Advancing a model family planning State Plan Amendment: a look at family planning expansions across the country

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Abstract

Although over half of the states in the US have implemented some form of Medicaid expansion for family planning services, through either a state plan amendment (SPA), 1115 waiver, or state-funded program, these programs operate very differently from one another. They vary in income eligibility, age and gender requirements, and more. Under guidance from Centers for Medicare & Medicaid Services (CMS), however, states have the opportunity to expand access and implement certain inclusions, such as presumptive eligibility and the good-cause exception, that address issues regarding timely enrollment and confidentiality concerns. Through state-wide research, this paper examines extended family planning programs and the inclusions that define a model family planning state plan amendment.

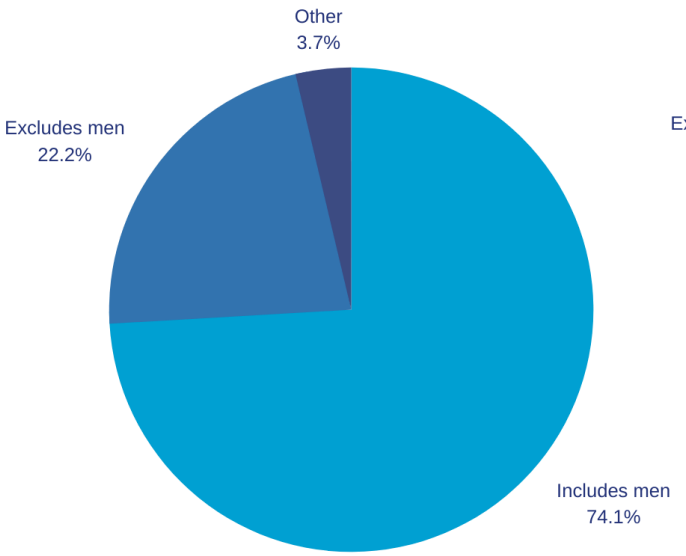
Keywords: family planning state plan amendment, presumptive eligibility, good-cause exception

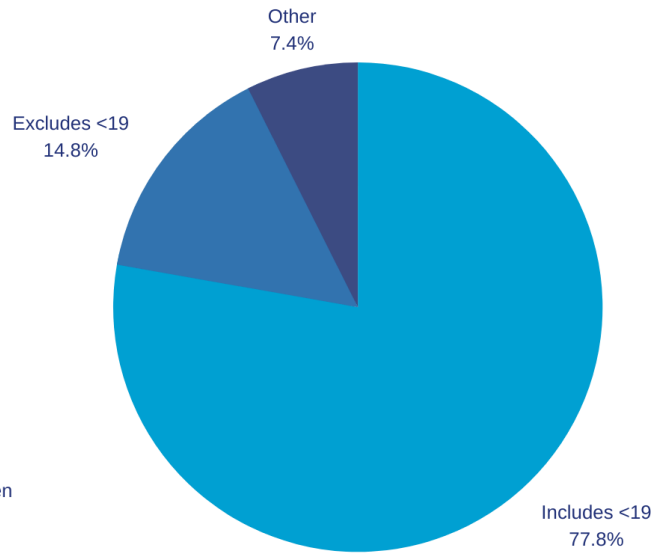
1. Introduction

Over the past few decades, many states have implemented Medicaid expansions for family planning services, extending coverage to individuals who would not otherwise qualify for full-benefit Medicaid. Previously, states have done so through a Section 1115 demonstration waiver from the Centers for Medicare & Medicaid Services (CMS), but with the introduction of the Affordable Care Act (ACA), states were given the option to permanently amend their Medicaid programs through a family planning State Plan Amendment (SPA) [1]. Currently, 17 states have expanded coverage through a SPA, 10 through a waiver, and 3 through fully state-funded programs. While it is essential that these states have recognized the importance of expanding access to family planning services to low income individuals, the different features of these limited benefits programs underline the fact that simply having an extended family planning program is not enough. This paper will briefly analyze family planning waivers and SPAs across the country, in order to examine what elements make up a model family planning State Plan Amendment.

2. Overview of Eligibility

Eligibility requirements for family planning expansions vary widely across states. Below is a table that highlights some of the main differences.





