medicaid births averted: In the 2006 report, some of the births averted in several scenarios would have been to women above a given state's income eligibility cutoff for Medicaid-covered maternity care, and we therefore had to include an additional step in methodology to identify those births. That is not the case in the current report: By the nature of the Nominal Parity and True Parity scenarios, all births averted would be Medicaid-eligible births, and no additional calculations are necessary.

First-year estimates: For this report, we were looking to estimate the potential impact and savings from averting Medicaid births during an expansion's first year from a state's budgetary perspective: only those births prevented that would have occurred during the given year are counted as part of first-year savings. To that end, we counted only one-quarter of the number of averted births otherwise projected, to account for the nine-month duration of pregnancy.

Cost of Medicaid Births

Data on the cost of a Medicaid-funded birth (defined as the cost of prenatal care, delivery, postpartum care and one year of medical care for the infant) were not available for every state, but were available for 24 states from their applications for and evaluations of Medicaid family planning expansions. From these data, we estimated the cost of a Medicaid-funded birth for the remaining states.

First, we updated the existing cost data to reflect 2008 dollars using the Consumer Price Index for medical care and calculated an average cost per birth for these 24 states. We used this average to calculate state-level estimates of cost per birth for the remaining 26 states and the District of Columbia. In making these estimates, we adjusted the average cost for state-level differences in medical costs using, as appropriate, one index reflecting Medicaid fee-for-service (FFS) physician fees and one reflecting statewide Medicaid managed care capitation rates.

Finally, we multiplied the number of unintended Medicaid births averted by the cost per birth to arrive at savings from Medicaid births averted for each state under each scenario.

We did not estimate any government savings from

averted abortions. Because few abortions are covered under Medicaid and because of the relative costs of births and abortions, any such savings would be negligible in comparison to the savings from averted births. Similarly, we do not try to estimate savings from fetal losses, any improvement in how effectively contraceptives are used or any other beneficial impact of the reproductive health services that would likely be provided as part of the expansions under all scenarios.

Notable changes since 2006:

Updated data: Updated 2010 data on the cost of Medicaid births are available.[34] Compared with the 2006 data, the 2010 iteration includes figures from two additional states and updated data from 13 states. It reports the results in 2008 dollars, and makes use of more up-to-date reports on Medicaid managed care enrollment and Medicaid physician fees.[41,42,43,44]

Cost of the Family Planning Expansion

In contrast to information on Medicaid-funded births, data on Medicaid family planning services were available for every state through MSIS.[45] Using 2008 data for women aged 13–18 and 19–44, we divided the total FFS family planning spending reported in MSIS by the total number of beneficiaries who received FFS family planning services to calculate Medicaid family planning costs per user for each age-group. After identifying problematic data for eight states and the District of Columbia, we estimated their costs per user as the average among the remaining states, adjusted for state-level differences in FFS physician fees.

It should be noted that these program costs reflect only those services that states may claim at the special 90% matching rate for family planning services. To account for outreach and administration, as well as other costs not captured by these data, we inflated each state's cost per user by 10%, a proportion that is the maximum percentage of CHIP costs that can be spent on administrative costs and an estimate we judge to be conservatively high on the basis of existing program data. We added another 1% to account for transportation costs (see "additional services," below).

Finally, we multiplied the number of expected expansion participants (female and male) in each age-group by the appropriate family planning cost per user to calculate program costs for each state under each scenario. (See Appendix Table F for details.)

Although the 11% adjustment addresses some potentially missing administrative costs of implementing a program, states may provide participants with additional, related clinical services (e.g., treatment for STIs diagnosed in the course of a family planning visit), and are required to provide at least some such services (although CMS has not established a minimum package). To the extent that states provide additional services, the overall cost of a state's program may be higher than our estimate. Those additional services may also generate additional savings for the government; such costs and savings are beyond the scope of this study and are not reflected in the results presented.

Notable changes since 2006:

Updated data: More recent data were available from MSIS (for 2008, except in Hawaii and Utah, for which we used 2007 data). A larger number of jurisdictions (nine for this analysis, compared with five for the 2006 analysis) appeared problematic: Arizona, the District of Columbia, Florida, Georgia, Kansas, Mississippi, Rhode Island, South Carolina and West Virginia. The warning signs were similar to those seen in 2006: The states often had very high rates of managed care enrollment, leaving few FFS users upon which to base our estimates, or reported data that were either high or low enough to be considered outliers.

