



Informing the **Public** & Guiding **Policy** by **Conducting** Research

Family Planning Clinics in Iowa

Impact of the ACA and Health
System Change on the Iowa
Safety Net

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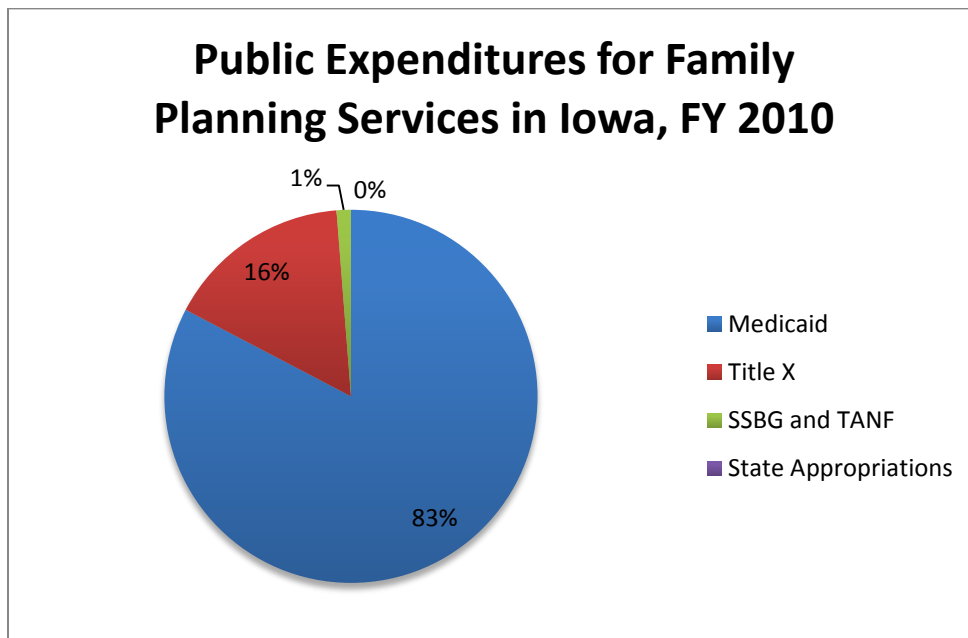
Family Planning Clinics in Iowa

This is a report that inventories all the information we have collected on the funding, patients, providers, and Title X as it relates to Iowa's Family Planning Clinics. This information was collected as part of a study funded by The Commonwealth Fund to study the implications of the Affordable Care Act (ACA) on safety net health care providers. This report includes language from the ACA that relates to Family Planning Clinics.

Financing of Family Planning Services in Iowa

Family planning services in Iowa are federally funded by Title X, Medicaid, Social Security Block Grants (SSBG), and the Temporary Assistance for Needy Families (TANF) program. In the 2010 fiscal year, Medicaid provided the largest portion of Iowa's family planning public expenditures with 83% (\$16,536,000) (Figure 1). Title X was the second largest public funding source in Iowa with 16% (3,217,000) (Figure 1). Iowa did not receive any family planning funds from SSBG or TANF in FY2010.¹

Figure 1



Source: Sonfield et al.

Additionally some states receive funding for family planning through the Maternal and Child Health (MCH) block grant, which accounts for 2 percent of the total \$1.8 billion U.S. family planning public expenditure.² For Fiscal Year 2010 in Iowa, expenditures of federally allocated funds totaled approximately \$6 million (thirty-eight percent of Iowa's total maternal and child health expenditures).³

Table 1. Total Public Expenditures for Family Planning Client Services (in 000s of constant 2006 dollars)

	1980	1987	1994	2001	2006	% change from 1994 to 2006	% change from 1980 to 2006
Iowa	\$14,189	\$13,125	\$8,477	\$8,546	\$13,477	59.0	-5.0
U.S.	\$1,570,099	\$1,067,152	\$1,133,067	\$1,550,308	\$1,846,963	63.0	17.6

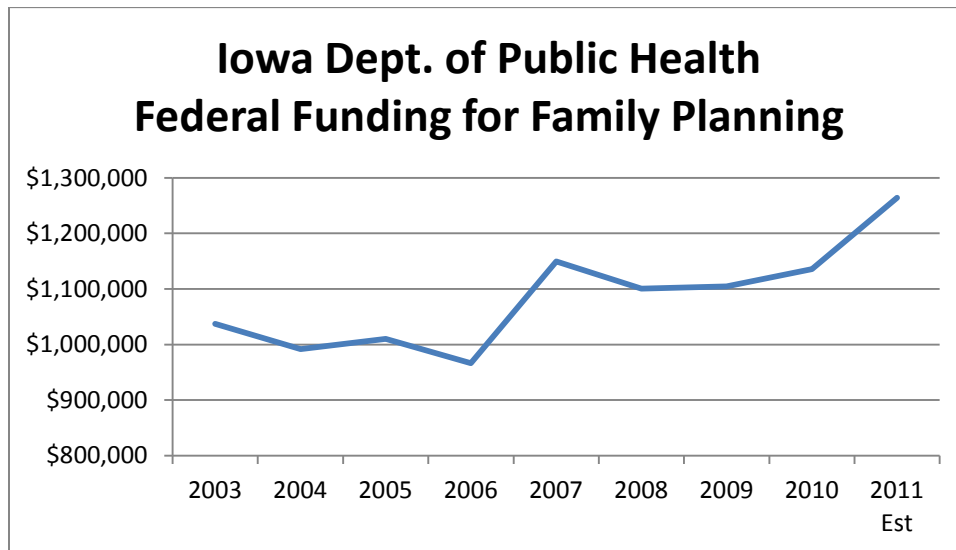
Source: Sonfield, Alrich, & Gold, 2008

Table 1 shows that public expenditures for family planning services have increased from Fiscal Year 1994 to Fiscal Year 2006 at the national level (63%) and at the state level for Iowa (59%). However, compared to 1980, state public expenditures have decreased by 5 percent while national totals have increased 18 percent.⁴

IDPH Family Planning Financing

Federal funding supplied \$1.3 million to the Iowa Department of Public Health for family planning services in 2010. This is a 9.5 percent increase from 2003 funding levels. Additionally, IDPH’s estimated federal funding for 2011 is \$1.4 million.⁵