In summary, 20 states provide services to both men and women (Alabama does however cover vasectomies for men over the age of 21), and 21 states also include individuals under the age of 19, while Georgia includes women 18+ and Texas also covers 15-17 year olds with parental consent.

Some requirements remain relatively consistent state-wide. This includes requirements regarding citizenship and residency (programs do not include undocumented immigrants), reproductive capacity (programs exclude those who have been sterilized or are unable to reproduce), and additional third-party payors such as private health insurance, Medicaid or Medicare, though this last requirement has quite a few relevant exceptions which will be discussed later on.

State	Medicaid Expansion States	State Plan Amendment	FP Waiver	Eligibility: Income (%FPL) or losing full-benefit coverage	Includes Men	Includes Individuals <19
Alabama [2]			X	141%	21+ for vasectomies only	No

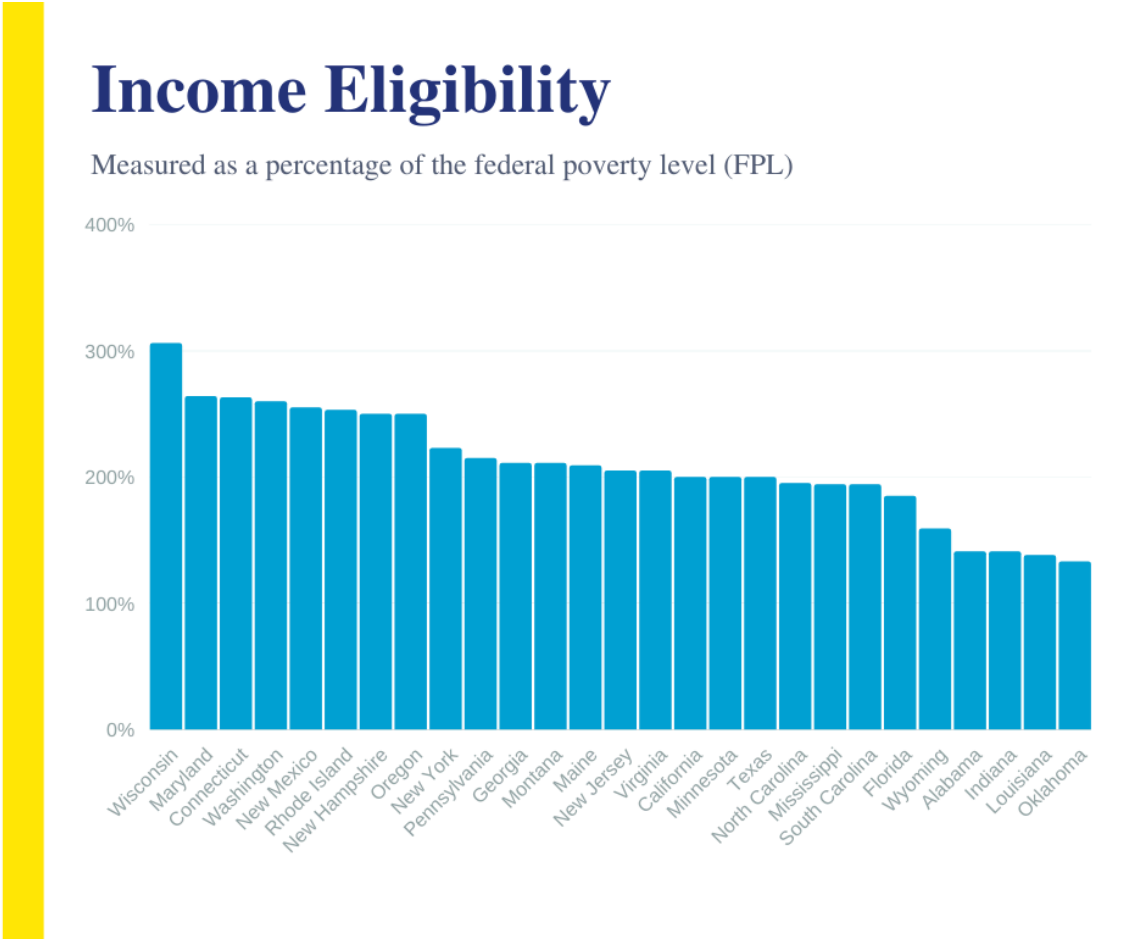
California [3]	X	X		200%	Yes	Yes
Connecticut [4]	X	X		263%	Yes	Yes
Florida [5]			X	For any reason, 185%	No	Yes
Georgia [6]			X	211%	No	18+
Indiana [7]	X	X		141%	Yes	Yes
Louisiana [8]	X	X		138%	Yes	Yes
Maine [9]	X	X		209%	Yes	Yes
Maryland [10]	X	X		264%	Yes	Yes
Minnesota [11]	X	X		200%	Yes	Yes
Mississippi [12]			X	194%	Yes	Yes
Montana [13]	X		X	211%	No	No
New Hampshire [14]	X	X		250%	Yes	Yes
New Jersey [15]	X	X		205%	Yes	No
New Mexico [16]	X	X		255%	Yes	Yes
New York [17]	X	X		223%	Yes	Yes
North Carolina [18]		X		195%	Yes	Yes
Oklahoma [19]	X (not yet implemented)	X		133%	Yes	Yes
Oregon [20]	X		X	250%	Yes	Yes
Pennsylvania [21]	X	X		215%	Yes	Yes

