National
Family Planning
& Reproductive Health Association

Testimony of Robin Summers
National Family Planning & Reproductive Health Association

Submitted to the
House Finance Committee

Re: Medicaid Family Planning State Plan Amendment

February 25, 2014

Chairman Austerman, Chairman Stoltze, members of the House Finance Committee, good afternoon. My name is Robin Summers and I am a Senior Policy Director with the National Family Planning & Reproductive Health Association (NFPRHA). NFPRHA is a national membership organization representing the nation's family planning providers—nurse practitioners, nurses, administrators and other key health care professionals. NFPRHA's members operate or fund a network of nearly 5,000 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals around the country, including Alaska.

I am pleased to be speaking with the Committee today about the importance of expanding Alaska's Medicaid eligibility for family planning services through a state plan amendment (SPA). I respectfully request that my written statement be submitted for the record.

Public health providers, scholars and advocates, and federal lawmakers agree: family planning is cost-saving preventive health care for women and men. The Centers for Disease Control and Prevention (CDC) has cited family planning as one of the ten great public health achievements of the 20th century, stating, "Smaller families and longer birth intervals have contributed to the better health of infants, children, and women, and have improved the social and economic role of women."[i]

Access to family planning has improved the social and economic lives of women and families, prevented unintended pregnancies and the transmission of sexually transmitted diseases, including HIV/AIDS, and decreased infant, child and maternal deaths. These public health, education, and economic gains are even bigger in poor and low-income communities which traditionally lack access to basic health care.

In the 1990s, states began broadening eligibility for their Medicaid programs to provide family planning services and supplies to individuals who are not otherwise eligible for Medicaid.[ii] Originally these expansions were done through a Medicaid waiver authorized by §1115 of the Social Security Act, but the Affordable Care Act (ACA) gave states the option to amend their state Medicaid plans to

expand eligibility for family planning services and supplies to individuals who are not pregnant and who have an income that does not exceed the income-eligibility level set by the state for coverage for pregnancy-related care. Today, 30 states have chosen to expand Medicaid eligibility for family planning; 12 of those states have received approval to operate their family planning expansions through a SPA.[iii]

Medicaid family planning expansion programs provide a broad range of family planning and family planning-related services, including the full range of contraceptive methods, pap tests, and other associated examinations and laboratory tests. A Medicaid family planning SPA does not cover abortion. Recognizing the value of family planning, the federal government reimburses these services and supplies at an enhanced matching rate of 90% .

Medicaid family planning expansion programs are proven to save states money by expanding access to contraception and increasing women's contraceptive use of more effective contraceptive methods—essential factors in reducing high rates of unintended pregnancy among low-income women.[iv] According to the Guttmacher Institute, in 2010, publicly funded family planning services helped women avoid 2.2 million unintended pregnancies, which would likely have resulted in about 1.1 million unintended births and 760,000 abortions.[v] Additionally, improved contraceptive use has helped women to plan and space their pregnancies, which has positive implications for the health of pregnant women and newborns and the economic and social well-being of families. [vi]

Medicaid family planning expansion programs make family planning services more accessible. Health centers in states with Medicaid family planning expansions are more likely to provide patients with a broad range of contraceptive options and to have extended service hours than health centers in other states.[vii] They are also less likely to report difficulty stocking certain contraceptive methods due to cost.[viii] Medicaid family planning expansion programs also improve the geographic availability of services and broaden private physician participation in the provider network.[ix]

Family planning health centers in states with Medicaid family planning expansions serve one-third more women in need of care, compared to health centers in other states.[x] In 2006, family planning health centers in states with income-based Medicaid family planning expansions served 48% of women in need, compared to 36% of women in need in other states.[xi]

Publicly funded family planning services not only improve public health, they save taxpayer dollars while doing it. The Guttmacher Institute finds that every $1.00 spent on publicly funded family planning saves $5.68 in Medicaid expenditures that otherwise be needed to be spent related to unintended pregnancies.[xii] The Brookings Institution estimates that Medicaid family planning expansion programs save taxpayers $1.32 billion annually.[xiii] Births resulting from unintended pregnancy cost US taxpayers approximately $12.5 billion annually.[xiv] Without publicly funded family planning services, these costs would be doubled—costing taxpayers $25 billion a year.[xv]