Figure 2. Federal Financing of Family Planning Services in Iowa through IDPH



Source: Iowa Department of Public Health

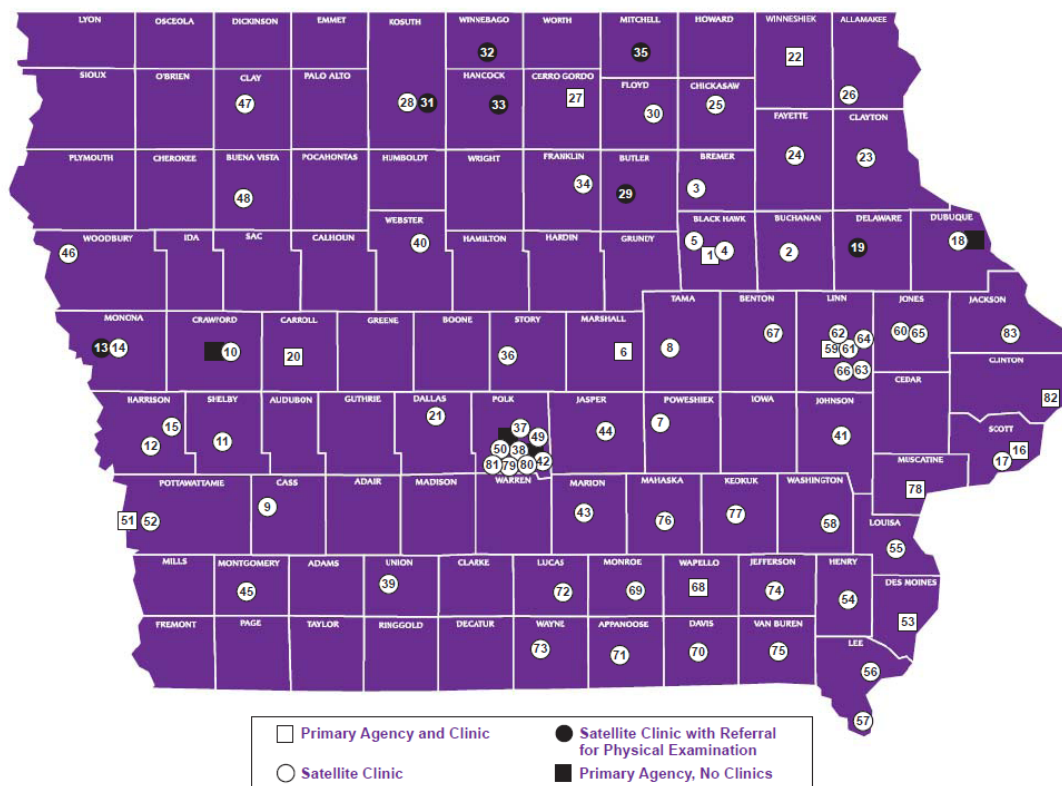
Family Planning Providers

Title X family planning services in Iowa are administered by two independent organizations: the Iowa Department of Public Health (IDPH) and the Family Planning Council of Iowa. IDPH’s Family Planning Program administers Title X funding to eight family planning agencies within the state. These eight agencies oversee 52 family planning clinics located in 45 counties.⁶ The Family Planning Council of Iowa

administers Title X funding to a network of six agencies in the state which provide services through local clinics to 54 Iowa counties.⁷ One of the Family Planning Council's agencies, Planned Parenthood of the Heartland, is often considered three separate agencies (Planned Parenthood of Greater Iowa, Planned Parenthood of Nebraska & Council Bluffs, and Planned Parenthood of Southeast Iowa) creating a total of eight agencies.⁸ There are 28 clinics associated with these eight agencies, creating a total of 80 family planning clinics in the state.⁹

Each of the 16 Family Planning agencies in the state of Iowa that receive federal Title X funding participates in the Iowa Collaborative Safety Net Network. The locations of Iowa's Title X family planning agencies and clinics are illustrated in Figure 3.

Figure 3. Family Planning Agencies and Clinics in Iowa



Source: http://www.idph.state.ia.us/hpcdp/common/pdf/fp_map.pdf

The provider mix at Family Planning Council clinics shows a continual increase from 2009 to 2010; physicians are more represented (measured by Full Time Equivalents) at clinics in 2010 compared to 2009 in contrast to mid-level providers (e.g. Nurse Practitioners (NPs) and Physician Assistants (PAs)) who experienced substantial declines in 2010 compared to 2009 (Table 2).

Table 2. Provider FTEs in Family Planning Clinics in Iowa

Provider Type	2009	2010
Physicians	1.5	2.0
PAs/NPs/Midwives	20.1	10.8
Other clinical providers	28.3	1.7

Source: Family Planning Council of Iowa; n/a=not available.

For Family Planning Council Clinics, total patient encounters with clinical services decrease by 17.7%, but non-clinical providers increased by 39.7% in 2010 compared to 2009 (Table 3).

Table 3. Patient Encounters at Family Planning Clinics in Iowa

Provider Type	2009	2010	% Change
Clinical service providers	78,847	64,842	-17.7
Non-clinical providers	53,538	74,767	39.7
Total	132,385	139,609	5.4

Source: Family Planning Council of Iowa.

Family Planning Patient Demographics

In 2011, Iowa family planning agencies in the Safety Net Provider Network reported 79,579 unduplicated patients and 241,923 encounters. It decreased in 2012 to 51,239 unduplicated patients and 119,367 encounters. Services in those agencies were provided by a total of 2.7 physician (either an M.D. or D.O) FTEs and 17.7 non-physician (for example, physician assistants and nurse practitioners) FTEs in 2012 compared to 4.9 FTE physicians and 25.5 FTE mid-level providers in 2011.^{10 11}

The number of unduplicated patients at family planning agencies in Iowa has decreased from 2009 to 2012, as has the number of encounters.

Table 4. Unduplicated patient and encounters at Family Planning Clinics in Iowa

	2009	2010	2011	2012	% Change
Unduplicated patients	75,976	82,633	79,579	51,239	-32.6
Encounters	242,550	220,942	241,923	119,367	-50.7

Source: Iowa Collaborative Safety Net Provider Network

For 2008, researchers estimated that 322,207 women in Iowa (103,950 earning less than 250 percent of the Federal poverty level) needed contraceptive services and supplies.¹²

Patient Race¹

In 2012 eighty percent of patients at Iowa safety net network family planning agencies were White/Caucasian (Table 5). The second largest portion of the patient population was Black/African-American with 7 percent (Table 5). This proportion is similar to the racial proportions reported for only the Family Planning Council of Iowa clinics (Table 6). The overall Iowa population in 2010 was 91 percent White/Caucasian and 3 percent Black/African-American.¹³ Patient demographics have remained constant in recent years.¹⁴

Table 5. Racial demographics for clients at Iowa Family Planning Clinics

Race	2012		2011		2010	
	patients	Percent	patients	Percent	patients	Percent
White/Caucasian	41,076	80	67,909	85	70,141	85
Black/African-American	3,496	7	4,932	6	5,437	7
American Indian/Alaska Native	299	0.6	310	0.4	407	0.5
Asian/Pacific Islander	813	1.5	858	1	1,003	1
Other Race	548	1	2,541	3	1,736	2
>1 Race	1,001	2	763	1	783	1
Unknown	4,006	7.8	2,230	3	3,308	4
Total	51,239	100	79,543	100	82,815	100

Source: Iowa Collaborative Safety Net Provider Network CY 2010-2012 Data Reports

Table 6. Distribution of family planning patients by sex and race for 2010

Race	Female	Male	Total	Percent
American Indian or Alaska Native	64	2	66	0.4
Asian	154	4	158	0.8
Black	969	51	1,020	5.5
Native Hawaiian or other Pacific Islander	21	2	23	0.1
White	15,726	499	16,225	87
>1 race	118	7	125	0.7
Race Unknown	955	76	1,031	5.5
Total	18,007	641	18,648	100

Source: Iowa Department of Public Health

¹ Thirteen out of 16 family planning agencies in the safety net network provided race data for the CY 2010 Data Report.