Adolescents: As noted above, we have included adolescent-specific findings in this report. To enhance the accuracy of those estimates, we used age-group–specific per-user costs.

Males: For this report, we included in our estimates the projected costs for male clients. We assumed that a male client would have the same per-user costs as female client in the same state and age-group. It is likely that these costs do, in fact, differ, but we did not have sufficient data available from existing expansions that serve men to make any estimates of such a difference. (Given the contraceptive methods available to men—condoms and vasectomy—per-client costs for men could be expected to be very low or very high compared with the average cost per woman, with men's average cost depending on how many men choose each method.)

Additional services: Under the 2010 law, states establishing a family planning SPA must follow all standard Medicaid laws and regulations, including several requirements that had typically been "waived" for existing Medicaid family planning expansions. Notably, states must pay for transportation services for expansion participants under a SPA. We have estimated those costs as an additional 1% of per-user family planning costs, based on 2008 MSIS data showing that transportation services accounted for, on average, 0.8% of total Medicaid costs among women

13–44. This estimate should be conservative, both because we have rounded it up to 1% and because the MSIS data include expenditures on emergency transportation, which should be almost entirely irrelevant for family planning expansion participants.

Another standard Medicaid requirement that states must follow under a family planning SPA is to reimburse federally qualified health centers (FQHCs) at a special per-visit prospective payment rate, rather than on a FFS basis. To the extent that states are currently claiming the family planning portion of those expenditures at the special 90% matching rate, the MSIS data we use for estimating per-user costs would already incorporate the FQHC expenditures. Nevertheless, this requirement may result in additional costs for some states that are not accounted for in this study.

Net Savings and State Costs and Savings

The final steps in our study were simple: We subtracted the family planning program costs from the savings produced by averted Medicaid births. That left us with the net savings from the expansion for each state under each scenario.

In addition, we apportioned the costs and savings under each scenario to the federal and state governments and present the state-level costs and savings in this report. We apportioned the savings from averted Medicaid births according to the 2008 rate of federal reimbursement (the federal medical assistance percentage, FMAP), which varied by state from 50% to 76%.[46] In apportioning the costs of the family planning services provided, we assumed that the costs for family planning services and supplies would be reimbursed at the special 90% federal matching rate for family planning, and that the 11% added to estimate outreach, administrative and transportation costs would be reimbursed at the 50% rate that is required for Medicaid administrative costs. Overall, that meant that 86% of the total program costs were apportioned to the federal government and 14% to the states.

Notable changes since 2006:

Updated data: We used more recent FMAP rates (from 2008).

Transportation costs: We have assumed that the extra 1% for transportation costs would be claimed by states as administrative services at a 50% federal matching rate; states can instead claim transportation services as optional medical services and be reimbursed at their regular FMAP, but additional requirements apply.

Male participants: It should be repeated that the cost of services for male participants have been included in these estimates, but no resulting savings have been estimated, because of methodological limitations. Nevertheless, it is clear that services to male participants must result in at least some level of savings from couples' improved contraceptive use and the resulting unintended pregnancies and births that would be averted.

The average cost, nationally, of a Medicaid birth in 2008 is $12,613, compared with costs of $320 per adult participant in a family planning expansion. By those numbers, if just 25 births were averted for every 1,000 male participants (a rate that would be roughly one-sixth the rate estimated for female participants), the inclusion of men in a family planning expansion would be cost neutral or provide net savings.

National-level estimates: Unlike its 2006 predecessor, this report does not present national-level estimates for the impact of expansions. In 2006, the most pressing policy-related decision was at the national level: whether Congress would require or allow states to establish Medicaid family planning expansions without going through the burdensome waiver process. Today, the most pressing decisions are at the state level: whether individual states will choose to take up the new authority that Congress has granted them.

APPENDIX TABLE A: Income eligibility levels for True Parity scenario, dollar values and equivalent percentage of the federal poverty level, FY 2010