Rhode Island [22]	X		X	253%	No	Yes
South Carolina [23]		X		194%	Yes	Yes
Texas [24]			X	200%	No	18-44, 15-17 with parental consent
Virginia [25]	X	X		205%	Yes	Yes
Washington [26]	X		X	260%	Yes	Yes
Wisconsin [27]		X		306%	Yes	Yes
Wyoming [28]			X	Postpartum, 159%	No	No

Nearly all states provide family planning benefits to individuals based on income (see chart below), with the exceptions of Wyoming, which provides benefits to women losing full-benefit Medicaid coverage postpartum, and Florida, which provides benefits to women losing full coverage for any reason [1]. For most states, the income ceiling (measured as a percentage of the federal poverty level (FPL)) is around 200%, with 8 states above 250% FPL and 5 states below 160% FPL, the lowest being Oklahoma with an income ceiling of 133% FPL. Additionally, a 5% income disregard is applied when determining income eligibility; some state websites already incorporate this in their reported income requirements, though others do not [29].

Another aspect of income eligibility that comes into play is determining eligibility based on individual or household income. While utilizing the former could help minors, young people and victims of intimate partner violence, only Wisconsin and Maine have chosen to do so. However, some states have addressed part of this issue in a different way. When determining income eligibility for minors, California and Maryland exclude

the parents' income [30,31]. Furthermore, Minnesota does this for anyone under the age of 21 and in Washington, some teens qualify based on their own income [11,26].



3. Presumptive Eligibility

In order to ensure timely access to family planning services for eligible clients, several states have implemented presumptive eligibility (PE). This allows individuals, who are deemed presumptively eligible through a shortened application, access to same day coverage before a complete eligibility screening is processed. If later determined ineligible for the extended family planning program, the services they previously received would still be covered [32].

At least 7 states (Connecticut, Indiana, Minnesota, New York, North Carolina, Texas and Wisconsin) have PE. Additionally, California not only utilizes same day application and certification for their family planning program (different from PE), but also offers retroactive eligibility (RE) in some cases, which allows eligible individuals to apply for reimbursement of family planning services they received in the last three months prior to becoming a client [33]. While PE is a start to ensuring timely access to services, RE goes even further to improve the reproductive experiences of low income individuals.

4. The Good Cause Exception

As mentioned earlier, all states have requirements regarding additional third-party payors. In some states, individuals who have another form of insurance that covers family planning services are not eligible for extended family planning programs, but in others, these individuals are still allowed to enroll. However, as Medicaid is still the payer of last resort under standard Medicaid practices, any third-party payor will be billed first [32]. This is called third-party liability (TPL) and can pose a significant challenge for individuals who are insured as dependents and seeking confidential care, especially for minors and victims of intimate partner violence.