Patient Ethnicity²

In 2012, the majority (86%) of family planning patients in Iowa were not of Hispanic/Latino ethnicity (Table 7). The proportion of Hispanic/Latino patients was substantially higher for 2011 compared to other years.

Table 7. Ethnicity of clients at Iowa Family Planning Clinics

Ethnicity	2010		2011		2012	
	patients	Percent	patients	Percent	patients	Percent
Hispanic (Latino)	7,029	8	5,921	18	4,340	8.5
Not Hispanic (Latino)	73,474	88	27,116	81	44,216	86
Unknown	2,619	3	625	2	2,683	5.5
Total	83,122	100	33,662	100	51,239	100

Note: percentages might not equal 100 due to rounding.

According to the Iowa Department of Public Health, the number of family planning clinic patients with limited English proficiency substantially declined from 2009 to 2010 (Table 8).

Table 8. Number of clinic patients with limited English proficiency 2009-2010

	2010	2009	% Change
Number of patients	1,053	1,264	-16.7

Source: Iowa Collaborative Safety Net Provider Network CY 2009-2010 Data Reports

Patient Sex³

In 2012 approximately 93 percent of unduplicated patients at all family planning agencies in Iowa were female, compared to 7 percent of patients that were male.¹⁵ Several reasons account for men's lower utilization of family planning services. First, Medicaid traditionally does not reimburse for services provided to either single men or single male parents. Second, men are usually interested in non-clinical contraceptive methods and Title X focuses on clinical contraceptive methods.¹⁶ Finally, family planning experts have not defined a core set of sexual and reproductive health services that should be provided to men.¹⁷

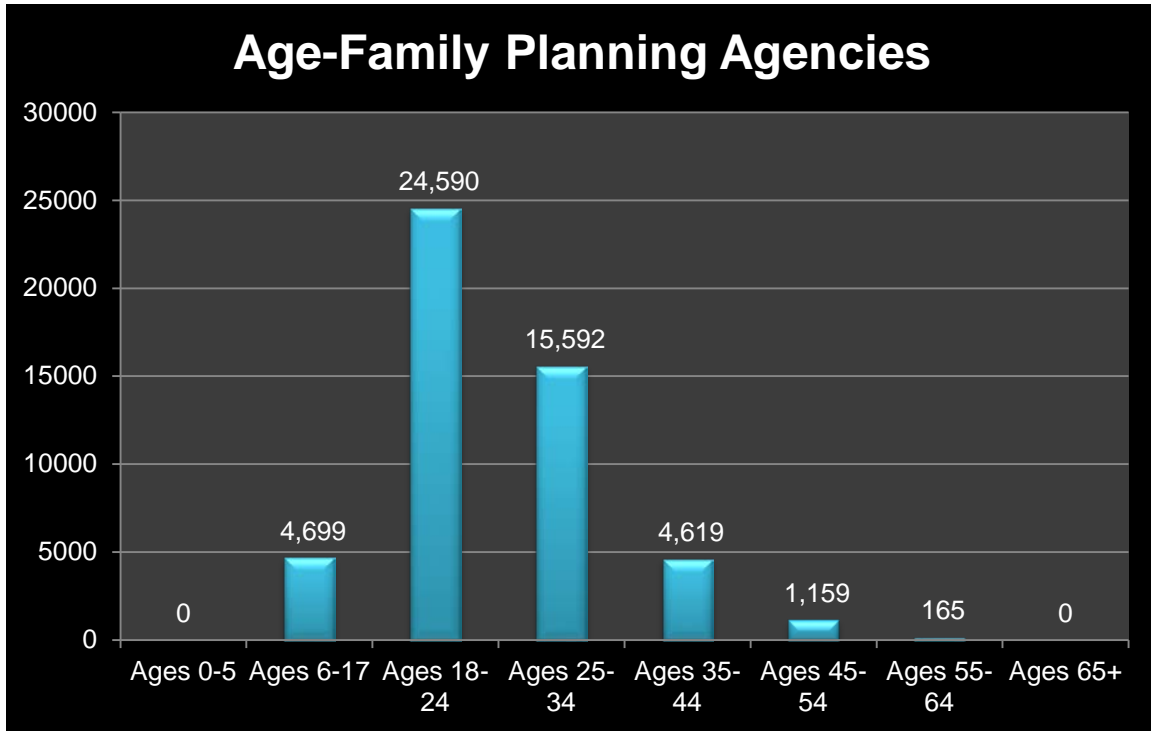
² Fifteen out of 16 safety net family planning agencies provided ethnicity data for the CY 2010 Data Report.

³ Twelve out of 16 safety net family planning agencies provided gender data in the CY 2010 Data Report.

Patient Age⁴

In 2012 approximately half of all family planning patients were between the ages of 18-24 (Figure 4). The next largest age categories were 25 to 34 year olds with 30% and 6 to 17 year olds as well as 35-44 year olds with approximately 10%. Comparing the data from Family Planning Council of Iowa clinics to data for all family planning agencies, the proportions of the age groups are very similar for both males and females (Table 9).

Figure 4. Age of Clients at Iowa Family Planning Clinics, 2012



Source: Iowa Collaborative Safety Net Provider Network CY 2012 Data Report

Table 9. Distribution of family planning patients by sex and age for 2010.

Age	Female	Male	Total	Percent
<15-17	2,569	53	2,622	14
18-24	8,084	322	8,406	45
25-34	4,926	190	5,116	27
35-44	1,672	40	1,712	9
>44	756	36	792	4
Total	18,007	641	18,648	100

Source: Iowa Department of Public Health

⁴ Twelve out of 16 safety net family planning agencies reported age data in the CY 2010 Data Report.

Patient Insurance Status⁵

Individuals visiting Iowa's family planning clinics in 2010 were mostly uninsured (53%), followed by privately insured (27%) and public insurance (17%).¹⁸ (Table 11).

Table 11. Distribution of family planning patients by insurance type covering primary medical care for 2010

Health Insurance	Total	Percent
Public	9,693	17
Private	15,122	27
Uninsured	29,862	53
Unknown	1,414	3
Total	56,091	100

Source: Iowa Department of Public Health

Patient Income

The National Family Planning and Reproductive Health Association estimated that in 2010, 62 percent of patients visiting Iowa's family planning agencies had incomes either equal to or below 100 percent of the federal poverty level (FPL). An additional 18 percent of all family planning clinic patients had incomes between 100 percent and 250 percent of the FPL.¹⁹ Examining data from only Family Planning Council of Iowa clinic patients reveals similar proportions: 58.8 percent of patients earned less than 100 percent of the FPL; however, 73.3 percent of patients earned less than 250 percent of the FPL (Table 12). 26 patients did not report, or had unknown income levels.