Percentage of poverty level	Family size	Income level (in dollars)	Income level if pregnant (in dollars)	Equivalent percentage of poverty
100%				
	1	10,830	14,570	135%
	2	14,570	18,310	126%
	3	18,310	22,050	120%
133%				
	1	14,404	19,378	179%
	2	19,378	24,352	167%
	3	24,352	29,327	160%
150%				
	1	16,245	21,855	202%
	2	21,855	27,465	189%
	3	27,465	33,075	181%
175%				
	1	18,953	25,498	235%
	2	25,498	32,043	220%
	3	32,043	38,588	211%
185%				
	1	20,036	26,955	249%
	2	26,955	33,874	232%
	3	33,874	40,793	223%
200%				
	1	21,660	29,140	269%
	2	29,140	36,620	251%
	3	36,620	44,100	241%
235%				
	1	25,451	34,240	316%
	2	34,240	43,029	295%
	3	43,029	51,818	283%
250%				
	1	27,075	36,425	336%
	2	36,425	45,775	314%
	3	45,775	55,125	301%
275%				
	1	29,783	40,068	370%
	2	40,068	50,353	346%
	3	50,353	60,638	331%
300%				
	1	32,490	43,710	404%
	2	43,710	54,930	377%
	3	54,930	66,150	361%

APPENDIX TABLE B: Findings for new adolescent participants (aged 13–18), mature year

State	No. of expansion participants	No. of events averted			Total costs and savings (in 000s)		
		Unintended pregnancies	Abortions	Medicaid births	Savings from Medicaid births averted	Expenditures on expansion services	Net savings
Alabama*	8,000	1,140	390	600	$5,601	$2,249	$3,352
Alaska	1,500	210	70	110	$2,615	$423	$2,193
Arizona	13,900	1,970	680	1,040	$11,091	$4,468	$6,622
Arkansas*	100	0	0	0	$0	$29	–$29
California*	0	0	0	0	$0	$554	–$554
Colorado	8,000	1,130	390	600	$6,185	$2,353	$3,832
Connecticut	4,200	590	200	310	$4,445	$751	$3,694
Delaware	1,300	190	60	100	$1,333	$291	$1,042
District of Columbia	1,000	150	50	80	$1,003	$202	$802
Florida	49,800	7,070	2,430	3,720	$37,472	$9,840	$27,631
Georgia*	12,800	1,800	620	950	$13,477	$3,472	$10,005
Hawaii	500	80	30	40	$452	$125	$327
Idaho	2,100	300	100	160	$2,491	$481	$2,010
Illinois*	4,900	700	240	370	$3,943	$1,116	$2,827
Indiana	7,200	1,030	350	540	$6,515	$741	$5,773
Iowa*	100	0	0	0	$0	$27	–$27
Kansas	4,400	620	210	330	$3,534	$1,168	$2,366
Kentucky	6,100	870	300	460	$6,587	$1,775	$4,812
Louisiana*	1,200	170	60	90	$1,418	$311	$1,107
Maine	1,100	150	50	80	$770	$225	$545
Maryland	7,800	1,120	380	590	$8,215	$1,845	$6,370
Massachusetts	5,000	700	240	370	$5,145	$834	$4,312
Michigan*	4,500	640	220	340	$3,196	$550	$2,646
Minnesota*	0	0	0	0	$0	$8	–$8
Mississippi*	100	0	0	0	$0	$45	–$45
Missouri*	9,100	1,290	440	680	$7,828	$2,092	$5,736
Montana	2,000	280	100	150	$1,837	$447	$1,390
Nebraska	2,500	350	120	180	$2,675	$522	$2,153
Nevada	5,700	810	280	430	$4,266	$939	$3,327
New Hampshire	900	130	40	70	$866	$197	$669
New Jersey	13,700	1,950	670	1,020	$15,590	$2,767	$12,823
New Mexico*	1,200	160	60	90	$938	$403	$535
New York*	0	0	0	0	$0	$9	–$9
North Carolina*	3,700	520	180	270	$3,820	$975	$2,845
North Dakota	800	110	40	60	$921	$174	$747
Ohio	13,000	1,850	640	970	$11,638	$1,804	$9,834
Oklahoma*	5,400	780	270	410	$4,167	$1,177	$2,990
Oregon*	0	0	0	0	$0	$13	–$13
Pennsylvania*	6,600	930	320	490	$5,077	$1,369	$3,707
Rhode Island	1,600	230	80	120	$1,526	$215	$1,311
South Carolina*	200	0	0	0	$0	$91	–$91
South Dakota	1,300	190	70	100	$1,408	$292	$1,116
Tennessee	8,300	1,180	400	620	$7,810	$1,819	$5,990
Texas*	11,500	1,620	560	850	$8,977	$1,469	$7,508
Utah	6,300	890	310	470	$5,316	$1,190	$4,126
Vermont	600	90	30	50	$685	$135	$550
Virginia*	1,200	160	60	90	$1,377	$267	$1,110
Washington*	0	0	0	0	$0	$10	–$10
West Virginia	1,100	150	50	80	$969	$271	$698
Wisconsin*	0	0	0	0	$0	$17	–$17
Wyoming	700	100	40	60	$1,173	$158	$1,014

*This state has an existing expansion; for some of these states, adolescents are included in the existing expansion, and no new adolescents would be served but new transportation costs would be added.