Confidentiality is most often breached through insurance communications (like explanation of benefits (EOBs)) that are sent to the policy holder and can potentially put the dependent at risk of emotional or physical harm. States have acknowledged this issue by imposing regulations that apply to Medicaid, but confidentiality concerns remain pressing for those with private health insurance [32]. Under already existing federal statutes and regulations, however, states are permitted to implement a “good-cause exception,” which allows TPL to be waived if an individual’s emotional or physical safety would be put at risk by using their private insurance [34]. Below are some states that utilize some form of the good-cause exception (GCE), or implement measures that address the same problem:

California implements the GCE on the application form for their extended family planning program (Family PACT). The question reads: “Does your concern that your partner, spouse, or parent learn about your family planning appointment keep you from using your health care insurance?” Individuals who check this box are eligible to apply for Family PACT [35].

Maryland does not have a GCE that allows individuals with confidentiality concerns to utilize their family planning program instead of their private insurance, but they do have measures to deal with confidentiality concerns for teens and victims of abuse/trafficking. When this is the case, providers are instructed not to bill Medicaid or any third-party insurance. Instead, they are permitted to provide services and charge patients per clinic protocol or refer a client to a Title X funded family planning clinic [31].

Minnesota requires individuals to report whether they have other private insurance unless doing so would put them at risk of emotional or physical harm. On the application form for their program, individuals can indicate this by checking the box that says: “Yes, I have or may have health insurance. But I do not want you to contact my insurance company. I have good reason for not giving you insurance information. I would be at risk of physical or emotional harm if I gave it. The risk could come from asking the policyholder for insurance information, or from the insurance company’s telling the policyholder about the services I get” [36].

New York provides a question on their application form for their Family Planning Benefit Program that asks, “If you are not the policyholder, do you have a reason the health insurance company should not be billed?” [37]. If the client states that using their private insurance could “jeopardize their emotional or physical health, safety and/or confidentiality and privacy...the provider is required to call the New York Health Options Statewide Call Center (1-800-541-2831) to request a ‘good cause waiver authorization’” [38].

Oregon implements the GCE by asking, “If you have private health insurance are you worried your partner, spouse or parent will find out about the services you get today?” on the Oregon ContraceptiveCare Enrollment Form [39]. Additionally, the Oregon legislature also passed a bill that protects confidentiality by requiring all health insurance plans to allow individuals of any age to request that communications (like EOBs) be sent directly to them instead of the policyholder [20].

Pennsylvania includes a question on the addendum of their application that allows individuals to indicate that, “Using my current insurance would cause me physical, emotional, or other harm” [40].

Texas does not allow individuals with private insurance that covers family planning services to apply for their program (Healthy Texas Women (HTW)), unless “filing a claim on the health insurance would cause physical, emotional or other harm from a spouse, parent or other person.” However, this GCE is flawed as a legal guardian is required to fill out the application form for individuals aged 15-17 [41].

Washington also does not allow individuals with private insurance that covers family planning services to apply for their program (Take Charge), unless an individual is either a “minor child age 18 or younger, covered under your parent’s health insurance and you do not want your parents to know you are seeking family planning services,” or a “victim of domestic violence and covered under the perpetrator’s health insurance.” This can be indicated on the application form for Take Charge [42].

5. A Note About State Funded Programs

Of the 30 states that have implemented an extended family planning program, 3 states (Iowa, Missouri, and Vermont) operate programs that are completely state funded. Doing so exempts states from following certain federal regulations. In the case of Missouri and Iowa, they have opted to exclude abortion providers from their programs. While extended family planning programs do not cover abortions, Iowa and

Missouri even exclude providers who offer other essential family planning services, while also providing abortion services [1]. Previously, Texas's program was also fully state funded, but now only a few portions have been carved out. This includes services for minors, which remains state funded in order to require parental consent for family planning services.

Conclusion

It is clear that family planning SPAs vary in efficacy, reach, and inclusiveness. Implementing a model family planning SPA, containing inclusions like presumptive eligibility and the good-cause exception, is not only about expanding, but also ensuring access to family planning services to all eligible individuals, removing barriers and strengthening enrollment. Furthermore, states themselves would also benefit from expanded access to coverage, gaining financially from the decrease in unintended pregnancies that would result from wider access to contraceptives. In summary, model family planning SPAs have the potential to positively impact both the reproductive lives of tens of thousands of low income individuals, and the states that implement them. Advancing a model family planning state plan amendment brings us one step closer to adequate, equitable and impactful reproductive healthcare.

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