In 2010, 37,400 women in Alaska were in need of publicly supported contraceptive services and supplies.[xvi] 7,000 pregnancies in Alaska were unintended in 2008, 47% of all pregnancies in the

state.[xvii] In 2008, there were 11,400 births in Alaska;[xviii] 4,500 (40%) resulted from unintended pregnancies,[xix] and 5,900 (52%) were paid for by Medicaid.[xx] In total, there were 3,000 publicly funded births in Alaska in 2008 that resulted from unintended pregnancies,[xxi] representing 26% of all births in the state, 51% of the state's Medicaid-funded births, and 67% of the births resulting from unintended pregnancies. The cost to the state and federal government of births resulting from unintended pregnancies was $71 million in 2008; of that, $34 million was paid for by Alaska.[xxii]

Implementing a Medicaid family planning expansion has been a proven, successful strategy to combat unintended pregnancy and save public dollars for many states, and would be a wise investment for Alaska. According to a 2011 projection from the Guttmacher Institute, implementing a Medicaid family expansion SPA in Alaska could help the state provide family planning services to up to 9,200 individuals annually, helping women and couples avoid up to 1,310 unintended pregnancies per year, which might otherwise result in 430 abortions and 680 births, resulting in a potential net savings of $10.7 million a year, including $7 million for Alaska.[xxiii]

A Medicaid family planning SPA is not duplicative of the coverage Alaska currently provides to categorically eligible individuals in the state's Medicaid program. Although family planning services are a mandatory benefit of the Medicaid program, Medicaid eligibility in Alaska is currently limited to specific categories of persons (including working parents, disabled individuals, and pregnant women). Childless adults do not qualify for full-benefit Medicaid in Alaska, and consequently do not have access to Medicaid-funded family planning.

A Medicaid family planning SPA would expand eligibility for family planning services under Medicaid in two ways: it would expand eligibility to all individuals not currently categorically eligible for Medicaid; it would also expand the income eligibility threshold, up to the level the state has set for pregnancy-related care. Today, a single mother with one child (working parent, household of 2) is eligible for Medicaid if she earns less than $2,111 per month. However, eligibility for that same single mother with one child, if she becomes pregnant, goes up to $4,124 per month during her pregnancy. A childless adult is not eligible at all, unless she has a qualifying condition (e.g. disabled). A Medicaid family planning SPA would provide family planning services to childless adults who are not otherwise eligible for Medicaid, as well as to those single mothers with incomes that fall in the gap between $2,111 and pregnancy eligibility.

Further, a Medicaid family planning SPA is not duplicative of the ACA's coverage expansion, but is in fact a compliment to it that will help states meet what is sure to be a growth in health care demand, particularly from individuals who have traditionally lacked health care coverage. Although the ACA will expand insurance coverage to millions, there will still be significant coverage gaps—even if Alaska ultimately decides to move forward with the ACA's expansion of Medicaid to individuals with incomes up to 138% FPL—and Medicaid family planning expansion programs remain a cost-effective means of providing essential health services post-ACA implementation.

An estimated 30 million people were left out of the ACA's coverage provisions,[xxiv] many of whom are poor or low-income and who will continue to need and seek publicly funded health services.

Moreover, evidence from Massachusetts, a state that is several years farther down the road to health care reform than the country as a whole, shows that even with "universal" coverage, there will be coverage gaps. According to the Guttmacher Institute, although only 2% of all Massachusetts residents were uninsured in 2010 (compared with over 6% in 2006), 3 in 10 clients who sought care at family planning centers in Massachusetts in 2011 "either had no insurance coverage or had coverage they could not use for their care."[xxv] A new report published by the CDC echoes these findings, detailing how in the 6 years following health reform in Massachusetts, many individuals continued to need and seek publicly funded family planning care.[xxvi]

There will be individuals without coverage because they are cycling on and off of insurance coverage due to changing life circumstances - they lost their job, their income level fluctuates, they get married or divorced, all of which can affect someone's insurance eligibility and status—in a process known as "churning." These are people our member-health care providers encounter every day. The woman in her early thirties who lost her job and, with it, her employer-sponsored insurance coverage or her ability to pay for the insurance she was paying for out of her own pocket. Or the woman in her twenties who works two retail jobs, whose hours, and therefore monthly income, fluctuates depending on how good business. Or the woman who was eligible for Medicaid when she was single, but whose new husband makes slightly too much money for her to qualify for Medicaid but not enough to afford to buy insurance.

Furthermore, while eligibility for full-benefit Medicaid and the ACA's subsidies to purchase commercial insurance is based on family income, Medicaid family planning SPAs often allow individuals to qualify for services based on their own, individual income, as opposed to that of their family. This means that individuals who may not be able to access full-benefit Medicaid or commercial insurance coverage because their family income is too high may still be able to qualify for and receive services through a Medicaid family planning SPA based on their individual income level.