APPENDIX TABLE B (cont.): Findings for new adolescent participants (aged 13–18), mature year

State	State costs and savings (in 000s)		
	Savings from Medicaid births averted	Expenditures on expansion services	Net savings
Alabama*	$1,813	$314	$1,499
Alaska	$1,243	$59	$1,184
Arizona	$3,749	$624	$3,125
Arkansas*	$0	$8	–$8
California*	$0	$277	–$277
Colorado	$3,092	$329	$2,764
Connecticut	$2,223	$105	$2,118
Delaware	$666	$41	$626
District of Columbia	$301	$28	$273
Florida	$16,176	$1,374	$14,802
Georgia*	$4,973	$493	$4,480
Hawaii	$197	$17	$179
Idaho	$751	$67	$683
Illinois*	$1,971	$156	$1,816
Indiana	$2,431	$104	$2,327
Iowa*	$0	$7	–$7
Kansas	$1,434	$163	$1,271
Kentucky	$1,991	$248	$1,743
Louisiana*	$390	$43	$347
Maine	$282	$31	$251
Maryland	$4,108	$258	$3,850
Massachusetts	$2,573	$116	$2,456
Michigan*	$1,339	$77	$1,262
Minnesota*	$0	$4	–$4
Mississippi*	$0	$12	–$12
Missouri*	$2,942	$292	$2,650
Montana	$578	$62	$516
Nebraska	$1,123	$73	$1,050
Nevada	$2,020	$131	$1,889
New Hampshire	$433	$28	$406
New Jersey	$7,795	$386	$7,409
New Mexico*	$272	$57	$215
New York*	$0	$4	–$4
North Carolina*	$1,373	$136	$1,237
North Dakota	$334	$24	$310
Ohio	$4,563	$252	$4,312
Oklahoma*	$1,371	$164	$1,207
Oregon*	$0	$7	–$7
Pennsylvania*	$2,331	$193	$2,138
Rhode Island	$725	$30	$695
South Carolina*	$0	$24	–$24
South Dakota	$563	$41	$522
Tennessee	$2,834	$254	$2,580
Texas*	$3,543	$207	$3,336
Utah	$1,508	$166	$1,342
Vermont	$281	$19	$262
Virginia*	$688	$37	$651
Washington*	$0	$5	–$5
West Virginia	$250	$38	$212
Wisconsin*	$0	$8	–$8
Wyoming	$586	$22	$564

*This state has an existing expansion; for some of these states, adolescents are included in the existing expansion, and no new adolescents would be served but new transportation costs would be added.

APPENDIX TABLE C: Reported levels of expansion program participation and calculated rate of use among likely participants

State	Females: First full year — Year	Female participants	Rate of use among likely participants	Females: Most recent full year — Year	Female participants	Rate of use among likely participants
Average	—	—	31.5%	—	—	51.9%
Alabama	2001	47,685	76.6%	2009	60,186	96.6%
Arkansas	1998	31,701	49.8%	2005	42,050	44.7%
California	1998	642,000	56.5%	2009	1,538,291	135.4%
Illinois	2007	25,194	12.9%	—	—	—
Iowa*	2006	—	—	2007	26,454	58.5%
Louisiana	2007	9,411	6.9%	—	—	—
Michigan	2006	25,000	16.1%	2009	37,125	23.9%
Minnesota	2007	20,920	30.1%	—	—	—
Mississippi	2004	—	—	2007	42,000	52.3%
New Mexico	1999	3,207	4.9%	2005	12,515	19.3%
New York	2003	—	—	2006	30,520	8.6%
North Carolina	2006	9,819	5.0%	2009	25,017	12.6%
Oklahoma	2005	11,235	14.9%	2008	23,373	30.9%
Oregon	1999	46,201	48.2%	2008	79,021	82.4%
Pennsylvania	2008	43,129	30.2%	—	—	—
South Carolina	1998	62,902	62.3%	2005	66,182	65.6%
Texas	2007	58,982	7.6%	2009	88,491	11.4%
Virginia	2008	3,946	5.3%	—	—	—
Washington	2002	74,818	53.8%	2007	50,778	36.5%
Wisconsin	2003	37,224	54.2%	2006	68,886	100.4%

State	Males: Most recent full year — Year	Male participants	Males per 1,000 females
Average	—	—	17.0
California	2009	227,265	147.7
North Carolina	2009	284	11.4
Oklahoma	2008	294	12.6
Oregon	2008	694	8.8
Virginia	2009	41	13.5
Washington	2005	4,787	38.9

*Year two data; not included in average. *Notes:* Average for males per 1,000 females excludes California. Data for some states and some years were not available for this analysis.