Table 12. Distribution of family planning patients by income level for 2010

Income (% of FPL)	Total	Percent
≤100	32,959	58.8
101-150	4,360	7.7
151-200	2,391	4.2
201-250	1,365	2.4
>250	14,990	26.7
Total	56,091	100

Sums may not equal 100% due to rounding

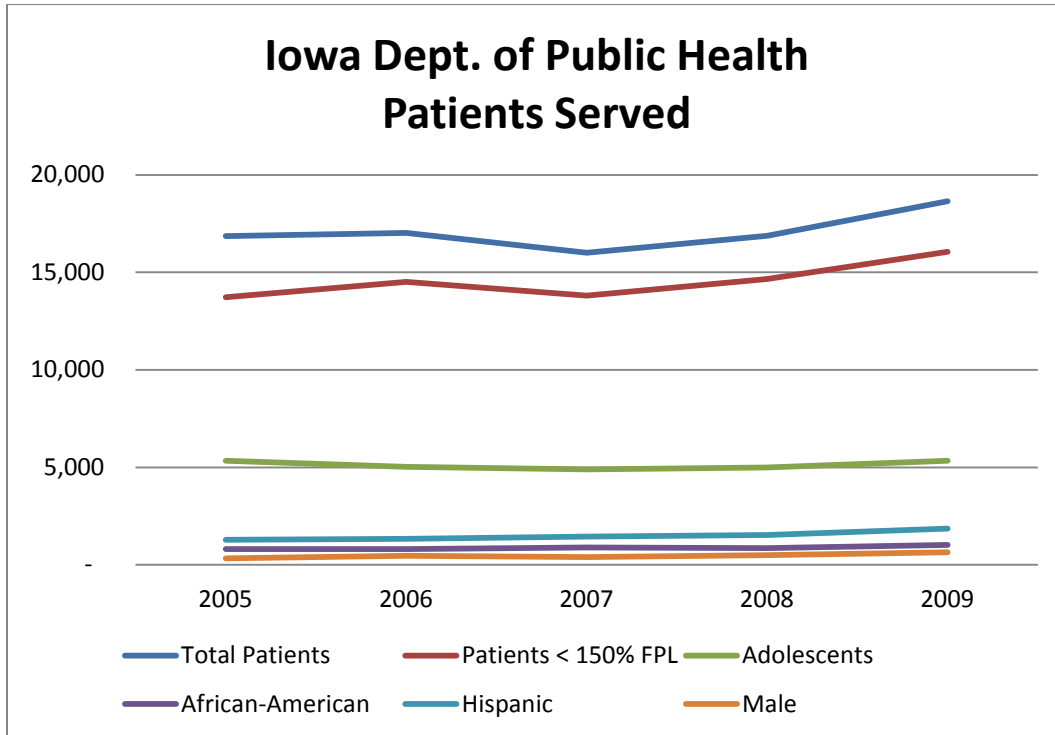
IDPH Patient Information

The number of unduplicated patients served by IDPH family planning agencies increased from 16,854 patients in 2005 to 18,648 in 2009 (a 11 percent increase).

Among the clients utilizing IDPH family planning services in 2009: 16,059 were low-income (a 32% increase from 2000); 5,337 were adolescents (a 1.3% increase from 2001); 1,020 were African-American

⁵ Twelve out of 16 safety net family planning agencies reported insurance status data in the CY 2010 Data Report.

(a 37% increase from 2001); 1,857 were Hispanic (a 108% increase from 2001); and 641 were males (a 91% increase from 2004).²⁰



Patient Utilization of Family Planning Services

Testing for sexually transmitted diseases is one service provided by family planning clinics. As demonstrated in the following tables, from 2009 to 2010 most screening tests showed a general decline in the number of patients receiving those tests at Family Planning Council of Iowa clinics (Tables 13, 14, 15, and 16). However, testing for chlamydia and syphilis did increase.

Table 13. Number of unduplicated female patients and cervical cancer screening tests

	Number of Patients/Tests		% Change
	2009	2010	
Patients obtaining Pap smear	21,343	17,599	-17.5
Pap tests performed	22,305	18,508	-17
Pap tests with ASC or higher	3,222	3,090	-4.1
Pap tests with HSIL or higher	138	80	-42

Source: Iowa Collaborative Safety Net Provider Network CY 2009-2010 Data Reports.

Table 14. Unduplicated number of patients receiving a clinical breast exam

	Number of Patients		% Change
	2009	2010	
Received breast exam	28,589	23,746	-16.9
Referred based on exam	1,065	68	-93.6

Source: Iowa Collaborative Safety Net Provider Network CY 2009-2010 Data Reports.

Table 15. Number of unduplicated patients tested for Chlamydia by sex

	2009		2010		% Change
	2009	2010	2009	2010	
Female	24,069	24,135	24,069	24,135	0.3
Male	2,067	2,231	2,067	2,231	7.9

Source: Iowa Collaborative Safety Net Provider Network CY 2009-2010 Data Reports.

Table 16. Number of clinic patients tested for gonorrhea, syphilis, and HIV by sex

	Number of Patients		
	2009	2010	% Change
Gonorrhea			
Female	26,783	23,426	-12.5
Male	2,311	2,271	-1.7
Syphilis			
Female	215	226	5.1
Male	155	213	37.4
HIV			
Female	5,969	5,712	-4.3
Male	859	988	15

Source: Iowa Collaborative Safety Net Provider Network CY 2009-2010 Data Reports

Counseling and providing contraception to males and females are additional services provided by family planning clinics. Oral contraceptives are the most popular birth control method for females visiting family planning clinics; next most popular are the three-month injection and the male condom (Table 17). Additionally, the male condom is the most common contraceptive method reported by males visiting family planning clinics in 2010 (Table 17). Among males not utilizing a contraceptive method themselves, a medical reason was the most common explanation for not using contraception (Table 18).

Table 17. Number of unduplicated female clinic patients by most common primary female contraception methods, male contraception methods, and age for 2010

Method	Number of Females by Age					Total
	<17	18-24	25-34	35-44	>44	
Oral pill	2,302	11,060	5,134	1,177	347	20,020
3-month injection	1,025	2,440	1,591	653	188	5,897
Male condom	662	2,525	1,410	428	129	5,154
Hormonal implant	355	801	313	60	9	1,538
Intrauterine device	126	1,274	1,327	415	74	3,216
Vaginal ring	211	2,019	1,043	113	17	3,403
Sterilization	0	29	407	460	335	1,231
Patch	164	545	352	90	6	1,157
Abstinence	120	174	135	68	38	535
Other method	101	503	289	131	71	1,095
Vasectomy	0	2	54	103	46	205

Source: Iowa Collaborative Safety Net Provider Network CY 2009-2010 Data Reports

Table 18. Number of unduplicated male clinic patients by primary contraception method and age for 2010

Method	Number of Males by Age					Total
	<17	18-24	25-34	35-44	>44	
Male condom	91	882	502	88	54	1,817
Other method	11	56	36	10	9	122
Vasectomy	0	1	6	6	5	18
Abstinence	33	10	6	1	3	53
No Contraceptive Method						
Other medical reason	35	292	220	44	20	611
Rely on partner's method	14	120	90	18	7	249
Partner pregnant	2	32	11	2	0	47