Although many people are likely to have a pathway to coverage under the ACA, there is a sizable group of individuals for whom regular insurance processes fail, for the reasons I outlined and more. Medicaid family planning SPAs provide a stop-gap measure to help ensure continued access to family planning for millions of low-income individuals.

Additionally, even with the ACA's new women's preventive health services benefit, women may not have access to the contraceptive methods and services most effective for them. The ACA requires new commercial insurance plans to cover a range of women's preventive health services, including all FDA-approved contraceptive methods, counseling, and an annual well-woman visit. However, current rules regarding this benefit give some flexibility to insurance plans, which are doing things like tiering services (i.e. the patient can only access generics, or certain brands and/or supply types) or even excluding certain methods, such as intrauterine devices (IUDs) and other long-acting contraceptive methods. Medicaid family planning expansion programs provide a broad range of contraceptive method options, helping to ensure that women can choose and access the method that is most effective for them - saving taxpayer dollars that might otherwise be spent on unintended pregnancy.

Full implementation of the ACA will take years. Family planning is a preventive service and should not be inaccessible because of the administrative burdens required to implement national health reform. Medicaid family planning SPAs ensure continuity of services and supplies necessary to prevent unintended pregnancy while people are being enrolled into coverage under the ACA.

Finally, I would re-emphasize that Medicaid family planning expansion programs are money-savers. Since Medicaid is a payer of last resort, Medicaid family planning expansions only pay for services not otherwise paid for, and save states money while doing it. Implementing a Medicaid family planning SPA would give Alaska's health care providers a critical tool to help provide essential health care services to women and men in need of these services, leading to a healthier state while saving taxpayer dollars.

Thank you for inviting me to testify on this important issue, and I look forward to answering your questions.

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[i] US Centers for Disease Control and Prevention, *Ten Great Public Health Achievements -- United States, 1900-1999*, Morbidity and Mortality Weekly Report, April 2, 1999, http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm.
[ii] Rachel Benson Gold, "Back to Center Stage: ACA Decision Gives New Significance to Medicaid Family Planning Expansions," *Guttmacher Policy Review*, Fall 2012, Volume 15, Number 4, http://www.guttmacher.org/pubs/gpr/15/4/gpr150413.html.
[iii] California, Connecticut, Indiana, New Hampshire, New Mexico, New York, Ohio, Oklahoma, South Carolina, Virginia, and Wisconsin are all operating family planning SPAs. North Carolina's SPA goes into effect April 30, 2014.
[iv] Adam Sonfield and Rachel Benson Gold, *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future*, Guttmacher Institute, December 2011, http://www.guttmacher.org/pubs/Medicaid-Expansions.pdf.
[v] Jennifer Frost, Mia Zolna, and Lori Frohwirth, *Contraceptive Needs and Services, 2010*, Guttmacher Institute, July 2013, http://www.guttmacher.org/pubs/win/contraceptive-needs-2010.pdf .
[vi] Gold, "Back to Center Stage: ACA Decision Gives New Significance to Medicaid Family Planning Expansions."
[vii] Jennifer Frost et al., *Variation in Service Delivery Practices Among Clinics Providing Publicly Funded Family Planning Services in 2010*, May 2012, http://www.guttmacher.org/pubs/clinic-survey-2010.pdf.
[viii] Ibid.
[ix] Sonfield and Gold, *Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future.*
[x] Rachel Benson Gold et al., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System*, Guttmacher Institute, 2009, http://www.guttmacher.org/pubs/NextSteps.pdf.
[xi] Ibid.
[xii] Guttmacher Institute, "Facts on Publicly Funded Contraceptive Services in the United States," July 2013, http://www.guttmacher.org/pubs/fb_contraceptive_serv.html.
[xiii] Adam Thomas, *Policy Solutions for Preventing Unplanned Pregnancy*, Brookings Institution, March 2012, accessed March 7, 2013, http://www.brookings.edu/research/reports/2012/03/unplanned-pregnancy-thomas.
[xiv] Adam Sonfield and Kathryn Kost, "The Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008," Guttmacher Institute, http://www.guttmacher.org/pubs/public-costs-of-UP.pdf.
[xv] Ibid.
[xvi] Guttmacher Institute, *State Facts About Unintended Pregnancy: Alaska*, accessed February 24, 2014, http://www.guttmacher.org/statecenter/unintended-pregnancy/AK.html.
[xvii] Ibid.
[xviii] Sonfield and Kost, "The Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008."
[xix] Guttmacher Institute, *State Facts About Unintended Pregnancy: Alaska.*
[xx] Sonfield and Kost, "The Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008."
[xxi] Ibid.
[xxii] Guttmacher Institute, *State Facts About Unintended Pregnancy: Alaska.*
[xxiii] Adam Sonfield, Jennifer Frost, and Rachel Benson Gold, "Estimating the Impact of Expanding Medicaid Eligibility For Family Planning Services: 2011 Update," January 2011, http://www.guttmacher.org/pubs/Medicaid-Family-Planning-2011.pdf. It should be noted that these estimates were made prior to the US Supreme Court's 2012 decision making the ACA's Medicaid expansion effectively optional for states, and would likely be different in a post-Supreme Court decision environment.
[xxiv] Congressional Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act*, September 2012, http://www.cbo.gov/publication/43628.