APPENDIX TABLE D: Findings for every 1,000 new adult female participants, mature year

For all states:

Unintended pregnancies averted: 140 **Abortions averted: 50** **Unintended Medicaid births averted: 70**

State	Total costs and savings (in 000s)			State costs and savings (in 000s)		
	Savings from Medicaid births averted	Expenditures on expansion services	Net savings	Savings from Medicaid births averted	Expenditures on expansion services	Net savings
Alabama*	$703	$427	$276	$228	$60	$168
Alaska	$1,806	$692	$1,114	$858	$97	$762
Arizona	$802	$464	$338	$271	$65	$206
Arkansas*	$897	$281	$615	$243	$39	$203
California*	$726	$350	$376	$363	$49	$314
Colorado	$778	$601	$177	$389	$84	$305
Connecticut	$1,073	$180	$893	$536	$25	$511
Delaware	$1,007	$243	$764	$504	$34	$470
District of Columbia	$964	$279	$686	$289	$39	$250
Florida	$755	$285	$470	$326	$40	$286
Georgia*	$1,066	$388	$679	$393	$54	$339
Hawaii	$858	$295	$564	$373	$41	$332
Idaho	$1,172	$239	$933	$353	$33	$320
Illinois*	$809	$349	$459	$404	$49	$356
Indiana	$903	$169	$734	$337	$24	$313
Iowa*	$1,175	$303	$872	$450	$42	$407
Kansas	$809	$384	$425	$328	$54	$275
Kentucky	$1,084	$329	$754	$328	$46	$282
Louisiana*	$1,179	$370	$809	$325	$52	$273
Maine	$714	$210	$504	$262	$29	$233
Maryland	$1,050	$337	$714	$525	$47	$478
Massachusetts	$1,041	$287	$755	$521	$40	$481
Michigan*	$715	$141	$574	$299	$20	$280
Minnesota*	$745	$302	$443	$372	$42	$330
Mississippi*	$498	$365	$133	$118	$51	$67
Missouri*	$865	$311	$554	$325	$43	$282
Montana	$919	$577	$342	$289	$81	$209
Nebraska	$1,093	$307	$785	$459	$43	$416
Nevada	$750	$204	$546	$355	$29	$327
New Hampshire	$971	$401	$570	$485	$56	$429
New Jersey	$1,142	$234	$908	$571	$33	$538
New Mexico*	$824	$458	$366	$239	$64	$175
New York*	$1,085	$261	$824	$543	$36	$506
North Carolina*	$1,044	$377	$668	$375	$53	$323
North Dakota	$1,180	$347	$833	$428	$48	$379
Ohio	$898	$275	$623	$352	$38	$314
Oklahoma*	$766	$229	$537	$252	$32	$220
Oregon*	$514	$244	$270	$201	$34	$167
Pennsylvania*	$774	$193	$581	$356	$27	$329
Rhode Island	$933	$189	$744	$443	$26	$417
South Carolina*	$853	$397	$456	$258	$55	$202
South Dakota	$1,049	$284	$765	$419	$40	$379
Tennessee	$946	$284	$662	$343	$40	$304
Texas*	$790	$200	$591	$312	$28	$284
Utah	$849	$519	$330	$241	$72	$168
Vermont	$1,101	$269	$832	$451	$38	$414
Virginia*	$1,191	$216	$975	$596	$30	$565
Washington*	$991	$249	$743	$481	$35	$446
West Virginia	$893	$359	$534	$230	$50	$180
Wisconsin*	$890	$203	$687	$377	$28	$349
Wyoming	$1,595	$745	$850	$797	$104	$693

*This state has an existing expansion. *Note:* Expenditures on expansion services include those for male participants, generally estimated at a ratio of 17 males per 1,000 females.