Source: Iowa Collaborative Safety Net Provider Network CY 2009-2010 Data Reports

Title X Information

Established in 1970 as Title X of the Public Health Service Act (Pub.L. 91-572), the National Family Planning program funds family planning education, counseling, and medical services. The program is administered by the Department of Health and Human Services's Office of Family Planning. Title X allows individuals to access contraceptive services, supplies, and family planning information. By law, a minimum of 90 percent of Title X funding must be used for clinical family planning services.²¹

Relationship between Title X and Medicaid

Recently, Medicaid became the primary funding source for family planning as Title X funding decreased.²² However, Title X funding can cover services not covered by Medicaid in addition to services for individuals who are ineligible for Medicaid—essentially wrapping around the “core” services covered by Medicaid. According to the National Family Planning & Reproductive Health Association:

Title X-funded health centers in Iowa deliver a wide range of services, including: abstinence education; hormonal contraceptives; long-acting, reversible contraceptives; vasectomy and female sterilization; cervical and breast cancer screening; management of abnormal Pap smears; vaccination services; domestic violence screening/referrals; depression screening/referrals; assessment and assistance with substance use; STD and HIV screening, education and referral for management of positive HIV tests; pregnancy testing with referrals, and WIC enrollment when possible; prenatal vitamins for women with positive pregnancy tests; and reproductive life counseling.²³

Utilizing a Medicaid waiver from CMS, Iowa family planning clinics can provide the emergency contraceptive pill; tubal ligation and vasectomy; and provide HPV vaccine for adults aged 21-26.²⁴

Eligibility for family planning Medicaid coverage in Iowa requires an income less than, or equal to, 200 percent of the Federal Poverty Level, United States citizenship, and Iowa residence.²⁵

Family planning centers often rely on the federal 340B Drug Pricing Program, which allows clinics to procure contraceptives at reduced prices. However, studies during the previous 10 years document an increase in the cost for contraceptives and supplies purchased by family planning clinics due to changing pharmaceutical business models and new contraceptive methods.²⁶

A provision in the Patient Protection and Affordable Care Act (Pub.L. 111-148) allows states an alternate option for covering family planning services under Medicaid: states can expand Medicaid coverage without obtaining a waiver by modifying the State Medicaid Plan to create parity between the SPA eligibility level and the poverty percentage utilized for calculating pregnancy-related care eligibility; or the state can offer true parity by establishing an SPA eligibility procedure equivalent to the process for pregnancy-related care eligibility.²⁷ However, if the State alters the State Medicaid Plan, the State must cover men and adolescents, which is not required by the current Medicaid waivers.²⁸

See Appendix A for the legal review of Affordable Care Act Provisions relating to Family Planning Clinics.

Sites for Additional Information

The following web sites provide additional information for anyone interested in learning more about family planning clinics, services, funding, and patients:

Organization	Web Site
The Iowa Department of Public Health (family planning)	http://www.idph.state.ia.us/hpcdp/family_planning.asp
National Family Planning and Reproductive Health	http://www.nfprha.org
Kaiser Family Foundation (Women’s Health)	http://www.statehealthfacts.org
Office of Population Affairs, Department of Health and Human Services	http://www.hhs.gov/opa/title-x-family-planning/
The Alan Guttmacher Institute	http://www.guttmacher.org

¹ Sonfield et al. Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2006; Accessed from <http://www.guttmacher.org/pubs/2008/01/28/or38.pdf> on 7/28/11

² Sonfield et al. Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2006; Accessed from <http://www.guttmacher.org/pubs/2008/01/28/or38.pdf> on 7/28/11

³ Health Resources and Services Administration, Title V Information System. Available at: <https://mchdata.hrsa.gov/TVISReports/Snapshot/SnapShot.aspx?statecode=IA> [accessed 30 January 2012].

⁴ Sonfield et al. Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2006; Accessed from <http://www.guttmacher.org/pubs/2008/01/28/or38.pdf> on 7/28/11

⁵ Iowa Department of Public Health Annual Reports for 2004-2010. Accessed on 10/13/11 from http://www.idph.state.ia.us/adper/annual_reports.asp.

⁶ Family Planning Grantees, Delegates, and Clinics: Office of Population Clearinghouse Family Planning Database, Region VII. Accessed from <http://www.opaclearinghouse.org/pdf/dynamic/region.cfm?regionID=7&pdf=1> on 10/3/11; Family Planning; Iowa Department of Public Health. Accessed on 10/3/11 from: http://www.idph.state.ia.us/hpcdp/family_planning.asp

⁷ Mission and Vision – Family Planning Council of Iowa. Accessed from <http://www.fpcouncil.com/about/view/57/About+--+Mission+%26+Vision.html> on 10/3/11
Family Planning; Iowa Department of Public Health. Accessed from http://www.idph.state.ia.us/hpcdp/family_planning.asp on 10/3/11

⁸ Family Planning Grantees, Delegates, and Clinics: Office of Population Clearinghouse Family Planning Database, Region VII. Accessed from <http://www.opaclearinghouse.org/pdf/dynamic/region.cfm?regionID=7&pdf=1> on 10/3/11

⁹ Family Planning Grantees, Delegates, and Clinics: Office of Population Clearinghouse Family Planning Database, Region VII. Accessed from <http://www.opaclearinghouse.org/pdf/dynamic/region.cfm?regionID=7&pdf=1> on 10/3/11