[xxv] Gold, "Back to Center Stage: ACA Decision Gives New Significance to Medicaid Family Planning Expansions."
[xxvi] Marion Carter et al., "Trends in Uninsured Clients Visiting Health Centers Funded by the Title X Family Planning Program—Massachusetts, 2005-2012," Morbidity and Mortality Weekly Report, January 24, 2014, 63(03); 59-62, Centers for Disease control and Prevention, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6303a3.htm?s_cid=mm6303a3_w.

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2/25/14

RE: SS SB49 am & HB 173
Thank you Mr. Chairman and members of House Finance.

We agree that we want fewer abortions to be performed. We disagree on the best ways to accomplish that goal; the acceptable ways to accomplish that goal; whether public funds should be used if the pregnant girl or woman is on Medicaid.

Before the Legislature started meeting again last month, public officials were casting serious warnings about the fact that we have to be much more careful in spending public money. I think we agree about that too.

There is too much public money being wasted and both of these proposals have already wasted time and money unnecessarily.

In spite of the court case challenging essentially the same language which is in regulations, Senator Coghill –sponsor of SB49, is described in the news as pressing forward, regardless of the lawsuit because laws hold more weight than regulations. And he says it's also a fiscal conservative issue.

In this instance, Legislators who want to behave in a fiscally conservative way should put these 2 bills in the drawer until we find out what the court says.

If the court upholds the regulations, then the bills are unnecessary and it's been a waste of time and money to bring them this far into the process.

If the court strikes down the regulations as unconstitutional, then the decision will have to be analyzed to understand whether or what guidance the decision provides as to how broadly the term 'medically necessary abortion' is to be construed. And, these bills will have to be sent back down the line for re-drafting, and to start the process all over again. Another waste of time and money.

Please be fiscally prudent and hold these bills where they are until you have the necessary information for an informed decision about whether to move them forward or send them back to the drafters.

Thank you.

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WRITTEN TESTIMONY

NAME: Bethany Swenson
REPRESENTING: Self
BILL # or SUBJECT: SB 49
COMMITTEE: House Finance **DATE:** 2-25-14

Women have the reproductive right to choose abortion. The reasons for choosing an abortion and the circumstances under which a woman becomes pregnant do not matter. It is her choice and no one else's. It is her right to manage her reproductive ability and control what happens to her body, which are examples of autonomy (http://www.merriam-webster.com/medlineplus/autonomy). A woman has her reasons. Her reasons and rights outweigh those of the created life.

Abortion is medical care. If early enough in the pregnancy, medication can be administered to cause an abortion. The drug is called mifepristone (http://www.merriam-webster.com/medlineplus/ru-486). It must be prescribed and administered. It cannot be purchased over-the-counter. Later pregnancies require a D & C, a medical procedure.

I understand that in the medical community, a "therapeutic" abortion is one in which the pregnancy should be ended because of some health complication (http://www.merriam-webster.com/medlineplus/therapeutic%20abortion). However, I don't think that choosing an abortion for any other reason makes it "unnecessary." Abortion is not like electing for breast augmentation. It has the paradoxical nature of being both elective and necessary. Any woman can choose to abort. Any woman can choose to carry on with a pregnancy and/or become a mother. I have known women who chose to be mothers to children conceived from rape. Even women with high health risks for pregnancy and birth may choose to carry on, against medical advice. Such a decision made against medical advice is an exercise of autonomy, an ethical principle well known in the medical profession. It's about choice. Once an abortion is chosen it becomes necessary. The pregnancy is not going to end by a woman simply wishing it so - a medical treatment must be given. Any woman can talk with her doctor about making a decision that is best for her health, both her mental health and the health of the rest of her body.