APPENDIX TABLE E: Estimated male participants and costs of providing male expansion services, mature year

State	Nominal Parity			True Parity		
	No. of expansion participants	Total expenditures (in 000s)	State expenditures (in 000s)	No. of expansion participants	Total expenditures (in 000s)	State expenditures (in 000s)
Alabama*	1,000	$430	$60	1,300	$545	$76
Alaska	100	$70	$10	100	$88	$12
Arizona	900	$421	$59	1,200	$538	$75
Arkansas*	600	$179	$25	700	$194	$27
California*	0	$0	$0	18,300	$5,591	$781
Colorado	1,000	$566	$79	1,000	$608	$85
Connecticut	300	$61	$9	400	$68	$10
Delaware	100	$22	$3	100	$25	$3
District of Columbia	100	$18	$3	100	$20	$3
Florida	3,500	$982	$137	4,100	$1,140	$159
Georgia*	2,000	$768	$107	2,200	$826	$115
Hawaii	100	$24	$3	100	$28	$4
Idaho	200	$51	$7	300	$67	$9
Illinois*	400	$147	$21	500	$165	$23
Indiana	1,000	$167	$23	1,100	$184	$26
Iowa*	500	$145	$20	600	$167	$23
Kansas	300	$120	$17	400	$154	$21
Kentucky	900	$286	$40	1,000	$326	$46
Louisiana*	200	$58	$8	200	$62	$9
Maine	100	$22	$3	100	$26	$4
Maryland	700	$240	$34	800	$267	$37
Massachusetts	300	$82	$11	300	$90	$13
Michigan*	600	$87	$12	700	$101	$14
Minnesota*	0	$13	$2	100	$25	$4
Mississippi*	600	$215	$30	700	$243	$34
Missouri*	900	$286	$40	1,100	$326	$46
Montana	100	$70	$10	200	$87	$12
Nebraska	300	$76	$11	300	$86	$12
Nevada	500	$91	$13	500	$107	$15
New Hampshire	100	$56	$8	200	$65	$9
New Jersey	1,100	$259	$36	1,200	$285	$40
New Mexico*	200	$110	$15	300	$119	$17
New York*	0	$0	$0	100	$15	$2
North Carolina*	0	$0	$0	0	$14	$2
North Dakota	100	$20	$3	100	$25	$3
Ohio	1,600	$423	$59	1,700	$461	$64
Oklahoma*	0	$0	$0	0	$10	$1
Oregon*	0	$0	$0	100	$23	$3
Pennsylvania*	700	$132	$18	800	$155	$22
Rhode Island	200	$28	$4	200	$32	$4
South Carolina*	900	$355	$50	1,100	$417	$58
South Dakota	100	$21	$3	100	$27	$4
Tennessee	1,000	$292	$41	1,100	$320	$45
Texas*	1,400	$279	$39	1,600	$323	$45
Utah	300	$144	$20	400	$186	$26
Vermont	100	$17	$2	100	$20	$3
Virginia*	0	$7	$1	0	$8	$1
Washington*	0	$0	$0	100	$24	$3
West Virginia	300	$103	$14	400	$124	$17
Wisconsin*	200	$35	$5	300	$63	$9
Wyoming	100	$43	$6	100	$56	$8

*This state has an existing expansion; for some of these states, men are included in the existing expansion, and no new men would be served under the Nominal Parity scenario.