¹⁰ Iowa Collaborative Safety Net Provider Network CY 2010 Data Report

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- ¹¹ Iowa Collaborative Safety Net Provider Network CY 2012 Data Report
- ¹² Frost, Henshaw, and Sonfield (2008), Contraceptive Needs and Services, National and State Data, 2008 Update; available at: <http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf> [accessed 10 October 2011].
- ¹³ Iowa Quickfacts from the U.S. Census Bureau. 2010. Accessed on 10/6/11 from <http://quickfacts.census.gov/qfd/states/19000.html>
- ¹⁴ Iowa Collaborative Safety Net Provider Network CY 2008-2010 Data Reports
- ¹⁵ Iowa Collaborative Safety Net Provider Network CY 2012 Data Report
- ¹⁶ R. Gold, A. Sonfield, C. Richards, J. Frost. (2011). Next Steps for America's Family Planning Program: leveraging the potential of Medicaid and Title X in an evolving health care system. Guttmacher Institute: available online [accessed 25 July 2011].
- ¹⁷ R. Gold, A. Sonfield, C. Richards, J. Frost. (2011). Next Steps for America's Family Planning Program: leveraging the potential of Medicaid and Title X in an evolving health care system. Guttmacher Institute: available online [accessed 25 July 2011].
- ¹⁸ Iowa Collaborative Safety Net Provider Network CY 2012 Data Report
- ¹⁹ Title X in Iowa: Improving Public Health and Saving Taxpayer Dollars – February 2011. Accessed on 10/6/11 from the National Family Planning and Reproductive Health Association at http://www.nfprha.org/images/insert/Title_X_IA.pdf
- 2010 Poverty Guidelines. Accessed on 10/6/11 from <https://www.cms.gov/medicaideligibility/downloads/POV10Combo.pdf>
- ²⁰ Iowa Department of Public Health Annual Reports for 2004-2010. Accessed on 10/13/11 from http://www.idph.state.ia.us/adper/annual_reports.asp.
- ²¹ Title X Family Planning: Office of Population Affairs. Accessed from <http://www.hhs.gov/opa/title-x-family-planning/> on 10/3/11.
- ²² R. Gold, A. Sonfield, C. Richards, J. Frost. (2011). Next Steps for America's Family Planning Program: leveraging the potential of Medicaid and Title X in an evolving health care system. Guttmacher Institute: available at: <http://www.guttmacher.org/pubs/NextSteps.pdf> [accessed 10 October 2011].
- ²³ National Family Planning & Reproduction Health Association (February 2011), Title X in Iowa: improving public health and saving taxpayer dollars, available at: http://www.nfprha.org/images/insert/Title_X_IA.pdf [accessed 10 October 2011].
- ²⁴ From the Kaiser Family Foundation, available at: statehealthfacts.org [accessed 4 August 2011].
- ²⁵ Kaiser Family Foundation, available at: statehealthfacts.org [accessed 4 August 2011].
- ²⁶ A. Sonfield. (2006). Summer Price Spike: a case study about publicly funded clinics and the cost of contraceptive supplies. Guttmacher Policy Review, 9(4), available at: <http://www.guttmacher.org/pubs/gpr/09/4/gpr090402.html> [accessed 10 October 2011]; R.B. Gold. (2002). Nowhere but Up: Rising Costs for Title X Clinics. The Guttmacher Report on Public Policy, 5 (5), available at: <http://www.guttmacher.org/pubs/tgr/05/5/gr050506.html> [accessed 10 October 2011].

²⁷ A. Sonfield, J.J. Frost, & R.B. Gold. (2011). Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services: 2011 Update. Guttmacher Institute; available at: <http://www.guttmacher.org/pubs/Medicaid-Family-Planning-2011.pdf> [accessed 2 February 2012].

²⁸ A. Sonfield, J.J. Frost, & R.B. Gold. (2011). Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services: 2011 Update. Guttmacher Institute; available at: <http://www.guttmacher.org/pubs/Medicaid-Family-Planning-2011.pdf> [accessed 2 February 2012].

Appendix A

Legal Review of the Impact of the ACA on Family Planning Clinics

The Patient Protection and Affordable Care Act (“ACA”) expands the coverage of family planning services to individuals of childbearing age who are not pregnant and earn an income equal to, or less than, the Medicaid income limits for pregnant women.²⁹ When determining income for family planning service eligibility, states can consider only the applicant’s income.³⁰ Additionally, states can offer family planning services to individuals who would be covered under a Section 1115 waiver.³¹

The primary care services for expanded eligibility that the ACA allows are evaluation and management services and the ACA limits benefits to the expanded eligibility group are family planning supplies and services provided as part of a family planning service in a family planning setting.³²

Entities furnishing services and supplies covered by Medicaid and deemed capable of making presumptive eligibility determinations by the State agency may presumptively consider individuals covered based on preliminary information.³³ After determining presumptive eligibility, an eligible entity may provide family planning services to the presumptively eligible individual.

However, presumptively eligible individuals must apply for medical assistance in order to continue—if deemed eligible—family planning services after the application deadline.³⁴ Until the state Medicaid agency determines that an individual is not eligible for Medicaid, the presumptively eligible individual can continue receiving family planning services.³⁵

Finally, certain primary care physicians are guaranteed by the Health Care and Education Reconciliation Act (“HCRA”) at least 100 percent of the Medicare payment rate through Medicaid for providing evaluation and management and immunization administration-related services.³⁶

Text for Affordable Care Act Provisions Affecting Family Planning

42 USC Section 1396a(10) as amended by ACA Section 2303(a)(1),(2),and (3)

(10) provide--

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1905(a) [[42 USCS § 1396d\(a\)](#)], to--

(i) all individuals--

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV [[42 USCS §§ 301](#) et seq., [1201](#) et seq., [1351](#) et seq., or [1381](#) et seq., or [601](#) et seq. or [670](#) et seq.] (including individuals eligible under this title [[42 USCS §§ 1396](#) et seq.] by reason of section 402(a)(37), 406(h), or 473(b) [[42 USCS § 673\(b\)](#)], or considered by the State to be receiving such aid as authorized under section 482(e)(6)),

(II) (aa) with respect to whom supplemental security income benefits are being paid under title XVI [[42 USCS § 1381](#) et seq.] (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ([P.L. 104-193](#)) [enacted Aug.

22, 1996] and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1905(q) [42 USCS § 1396d(q)]), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI [42 USCS §§ 1381 et seq.] if subparagraphs (A) and (B) of section 1611(c)(7) [42 USCS § 1382(c)(7)] were applied without regard to the phrase "the first day of the month following",

(III) who are qualified pregnant women or children as defined in section 1905(n) [42 USCS § 1396d(n)],

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family;[,] or

(V) who are qualified family members as defined in section 1905(m)(1) [42 USCS § 1396d(m)(1)],

(VI) who are described in subparagraph (C) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) for such a family,

(VII) who are described in subparagraph (D) of subsection (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) for such a family;

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII [42 USCS §§ 1395c et seq.], or enrolled for benefits under part B of title XVIII [42 USCS §§ 1395j et seq.], and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5) [42 USCS § 1397j(c)(5)]) applicable to a family of the size involved, subject to subsection (k); or

(IX) [Caution: This subclause takes effect on January 1, 2014, as provided by § 2004(d) of Act March 23, 2010, P.L. 111-148, which appears as a note to this section.] who--

(aa) are under 26 years of age;

(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii) [42 USCS § 675(8)(B)(iii)]; and

(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) [42 USCS § 1396d(a)] (or, in the case of individuals described in section 1905(a)(i) [42 USCS § 1396d(a)(i)], to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if

coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.], or a State supplementary payment;[,]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C) [42 USCS § 1396b(f)(4)(C)],

(VI) who would be eligible under the State plan under this title [42 USCS §§ 1396 et seq.] if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1915 [42 USCS § 1396n(c), (d), or (e)] they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1915 [42 USCS § 1396n(c), (d), or (e)],

(VII) who would be eligible under the State plan under this title [42 USCS §§ 1396 et seq.] if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o) [42 USCS § 1396d(o)];[,]

(VIII) who is a child described in section 1905(a)(i) [42 USCS § 1396d(a)(i)]--

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV [42 USCS §§ 670 et seq.]) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV [42 USCS §§ 670 et seq.] were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV [42 USCS §§ 601 et seq.];[,]

(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);[,]

(X) who are described in subsection (m)(1);[,]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI [42 USCS §§ 1381 et seq.]), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a