Abortion should be accessible if it is truly a choice. If a woman cannot afford an abortion, she cannot have one and therefore she essentially doesn't have a choice. Women on Medicaid are poor. They already can't pay for most of their medical care; that is why they are on Medicaid. The proposed restrictions will force many poor women on Medicaid to bear children against their wishes, simply because they will be denied coverage and cannot afford the abortions themselves. "Studies published over the course of two decades looking at a number of states concluded that 18–35% of women who would have had an abortion continued their pregnancies after Medicaid funding was cut off" (http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html). It should be obvious that a woman who decides on abortion but is denied one is harmed in health, both the psychological health of the brain and the rest of her body. The proposed restrictions sabotage the right to choose.

Furthermore, it is judgmental and unfair to cherry-pick the reasons why an abortion should be covered by Medicaid. The reasons and circumstances do not matter, because it's about a woman's unique choice. Every choice is equal and should be equally covered. It does not matter if the woman didn't use contraception, contraception failed, contraception was sabotaged, sterilization failed, the woman was raped, or a doctor is telling a woman that she might die if her pregnancy is not ended. The reasons and circumstances should not be favored one over the other. Favoring against equality is defined as injustice. Justice is fair treatment of all.

Alaska provides its own funds for Medicaid. It is not required to follow the lead of the unjust Hyde Amendment. Medicaid coverage of abortion should not be restricted, it should be expanded.

I strongly urge you to oppose these bills and, despite your personal opinions and beliefs, to not interfere with women's autonomy. The proposed restrictions are unconstitutional and will harm many women.

Louise Taylor-Thomas

From: Eric McCallum <ericmccallum5@gmail.com> on behalf of Eric Mccallum <mccallum@alaska.net>
Sent: Saturday, April 13, 2013 11:03 AM
To: Louise Taylor-Thomas
Subject: SB 49

I want to thank the committee for allowing me this opportunity to testify against SB49. I will address cost concerns, medical consequences and the definition of medically necessary.

First I would respectfully like to remind the committee that these abortions are not paid with an individual's hard earned tax dollars. They will be paid from our oil tax revenue. I believe this allows for a broader use of these funds. This bill will deny a woman's her own medical choices. And if this bill passes there will be more prenatal care, pregnancies and well-baby check-ups that will need to be paid for by Medicaid. So this bill will create a net financial loss for Alaska.

Additionally, if passed SB 49 will be challenged in court because as many have testified it unconstitutional according to previous Alaska Supreme Court decisions.
The estimated court costs are $1M. That money would be better spent on the Medicaid Family Planning program in the new amendment to this bill. It will prevent unintended pregnancies that lead to the abortions addressed in this bill.

Second. What is "medically necessary" and who should decide? Is prenatal care really "medically necessary" or do we provide this care for the benefit of the mother and fetus. Are vaccinations medically necessary? Or are they there to prevent bad outcomes? If a woman chooses to not report a rape does that make the abortion elective? Are we planning on defining "medically necessary" for all healthcare? Because I do not want government determining whether my healthcare is "medically necessary" or not.

I believe men feel the same way. Recently, treatment of prostate cancer has become controversial. Do the gentlemen on this committee really want the government determining their treatment if they have prostate cancer? Or do you want your physician helping you make those choices?

Finally, an abortion costs approximately $700. For women already on the edge financially this is a huge problem. SB 49 will force some women who want an abortion to carry their pregnancy to term, they may delay care, attempt to abort on their own or consider suicide. And we now know that women in Alaska commit suicide at twice the national average. We forget that before abortion was legalized many women died or were permanently damaged by self-induced abortions.

Nothing I say will change anyone's beliefs here today. Nor should it. Every one is entitled to their own beliefs. But just as none of us wants a woman to be forced to have an abortion, I do not want a woman forced to carry a pregnancy to term and potentially risk her health.

A few problems with forcing a woman to continue a pregnancy are:

- It is potentially not good for the woman or the fetus if the woman delays or doesn't seek appropriate prenatal care, or continues with an addiction or risky behavior. These may cause complicated deliveries, premature births and potential birth defects. All adding to our Medicaid cost
- Domestic Violence is a huge problem in Alaska. Pregnancy often makes domestic violence worse, putting the woman at greater risk.
- It would force a woman to carry to term a child who may be born with severe anomalies such as anencephaly.

Please respect all women. Don't limit healthcare access for women who really need it. Please stop this bill.

Robin Smith
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