APPENDIX TABLE F: Cost per Medicaid family planning user, 2008

State	Women 13–18		Women 19–44	
	Family planning costs per user	Adjusted costs per user	Family planning costs per user	Adjusted costs per user
U.S. average	$203	$225	$288	$319
Alabama	$254	$281	$378	$420
Alaska	$262	$291	$613	$680
Arizona*	$290	$322	$411	$457
Arkansas	$240	$266	$249	$277
California	$249	$276	$275	$305
Colorado	$266	$295	$533	$591
Connecticut	$163	$181	$159	$177
Delaware	$197	$219	$216	$239
District of Columbia*	$174	$193	$247	$274
Florida*	$178	$198	$253	$280
Georgia*	$242	$269	$343	$381
Hawaii	$213	$237	$261	$290
Idaho	$203	$225	$212	$235
Illinois	$206	$228	$310	$344
Indiana	$92	$102	$150	$166
Iowa	$252	$279	$269	$298
Kansas*	$240	$267	$341	$378
Kentucky	$262	$291	$292	$324
Louisiana	$232	$258	$328	$364
Maine	$187	$208	$186	$207
Maryland	$212	$235	$298	$331
Massachusetts	$151	$168	$254	$282
Michigan	$110	$123	$125	$138
Minnesota	$254	$282	$268	$297
Mississippi*	$228	$253	$323	$359
Missouri	$208	$230	$276	$306
Montana	$201	$223	$511	$567
Nebraska	$191	$213	$272	$302
Nevada	$148	$164	$181	$201
New Hampshire	$199	$220	$355	$394
New Jersey	$182	$202	$207	$230
New Mexico	$313	$347	$406	$451
New York	$215	$239	$231	$257
North Carolina	$241	$267	$336	$372
North Dakota	$200	$222	$308	$341
Ohio	$125	$139	$243	$270
Oklahoma	$195	$217	$203	$226
Oregon	$163	$181	$218	$242
Pennsylvania	$186	$206	$171	$190
Rhode Island*	$118	$131	$167	$186
South Carolina*	$248	$275	$352	$391
South Dakota	$195	$217	$252	$279
Tennessee	$198	$220	$251	$279
Texas	$115	$127	$177	$196
Utah	$171	$189	$460	$510
Vermont	$195	$217	$238	$265
Virginia	$208	$231	$192	$214
Washington	$185	$206	$216	$239
West Virginia*	$224	$249	$318	$353
Wisconsin	$173	$193	$180	$200
Wyoming	$193	$214	$660	$733

* Estimated data. *Notes:* Adjusted data include an 11% inflation for outreach, transportation services and other administrative costs. Data for Hawaii and Utah are from 2007.

References

1. Frost JJ, Sonfield A and Gold RB, Estimating the impact of expanding Medicaid eligibility for family planning services, *Occasional Report,* New York: Guttmacher Institute, 2006, No. 28.

2. *Federal Register,* 75:45628–45629, 2010.

3. Kaiser Family Foundation, Medicaid and state funded coverage income eligibility limits for low-income adults, 2009, <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>, accessed Nov. 21, 2010.

4. Kaiser Family Foundation, Income eligibility levels for pregnant women by annual income and as a percent of federal poverty level, 2009, <http://www.statehealthfacts.org/comparetable.jsp?ind=206&cat=4>, accessed Nov. 21, 2010.

5. Kaiser Family Foundation, Births financed by Medicaid as a percent of total births, 2003, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=223&cat=4>, accessed Nov. 21, 2010.

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. P.L. 111–226, Aug. 10, 2010.

9. Guttmacher Institute, State Medicaid family planning eligibility expansions, *State Policies in Brief (as of December 15, 2010),* 2010, <http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf>, accessed Dec. 22, 2010.

10. 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.

11. 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, San Francisco, 2010, <http://bixbycenter.ucsf.edu/publications/files/FamilyPACTCost-BenefitAnalysis2007_2010Apr.pdf>, accessed Nov. 21, 2010.

12. Oregon Department of Human Services, *Family Planning Expansion Project, Project Evaluation Report: Initial 5-Year Waiver and 3-Year Renewal Period,* unpublished evaluation submitted to Centers for Medicare and Medicaid Services, Jan. 2008.

13. Research and Data Analysis Division, Washington Department of Social and Health Services, *Take Charge: Final Evaluation, First Five Years: July 2001–June 2006,* 2006, <http://www.dshs.wa.gov/pdf/ms/rda/research/9/83.pdf>, accessed Dec. 15, 2010.

14. Fay W. Boozman College of Public Health, University of Arkansas for Medical Services (UAMS), *Evaluation of the Women's Health Waiver,* unpublished evaluation submitted to Arkansas Department of Health and Human Services, revised June 2007.

15. New Mexico Medical Review Association, *Family Planning Waiver Evaluation: July 1, 1998–June 30, 2006,* unpublished evaluation submitted to New Mexico Human Services Department, revised Dec. 2006.

16. Unpublished tabulations of data from the RIte Care Research and Evaluation Project, 2005.

17. Texas Health and Human Services Commission, *Women's Health Program Annual Report 2008,* no date, <http://www.hhsc.state.tx.us/reports/2010/WHP_2008AnnualReport.pdf>, accessed Dec. 15, 2010.

18. National Governors Association, Center for Best Practices, *Healthy Babies: Efforts to Improve Birth Outcomes and Reduce High Risk Births,* 2004, <http://www.nga.org/cda/files/0406births.pdf>, accessed Nov. 21, 2010.

19. 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.

20. March of Dimes, Medicaid family planning state option, no date, <http://www.marchofdimes.com/files/medicaid_family_planning_state_option.pdf>, accessed Feb. 5, 2009.