State that does not have an agreement with the Commissioner of Social Security under section 1616 or 1634 [42 USCS § 1382e or 1383c];

(XII) who are described in subsection (z)(1) (relating to certain TB-infected individuals);

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 USCS § 9902(2)]) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B) [42 USCS § 1396d(q)(2)(B)], would be considered to be receiving supplemental security income (subject, notwithstanding section 1916 [42 USCS § 1396o], to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

(XIV) who are optional targeted low-income children described in section 1905(u)(2)(B) [42 USCS § 1396d(u)(2)(B)];

(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B) [42 USCS § 1396d(q)(2)(B)], would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) [42 USCS § 1396d(v)(1)] and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1) [42 USCS § 1396d(w)(1)]), or who are within any reasonable categories of such adolescents specified by the State;

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(XIX) who are disabled children described in subsection (cc)(1);

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5) [42 USCS § 1397j(c)(5)]) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards); or

(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i) [42 USCS § 1396n(i)], or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;

(B) that the medical assistance made available to any individual described in subparagraph (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) [42 USCS § 1396d(a)] who are not described in subparagraph (A) or (E), then--

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance--

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) [42 USCS § 1396d(a)(1)-(5) and (17)] or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)

(i) but, for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3) [42 USCS § 1396d(p)(3)]) for qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)];

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) [42 USCS § 1396d(p)(3)(A)(i)] for qualified disabled and working individuals described in section 1905(s) [42 USCS § 1396d(s)];

(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)(ii)] subject to section 1905(p)(4) [42 USCS § 1396d(p)(4)], for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) [42 USCS § 1396d(p)(2)] but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1933 and 1905(p)(4) [42 USCS §§ 1396u-3, 1396d(p)(4)], for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2012) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)(ii)] for individuals who would be qualified medicare

beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) [42 USCS § 1396d(p)(2)] and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1) [subsec. (u)(1) of this section]; and

(G) that, in applying eligibility criteria of the supplemental security income program under title XVI [42 USCS §§ 1381 et seq.] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1613 [42 USCS § 1382b];

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) [42 USCS § 1396d(a)(4), (14) or (16)] to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII [42 USCS §§ 1395j et seq.] to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 [42 USCS § 1395v] or by reason of the payment of premiums under such title [42 USCS §§ 1395 et seq.] by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII [42 USCS §§ 1395j et seq.] for individuals eligible for benefits under such part [42 USCS §§ 1395j et seq.], shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) [42 USCS § 1396o(a)(2) or (b)(2)] shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) [42 USCS § 1396d(o)] to receive hospice care instead of medical assistance for certain other services, such

assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII [42 USCS §§ 1395 et seq.], and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3) [42 USCS § 1396d(p)(3)]), subject to the provisions of subsection (n) and section 1916(b) [42 USCS § 1396o(b)], (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A) [42 USCS § 1396r-4], as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 [42 USCS § 1396e] shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)), (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer[,] (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1), (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) [42 USCS § 1396d(a)(4)(C)] including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting[,] and (XVII) if an individual is described in subclause (IX) of subparagraph (A)(i)

and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII);

Section 1396a as amended by ACA Section 2303(a)(2)

(ii) Individuals eligible for optional family planning services.

(1) Individuals described in this subsection are individuals--

(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI [\[42 USCS §§ 1397aa et seq.\]](#)) for pregnant women; and

(B) who are not pregnant.

(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XVI) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115 [\[42 USCS § 1315\]](#).

(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.

(jj) Primary care services defined. For purposes of subsection (a)(13)(C), the term "primary care services" means--

(1) evaluation and management services that are procedure codes (for services covered under title XVIII [\[42 USCS §§ 1395 et seq.\]](#)) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) [\[42 USCS § 1395w-4\(c\)\(5\)\]](#) as of December 31, 2009, and as subsequently modified); and

(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.

42 USC Section 1396d(a) as amended by ACA Section 2303(a)(4)

(a) Medical assistance. The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A) [\[42 USCS § 1396a\(a\)\(10\)\(A\)\]](#)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [\[42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.\]](#), and with respect to

whom supplemental security income benefits are not being paid under title XVI [42 USCS §§ 1381 et seq.], who are--

- (i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
- (ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV [42 USCS §§ 601 et seq.],
- (iii) 65 years of age or older,
- (iv) blind, with respect to States eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.],
- (v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.],
- (vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq.],
- (vii) blind or disabled as defined in section 1614 [42 USCS § 1382c], with respect to States not eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.],
- (viii) pregnant women,
- (ix) individuals provided extended benefits under section 1925 [42 USCS § 1396r-6],
- (x) individuals described in section 1902(u)(1) [42 USCS § 1396a(u)(1)],
- (xi) individuals described in section 1902(z)(1) [42 USCS § 1396a(z)(1)],
- (xii) employed individuals with a medically improved disability (as defined in subsection (v)),
- (xiii) individuals described in section 1902(aa) [42 USCS § 1396a(aa)],
- (xiv) individuals described in section 1902(a)(10)(A)(i)(VIII) or 1902(a)(10)(A)(i)(IX) [42 USCS § 1396a(a)(10)(A)(i)(VIII) or (IX)],
- (xv) individuals described in section 1902(a)(10)(A)(ii)(XX) [42 USCS § 1396a(a)(10)(A)(ii)(XX)],
- (xvi) individuals described in section 1902(ii) [42 USCS § 1396a(ii)], or
- (xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i) [42 USCS § 1396n(i)], or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,

but whose income and resources are insufficient to meet all of such cost

42 USC Section 1396b(f)(4) as amended by ACA Section 2303(a)(4)(B)

(f) Limitation on Federal participation in medical assistance.

(1) (A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B) (i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the

Secretary, to be equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act [42 USCS §§ 601 et seq.]

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of \$ 100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of \$ 100 or such other amount, as the case may be.

(2) (A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1916 [42 USCS § 1396o] at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act [42 USCS §§ 601 et seq.] shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(i)(VIII), 1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XIV), [or] 1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI), 1902(a)(10)(A)(ii)(XVII), 1902(a)(10)(A)(ii)(XVIII), 1902(a)(10)(A)(ii)(XIX), 1902(a)(10)(A)(ii)(XX), 1902(a)(10)(A)(ii)(XXI), 1902(a)(10)(A)(ii)(XXII), [or] 1905(p)(1) [42 USCS § 1396a(a)(10)(A)(i)(III), (IV), (V), (VI), (VII), (VIII), (IX), (ii)(IX), (X), (XIII), (XIV), (XV), (XVI), (XVII), (XVIII), (XIX), (XXI), (XXII), or 1396d(p)(1)] or for any individual--

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.], or with respect to whom supplemental security income benefits are being paid under title XVI [42 USCS §§ 1381 et seq.], or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect

to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A) [42 USCS § 1396a(a)(10)(A)], or who is a PACE program eligible individual enrolled in a PACE program under section 1934 [42 USCS § 1396u-4], but only if the income of such individual (as determined under section 1612 [42 USCS § 1382a], but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) [42 USCS § 1382(b)(1)],

at the time of the provision of the medical assistance giving rise to such expenditure.

42 USC Section 1396r-1c as amended by ACA Section 2303(b)(1)

§ 1396r-1c. Presumptive eligibility for family planning services

(a) State option. State plan approved under section 1902 [42 USCS § 1396a] may provide for making medical assistance available to an individual described in section 1902(ii) [42 USCS § 1396a(ii)] (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii) [42 USCS § 1396a(ii)], such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) [42 USCS § 1396d(a)(4)(C)] and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

(b) Definitions. For purposes of this section:

(1) Presumptive eligibility period. The term "presumptive eligibility period" means, with respect to an individual described in subsection (a), the period that--

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii) [42 USCS § 1396a(ii)]; and

(B) ends with (and includes) the earlier of--

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity.

(A) In general. Subject to subparagraph (B), the term "qualified entity" means any entity that--

(i) is eligible for payments under a State plan approved under this title; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Rule of construction. Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

(c) Administration.

(1) In general. The State agency shall provide qualified entities with--

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements. A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall--

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance. In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

(d) Payment. Notwithstanding any other provision of law, medical assistance that--

(1) is furnished to an individual described in subsection (a)--

(A) during a presumptive eligibility period; and

(B) by a entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b) [[42 USCS § 1396d\(b\)](#)].

42 USC Section 1396a(47) as amended by ACA Section 2303(b)(2)(A)

(47) provide--

(A) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 [[42 USCS § 1396r-1](#)] and provide for making medical assistance for items and services described in subsection (a) of section 1920A [[42 USCS § 1396r-1a](#)] available to children during a presumptive eligibility period in accordance with such section [[42 USCS § 1396r-1a](#)] and provide for making medical assistance available to individuals described in subsection (a) of section 1920B [[42 USCS § 1396r-1b](#)] during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920C [[42 USCS § 1396r-1c](#)] during a presumptive eligibility period in accordance with such section; and

(B) [Caution: This subparagraph takes effect on January 1, 2014, and applies to services furnished on or after that date, as provided by § 2202(c) of Act March 23, 2010, [P.L. 111-148](#), which appears as a note to this section.] that any hospital that is a participating provider under the State plan may elect to be a

qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, 1920B, or 1920C [42 USCS § 1396r-1, 1396r-1a, 1396r-1b, or 1396r-1c] (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;

42 USC Section 1396b(u)(1)(D)(v) as amended by ACA Section 2303(b)(2)(B)

(D) (i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of--

(I) payments under the State plan with respect to ineligible individuals and families, and
(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1912(a)(1)(C) [42 USCS § 1396k(a)(1)(C)] or 402(a)(26)(C) or with respect to payments made in violation of section 1906 [42 USCS § 1396e].

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1) [42 USCS § 1396r-1(b)(1)]) for items and services described in subsection (a) of section 1920A [42 USCS § 1396r-1a] provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in subsection (a) of section 1920B [42 USCS § 1396r-1b] during a presumptive eligibility period under such section, [or] for medical assistance provided to an individual described in subsection (a) of section 1920C [42 USCS § 1396r-1c] during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) [42 USCS § 1396a(a)(47)(B)] to be a qualified entity for such purpose.

42 USC Section 1396u-7(b) as amended by ACA Section 2303(c)

(b) Benchmark benefit packages.

(1) In general. For purposes of subsection (a)(1), subject to paragraphs (5) and (6), each of the following coverages shall be considered to be benchmark coverage:

(A) FEHBP-equivalent health insurance coverage. The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code [[5 USCS § 8903\(1\)](#)].

(B) State employee coverage. A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(C) Coverage offered through HMO. The health insurance coverage plan that--

(i) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act [[42 USCS § 300gg-91\(b\)\(3\)](#)]), and

(ii) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(D) Secretary-approved coverage. Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage.

(2) Benchmark-equivalent coverage. For purposes of subsection (a)(1), subject to paragraphs (5) and (6) coverage that meets the following requirement shall be considered to be benchmark-equivalent coverage:

(A) Inclusion of basic services. The coverage includes benefits for items and services within each of the following categories of basic services:

(i) Inpatient and outpatient hospital services.

(ii) Physicians' surgical and medical services.

(iii) Laboratory and x-ray services.

(iv) Coverage of prescription drugs.

(v) Mental health services.

(vi) Well-baby and well-child care, including age-appropriate immunizations.

(vii) Other appropriate preventive services, as designated by the Secretary.

(B) Aggregate actuarial value equivalent to benchmark package. The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph (1).

(C) Substantial actuarial value for additional services included in benchmark package. With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package:

(i) Vision services.

(ii) Hearing services.

(3) Determination of actuarial value. The actuarial value of coverage of benchmark benefit packages shall be set forth in an actuarial opinion in an actuarial report that has been prepared--

- (A) by an individual who is a member of the American Academy of Actuaries;
- (B) using generally accepted actuarial principles and methodologies;
- (C) using a standardized set of utilization and price factors;
- (D) using a standardized population that is representative of the population involved;
- (E) applying the same principles and factors in comparing the value of different coverage (or categories of services);
- (F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- (G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this [title \[42 USCS §§ 1396 et seq.\]](#) that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(4) Coverage of rural health clinic and FQHC services. Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless--

(A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1905(a)(2) [\[42 USCS § 1396d\(a\)\(2\)\]](#); and

(B) payment for such services is made in accordance with the requirements of section 1902(bb) [\[42 USCS § 1396a\(bb\)\]](#).

(5) Minimum standards. Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act [\[42 USCS § 18022\(b\)\]](#).

(6) Mental health services parity.

(A) In general. In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a Medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act [\[42 USCS § 300gg-4\(a\)\]](#) in the same manner as such requirements apply to a group health plan.

(B) Deemed compliance. Coverage provided with respect to an individual described in section 1905(a)(4)(B) [\[42 USCS § 1396d\(a\)\(4\)\(B\)\]](#) and covered under the State plan under section 1902(a)(10)(A) [\[42 USCS § 1396a\(a\)\(10\)\(A\)\]](#) of the services described in section 1905(a)(4)(B) [\[42 USCS § 1396d\(a\)\(4\)\(B\)\]](#) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r) [\[42 USCS § 1396d\(r\)\]](#)) and provided in accordance with section 1902(a)(43) [\[42 USCS § 1396a\(a\)\(43\)\]](#), shall be deemed to satisfy the requirements of subparagraph (A).

(7) Coverage of family planning services and supplies. Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage

includes for any individual described in section 1905(a)(4)(C) [[42 USCS § 1396d\(a\)\(4\)\(C\)](#)], medical assistance for family planning services and supplies in accordance with such section.

²⁹ ACA Section 2303(a)(2).

³⁰ ACA Section 2303(a)(2).

³¹ ACA Section 2303(a)(2).

³² ACA Sections 2303(a)(2),(3).

³³ ACA Section 2303(b)(1).

³⁴ ACA Section 2303(b)(1).

³⁵ ACA Section 2303(b)(1).

³⁶ HCRA Section 1202(a)(1).