21. 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.

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

23. Texas Health and Human Services Commission, *Rider 64 Report: Annual Savings and Performance Report for the Women's Health Program*, 2010, <http://www.hhsc.state.tx.us/reports/2010/Rider64-Oct2010.pdf>, accessed Dec. 15, 2010.

24. Patient Protection and Affordable Care Act, P.L. 111–148, Sec. 2303, Mar. 23, 2010.

25. Guttmacher Institute, special analysis of state Medicaid family planning waiver approvals, 2010.

26. 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, OR: Oregon Public Health Division, Oct. 25, 2010, <http://www.guttmacher.org/pubs/Family-planning-SPA.pdf>, accessed Dec. 23, 2010.

27. 111th Congress, House of Representatives, *America's Affordable Health Care Choices Act of 2009, Report of the Committee on Energy and Commerce on H.R. 3200, Together with Dissenting Views*, Washington, DC: U.S. Government Printing Office, 2009, p. 616, <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_reports&docid=f:hr299p1.111.pdf>, accessed Mar. 23, 2010.

28. 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.

29. Sonfield A, Evidence mounts of recession's impact on women of reproductive age, *Guttmacher Policy Review*, 13(4):17–18.

30. Guttmacher Institute, *A Real-Time Look at the Impact of the Recession on Women's Family Planning and Pregnancy Decisions,* 2009, <http://www.guttmacher.org/pubs/RecessionFP.pdf>, accessed Dec. 3, 2010.

31. Guttmacher Institute, *A Real-Time Look at the Impact of the Recession on Publicly Funded Family Planning Centers,* 2009, <http://www.guttmacher.org/pubs/RecessionFPC.pdf>, accessed Dec. 3, 2010.

32. Kaiser Commission on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid,* 2010, <http://kff.org/medicaid/upload/7580-07.pdf>, accessed Dec. 3, 2010.

33. Guttmacher Institute, *Contraceptive Needs and Services, 2006,* 2009, <http://www.guttmacher.org/pubs/win/allstates2006.pdf>, accessed Nov. 21, 2010.

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

35. Jones R, special tabulations of data from the 2008–2010 Current Population Surveys, 2010.

36. Guttmacher Institute, special tabulations of data from the 2002 National Survey of Family Growth, 2006.

37. Swann D, ed., *Family PACT Program Report Fiscal Year 2008–2009,* San Francisco: Bixby Center for Reproductive Health Research and Policy, University of California, San Francisco, 2010, <http://www.familypact.org/Files/Provider/Research%20Reports/FamPACT_AnnualReport_FY0809_2010-0901.pdf>, accessed Dec. 13, 2010.

38. Guttmacher Institute, special analysis of state Medicaid family planning waiver evaluations, 2010.

39. Guttmacher Institute, special tabulations of data from the 2006–2008 National Survey of Family Growth, 2010.

40. Frost JJ, Finer LB and Tapales A, The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings, *Journal of Health Care for the Poor and Underserved,* 2008, 19(3):777–795.

41. Bureau of Labor Statistics, U.S. Department of Labor, Consumer Price Index—all urban consumers, medical care, no date, <http://data.bls.gov/cgi-bin/dsrv?cu>, accessed Nov. 24, 2009.

42. Centers for Medicare and Medicaid Services, Medicaid managed care enrollment as of December 31, 2008, no date, <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/08Dec31f.pdf>, accessed Nov. 24, 2009.

43. Zuckerman S, Williams AF and Stockley KE, Trends in Medicaid physician fees, 2003–2008, *Health Affairs,* 2009, 28(3):w510–w519.

44. Holahan J and Suzuki S, Medicaid managed care payment methods and capitation rates in 2001, *Health Affairs,* 2003, 22(1):204–218.

45. Centers for Medicare and Medicaid Services, Medicaid Statistical Information System (MSIS) State Summary Datamart, <http://msis.cms.hhs.gov/>, accessed Nov. 21, 2010.

46. Kaiser Family Foundation, Federal medical assistance percentage for Medicaid and multiplier, <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4>, accessed Nov. 21, 2010.

Advancing sexual and reproductive health worldwide through research, policy analysis and public education

125 Maiden Lane
New York, NY 10038
(212) 248-1111; fax (212) 248-1951
info@guttmacher.org

1301 Connecticut Avenue NW, Suite 700
Washington, DC 20036
policyinfo@guttmacher.org

www.guttmacher.org